
**UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION**

In the Matter of

EVANSTON NORTHWESTERN HEALTHCARE CORP.

Docket No. 9315

**COMPLAINT COUNSEL'S PROPOSED FINDINGS
OF FACT, CONCLUSIONS OF LAW, AND ORDER**

(Public Version)

Volume I

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COMPLAINT COUNSEL'S PROPOSED FINDINGS
OF FACT, CONCLUSIONS OF LAW, AND ORDER

Pursuant to Rule 3.46 of the Commission's Rules of Practice and the Court's Order on Post Trial Briefs dated April 6, 2005, its Scheduling Order dated March 24, 2004, as amended, and its letter dated December 14, 2004, Complaint Counsel respectfully submit the following Proposed Findings of Fact, Conclusions of Law, and Order. We are filing separately our supporting Brief.

I. INTRODUCTION

1. Counts I and II of the Complaint allege that Evanston and Highland Park consummated a merger in violation of Section 7 of the Clayton Act. Count I alleges the violation using a structural analysis drawn from the Merger Guidelines,¹ but adapted to the facts of this case in which Complaint Counsel challenges a merger that has already taken place and for which pricing data is available. Count II alleges the violation based on direct evidence of competitive effects of the merger. (See CCFF 83).²
2. "Market power" is the ability of a firm to raise its prices above competitive levels. The term "competitive levels" means a long-term analysis to determine the price that would just allow a firm to break-even or earn "zero economic profit." (See CCFF 104).
3. The direct evidence of anticompetitive effects of the merger includes evidence of ENH's post-merger price increases (both absolute price increases and price increases relative to other hospitals in the Chicago area). (See, e.g., CCFF 373-745, 822-1337).
4. The direct evidence of anticompetitive effects of the merger includes party admissions. (See CCFF 1346-1461. See also CCFF 1462-1508).
5. The area adjacent to or contiguous to the three hospital campuses that make up ENH, Evanston Hospital, Highland Park Hospital and Glenbrook Hospital, has been termed a "triangle." (See CCFF 54).
6. The North Shore triangle includes the area inside the three points of the hospitals. There are only three hospitals in the triangle - Evanston, Glenbrook, and Highland Park. This constitutes a large geographic area with no hospital other than Evanston, Glenbrook and Highland Park. (See CCFF 55).
7. { [REDACTED] } (See CCFF 51, *in camera*).
8. The merger of Evanston and Highland Park was seen as an opportunity for the hospitals to "join forces and grow together rather than compete with each other." (See CCFF 71).
9. Health plans typically do not contract with all the hospitals in a given geographic area. They engage in selective contracting. Selective contracting is the process by which health

¹ U.S. Dept. of Justice & Federal Trade Commission, *Horizontal Merger Guidelines* (1992 rev'd 1997).

² "CCFF" refers to Complaint Counsel's Proposed Findings of Fact.

plans choose to contract with some, but not all, of the acute care hospitals in a geographic area. The health plan seeks to contract with a sufficient number of hospitals to form an attractive network to offer its potential buyers. At the same time the health plan seeks to contract with fewer than all the hospitals in an area in the hope that the hospitals with which it contracts will offer lower prices, permitting the health plan to keep the premiums or the price at which it sells its products low. (*See* CCFF 195-283).

10. Through the process of selective contracting, the health plan seeks to negotiate a lower price with the hospital while the hospital seeks to negotiate for a higher price. A bargain is struck between the two price objectives. The health plan will only include those hospitals in its provider network with which there is this sort of bargain over price. The ability of the health plan to exclude a hospital from its network is a powerful tool and defines each side's bargaining position. (*See* CCFF 196-197, 200).
11. Before the merger, if Evanston went into a negotiation with a health plan and asked for what the health plan thought was an extremely high, unreasonable price, that health plan could choose to include Highland Park and other hospitals in the provider network while excluding Evanston Hospital. (*See* CCFF 256). Pre-merger, if it was Highland Park that requested unreasonably high rates, the health plan could have turned instead to Evanston and other hospitals. (*See* CCFF 263).
12. After the merger, when ENH demanded a price that the health plan thought was unreasonably high, the alternative of excluding Evanston but including Highland Park and various other hospitals was no longer possible. The health plan would have to exclude both Evanston and Highland Park or neither hospital. (*See* CCFF 257).
13. Evanston and Highland Park were direct competitors before the merger. The merger eliminated the competition between the two competitors. (*See* CCFF 284-301).
14. Health plans were unable to exclude the post-merger ENH from their networks. (*See* CCFF 261-283).
15. Highland Park was already a good hospital before the merger. (*See* CCFF 2295-2352). Highland Park was considered by many as "one of the finest community hospitals in the country." (*See* CCFF 368).
16. Absent the merger, Highland Park would have remained a viable competitor. It could have continued as a stand-alone competitor without the merger, and it was an attractive candidate for other mergers. (*See* CCFF 302-372).
17. The pricing of ENH to health plans following the merger provides direct evidence of anticompetitive effects. (*See* CCFF 373-745, 822-1337).

18. ENH raised prices post-merger in various ways, including:
 - a. Moving health plans to one contract for all three ENH facilities, *i.e.*, the Evanston or Highland Park pre-merger contract, whichever had the higher rate. (See CCFF 822-847);
 - b. Adding a premium to the higher of the Evanston or Highland Park contract rates. (See CCFF 848-880);
 - c. Moving health plans from a fixed price contract to a discount off charges contract or to a contract that contained more discount off charges provisions than the pre-merger contract. (See CCFF 817-821);
 - d. Adopting in 2000 the higher of the Evanston or Highland Park chargemaster list price for the particular product or service. (See CCFF 881-903); and
 - e. Increasing the chargemaster rates in the years following the merger. (See CCFF 918-924, 942-951).
19. ENH increased its net revenues from health plans by a minimum of \$18 million annually due just to the 2000 managed care contract re-negotiations. (See CCFF 1329-1337).
20. This \$18 million in additional annualized net revenue includes only six named health plans (out of approximately 35-40 total ENH contracts) and some small PPO contracts. (See CCFF 1333). The \$18 million in additional annualized net revenue does not include:
 - a. Any additional revenue from other contracts, such as the January 2001 re-negotiated One Health contract. (See CCFF 1333);
 - b. Any additional annualized revenue achieved through the shifting of health plans to the higher (in terms of rates) of the Evanston or Highland Park pre-merger contracts. (See CCFF 1334, 822-847);
 - c. Any additional annualized revenue achieved through ENH's adoption in 2000 of the higher of the Evanston or Highland Park pre-merger chargemaster rates. (See CCFF 1335, 881-903); and
 - d. Any additional annualized revenue achieved through ENH's chargemaster increases in 2002 and later. (See CCFF 1336, 918-924, 942-951).

21. The first major chargemaster increase in 2002 raised ENH's net revenue by \$20 million to \$26 million annually. ENH was not concerned that health plans would switch to other hospitals due to the price increase. (See CCFF 942-954).
22. There is no dispute that ENH raised prices to health plans following the merger. (See CCFF 392-502).
23. There is also no dispute that, following the merger, ENH raised prices to health plans relative to other hospitals in the Chicago area. (See CCFF 503-579).
24. When hospitals increase their prices, health plans pass the price increases on to their customers. (See CCFF 1338-1345).
25. There was no significant quality improvement at Highland Park Hospital due to the merger. (See CCFF 2032-2443).
26. ENH did not negotiate price increases with health plans on the basis of quality improvements. (See CCFF 2470-2496). Indeed, virtually all of the alleged quality improvements occurred after health care contracts were re-negotiated. (See CCFF 2444-2469).
27. ENH'S non-profit status did not restrain its exercise of market power. (See CCFF 2497-2534).
28. Divestiture, the proposed remedy, is practicable and will restore competition. (See CCFF 2560-2566).

II. THE MERGING PARTIES

A. Evanston Northwestern Healthcare

29. Evanston Northwestern Healthcare ("ENH") is a non-profit corporation organized, existing and doing business under, and by virtue of, the laws of Illinois, with its office and principal place of business located at 1301 Central Street, Evanston, Illinois 60201. (Complaint, ¶ 4; Answer to Complaint, ¶ 4). Prior to merging with Lakeland Health Services in 2000 (CX 501), ENH was comprised of Evanston Hospital, Glenbrook Hospital, ENH Medical Group, ENH Research Institute and ENH Homecare Services. (CX 84 at 6). The Evanston Northwestern Healthcare name was adopted in 1997. (CX 681 at 1). (Generally, pre-merger ENH is referred to below as "Evanston" and post-merger ENH is referred to as "ENH").
30. Evanston's operating revenue in fiscal year 1998 was \$441 million. The corporation had an investment portfolio balance of \$700 million and \$400 million of long-term debt. (CX 84 at 16; RX 691 at ENH JH 007546).
31. According to a 1999 Evanston presentation to the board of directors, 51% of Evanston's revenue came from managed care, 34% from Medicare, 3% from Medicaid and 12% from other sources. (CX 84 at 8).
32. Evanston and Glenbrook Hospitals had a total of 596 licensed beds and 481 staffed beds in fiscal year 1998. There were 33,808 admissions and 152,820 patient days during this period. (CX 84 at 7, 16). Two 1999 Evanston strategic documents describe Evanston as having a medical staff of approximately 1,100 physicians serving both hospitals. (CX 84 at 7; CX 681 at 1).
33. Prior to the merger, Evanston offered some tertiary services. (Haas-Wilson, Tr. 2491). At the time of the merger, Evanston did not offer quaternary services. (See, e.g., Newton, Tr. 297, 299; Haas-Wilson, Tr. 2665). In the pre-merger period, Evanston offered obstetrical services, including a level III perinatal center (CX 84 at 8; Newton, Tr. 299; Spaeth, Tr. 2083); pediatric services (Spaeth, Tr. 2083); diagnostic services (CX 84 at 15); a skilled nursing facility (CX 84 at 15); psychiatric care (Newton, Tr. 299; Spaeth, Tr. 2088); neurosurgery (CX 84 at 8; Newton, Tr. 299); radiation therapy (Spaeth, Tr. 2083-84); cardiology services, including cardiac surgery (CX 681 at 2; CX 84 at 8); orthopedics (Neaman, Tr. 1292); Level I and Level II trauma centers (CX 84 at 8; CX 681 at 2); and the Kellogg Cancer Care Center (CX 84 at 8).
34. Evanston Hospital, which opened in 1891, is located in Evanston, Illinois. (CX 681 at 1; CX 84 at 7). [REDACTED]

[REDACTED] } (Ballengee, Tr. 159; RX 2015 at ENHL MO 003489. See also Holt-Darcy, Tr. 1506-07, *in camera*). Evanston 1999 strategic documents reference the hospital's 452 licensed acute care beds and 32 skilled nursing facility beds. (CX 681 at 1; CX 84 at 6).

35. Glenbrook Hospital, located in Glenview, Illinois, is a community hospital that was developed and opened by Evanston Hospital in 1977. (CX 84 at 7; Neaman, Tr. 1286; Neaman, Tr. 1292; CX 681 at 1). { [REDACTED] } (Holt-Darcy, Tr. 1507, *in camera*). According to a 1999 document, Glenbrook had 144 licensed acute care beds, 19 of which were leased to Children's Memorial Hospital. (CX 681 at 2).

B. Lakeland Health Services

36. Lakeland Health Services, Inc. ("LHS", also referred to as Highland Park Hospital or "HPH"), the parent company of Highland Park Hospital prior to the merger, was a non-profit Illinois corporation with its principal place of business located at 718 Glenview Avenue, Highland Park, Illinois 60035. (CX 541 at 1). Before merging with Evanston, Lakeland Health Services was comprised of Highland Park Hospital, Highland Park Hospital Foundation and the for-profit Lakeland Health Ventures, Inc. (CX 84 at 11). LHS was incorporated in 1982 as a holding company. (CX 84 at 12).
37. Lakeland Health Service's operating revenue for fiscal year 1998 was \$101 million. The corporation had an investment portfolio balance of \$218 million and \$120 million of debt. (CX 84 at 16).
38. According to a 1999 document, 45% of LHS's revenue came from managed care, 41% from Medicare, 2% from Medicaid and 12% from other sources. (CX 84 at 13).
39. Highland Park Hospital, located in Highland Park, Illinois, first opened in 1918. (CX 1874 at 1; CX 84 at 12).
40. In fiscal year 1998, HPH had 188 staffed acute care beds and 28 skilled nursing facility beds. (CX 84 at 16, 11). There were 9,957 admissions and 41,311 patient days during this period. (CX 84 at 16). According to a 1999 document, the hospital had a medical staff of 562 physicians. (CX 84 at 12).
41. Prior to the merger, HPH offered obstetrical services, including a level II perinatal center (CX 84 at 13; Newton, Tr. 299); pediatric services (Spaeth, Tr. 2083); diagnostic services (CX 84 at 15); a skilled nursing facility (CX 84 at 15); a fertility center (CX 84 at 13); psychiatric care (Newton, Tr. 299; Spaeth, Tr. 2088); neurosurgery (Newton, Tr. 299); radiation therapy (Spaeth, Tr. 2083-84); cardiology services, including an adult cardiac

catherization lab (CX '84 at 13); an oncology program (CX 699 at 24; Spaeth, Tr. 2084); and a level II trauma center (CX 84 at 13).

42. Highland Park Hospital was a "strong community hospital" prior to the merger. (CX 852 at 5; CX 874 at 5; Spaeth, Tr. 2095). The quality of care at HPH until the merger with Evanston in 2000 was "very good, if not excellent." (Newton, Tr. 376). The hospital was well-respected in the community and considered by many to be one of the "finest community hospitals in the country." (Newton, Tr. 301).
43. Prior to the merger, HPH had a strong balance sheet with a significant amount of cash. (Noether, Tr. 6035; Kaufman, Tr. 5860).
44. The Highland Park Hospital Foundation was the philanthropic arm of Lakeland Health Services. (CX 84 at 11). "It was an entity that raised funds from the community . . . for reinvestment for philanthropic purposes back into Highland Park Hospital." (Newton, Tr. 283). On December 31, 1998, the Foundation had approximately \$67,000,000 in assets. (CX 628 at 4).
45. Lakeland Health Ventures were for-profit entities owned by Lakeland Health Services. These entities were: Lakeland Primary Care Associates, physician practice management services, real estate ventures and joint ventures, including a fitness center and a mail order pharmacy. (CX 681 at 3).

C. The North Shore

1. Location

46. The North Shore region of the Chicago area includes communities along Lake Michigan north of Chicago, starting at Evanston and extending to Highland Park and further north. The North Shore consists of communities starting at Evanston and encompassing Wilmette, Winnetka, Kenilworth, Highland Park, Lake Forest, Glencoe and other communities in the area. (Ballengee, Tr. 162-63; Holt-Darcy, Tr. 1425-1427; Mendonsa, Tr. 484-85 ("starting in Evanston, moving up to Wilmette, Winnetka, Kenilworth, Highland Park, Glencoe, that kind of area.")).
47. A person traveling up the North Shore from Chicago "would stop at Evanston" first and then "Highland Park would be the next hospital." (Holt-Darcy, Tr. 1426). Evanston and Highland Park Hospitals compete for patients from people living in between the two communities. (Holt-Darcy, Tr. 1426; Neary, Tr. at 600-01; CX 1 at 3-5; CX 2 at 7).
48. The North Shore community viewed Evanston and Highland Park as competing hospitals where people on the North Shore could choose either to go north to one or south to the

other to receive the same services at the same level. (Ballengee, Tr. at 166, 170-171 (“competitive environment between the two hospitals”)).

49. The North Shore area also roughly corresponds to the Evanston-Highland Park Hospital Combined Core Service Area (“CCSA”), which includes the towns of Deerfield, Highland Park, Fort Sheridan, Highwood, Lake Forest, Glencoe, Northbrook, Glenview, Golf, Kenilworth, Techny, Wilmette, Winnetka, Evanston and Skokie. This area spans a densely populated suburban corridor that runs for about 15 miles north-south along the shore of lake Michigan, and extends roughly ten miles west of the Lake. (CX 348 at 2; CX 360 at 7; CX 359 at 16; CX 84 at 21).

2. Socio-Economic Demographics

50. { [REDACTED] } (Mendonsa, Tr. 516-17, *in camera*; Foucre, Tr. 901-02; Newton, Tr. at 360; Neary, Tr. 602).
51. { [REDACTED] } (Mendonsa, Tr. 517, *in camera*; Foucre, Tr. at 902; Newton, Tr. 360).
52. { [REDACTED] } (Newton, Tr. at 327, 352; Mendonsa, Tr. 516, *in camera*, Neary, Tr. at 602)
53. The Combined Core Service Area of Evanston and Highland Park, which roughly corresponds to the North Shore area, had a population of 363,000 at the time of the merger, with an average household income of \$122,975. (CX 360 at 12).

3. Other Hospitals

The Hospitals in the Triangle Area on the North Shore

54. The area adjacent to or contiguous to the three hospital campuses that make up ENH, Evanston Hospital, Highland Park Hospital and Glenbrook Hospital, has been termed a “triangle.” (Haas-Wilson, Tr. 2452; 2667; Newton, Tr. 351-52; Foucre, Tr. 901-903; Ballengee, Tr. 168; Holt-Darcy, Tr. 1425-1427).
55. The North Shore triangle is a contiguous area that includes the area inside the three points of the hospitals. There are only three hospitals in the triangle – Evanston, Glenbrook, and Highland Park. This constitutes a large geographic area with no hospital other than

Evanston, Glenbrook and Highland Park. (Haas-Wilson, Tr. 2452, 2667; Foucre, Tr. 902; Ballengee, Tr. 167-68, 184. *See also* Mendonsa, Tr. 543-44 ({}), *in camera*).

Hospitals Identified by Respondent's Documents Relating to the Merger

56. Some of the Respondent's documents defining the service area of Respondent hospitals are based on patient flow data. A geographic area that is identified on the basis of patient flow data will be larger than the actual geographic market of an acute care hospital, and will erroneously understate the market shares of the merging hospitals. (Elzinga, Tr. 2393-94). These documents show that there was a substantial competitive overlap between Evanston and Highland Park before the merger and few other strong competitors. (*See, e.g.*, CX 84; CX 1876; CX 359). This close competitive overlap between Evanston and Highland Park was clear to health plans, too. (Ballengee, Tr. 156, 162; Neary, Tr. 600-01).
57. Reports produced for the Evanston and Highland Park boards in 1999, as part of the merger process, highlighted the competitive overlap between Highland Park and Evanston. Internal presentations showed that ENH (44%) and Highland Park (11%) together comprised a 55% share of the combined core service area of the two hospitals. (CX 84 at 21 (Evanston Northwestern Healthcare and Lakeland Services Proposed Merger, Presentation to the Board of Directors, June 25, 1999); CX 1876 at 18 (Lakeland Health Services, Inc. and Evanston Northwestern Healthcare: Proposed Merger, Presentation to the Board of Directors, Lakeland Health Services, Inc., June 28, 1999); CX 359 at 16 (Evanston Northwestern Healthcare and Lakeland Services Proposed Merger, Presentation to the Executive Committee, April 14, 1999). (Hillebrand, Tr. 1792-94).
58. Reports produced for the Evanston and Highland Park boards in 1999, as part of the merger process, downplayed the competitive importance of other hospitals in the North Shore and beyond. The only hospitals besides Evanston, Glenbrook and Highland Park that Evanston specifically identified as having a share in the Combined Core Service Area were: Rush North Shore (14%), Lutheran General (7%), St. Francis (7%), and Lake Forest (3%). (CX 84 at 21 (Evanston Northwestern Healthcare and Lakeland Services Proposed Merger, Presentation to the Board of Directors, June 25, 1999); CX 1876 at 18 (Lakeland Health Services, Inc. and Evanston Northwestern Healthcare: Proposed Merger, Presentation to the Board of Directors, Lakeland Health Services, Inc., June 28, 1999); CX 359 at 16 (Evanston Northwestern Healthcare and Lakeland Services Proposed Merger, Presentation to the Executive Committee, April 14, 1999)). ENH Executives also told PHCS³ that excluding from the network St. Francis, Rush North Shore, and Condell

³ "PHCS" refers to Private Healthcare Systems.

would not justify a lower rate because those hospitals were not viewed by ENH as significant competitors. (Ballengee, Tr. at 181-82).

59. Evanston's December 7, 1999, Presentation to Standard and Poor's, Strategic and Capital Structure Review, identified few hospitals by name as competitors. It refers to the Combined Core Service Area of Evanston and Highland Park as the "Service Area and Competition." Besides the three merging hospitals, Evanston's presentation to Standard and Poors identifies the market share of only Rush North Shore (14%), Lutheran General (7%), St. Francis (7%), and Lake Forest (3%) within Evanston's Combined Core Service Area with Highland Park. (RX 704 at ENH HL 001631).
60. Before the merger, in Evanston and Highland Park's overall service area consisting of 50 zip codes, typically the only other individual hospitals Evanston showed with specific shares (beyond those stated in the CCSA) were Condell and Northwest Community. (CX 84 at 25 (Evanston Northwestern Healthcare and Lakeland Services Proposed Merger, Presentation to the Board of Directors, June 25, 1999); CX 1876 at 15 (Lakeland Health Services, Inc. and Evanston Northwestern Healthcare: Proposed Merger, Presentation to the Board of Directors, Lakeland Health Services, Inc., June 28, 1999; RX 704 at ENH HL 001632).
61. Before the merger, Highland Park regarded Evanston, Lake Forest, Condell, and Rush North Shore as competing hospitals. (Newton, Tr. 406-07; Spaeth, Tr. 2088, 2127, 2139-40, 2107, 2157, 2163)

Hospitals Identified by the Respondent's Management Documents After the Merger

62. After the merger, for ENH's overall 50 zip code service area (which is larger than the CCSA), ENH's "Market Dashboard" listed as "Top Competitors" only Lutheran, Northwest Community, Condell, St. Francis and Swedish Covenant. (RX 1430 at ENHE F16 00 6171 (2003 FY); RX 1300 at ENH MN003108-09 (FY 02); CX 350 at 2 (2002)).
63. In a 2002 report, there were just six hospitals with a 5% or greater share in ENH's 50 zip code area. These hospitals were: Lutheran General with 9.1%, Northwest Community Hospital with 7.1%, Condell Medical Center with 5.7%, St Francis with 5.6%, Swedish Covenant with 5.3%, and Rush North Shore with 5.0%. (RX 1361 at ENHE DL 006610-11).
64. In a September 2002 ENH management committee discussion document, "Positioning for Growth," ENH listed the specific shares within its 50 zip code area of only the following hospitals: Lutheran General (9.5%), Northwest Community (7.1%), Condell (5.7%), Swedish Covenant (5.3%), Rush North Shore (4.9%), St. Francis (4.9%), Northwestern Memorial Hospital (3.9%) and Lake Forest Hospital (2.9%). (RX 1331 at ENHE DL 011877, at 83).

65. Most of the hospitals that draw patients from ENH's overall service area have no significant market presence on the North Shore. For example, in 2002, there were 24 hospitals that had less than a 5% market share in ENH's 50 zip code service area. Twenty of these hospitals had less than a 3% market share. (RX 1361 at ENHE DL 011883).

66. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Neaman, Tr. 1303, Foucre, Tr. 933-34; RX 1503, *in camera*).

Downtown Teaching Hospitals Considered a Separate Group by ENH

67. Before the merger, in communications with board members, Evanston and Highland Park did not identify specific downtown hospitals as competitors. For example, reports produced for the Evanston and Highland Park Boards in 1999 as part of the merger process aggregated all the downtown teaching hospitals as a single entry with a 7% market share in the Combined Core Service Areas of the hospital and 4.7% market share in the overall service areas of the two hospitals. (CX 84 at 21, 25 (Evanston Northwestern Healthcare and Lakeland Services Proposed Merger, Presentation to the Board of Directors, June 25, 1999); CX 1876 at 18, 15 (Lakeland Health Services, Inc. and Evanston Northwestern Healthcare: Proposed Merger, Presentation to the Board of Directors, Lakeland Health Services, Inc., June 28, 1999).

68. Before the merger, in communications with Standard and Poors, Evanston lumped all the downtown teaching hospitals together with a 7% market share in the Combined Core Service Areas of the two hospitals and a 4.7% market share in the overall service area. (RX 704 at ENH HL 001631-32).

III. THE MERGER

69. On more than one occasion, Evanston and Highland Park considered merging. For example, there were some "pre-merger discussions" in May 1997. (Spaeth, Tr. 2202). A merger was one of several strategies Mr. Spaeth and Mr. Neaman considered in order for the two hospitals to "align" themselves. (Spaeth, Tr. 2202-03; CX 1861 at 1-2).
70. The merger discussions that resulted in the actual merger started in late 1998 or early 1999. (CX 1 at 2; CX 2 at 7).
71. This merger was seen as an opportunity for the hospitals to "join forces and grow together rather than compete with each other." (CX 2 at 7)
72. The merging parties, including Evanston Northwestern Healthcare, Lakeland Health Services, and Highland Park Hospital, signed a letter of intent to merge effective July 1, 1999. (Neaman, Tr. 1328; RX 567 at ENH MN 001365).
73. The merger agreement was finalized on October 29, 1999. (CX 501 at 16).
74. Kaufman, a consultant hired by Highland Park Hospital, estimated the value of Highland Park around the time of the merger to be approximately \$272 million. This figure includes \$100 million in capital avoidance and accounts for \$120 million in long-term debt. (CX 1875 at 1).
75. In April 1999, Evanston and Highland Park signed an agreement to develop a cardiac surgery program at Highland Park Hospital. (Rosengart, Tr. 4527-30; CX 2094). In November 1999, the state approved a certificate of need for an open heart surgery program at Evanston and Highland Park. (Newton, Tr. 423).
76. Deloitte, a consultant hired by Evanston Northwestern Healthcare, stated in May of 1999 that an external buyer might purchase Lakeland Health Services for \$70-94 million. Deloitte also stated that "When added to their investment fund (after retiring long-term debt) the result is \$162-\$186 million in proceeds." (RX 536 at ENH HJ 000323).
77. In the fall of 1999, executives of Evanston and Highland Park met with Bain and developed a pricing strategy linked to the merger of Evanston and Highland Park. During these pre-merger meetings, the Evanston and Highland Park executives and consultants from Bain exchanged pricing information and discussed how to leverage the merger of the two hospitals to obtain higher rates and convert fixed rate contracts to discount off charges. (See CCF 1497-1504, 1509-1530).

78. In the merger agreement, the parties agreed that Lakeland Health Services and Highland Park Hospital would be merged into Evanston Northwestern Healthcare (CX 501 at 17) and that Lakeland Health Services and Highland Park Hospital would no longer exist as separate corporations. (CX 501 at 17).
79. The merger was consummated on January 1, 2000. (*See, e.g.*, CX 501 at 17).

IV. PROCEDURAL HISTORY

A. Investigation and Complaint

1. Investigation

80. ENH was first notified of the Federal Trade Commission investigation in a letter dated November 6, 2001. The letter was addressed to Mark Neaman, President and Chief Executive Officer of ENH, from Attorney Oscar Voss of the FTC. (Neaman, Tr. 1269; CX 20 at 1).
81. The pre-Complaint investigation period ended with the issuance of the Complaint on February 10, 2004, in the matter of Evanston Northwestern Healthcare Corporation, *et al.* (Complaint, February 10, 2004). Respondents answered the Complaint in a filing dated March 17, 2004. (Respondents' Answer to Complaint, March 17, 2004). Subsequent to their initial filing, Respondents amended their answer to the Complaint on July 12, 2004. (See Respondents' First Amended Answer, July 12, 2004). Respondents amended their answer again in January 2005. (See Respondents' Second Amended Answer, January 11, 2005).
82. Discovery during the post-Complaint investigation included subpoenas for depositions, subpoenas for documents, requests for admissions and interrogatories. The FTC requested and obtained pertinent information and documents from Respondents. (See, e.g., CX 5940 at 1-46; Complaint Counsel's First Request for Production of Documents Issued to Evanston Northwestern Healthcare, February 24, 2004). Information and documents were also sought by Respondents and turned over by the FTC. (See, e.g., Respondent Evanston Northwestern Healthcare Corporation's First Request For Production of Documents, April 23, 2004). In addition, the post-Complaint discovery necessitated the production of information and documents from third parties, such as hospitals and health plans. (See, e.g., CX 5910 at 1-28).

2. Counts of the Complaint

83. Both Counts I and II of the Complaint allege that Evanston and Highland Park consummated a merger in violation of Section 7 of the Clayton Act. Count I alleges the violation using a structural analysis drawn from the Merger Guidelines, but adapted to the facts of this case in which Complaint Counsel challenges a merger that has already taken place and for which pricing data is available. (Complaint ¶ 16-18). Count II alleges the violation based on direct evidence of competitive effects of the merger, which gave ENH market power. (Complaint ¶ 28-31) Count III concerns physician price fixing, and on April 5, 2005, the Commission issued a non-final consent order regarding that count for

public comment. (Complaint ¶¶33-44). *Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc.*, Docket No. 9315, April 5, 2005.

a. **Count I**

84. Count I of the complaint discusses the relevant product market, geographic market, and market concentration HHIs. It alleges that the the merger resulted in a post-merger HHI increase in excess of 500 points to a level exceeding 3000 points. Based largely on market shares and concentration figures, Count I concludes that the merger was anticompetitive and lessened competition. (Complaint ¶¶ 16-18).

The Market Structure Analysis in Count I is Based on the Merger Guidelines Approach

85. The Merger Guidelines poses the following question to define the relevant product market:

If, in response to the price increase, the reduction in sales of the product would be large enough that a hypothetical monopolist would not find it profitable to impose such an increase in price, then the Agency will add to the product group the product that is the next-best substitute for the merging firm's product The price increase question is then asked for a hypothetical monopolist controlling the expanded product group. This process will continue until a group of products is identified such that a hypothetical monopolist over that group of products would profitably impose at least a "small but significant and nontransitory" increase in price ["SSNIP"], including the price of a product of one of the merging firms.

(Section 1.11 of the 1992 Merger Guidelines). There is a comparable question for defining the relevant geographic market (Section 1.21 of the Merger Guidelines).

86. Under the Merger Guidelines approach, once a market has been defined under the SSNIP test, the market shares of the merging firms are used to predict whether a proposed merger might be anticompetitive. In most merger cases, because the merger under analysis has not yet been consummated, the Merger Guidelines approach, including the market definition, is a predictive or inferential exercise, with no post-merger evidence to examine. (Elzinga, Tr. 2360).
87. Based on the principles laid out in the Merger Guidelines, and applying the hypothetical monopolist test, the product market is general acute care inpatient services, including primary, secondary and tertiary services, because ENH successfully over the long term raised the prices of that product. (Haas-Wilson, Tr. 2666-67; *see generally*, Neaman Tr. 1210-11; Hillebrand, Tr. 1756; Spaeth Tr. 2083-88; Holt-Darcy, Tr. 1422-23).
88. Based on the principles of the Merger Guidelines, and, in particular, the hypothetical monopolist test, the relevant geographic market in this case includes the area contiguous

to the three hospitals of ENH, which includes the campuses of Highland Park, Evanston and Glenbrook Hospitals, because ENH successfully raised its prices in a significant way over the long term and customers did not turn to alternative sellers located outside of the geographic area. (Haas-Wilson, Tr. 2452, 2667). This is a roughly triangular area. (Newton, Tr. 351-52; Chan, Tr. 939-40; Foucre, Tr. 901-903; Ballengee, Tr. 168; Holt-Darcy, Tr. 1425-1427)

89. The only hospitals in the relevant geographic market are the three ENH Hospitals. (Haas-Wilson, Tr. 2452, 2667). Accordingly, the post-merger HHIs in this market would be 10,000, "which is 100 squared, if you had a single monopolist in the market." (Noether, Tr. 5963).

90. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }
(Noether, Tr. 5928, 5939; RX 1912 at 57, *in camera*). Dr. Noether acknowledged that the post-merger HHIs are at what the Merger Guidelines terms the highly concentrated level "over 1900, increasing by about 300 from pre-merger levels" (Noether Tr, at 5963).

b. Count II

Determining Competitive Effects of the Merger Through Direct Evidence

91. Count II alleges that the merger is anticompetitive because it resulted in anticompetitive price increases. (Complaint ¶ 28-31).

92. For purposes of Count II, direct evidence of anticompetitive effects demonstrates the existence of market power. (Elzinga, Tr. 2355, 2363; Haas-Wilson, Tr. 2482).

93. After a merger has been consummated, an economist can rely on direct evidence such as price behavior in the marketplace after the merger was consummated, evidence from the merging parties themselves after the merger took place, (*i.e.*, how they assessed the merger), and the assessment of the consequences of the merger by people who buy in the marketplace, rather than inferential data based on market definition and share. (Elzinga, Tr. 2362; Haas-Wilson, Tr. 2468).

94. Dr. Haas-Wilson used a list of potential explanations to guide her analysis of how to design the empirical model that she used to evaluate her "testable hypotheses." Her methodology was designed to test specifically which of the potential explanations derived from economic theory "can or cannot explain the price increase." (Haas-Wilson, Tr. 2481).

95. If one eliminates the hypothesis that post-merger evidence of price increases is due to benign market forces, such as increases in market demand or increases in costs in the market, then the post-merger evidence of price increases is explicable by the market power that the two firms have in combination that they may not have had when they were independent centers of initiative in the marketplace. (Elzinga, Tr. 2365; Haas-Wilson, Tr. 2467; 2480-81).
96. Where there is direct evidence of anticompetitive effects of a merger proved through empirical study, there is no need to engage in the full process outlined in the Merger Guidelines for investigations where the merger has not yet occurred. (Haas-Wilson, Tr. 2468; Elzinga, Tr. 2355, 2362-63).
97. Where an analyst has persuasive post-merger evidence about the consequences of a merger, it is not necessary to define a relevant product or geographic market. If one has direct evidence that a merger is anticompetitive, one would rely on that direct evidence of anticompetitive effects rather than rely on the inferential evidence based on market definition and share. (Elzinga, Tr. 2355, 2363).

Count II Identifies Direct Evidence of Anticompetitive Effects Related to the Merger

98. Dr. Haas-Wilson, complaint counsel's economic expert, applied economic theory to systematically identify a number of potential explanations for the price increase at ENH after the merger. (Haas-Wilson, Tr. 2480).
99. Using economic theory, Dr. Haas-Wilson made a list of ten potential explanations for the "large, post-merger price increase at ENH," a list which is reflected in DX 7024. (Haas-Wilson, Tr. 2480-81).
100. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2734, *in camera*).
101. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 3 at 1; CX 1879 at 3-4; CX 1 at 3; CX 2 at 7; CX 4 at 1,2, 9; CX 1566 at 9; Neaman, Tr. 1138, *in camera*); { [REDACTED]
[REDACTED] } (CX 5 at 5; CX 6 at 7; CX 2070 at 3;

CX 12 at 2; CX 13 at 1; CX 16 at 1; and CX 17 at 2), { [REDACTED] } (CX 1099, *in camera*; CX 1519 at 1-2, *in camera*; CX 30 at 1; CX 23 at 2; CX 24 at 2; CX 26 at 1; CX 25 at 9; CX 31 at 1).

102. In addition to the empirical research of Dr. Haas-Wilson and the numerous documents illustrating ENH's exercise of market power, there is significant testimony from present and former executives of the merging parties that is consistent with a finding that the merger created market power. (Neaman, Tr. 1036, 39, 1200, 1202-04, 1207-09, 1211-12; Hillebrand, Tr. 1705, 1709-10, 1711-13, 1718-22, 1751, 1754-55, 1757-58, 1764, 1811-17, 2036; Spaeth, Tr. 2210-11; Newton, Tr. at 351-52, 354, 359-62, 363-65, 366-67; Chan, Tr. 694-97, 703-06, 709-10, 834, 839-41, 844-45).
103. Thus, the January 1, 2000, merger between Evanston Hospital and Highland Park Hospital enhanced the market power of ENH, and, after that merger, "the merged entity exercised market power." (Haas-Wilson, Tr. 2451).
104. "Market power" is the ability of a firm to raise its prices above competitive levels. The term "competitive levels" means a long-term analysis to determine the price that would just allow a firm to break-even or earn "zero economic profit." (Haas-Wilson, Tr. 2451):

c. Count III and the Count III Settlement

105. Count 3 relates to physician price fixing by the ENH Medical Group and Highland Park physicians. The Commission accepted the settlement of Count III for public comment on April 5, 2005. (*Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc.*, Docket No. 9315, April 5, 2005, <http://www.ftc.gov/opa/2005/04/050405evanston.htm>).

B. The Hearing

1. Schedule

106. The hearing began in Washington, D.C., on February 10, 2005. The last witness testified on April 7, 2005. (Tr. 1-6372).
107. The total number of hearing days as of May 1, 2005, was 29. (Tr. 1-6372).

2. Witnesses

108. Complaint Counsel called sixteen witnesses. These witnesses included health plans, present and former employees of Evanston and Highland Park, and an employee of the

state of Illinois. Complaint Counsel also called four experts, three in the field of economics and one in the field of quality of care. (Tr. 1-6372).

109. Respondent called nineteen witnesses. These witnesses included ENH employees such as nurses, physicians, and administrators, as well as two of ENH's consultants and the mayor of Highland Park. Respondent also called three experts, two in the field of economics and one in the field of quality of care. Respondent did not call any health plans or other customers as witnesses. (Tr. 1-6372).

3. Exhibits

110. Complaint Counsel introduced into evidence approximately 880 exhibits (referred to as CXs). (JX 1; Tr. 1-6372).
111. Respondent introduced into evidence approximately 700 exhibits (referred to as RXs). (JX 1; JX 2; Tr. 1-6372).
112. Exhibits from both Respondent and Complaint Counsel were admitted during court room proceedings and through several joint exhibits (referred to as JXs). There are seven JXs, which are marked as JX 1 to JX 7. However, JX 4 was replaced by JX 7. (JX 7).
113. The CX and RX exhibits consist mainly of documents from the Respondent's files. The remaining documents were for the most part obtained from third parties. (*See, e.g.*, JX 1).

V. INTERSTATE COMMERCE

114. At all times relevant to the Complaint, Respondent, which is located in Evanston, Illinois, was and is engaged in interstate commerce and activities affecting interstate commerce in the delivery of health care services (as the parties have stipulated). (Stipulation Regarding Interstate Commerce, 8/30/04).
115. Respondent received combined payments for the delivery of health care services well in excess of \$10 million in each year from 1999 through 2003 from the following companies and/or their subsidiaries:
- a. Aetna, with its corporate headquarters in Hartford, Connecticut.
 - b. Cigna, with its corporate headquarters in Philadelphia, Pennsylvania.
 - c. Humana, with its corporate headquarters in Louisville, Kentucky.
 - d. United, with its corporate headquarters in Minneapolis, Minnesota.
 - e. Private Healthcare Systems, with its corporate headquarters in Waltham, Massachusetts.
 - f. Great-West, with its corporate headquarters located in Greenwood Village, Colorado.
 - g. Preferred Plan, with its corporate headquarters located in Stow, Ohio.
- (Stipulation Regarding Interstate Commerce, 8/30/04).
116. "At all times relevant to the Complaint, Respondent ENH and the ENH Faculty Practice Associates (the ENH-employed physician group), have received and continue to receive in the aggregate significant payments from the federal Medicare Program, 42 U.S.C. §§ 1395 *et seq.*, and the federal/state Medicaid program, 42 U.S.C. §§ 1396 *et seq.*" (Stipulation Regarding Interstate Commerce, 8/30/04).
117. "At all times relevant to the Complaint, ENH, through its operations at Evanston Hospital, Glenbrook Hospital, and Highland Park Hospital, has engaged and continues to engage in commerce and in activities affecting commerce, as the term 'commerce' is defined by Section 1 of the Clayton Act. 15 U.S.C. § 12" (as the parties have stipulated). (Stipulation Regarding Interstate Commerce, 8/30/04).

VI. HEALTH CARE INDUSTRY BACKGROUND

A. Qualifications of Deborah Haas-Wilson

118. Complaint Counsel's expert witness, Dr. Deborah-Haas Wilson, provided, among other trial testimony, her expert opinion on the background of the health care industry and the dynamics of competition within the marketplace. (Haas-Wilson, Tr. 2453-67).
119. Dr. Haas-Wilson is a professor of economics at Smith College. She received her Bachelor Degree from the University of Michigan in Ann Arbor in economics, and she received a Ph.D. in economics from the University of California at Berkeley. Her fields of specialization for her Ph.D. were applied microeconomics with an emphasis in industrial organization and public finance. Dr. Haas Wilson's dissertation for her Ph.D. was a theoretical and empirical analysis of the effect of commercial practice restrictions in the market for ophthalmic goods and services. (Haas-Wilson, Tr. 2433-34).
120. Dr. Haas-Wilson has published articles in professional journals, including the Journal of Law and Economics, the Review of Economics and Statistics, the Journal of Health Economics, Journal of Economic Perspective, Journal of Political Economics, and Health Services Research. (Haas-Wilson Tr. 2435-37).
121. She is a full professor at Smith and has taught courses in introductory microeconomics, industrial organization and antitrust policy, a seminar in regulation and deregulation of industry, and a senior seminar in Smith's public policy program. (Haas-Wilson, Tr. 2435).
122. Dr. Haas-Wilson wrote a book titled *Managed Care and Monopoly Power: The Antitrust Challenge*, which was funded by the Robert Wood Johnson Foundation. It was published by Harvard University Press in 2003. (Haas-Wilson, Tr. 2436-38 (referring to DX 7052)).
123. Dr. Haas-Wilson's book, *Managed Care and Monopoly Power: The Antitrust Challenge*, is "a synthesis about what is known, particularly from an economic perspective, about application of the antitrust laws in markets for healthcare services; in particular markets for hospital services, physician services and healthcare financing." (Haas-Wilson, Tr. 2438).
124. Dr. Haas-Wilson spent four years as a member of one of the research study sections at the Agency for Healthcare Policy and Research. That is the study section that reviews applications that come in to the federal government for federal funding of research. (Haas-Wilson, Tr. 2438).

125. Dr. Haas-Wilson currently serves as an advisory member to the Petris Center on Healthcare Markets at the University of California, Berkeley. (Haas-Wilson, Tr. 2438).
126. Dr. Haas-Wilson is a peer reviewer for several economic journals. (Haas-Wilson, Tr. 2438).

B. Relationships Between Employee, Employer, Health Plan and Hospital

127. In order to understand the competitive dynamics of healthcare markets, it is necessary to understand the institutional relationships in healthcare. These markets are distinguishable from other markets in the United States economy. (Haas-Wilson, Tr. 2453).
128. There are four different institutional relationships relevant to understanding the competitive dynamics of hospital services. These institutional relationships are between: (1) hospitals and managed care organizations (health plans); (2) managed care organizations and employers; (3) employers and employees; and (4) employees and hospitals. (Haas-Wilson, Tr. 2456, 2460-61, 2462-64 (discussing DX 7026)).
129. The first institutional relationship related to competition for hospital services is the institutional relationship between hospitals and health plans. This relationship is referred to as "first-stage" competition in the economics literature. (Haas-Wilson, Tr. 2456)
130. The first institutional relationship between hospitals and health plans is particularly important because it is through this relationship that hospital prices are determined. (Haas-Wilson, Tr. 2456). Hospitals sell their services to health plans, and the health plans should be thought of as the consumer in this first-stage competition. (Haas-Wilson, Tr. 2456-2457; Noether, Tr. 5906).
131. The health plan puts together its network of health care providers by choosing which hospitals will be included in its different plans' networks, as well as which physician organizations and which other ancillary healthcare providers will be included in the provider networks that are offered as part of the health plan. (Haas-Wilson, Tr. 2456-57).
132. There are generically three types of hospitals: community, tertiary, and advanced teaching. Community has the basic services such as delivering babies and surgical procedures. Tertiary facilities offer more complex services (as well as basic services). Advanced teaching facilities offer the highest level services, including transplants, burn centers and hyperbaric centers. (Ballengee, Tr. 158-59).
133. All hospitals, including tertiary facilities, "offer a core of basic services," *i.e.*, a tertiary hospital offers more complex services as well as the basic services of a community hospital. (Noether, Tr. 6159-60).

134. The second institutional relationship related to competition for hospital services is the institutional relationship between the health plans and employers. Health plans sell their product, such as HMO and PPO products, to prospective buyers or employers. In the employment-based healthcare insurance system found in the United States, the employer selects which products of health plans to offer as a fringe benefit to employees. (Haas-Wilson, Tr. 2460-61 (discussing DX 7026)).
135. Viewed from the standpoint of this second institutional relationship, health plans compete with each other to offer provider networks that are both more attractive to employees and that have a low "premium" or price. (Haas-Wilson, Tr. 2461).
136. Consumers prefer a broader choice of hospitals in a health plan, and all products have financial incentives for the enrollee to use hospitals that are within the network. (Haas-Wilson, Tr. 2461).
137. All health plan products have financial incentives to use within-network providers, although they vary in how "harsh" those incentives are. (Haas-Wilson, Tr. 2462).
138. There is a trade-off between broader networks and lower prices. Health plans with better networks tend to have higher prices, and health plans with worse networks have lower prices. (Haas-Wilson, Tr. 2462).
139. The third institutional relationship related to competition for hospital services is the institutional relationship between employers and their employees. Employers who choose to offer health insurance to their employees are offering this health insurance coverage as a form of compensation to their employees. Nevertheless, the employee still bears the cost of the health insurance because economic theory shows that the cost of that insurance is "shifted back" to the employee in the form of lower wages. (Haas-Wilson, Tr. 2463 (discussing DX 7026)).
140. The fourth institutional relationship related to competition for hospital services is the institutional relationship between employees and hospitals. When an employee covered under an employer-based health insurance plan needs hospitalization, the employee will, together with his or her physician, select the hospital from which to get care. Frequently, the employee, because of the financial incentive offered by the health plan, will choose a hospital in the network. (Haas-Wilson, Tr. 2463-64 (discussing DX 7026)).
141. Hospitals compete, although not on price, to attract patients who are covered by the health plans with which the hospital has contracts. (Haas-Wilson, Tr. 2464). This competition for patients after the hospital has entered into contracts with health plans is called "second stage competition." (Haas-Wilson, Tr. 2465).

142. The four institutional relationships related to competition for hospital services have changed over time as a result of the increasing prevalence of managed care. Prior to managed care, most people were covered by "indemnity-based" insurance. Under indemnity-based insurance, these four different institutional relationships would not have existed as is the case today under managed care competition. (Haas-Wilson, Tr. 2463-65).
143. Before, under indemnity insurance, the enrollee of the health plan generally had insurance coverage for all hospitals and physician organizations. Under indemnity insurance, the individual covered by insurance could select any hospital, and the insurance company would reimburse the individual for the cost of care according to the plan benefits. So, under indemnity insurance, the customer of the hospital would be the individual patient, in contrast to under managed care, where the health plan acts as the consumer in first-stage competition. (Haas-Wilson, Tr. 2465-66).
144. Under indemnity insurance, hospitals did not have to compete to be part of a network, so there was not the same kind of competition as there is under managed care. Because there was no competition for a place in the provider network under indemnity insurance, hospitals were not competing on price to get contracts with health insurance companies. (Haas-Wilson, Tr. 2466).

Hospital Price Increases Ultimately Borne By Consumers

145. Health plan representatives confirmed that employees ultimately bear the cost of higher health care prices. { [REDACTED] } (Ballengee, Tr. 239, *in camera*; Mendonsa, Tr. 483; Dorsey, Tr. 1450).
146. Unexpected price increases have "a direct impact on [a self-insured customer's] bottom line" and will adversely affect the profitability of the self-insured's business. (Mendonsa, Tr. 483).
147. The only choice a self-insured customer or large employer group has in the event of unforeseen increases in expenses is to pass on the costs to its employees. (Mendonsa, Tr. 483-4; Ballengee, Tr. 239)
148. { [REDACTED] } (Mendonsa, Tr. 549, *in camera*).

149. In its contract negotiation advice, Bain advised ENH that “PHCS’s PPO business is largely ‘cost pass through’” and that rate increases from ENH to PHCS “will not hit [PHCS’s] margins directly.” (CX 67 at 39).
150. In response to ENH’s rate increases to PHCS in 2000, PHCS’s customers “had to raise their rates significantly in – the premiums to accommodate the increased rates at Evanston.” (Ballengee, Tr. 196-97).
151. “The big impact” of health plans passing on large increases to their smaller business customers is “small insureds dropping coverage altogether and people not having insurance.” (Meñdónsa, Tr. 483-4).

C. Government Payment System Versus Commercial Insurance Versus Uninsured

152. In the United States, the majority of people with private health insurance have their health insurance purchased through their employer. Not everyone is covered by employer-based healthcare insurance. There is a large sector of public health insurance, including the Medicare and Medicaid programs. (Haas-Wilson, Tr. 2454).
153. For both ENH and Highland Park, the major components of their revenue were Medicare and commercial health plans. Medicaid and the uninsured comprised a very small segment of their revenue. (Newton, Tr. 301; Neaman, Tr. 1312).

1. Differences and Similarities Among the Three Payment Systems

Government Payment System (Including Medicare, Medicaid, and State Programs)

154. Public health insurance programs cover a portion of patients who are not covered through employer-based health insurance. (Haas-Wilson, Tr. 2454).
155. Medicare and Medicaid are primary components of the public health insurance sector. (Haas-Wilson, Tr. 2454).
156. The Medicare program “is a federal health insurance program that provides health insurance for the elderly and those individuals suffering from . . . kidney failure and needing renal dialysis.” (Haas-Wilson, Tr. 2454).
157. The Medicaid program is “a joint federal/state program” under which “individuals of low income receive health insurance coverage.” (Haas-Wilson, Tr. 2454).
158. Medicare and Medicaid accounted for about 40 to 45% of ENH’s gross revenue. (Neaman, Tr. 1312).

159. For pre-merger Highland Park, the Medicaid program was a “de minimis” element of revenues. Medicare comprised about 45% of Highland Park’s business and managed care another 45%. “[E]ssentially, the major payer mix was commercial and Medicare.” (Newton, Tr. 301).

Commercial Insurance: Managed Care and Other Programs

160. In the United States the majority of people with private health insurance have their health insurance purchased through their employer. (Haas-Wilson, Tr. 2454).
161. Traditional indemnity insurance was the dominant form of commercial reimbursement in the 1980s. Indemnity insurance was insurance “where benefits were given to subscribers. Prices weren’t negotiated with the insurer.” Instead, the insurance company would pay the benefit on behalf of the patient. (Hillebrand, Tr. 1831-32).
162. Managed care plans grew in importance, crowding out traditional indemnity insurance. Managed care became “the predominant form of commercial health insurance.” (Hillebrand, Tr. 1832).

Uninsured or Self Pay

163. Those people who do not have health insurance, either through public sector or commercial plans, are referred to as “uninsured.” (Haas-Wilson, Tr. 2454).
164. After Medicare, Medicaid and the top health plans, there remained for ENH approximately 10% of gross revenues that fall into a separate category. (Neaman, Tr. 1312).
165. Most of this 10% increment was charity care, although there were a small number of self-pay patients in that mix as well. (Neaman, Tr. 1312).
166. Self-pay patients were a very small component of pre-merger Highland Park’s business. (Newton, Tr. 301).

2. Hospital Prices Under the Three Payment Systems

Government Payment System

167. The prices in public health insurance programs are not determined by competitive market forces. The prices are determined by the government. (Haas-Wilson, Tr. 2455).

168. The federal government unilaterally sets the rates for Medicare reimbursements. There is no negotiation between providers and the federal government to establish reimbursement rates. (Neaman, Tr. 1317-18).
169. The Federal Medicare program pays a case rate on the basis of Diagnosis Related Group ("DRG"), which is "a grouping of inpatients into hundreds of separate categories based on their diagnoses and the procedures they undergo while hospitalized." (Amended Glossary of Terms at 9, April 22, 2005). The DRG is "a method of payment in which the reimbursement for inpatient hospital services is set based on the DRG into which a patient is classified. As a general rule, the amount of payment will not vary if the hospital renders significantly greater or less services in treating the patient than is the estimated average, or if the hospital incurs costs that are greater or less than the typical cost incurred by hospitals." (Amended Glossary of Terms at 9, April 22, 2005).

Commercial Insurance: Managed Care and Other Programs

170. { [REDACTED] } (See, e.g., Holt-Darcy, Tr. 1521, *in camera*; Ballengee, Tr. 229, *in camera*; Ballengee, Tr. 227, *in camera*).
171. { [REDACTED] } (See, e.g., Ballengee, Tr. 174-76 (describing PHCS negotiations with ENH); Mendonsa, Tr. 535-36, *in camera* ([REDACTED])); Dorsey, Tr. 1434-38 (describing One Health negotiations with ENH); Foucre, Tr. 886-87 (describing United negotiations with ENH); Holt-Darcy, Tr. 1503-04, *in camera* ({ [REDACTED] })).
172. Under the per diem reimbursement, the fixed rate per day is an all-inclusive amount for each day that the patient is in the hospital, regardless of the amount of services or the costs or charges for the services that actually must be rendered to that patient. (Amended Glossary of Terms at 9, April 22, 2005).
173. { [REDACTED] } (Ballengee, Tr. 229, *in camera*).
174. { [REDACTED] } (Spaeth, Tr. 2129-30; Holt Darcy 1537-39, *in camera*; Mendonsa 525, *in camera*)
175. A discount off charges contract is an arrangement by which health plans pay a percentage discount off of the hospital's chargemaster list price for each component of a service rendered. (Chan, Tr. 667; Amended Glossary of Terms at 6, April 22, 2005).

176. Charges are the published prices for services provided by a hospital. These rates are found in the hospital's "chargemaster," which reflects tens of thousands of predetermined itemized amounts (list prices) to be billed for each good or service the hospital provides. Each hospital maintains its own chargemaster. (Amended Glossary of Terms at 4, April 22, 2005; Neaman, Tr. 1349; Hillebrand, Tr. 1710; Chan, Tr. 674; H. Jones, Tr. 4143).

Uninsured or Self Pay

177. Uninsured patients generally are treated "as a matter of charity or treated at zero price." (Elzinga, Tr. 2401).
178. About 10% of ENH's gross revenue falls outside of commercial insurance and Medicare/Medicaid. Most of that 10% are patients who have no insurance and do not pay their bills. ENH writes these patients off as charity care. "Every once in a while, there's a few people that pay cash, not very often, but every once in a while, there is." (Neaman, Tr. 1312).
179. Self-pay patients pay for services based on the hospital's chargemaster, which are essentially list prices. (Porn, Tr. 5685).

D. Types of Commercial Health Plan Products

1. HMO

180. Traditionally, health maintenance organizations ("HMOs") are managed care plans that "contrac[t] with a limited number of hospitals, doctors, and other providers, and which specifies that an enrollee of the HMO will bear a significant portion of (and possibly, all) fees for services that he or she receives from a provider with which the HMO does not contract." (Amended Glossary of Terms at 7, April 22, 2005).
181. HMO products tend to have more narrow networks of hospitals than PPO products. (Haas-Wilson, Tr. 2460).
182. An HMO product is an "insured product, meaning that the insurance company takes the risk. For any utilization or healthcare dollars that are spent, the insurance company pays those dollars." (Neary, Tr. 585).
183. With HMO products, consumers are essentially "lock[ed]-in" to the network. If patients obtain services out of the network, they receive no benefit. (Mendonza, Tr. 477).

2. PPO

184. A preferred provider organization (“PPO”) is a managed care plan that “contracts with a group of hospitals, doctors, and other health care providers that usually is somewhat larger than the groups with which an HMO may contract.” Enrollees generally are offered a financial incentive to obtain care from preferred providers, but may use outside providers at additional cost. (Amended Glossary of Terms at 10, April 22, 2005).
185. PPO products tend to include more hospitals in their networks than do HMO products. (Haas-Wilson, Tr. 2460).
186. With PPO products, the health plan provides a higher in-network benefit. The health plan does provide benefits if a patient chooses to obtain services outside the network, but the benefits are relatively lower than if the patient remains in-network. (Mendonsa, Tr. 477-78).

3. Other Products Offered by Health Plans

187. A point of service plan (“POS”) is a managed care plan that “contracts with a limited number of hospitals, doctors, and other providers and extends terms of coverage to enrollees based on terms that will vary depending on the provider from which the enrollee seeks care.” (Amended Glossary of Terms at 10, April 22, 2005).
188. A point of service plan is a variation of the PPO. “A point of service product is one where the in-network benefit or the higher benefit is accessed if [a patient] utilize[s] a primary care physician as opposed to just in and out of network, but there is an out-of-network benefit in that product.” (Mendonsa, Tr. 479).
189. With POS products, like with PPO products, the companies “that contracted with the insurance company are responsible ultimately for the payment of [healthcare services].” (Neary, Tr. 586).
190. Managed care plans generally fall within the broad HMO, POS, and PPO categories. “Nevertheless, the different types of managed care plans are difficult to distinguish because, over time, the managed care organizations have modified each type of plan to incorporate different elements of the other plans that consumers demand.” (Amended Glossary of Terms at 8, April 22, 2005).

4. Self Insurance

191. {

[REDACTED]

[REDACTED] } (Haas-
Wilson, Tr. 2571, *in camera*).

VII. SELECTIVE CONTRACTING

A. Competition in the Health Care Marketplace

1. Differences Between First and Second Stage Competition

192. The first institutional relationship related to competition for hospital services is between hospitals and health plans. This relationship is referred to as “first-stage” competition in the economics literature, and it is particularly important because it is through this competitive dynamic that hospital prices are determined. (Haas-Wilson, Tr. 2456).
193. The institutional relationship between employees and hospitals is often referred to as “second-stage competition” in the economics literature. Second-stage competition is the competition among hospitals for patients based on non-price variables. (Haas-Wilson, Tr. 2463-65).
194. Hospitals compete for the employees’ business but not necessarily on price. Instead, hospitals compete on non-price variables. Where the employee has a fixed deductible or fixed co-pay, e.g., a co-pay of \$100 a day, the employee’s out-of-pocket costs will not vary by hospital. Consequently, at that point, hospitals do not really compete for patients on the basis of price. (Haas-Wilson, Tr. 2463-65).

2. The Process of Selective Contracting

195. Health plans typically do not contract with all the hospitals in a given geographic area. Instead, they engage in selective contracting – the process by which health plans negotiate with hospitals. A health plan seeks to put together an attractive network for potential buyers, while at the same time keeping premiums (i.e. the prices at which it sells its products) low. (Haas-Wilson, Tr. 2457).
196. Through the process of selective contracting, the health plan seeks to negotiate a lower price with the hospital while the hospital seeks to negotiate for a higher price. A bargain is struck between the two price objectives. (Haas-Wilson, Tr. 2457-58).
197. The health plan will only include those hospitals in its provider network with which there is this sort of bargain over price. (Haas-Wilson, Tr. 2457-58).

3. Relative Bargaining Power in the Selective Contracting Process

198. In first-stage competition, the relative bargaining positions of the hospital and the health plan determine to a large extent the outcome of the negotiation. (Haas-Wilson, Tr. 2469-70).

199. The bargaining position of the hospital and the health plan in first-stage competition depends on the alternatives available to each. (Haas-Wilson, Tr. 2470).
200. The ability of the health plan to exclude a hospital from its network is a powerful tool that defines each side's bargaining position. (Haas-Wilson, Tr. 2470; Noether, Tr. 6189).
201. When a health plan is putting together its provider network, if one hospital is asking for what appears to be a particularly high and unreasonable price, the health plan will look at its alternatives. (Haas-Wilson, Tr. 2470).
202. One alternative for the health plan in constructing a network is to exclude hospitals that ask for the particularly high and unreasonable price, and to include other hospitals as substitutes. (Haas-Wilson, Tr. 2470).
203. In constructing its network, the health plan can also choose to pay for the higher priced hospital, but the health plan would most likely only pay for the higher priced hospital when suitable alternatives do not exist. (Haas-Wilson, Tr. 2470).
204. Hospitals, on the other hand, evaluate how much business a particular health plan is bringing to that hospital. (Haas-Wilson, Tr. 2471).
205. If a particular health plan has a large volume of patients (enrollees) that would potentially utilize the hospital's services, the hospital's alternative of not being in the health plan's network is less attractive than where the health plan is small and has few enrollees who use that hospital. (Haas-Wilson, Tr. 2471).
206. Dr. Haas-Wilson relied on a paper by R. Town and G. Vistnes called "Hospital Competition in HMO Networks," which was published in the Journal of Health Economics in 2001. (Haas-Wilson, Tr. 2475).
207. Town and Vistnes wrote in their 2001 article that "... a hospital's bargaining position with a plan, and hence its price depend on the incremental value that hospital brings to the plan's network. A hospital's incremental value, in turn, is a function of the plan's opportunity cost of turning to its next-best alternative network that excludes the hospital. That opportunity cost depends importantly on how well the alternative network provides the scope of coverage the plan's enrollees want (in terms of both perceived quality and access)." (Haas-Wilson, Tr. 2475 (discussing DX 7048)).
208. Town and Vistnes wrote in their 2001 article that "the more important a hospital is to [a health plan's revenues] the greater the hospital's bargaining leverage (or equivalently, the higher the [health plan's] opportunity cost of dropping the hospital from its network), and

the higher the resultant negotiated hospital price.” (Haas-Wilson, Tr. 2475 (discussing DX 7048)).

4. Impact of Hospital Mergers on the Selective Contracting Dynamic

209. A merger that affects the availability of formerly independent hospitals to become part of an alternative network for a health plan can create market power by changing the next-best alternative network available to the managed care. (Haas-Wilson, Tr. 2476).
210. Because bargaining position is related to the development of alternative hospital networks by health plans, a change in market power may occur even if the two merged hospitals are not each other’s closest competitors in either the first or second-stage of competition. Thus, it is possible for the merger to change the market power available to the merged entity even if patients do not consider the two hospitals to be next-best alternatives to each other and health plans also do not consider them as next-best alternatives. (Haas-Wilson, Tr. 2476).

B. Health Plans’ Perspectives on Selective Contracting

1. The Bases for Competition Between Health Plans

211. Health plans compete on many factors, but the two most important factors are the attractiveness of the network and the price. (Haas-Wilson, Tr. 2461, *see* Noether, Tr. 5936 (“[Managed care organizations] are in the business of competing in part based on the provider networks that they put together.”), *see* Noether, Tr. 5948 (The health plan, “to be able to compete, has to have a network that is attractive to enrollees who are the ultimate patients.”)).
212. Consumers prefer a broader choice of hospitals in a health plan. (Haas-Wilson, Tr. 2461).
213. Every health plan offers financial incentives so that enrollees will use hospitals that are in the health plan’s network. (Haas-Wilson, Tr. 2461-62).
214. If the enrollee of a plan chooses to use a hospital that is outside of the health plan’s network of hospitals, there is a financial penalty (i.e. the enrollee will pay more to use an out-of-network hospital) that normally varies by plan. (Haas-Wilson, Tr. 2461-62).
215. Health plans also compete on price. (Haas-Wilson, Tr. 2461).
216. The price that health plans charge customers is called the insurance premium. (Haas-Wilson, Tr. 2461).

217. Health plans compete with each other to keep their premiums low. (Haas-Wilson, Tr. 2461).
218. The more expensive, higher premium plan is often the insurance plan with the better network, while a plan with a low premium is often the insurance plan with the worst network. (Haas-Wilson, Tr. 2462).

2. Health Plans' Criteria for Creating Hospital Networks

219. From the health plans' perspective, their criteria for placing and retaining a hospital in a network include price, reputation, services offered, and location. (See, e.g., Mendosa, Tr. 485 (discussing importance of location); Neary, Tr. 587 (discussing importance of competitive prices); Holt-Darcy, Tr. 1421 (discussing importance of licensing and accreditation); Dorsey, Tr. 1451 (discussing importance of offering appropriate level of care and services)).

PHCS

220. PHCS has 75 hospitals in its network in the Chicago area. (Ballengee, Tr. 154).
221. When PHCS weighs whether or not to exclude a hospital, it takes into account other hospitals. (Ballengee, Tr. 155-56).
222. "We're looking at comparability or some degree of parity of rates for the services that are being rendered." (Ballengee, Tr. 156).
223. PHCS's customers seek hospitals that "provide good services . . . have a breadth of services . . . and . . . have good accessibility to those services within their communities." (Ballengee, Tr. 152).
224. Prices charged by the hospitals are a factor because PHCS's customers "want to know that they're receiving cost-effective healthcare as well as having the access." (Ballengee, Tr. 153).
225. PHCS knows that the location of a hospital matters to its customers because "People do not like to drive by a local hospital and have to go to another hospital." (Ballengee, Tr. 184).

Aetna

226. Aetna had a network of about 88 hospitals in the Chicago area at the time of the merger. (Mendonsa, Tr. 484).

227. Network composition is “critically vital” to Aetna’s ability to market a network to employers. Aetna has to have the “discounts so [it] can have the right pricing,” and “the proper access to get the business.” (Mendonsa, Tr. 485, 491).

228. { [REDACTED] } (Mendonsa, Tr. 517, *in camera*).

229. { [REDACTED] } (Mendonsa, Tr. 516-17, *in camera*).

230. { [REDACTED] } (Mendonsa, Tr. 485; Mendonsa, Tr. 568, *in camera*. See Mendonsa, Tr. 543, ({ [REDACTED] })), *in camera*).

231. The importance of Aetna’s network composition to its business is also communicated to its stockholders in its SEC filings. (RX 1047 at 12; RX 1650 at 12). Stockholders are told that “the most significant factors which distinguish competing health plans” are “comprehensiveness of coverage, cost . . . the geographic scope of provider networks, and the providers available in such networks and managed care programs.” (RX 1047 at 12; RX 1650 at 12).

One Health

232. In late 1999, One Health contracted with “roughly 105 hospitals” in Illinois. (Dorsey, Tr. 1430).

233. In the development and maintenance of its networks, One Health looked for “price-competitive” hospitals that will give One Health’s employer groups “adequate coverage.” (Neary, Tr. 587).

234. Network coverage is adequate when “there [are] enough providers in our network” that allow employer groups to “access the physicians and hospitals that they want to access.” (Neary, Tr. 587).

235. One Health's network management regularly interfaced with its sales group so that it knows "if the network [is] adequate or if we need to grow the network" to make it marketable to new employer groups. (Dorsey, Tr. 1433-34).
236. The "only way" that One Health can "stay in business" is to provide "the right number of hospitals, the right level of care, [and] the right number of physicians" to its members. (Dorsey, Tr. 1451).
237. If One Health's network composition is inadequate, "No [hospital] membership, no employer groups, no premium. No premium, no need to continue with One Health Plan." (Dorsey, Tr. 1451).

Unicare

238. { [REDACTED] } (Holt-Darcy, Tr. 1583, 1526, *in camera*).
239. Unicare considers "geographic need, . . . marketing needs" and "access" when developing its network. (Holt-Darcy, Tr. 1420).
240. To ensure that Unicare has sufficient network access, the health plan evaluates its covered lives in a particular area, considers its marketing department's evaluation of need, and verifies that providers are conveniently located near members' places of residence or employment. (Holt-Darcy, Tr. 1420).
241. Providers in Unicare's network must also meet credentialing criteria for "licensure, JCAHO accreditation, [and] insurance qualifications." (Holt-Darcy, Tr. 1420-21).
242. JCAHO accreditation is "very" important to Unicare. (Holt-Darcy, Tr. 1421). In fact, Unicare "can't credential a hospital that's not JCAHO . . . accredited" because accreditation by the Joint Commission is "like a minimum standard." (Holt-Darcy, Tr. 1421).

United

243. There were approximately 98 hospitals in United's network at the end of 2002. (Foucre, Tr. 881).
244. For a health plan to market and sell a hospital network, the geographic location of the hospitals is important for two reasons: (1) a consumer's "primary decision-making factor in selecting a hospital is very often the location of the hospital and the distance they have to travel to seek services," and (2) ensuring an adequate network compared to their

competitors in the geographies of where decision-makers of key employers reside is also important. (Foucre, Tr. 884-85).

C. Pre-Merger Competition By ENH and Highland Park for Network Inclusion

245. The ability of the health plan to exclude a hospital from its network is a powerful tool and defines each side's bargaining position. (Haas-Wilson, Tr. 2470; Noether, Tr. 6189).
246. Pre-merger, Evanston was concerned about being excluded from health plans' network of providers. (Neaman, Tr. 961).
247. In order to avoid exclusion from health plan networks, Evanston accepted price decreases in order to maintain access to health plan members as future patients. Evanston also increased the breadth, depth and quality of its services, and strove to control costs to remain in health plan networks. (Neaman, Tr: 961-62).
248. Pre-merger, Highland Park was "routinely concerned" about being excluded from health plans' networks. (Newton, Tr. 303). Avoiding exclusion was an "extremely important issue" to Highland Park because exclusion would "diminish [its] ability to be successful in the market, would diminish [its] ability for patients to come to [Highland Park Hospital]." (Newton, Tr. 303-04; CX 1868 at 3).
249. In order not to be excluded, Highland Park was "constrained" in pricing negotiations. Highland Park also had to demonstrate to health plans that it would be an "important member of the network adding value for [the health plans'] enrollees." (Newton, Tr. 304).
250. The quality of the hospital was a key component in adding "value" from the health plans' perspective. "If the institution had a poor image of quality, then they would not be attractive to enrollees, it would not be attractive to consumers . . . [T]he issue of value or quality is absolutely central in that relationship with the managed care companies." (Newton, Tr. 304-05).
251. The threat of exclusion also impacted on how Highland Park managed its costs. Highland Park was "constantly concerned" about its "cost profile" because it "did not have a lot of the flexibility in terms of just raising prices." (Newton, Tr. 305-06).
252. Highland Park recognized that competition existed for "participation in payer plans," forcing providers to "harness rising costs, reduce excess utilization and improve the quality and access of care delivery." (CX 1868 at 3).
253. Within Highland Park's core service area, the competition for network participation came "mainly from Lake Forest and Evanston." (CX 1868 at 3; Newton Tr. 324-25). The

competition from Evanston and other providers to Highland Park's south was "strong and focused, forcing [Highland Park] to pursue a defensive position." (CX 1868 at 3).

254. In order to maintain a high quality service offering, Highland Park approved plans for developing new clinical services, strengthening medical staff, enhancing quality of care for existing services, and utilizing more sophisticated information technology systems. (See CCF 2345-2356).

D. Impact of Evanston-Highland Park Merger on Selective Contracting Process

1. The Merger Reduced Viable Network Alternatives

255. The merger of Evanston and Highland Park changed the alternatives available to the health plans, thereby affecting the outcome of the bargain between health plans and the merged entity. (Haas-Wilson, Tr. 2472).
256. Before the merger, if Evanston went into a negotiation with a health plan and asked for what the health plan thought was an extremely high, unreasonable price, that health plan could choose to include Highland Park and other hospitals in the provider network while excluding Evanston Hospital. (Haas-Wilson, Tr. 2472).
257. After the merger, when ENH demanded a price that the health plan thought was unreasonably high, the alternative of excluding Evanston but including Highland Park and various other hospitals was no longer possible. At that point, the health plan would have to exclude both Evanston and Highland Park or neither hospital. (Haas-Wilson, Tr. 2473).
258. Selective contracting can occur even where there appear to be a large number of hospitals in a particular network. Excluding specialty hospitals like VA hospitals, children's hospitals, psychiatric and rehabilitation hospitals, there are around 80-85 acute care hospitals in the Chicago area, about 75 of which PHCS contracts with. (Ballengee, Tr. 154). Even contracting with 75 hospitals, PHCS excluded hospitals because their rates were too high relative to comparable hospitals. (Ballengee, Tr. 189-90.) When PHCS evaluates whether to exclude a hospital from its network, it looks at other hospitals to see if they will give PHCS the access that its clients want to the services they are looking for. (Ballengee, Tr. 155). Location plays a role in that evaluation. (Ballengee, Tr. 155-156). When PHCS decided to drop the University of Chicago, it looked to other hospitals that it considered "like" hospitals. (Ballengee, Tr. 155-56, 189-90.) Similarly, Aetna contracts with about 88 out of a total of 100 hospitals in the Chicago area. (Mendonsa, Tr. 484.)
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 568-569, *in camera*).

259. Dr. Haas-Wilson also relied on trial testimony from Jane Ballengee of PHCS who testified that PHCS viewed Highland Park and Evanston as competitors. If negotiations with the hospitals were not going well, PHCS could have chosen to include only one of the two hospitals in its network before the merger and worked them against each other. PHCS' strategy centered on the fact that it could have eliminated one of the hospitals from the network and utilized the other as the alternative hospital. (Haas-Wilson, Tr. 2477-79).
260. If, before the merger, Evanston had insisted upon a price that the health plan thought was unreasonably high, an alternative to that health plan would be to not include Evanston in the network, but instead, make up an alternative network that included Highland Park and various other hospitals in the Chicago area. (Haas-Wilson, Tr. 2479).

2. Health Plans Were Unable to Exclude the Post-Merger ENH from Their Networks

261. Post-merger, ENH management did not believe that other hospitals would change their prices as a result of ENH's price setting. In making price proposals to health plans, ENH management did not consider the risk of health plans switching to other hospitals. (Neaman, Tr. 1211-12; Newton, Tr. 367, Hillebrand, Tr. 1764-65).
262. { [REDACTED] } (See, e.g., Ballengee, Tr. 167 (pre-merger pricing more competitive); Mendonsa, Tr. 568-69, *in camera* ({ [REDACTED] }); Neary, Tr. 618-19 (One Health discovered that it was unable to market its network without ENH hospitals); Holt-Darcy, Tr. 1529, *in camera* ({ [REDACTED] }); Foucre, Tr. 931-34 (United could not market a network without ENH)).

PHCS

263. When Evanston and Highland Park were separate entities, PHCS could use one hospital and not the other. "If, in fact, the negotiation and the rates were not going well at one hospital . . . , we had the alternative." (Ballengee, Tr. 167).
264. PHCS "could choose between the two [hospitals] and work them against each other" because they were "competitors" prior to the merger. (Ballengee, Tr. 166-67).

265. According to Ms. Ballengee, “[t]he people would choose either to go north to one or south to the other. They could go either way and receive the same services at the same level.” (Ballengee, Tr. 166).
266. As a result of pre-merger negotiations, PHCS obtained lower prices than Evanston was demanding because PHCS “had a competitive environment between the two hospitals” and “could trade one off for the other.” (Ballengee, Tr. 170).
267. Not including every hospital in its network “allows us to utilize . . . natural competitiveness within the hospitals to negotiate better rates.” (Ballengee, Tr. 156).

Aetna

268. { [REDACTED]
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 530, *in camera*).
269. There have been times when Aetna has “not gotten business in the past because we didn’t have a facility that a competitor has, even though we showed better prices.” (Mendonsa, Tr. 491-2).
270. { [REDACTED]
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 516, *in camera*).
271. Aetna’s experience in terminating Northwestern Memorial taught the health plan that “miss[ing] significant facilities...compromises our ability to win business and our ability to keep business.” (Mendonsa, Tr. 491. *See also* Mendonsa, Tr. 516, ({ [REDACTED]
[REDACTED] }) *in camera*).
272. { [REDACTED]
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 568-69, *in camera*).
273. { [REDACTED]
[REDACTED] }
(Mendonsa, Tr. 569, *in camera*).
274. { [REDACTED]
[REDACTED]

[REDACTED] } (Mendonsa, Tr. 520, *in camera*).

One Health

- 275. Prior to the merger, One Health's network contained "some subset" of the hospitals in the North Shore because "the premise behind a hospital discounting their prices or a physician discounting their prices is that they are going to get something in return, and that would be additional membership or patients going to their office or hospital." (Neary, Tr. 587-8).
- 276. Before the merger, One Health's selectivity in choosing hospitals for its network forced hospitals to compete harder for the health plan's business. (Neary, Tr. 587-88).
- 277. The relative bargaining strength of One Health during hospital renegotiations depended upon the amount of business that the health plan is bringing a hospital, whether the hospital was currently in or out of the network, the competitive position of the hospital, and the availability of network and non-network-alternatives in the area offering similar services. (Neary, Tr. 589).
- 278. After receiving ENH's May 2000 price increase demands, One Health terminated ENH because it believed the increases to be "excessive" but was forced to return to the negotiating table – in a weakened negotiating position – because it could not market its network without the ENH hospitals. (Neary, Tr. 609-11, 615-16, 618-19).

Unicare

- 279. { [REDACTED] } (Holt-Darcy, Tr. 1518-9, *in camera*).
- 280. { [REDACTED] } (Holt-Darcy, Tr. 1517-8, *in camera*).
- 281. { [REDACTED] } (Holt-Darcy, Tr. 1529, *in camera*).
- 282. { [REDACTED] } (Holt-Darcy, Tr. 1561, *in camera*).

United

283. United could have had a network that did not include certain hospitals (such as hospitals in the Rush or Advocate system that are spread out over a larger geographic area), but United could not market a network without ENH, a system that "is not geographically dispersed." (Foucre, Tr. 931-34).

VIII. DIRECT EVIDENCE OF ANTICOMPETITIVE EFFECTS: ELIMINATION OF A DIRECT COMPETITOR

A. Evanston and Highland Park Were Direct Competitors Before the Merger

284. Evanston and Highland Park were direct competitors before the merger. (*See, e.g.*, Ballengee, Tr. 166-68; Neary, Tr. 600-601; CX 1868 at 3; Newton, Tr. 325; Neaman, Tr. 1046; Spaeth, Tr. 2088).
285. { [REDACTED] } (RX 1912 at 20, *in camera*; Newton, Tr. 351-52; Foucre, Tr. 901-903; Ballengee, Tr. 167-68; Holt-Darcy, Tr. 1425).
286. There are no other hospitals located between Highland Park and Evanston. (Ballengee, Tr. 168). The driving time between the two hospitals ranges from 15 to 30 minutes. (Rosengart, Tr. 4445-46; Spaeth, Tr. 2157; Noether, Tr. 5934).
287. Before the merger, the core service areas of Evanston (including Glenbrook) and Highland Park overlapped. (Neaman, Tr. 1058-59; Neary, Tr. 601-2; Spaeth, Tr. 2088, 2157-58; CX 1 at 3-5; CX 359 at 16; CX 350 at 2). Highland Park's internal documents indicate its concern with the overlapping areas. (CX 105 at 1; CX 360 at 5).
288. Prior to the merger, Evanston and Highland Park Hospitals competed for patients from the people living in between the two communities. (Holt-Darcy, Tr. 1426; Neary, Tr. 600-01). In fact, a patient could "choose to go north to one [hospital] or south to the other." (Ballengee, Tr. 166).
289. Highland Park was a community hospital before the merger. (Ballengee, Tr. 159; Newton, Tr. 383; Neaman, Tr. 1286). Glenbrook was also a community hospital prior to the merger. (Neaman, Tr. 1286).
290. The merging hospitals also overlapped in hospital services (Newton, Tr. 299; Neary, Tr. 601-02). Patients "could go either way [to Highland Park or Evanston] and receive the same services at the same level." (Ballengee, Tr. 166).
291. Prior to the merger, ENH offered, among other things, obstetrical services, including a perinatal center (CX 84 at 8; Newton, Tr. 299); diagnostic services (CX 84 at 15); a skilled nursing facility (CX 84 at 15); psychiatric care (Newton, Tr. 299; Spaeth, Tr. 2088); neurosurgery (CX 84 at 8; Newton, Tr. 299); cardiology services (CX 681 at 2; CX 84 at 8); orthopedics (Neaman, Tr. 1292); and a Level II trauma center (CX 84 at 8; CX 681 at 2); and cancer care (CX 84 at 8).

292. Prior to the merger, HPH also offered, among other things, obstetrical services, including a perinatal center (CX 84 at 13; Newton, Tr. 299); diagnostic services (CX 84 at 15); a skilled nursing facility (CX 84 at 15); psychiatric care (Newton, Tr. 299; Spaeth, Tr. 2088); neurosurgery (Newton, Tr. 299); cardiology services (CX 84 at 13); a Level II trauma center (CX 84 at 13); and cancer care (CX 699 at 24).
293. Evanston and Highland Park viewed each other as competitors pre-merger. (CX 1868 at 3; Newton, Tr. 325; Neaman, Tr. 1046; Spaeth Tr. 2088; CX 1 at 3).
294. Pre-merger, Highland Park strategic documents reported that “[w]ithin the hospital’s core, competition is mainly from Lake Forest and Evanston.” (CX 1868 at 3). In fact, as early as 1997, Highland Park believed competition from Evanston was increasing. (Spaeth, Tr. 2108).
295. { [REDACTED] }
(See, e.g., Ballengee, Tr. 166; Neary Tr. 600-01; Mendonsa, Tr. 569, *in camera*).
296. PHCS relied on Evanston and Highland Park as the “primary” alternatives to each other. (Ballengee, Tr. 166-68).
297. { [REDACTED] }
(Mendonsa, Tr. 530, 569, *in camera*).
298. { [REDACTED] } (Holt-Darcy, Tr. 1517-9, *in camera*).
299. One Health viewed Evanston and Highland Park as “main competitors” because their services were “comparable,” and the two hospitals drew patients from the same general population. (Neary, Tr. 600-01).
300. A goal of the merger was to stop Evanston and Highland Park from competing with each other. The two hospitals strategized to “join forces and grow together *rather than compete with each other*.” (CX 2 at 7 (emphasis added). See also CX 1879 at 3-4 (“Stop competing with each other.”); CX 4 at 1 (Highland Park and Evanston did not want to “d[o] battle with one another” in “a common battle ground”); CX 442 at 5 (“Do not ‘compete with self’ in covered markets”)).

301. The merger eliminated the competition between the two competitors by excluding an alternative provider available to health plans. (Haas-Wilson, Tr. 2472-73).

B. Absent the Merger, Highland Park Would Have Remained a Viable Competitor

1. Highland Park Could Have Continued As a Stand-Alone Competitor Without the Merger

a. Respondents Dropped the Failing Firm Affirmative Defense

302. The failing firm question is not an issue in this case. In their Second Amended Answer to Complaint Counsel's Complaint, Respondents dropped the affirmative defense that Highland Park Hospital was a failing firm. (*Compare* Respondents' Answer to Complaint, dated March 17, 2004, at 20 *with* Respondents' Second Amended Answer, dated January 11, 2005, at 21).

b. Pre-Merger, HPH Had a Strong Balance Sheet and Was Backed by Its Foundation's Assets

303. Highland Park had a strong balance sheet even up to the close of the merger. (Kaufman, Tr. 5860 (Highland Park had a "strong balance sheet")). Highland Park, along with its affiliated corporations, had assets much greater than their long-term debt. At the end of 1999, Lakeland Health Services, Highland Park Hospital's parent, had \$140 million greater in cash and unrestricted investments than long-term debt. (CX 693 at 16-17). Indeed, Highland Park was so well-capitalized that it insisted to ENH during the 1999 merger negotiations that it would contribute \$100 million to the establishment of an independent community foundation. (Kaufman, Tr. 5843; CX 1912 at 2).

304. Lakeland Health Services was the parent corporation of Highland Park Hospital and the pre-merger Highland Park Foundation. (Newton, Tr. 282).

305. Ken Kaufman is managing partner of Kaufman Hall & Associates, a financial consulting firm primarily servicing non-profit hospital systems. (Kaufman, Tr. 5773).

306. Mr. Kaufman and his firm provided financial and strategic consulting services to Highland Park Hospital prior to its merger with ENH. (Kaufman, Tr. 5774). Mr. Kaufman served as transaction counsel to Highland Park during the ENH merger negotiations. His engagement with HPH ended in July 1999. (Kaufman, Tr. 5838-39).

307. Mr. Kaufman served only as transaction counsel during the merger negotiations. He did not have discussions with Highland Park in 1999 about the status quo, unaffiliated option. (Kaufman, Tr. 5838-39).

308. In his role as transaction counsel, Mr. Kaufman advised the Highland Park board and management that "the financial condition of both parties [was] such that neither require a financial reason" to go forward with the merger and that "at no time should anyone in the community or the media be given that impression." (Kaufman, Tr. 5840; CX 1923 at 2).
309. At the end of 1998, Highland Park Hospital had 444 days of cash on hand. (CX 1912 at 1; Newton, Tr. 427-28). This was the equivalent of being able to run a fully functional hospital for 444 days without a penny of additional revenue. (Kaufman, Tr. 5860). The 444 days of cash on hand did not include any pre-merger foundation assets. (Kaufman, Tr. 5860).
310. In 1999, Mr. Kaufman advised Highland Park that the hospital "has always supported its credit position through exceptional liquidity." (CX 1912 at 2).
311. At the end of 1998, Highland Park Hospital had \$133.6 million in cash assets available to contribute to the ENH-HPH merged entity. (Kaufman, Tr. 5842; CX 1912 at 2). This \$133.6 million did not include the pre-merger Highland Park Foundation's assets. (Kaufman, Tr. 5842; CX 1912 at 2).
312. After the \$133.6 million contribution to the ENH-HPH merged entity, Lakeland Health Services still would have had \$102 million left over to fund the independent foundation. (Kaufman, Tr. 5842; CX 1912 at 3).
313. Even if LHS were to contribute the \$102 million to an independent foundation, Mr. Kaufman advised Highland Park that ENH would be receiving "an appropriately capitalized partner." (Kaufman, Tr. 5843; CX 1912 at 2).
314. Highland Park Hospital and the pre-merger, non-independent Highland Park Foundation constituted the "obligated group" for this long-term debt. In other words, the assets of the foundation and the hospital backed up the long-term debt. (Kaufman, Tr. 5846; CX 413 at 120).
315. At the end of 1998, the obligated group (Highland Park Hospital and the foundation) had \$120 million in long-term debt. (Kaufman, Tr. 5844; CX 1912 at 1). Highland Park's bond issues in the 1990s accounted for this long-term debt. (Kaufman, Tr. 5844).
316. When Mr. Kaufman calculated the debt indicators set forth in his February 1999 memorandum to Messrs. Stearns and Spaeth, he did not include the assets of the foundation. (Kaufman, Tr. 5846). Including the entirety of the obligated group's assets in the financial calculations would cause the debt indicators to improve compared to indicators that only utilized the hospital assets. (Kaufman, Tr. 5858).

317. For example, Mr. Kaufman calculated that, at the end of 1998, Highland Park Hospital had a debt service coverage ratio of 1.8 and a debt to capitalization ratio of 61%. (CX 1912 at 1). These calculations did not take into consideration the foundation assets. (Kaufman, Tr. 5858).
318. In contrast, Highland Park did include the pre-merger foundation assets in its calculations of debt indicators set forth in its 1999 Certificate of Need application to the Illinois Health Facilities Planning Board. (CX 413 at 120). For the end of 1998, Highland Park calculated a debt service coverage ratio of 2.3 and a debt to capitalization ratio of 46%. (CX 413 at 119).
319. Thus, including the entirety of the obligated group's assets improves the debt service coverage ratio from 1.8 to 2.3, a 40% improvement. (Compare CX 1912 at 1 to CX 413 at 119).
320. In addition, Highland Park projected that by 2003 the debt service coverage ratio would improve to 3.1 and the debt to capitalization ratio to 39%. (CX 413 at 119).
321. At the end of 1998, Highland Park Hospital and its affiliated corporations had a total of about \$235 million in cash and unrestricted investments. The components of this total were the \$102 million earmarked for the independent, post-merger foundation and \$133.6 million in cash and unrestricted investments that Highland Park planned to contribute to the ENH-Highland Park merged entity. (Kaufman, Tr. 5842, 5844).
322. If HPH and its corporate parent had used these funds to pay off the entirety of its long-term debt of \$120 million at the end of 1998, they would have been entirely debt-free and still would have had about \$115 million in cash and unrestricted investments. (Kaufman, Tr. 5844).
323. Because it had sufficient cash flow for its projected capital needs, Highland Park management believed that \$100 million "are justifiably excluded from the merger and left with the Community Foundation." (CX 1903 at 1).
324. Highland Park and its affiliated corporations experienced a decline in long-term debt and an increase in cash and unrestricted investments position from 1998 to 1999. In particular, long-term debt declined from \$120.5 million to \$116.7 million. (CX 693 at 17). Cash and unrestricted investments increased from \$217.8 million to approximately \$260 million. (CX 693 at 16).

c. Foundation Assets Would Not Have Exited HPH Without The Merger

325. Pre-merger, Highland Park Hospital, through its parent, Lakeland Health Services, was backed by the assets of its foundation. These funds were available for use by the hospital. (Styer, Tr. 4954) (“funds from the pre-merger Foundation went to support the hospital”). The post-merger, independent foundation was established in order to compensate the local community of Highland Park for the loss of control following Highland Park’s merger with Evanston. (Kaufman, Tr. 5855). Highland Park and its corporate affiliates contributed \$100 million for the independent foundation. (CX 501 at 113). Without the merger, the pre-merger foundation’s assets would have remained in the corporate structure of Highland Park, (Kaufman, Tr. 5856) and been used to the benefit of Highland Park Hospital.
326. The pre-merger Highland Park Hospital Foundation was “responsible for fund raising for and on behalf of Lakeland Health Services, Inc. (“Lakeland”), the Hospital [HPH] and their affiliates.” (CX 6321 at 61).
327. These raised funds were available to Highland Park Hospital. The foundation “maintains the funds received and distributes the funds based upon the needs of the affiliates, or, if restricted to a specific purpose, the directions of the donor.” (CX 6321 at 61). As the former chairman of the pre-merger foundation testified, “The funds from the pre-merger Foundation went to support the hospital, to fulfill needs.” (Styer, Tr. 4954).
328. Pre-merger, Highland Park Hospital executives “would bring [the foundation board] various projects that were ongoing in the hospital,” and the foundation members would select specific projects to fund, such as improvements to the hospital’s dialysis center. (Styer, Tr. 4959-60).
329. HPH believed a vital part of the ENH merger was to compensate the local community of Highland Park for the loss of control following the merger. (Kaufman, Tr. 5855).
330. The establishment of a separate post-merger foundation to serve Highland Park was designed to compensate the community for the loss of control. (Kaufman, Tr. 5855-56).
331. If there was no merger, there would be no loss of control and hence no need to compensate the community. (Kaufman, Tr. 5856).
332. The foundation was in fact established as an independent entity with \$100 million in total net unrestricted assets. (CX 501 at 113). Highland Park and its affiliated corporations contributed these assets at the time of the foundation’s formation. (Neaman, Tr. 1260).
333. The post-merger, independent foundation was renamed Healthcare Foundation of Highland Park. (RX 2037 at HFHP 001351; Styer, Tr. 4951).

334. If there was no merger, the \$100 million foundation contribution would have remained in the corporate structure of Highland Park and its affiliated companies and would not have been spun off to a separate entity. (Kaufman, Tr. 5856).

d. HPH's Management and Board Believed That HPH Was Financially Strong Pre-Merger

335. Both the Highland Park management and board believed that Highland Park was financially strong in 1999 and for the foreseeable future. (CX 1055 at 3 (Highland Park "can remain financially strong over the foreseeable future.")). The management and board contemplated that Highland Park's income would grow (CX 1055 at 2 (projecting increased net revenues)); its debt would decline (CX 1903 at 1 (projecting reduction in long-term debt)), and its operating margin would increase from 1999 into the future (CX 1055 at 2 (setting forth higher operating margin forecasts)). They also believed that Highland Park would be able to make necessary capital investments, as well as create new strategic initiatives to further increase operating revenue. (CX1903 at 1, 3 (outlining \$79 million in planned capital expenditures as well as \$28 million for strategic initiatives)).
336. The Highland Park board had assessed the financial position of the hospital and felt it was acceptable. Highland Park was not planning to file for bankruptcy before the merger. It never considered filing for bankruptcy. (Spaeth, Tr. 2308).
337. Mr. Spaeth testified that he never heard anyone on the board say that Highland Park should consider filing for bankruptcy. In addition, Mr. Spaeth had never heard anyone on the board say that they needed to think about closing the hospital. (Spaeth, Tr. 2308).
338. Mr. Stearns, Highland Park's Chairman of the Board, testified that he believed that Highland Park was not in danger of exiting the market for at least ten years. (CX 6305 at 5 (Stearns, Dep.)).
339. Before the merger, HPH "historically achieved strong financial results compared to the median for not-for-profit hospitals." (CX 545 at 3).
340. At the March 23, 1999 meeting, the Lakeland finance and planning committee concluded that Highland Park "can remain financially strong over the foreseeable future." (CX 1055 at 3; Newton, Tr. 432-34; Spaeth, Tr. 2147).
341. Highland Park's 1999-2003 financial plan set forth a "long range capital budget" that included \$43 million for "strategic initiatives and master plan items," including "ambulatory, assisted living and facility expansion." The plan also set aside \$65 million for "[h]ospital construction, routine capital and information technology" investments, and

- a small amount for Lakeland Health Ventures. The combined budget was in excess of \$100 million. (Newton, Tr. 430-31; CX 545 at 3; CX 1055 at 2).
342. According to Highland Park's 1999-2003 financial plan, "Cash and investments are forecasted to grow from \$238 million in 1998 to \$323 million in 2003." (CX 1055 at 3).
 343. HPH also forecasted that its investments would generate a return of \$28 million in incremental net revenues in 2003, reaching HPH's "market share target." (CX 1055 at 2).
 344. The 1999-2003 Highland Park financial plan emphasized that "[e]xisting cash and investments are available to fund strategic initiatives and generate new programs." (CX 545 at 3).
 345. Mr. Spaeth testified that Highland Park's "strong financial results" and ability to fund strategic initiatives and generate new programs through "existing cash and investments" was correct as of March 1999. (Spaeth, Tr. 2135; CX 545).
 346. On March 23, 1999, Lakeland's finance and planning committee approved the 1999-2003 Strategic Plan and Financial Plan. (Spaeth, Tr. 2146; CX 1055 at 3).
 347. At the April 30, 1999, Highland Park Hospital board meeting, the board members approved the 1999-2003 Strategic Plan and Financial Plans. (CX 96 at 4; Spaeth, Tr. 2155) The board members did not express doubt about Highland Park's ability to generate the \$100 million required to fund the projects. (Newton, Tr. 430-32).
 348. Highland Park's 1999-2004 Financial Plan projected that cash and investments would increase by \$48 million from 1999-2004, and that long-term debt would be reduced by \$24.3 million, excluding amortization. (CX 1903 at 1).
 349. Highland Park's financial forecasts established that it had sufficient cash flow for both the planned capital expenditures and the strategic initiatives. (CX 1903 at 1).
 350. The 1999-2004 financial plan included planned capital expenditures of \$79 million. These expenditures were comprised of "primarily routine capital for equipment and facility improvements, construction for renovation of patient care areas, information system enhancements and physician development." (CX 1903 at 1).
 351. The financial plan also included an additional \$28 million in planned expenditures for "Strategic/Master Plan Initiatives." These initiatives included development of a cath lab, additional parking, and additional facilities for oncology and radiation therapy. (CX 1903 at 1, 3).

e. **HPH's 1999 Operating Results Were Distorted Due to Merger-Related Expenses**

352. Lakeland Health Services, including Highland Park Hospital, showed an operating loss in 1999. This was primarily attributable to writing down in value a variety of assets and accruing expenses in anticipation of the Evanston merger. (Newton, Tr. 412-13).
353. Highland Park Hospital assumed more than \$9.6 million in various merger-related accruals for executive compensation as part of the merger. Total merger-related costs were estimated at \$11 million. (CX 1720 at 39).
354. On June 29, 1999, Highland Park replaced the employment agreements of the top executives at Highland Park. These new agreements replaced earlier ones and "offered additional retention bonuses as well as enhanced severance agreements." (CX 534 at 3). The amount required to cover these additional bonuses and severance agreements totaled \$8 million. (CX 534 at 3; Neaman, Tr. 1257-58)).
355. As of July 31, 1999, Highland Park's operating margin was a deficit of \$1.6 million due to "nonrecurring" or "one-time" costs from the merger with ENH. Without these non-recurring merger costs, Highland Park's operating margin would have been a surplus of \$1 million. (Hillebrand, Tr. 1777-80; CX 517 at 2-5).

f. **Highland Park Could Have Continued As a Stand-Alone Competitor Without the Merger**

356. Highland Park's board and management consistently contemplated and made plans for a stand-alone, "status quo" option in which Highland Park would not merge with another hospital. (CX 1055 at 1 (Highland Park strategic and financial plans "developed assuming no affiliation with another provider were to occur"); Spaeth, Tr. 2145-46 (plans set forth goals for "going forward without a merger"); CX 1869 at 5-6 (outlining benefits of stand-alone growth strategy)). Highland Park's stand-alone strategic plans projected continued growth and financial strength. (CCFF 335-351). In addition, Highland Park emphasized that it did not have a financial need to merge with ENH. (CX 1923 at 2 (Highland Park does not "require a financial reason" for the merger)).
357. In the fall of 1998, Highland Park contemplated both a merger strategy as well as an independent, stand-alone growth strategy. (CX 1869 at 5-6).
358. Highland Park believed that the benefits of an independent growth strategy were "[i]ndependence, [c]ontrol [and] [l]ocal [f]lavor." (CX 1869 at 5).
359. In his role as transaction counsel, Mr. Kaufman advised the Highland Park board and management that "[t]he financial condition of both parties [was] such that neither require

- a financial reason" to go forward with the merger and that "at no time should anyone in the community or the media be given that impression." (Kaufman, Tr. 5840; CX 1923 at 2).
360. Highland Park was prepared to proceed with the status quo, unaffiliated option if the ENH merger talks failed. (Kaufman, Tr. 5838).
 361. Mr. Stearns, Highland Park's Chairman of the Board, testified that he believed that Highland Park was not in danger of exiting the market for at least ten years. (CX 6305 at 5 (Stearns, Dep.)).
 362. If the merger with ENH had not closed, HP had "the financial wherewithal to sustain [itself]." HP management and board believed that "[t]here was no urgency to have an alternative immediately available." (CX 6305 at 11 (Stearns, Dep.)).
 363. From Highland Park management's perspective, pursuing the stand-alone, independent option in 1998-99 "was absolutely a viable alternative for Highland Park." (Newton, Tr. 319-20).
 364. Highland Park could remain independent due to a variety of factors. It had a quality medical staff with significant coverage over a range of about 45 specialties. It had a broad primary care network. It was efficient in managed care activities. (Newton, Tr. 320).
 365. The Highland Park community also strongly supported the hospital. Fund raising and donor support were strong, and the donor base was wealthy. (Newton, Tr. 320-21). For example, one fund-raising campaign conducted in the 1990s raised more than \$10 million for the development of new surgical suits. (Newton, Tr. 321). Another campaign raised funds for Highland Park Hospital's dialysis center, which was established in 1998. (Styer, Tr. 4959-60).
 366. At the March 23, 1999 meeting, the Lakeland finance and planning committee concluded that based on the 1999 strategic and financial plans, Highland Park "can remain financially strong over the foreseeable future." (CX 1055 at 3; Newton, Tr. 432-34; Spaeth, Tr. 2147). These plans were "developed assuming no affiliation with another provider were to occur." (CX 1055 at 1; Spaeth, Tr. 2145-46 (plans set forth goals for "going forward without a merger"))).
 367. Highland Park proposed a year 2000 budget in October 1999. The budget was prepared assuming no merger with ENH would take place; "therefore, no merger-related impact [was] included." (CX 397 at 1). The proposed budget for 2000 anticipated "dramatic improvement over 1999's results." (CX 397 at 1). For example, the budget projected net revenue increases of more than \$6.3 million in 2000 for the hospital. (CX 397 at 3).

2. Highland Park Was an Attractive Candidate for Other Mergers

368. Highland Park was considered by many as “one of the finest community hospitals in the country.” (Newton, Tr. 301).
369. Highland Park viewed itself as an attractive partnership candidate and considered other partners besides ENH. In the fall of 1998, Highland Park contemplated a number of potential merger partners, besides Evanston, including Northwest Community, Lake Forest and Condell. (CX 1869 at 6). Highland Park also had a strong balance sheet (CCFF 303-324), was backed by its foundation’s assets (CCFF 314-322), had an “attractive service area” (CX 6305 at 51 (Stearns, Dep.)), and anticipated positive growth in capital investments, strategic initiatives and operating margin (CCFF 339-351). (cross reference)).
370. If the ENH merger had not closed, Highland Park was prepared “to continu[e] to explore other options,” meaning “other partnership options.” (CX 6305 at 11 (Stearns, Dep.)).
371. According to Highland Park’s chairman of the board, Highland Park “had at least some contact with other institutions and . . . would have pursued those more aggressively had this — the merger with Evanston not gone through.” (CX 6305 at 11-12 (Stearns, Dep.)).
372. Highland Park had “an attractive service area,” and therefore, it “would be attractive to other partnership candidates.” (CX 6305 at 12 (Stearns, Dep.)).

IX. DIRECT EVIDENCE OF ANTICOMPETITIVE EFFECTS: THE PRICING OF ENH TO HEALTH PLANS FOLLOWING THE MERGER WITH HIGHLAND PARK PROVIDES DIRECT EVIDENCE OF ANTICOMPETITIVE EFFECTS

A. Introduction to the Data Relied Upon by Dr. Haas-Wilson

373. Dr. Haas-Wilson used four different data sources in her empirical analysis to examine whether prices increased at ENH after the merger. The four data sources were: (1) data from the Universal Dataset from the Illinois Department of Public Health (“IDPH Universal Dataset”); (2) data from the economic consulting firm NERA submitted to the FTC on behalf of ENH; (3) data submitted directly by ENH in response to an FTC Civil Investigative Demand (“CID”); and (4) commercial payer claims data. (Haas-Wilson, Tr. 2495-2500 (referring to DX 7025)).

1. Data from the IDPH Universal Dataset

374. { [REDACTED] } (Haas-Wilson, Tr. 2500; Haas-Wilson, Tr. 2582-83, *in camera*).

375. The IDPH Universal Dataset includes the hospital’s “list prices” for each procedure which reflect each hospital’s chargemaster. The Universal Dataset does not include information on the actual transaction prices that hospitals charge health plans. (Haas-Wilson, Tr. 2500).

376. { [REDACTED] } (Haas-Wilson, Tr. 2527, *in camera*).

377. { [REDACTED] } (Haas-Wilson, Tr. 2527-28, *in camera*). { [REDACTED] } (Haas-Wilson, Tr. 2527). { [REDACTED] } (Haas-Wilson, Tr. 2529, *in camera*).

378. { [REDACTED] } (Haas-Wilson, Tr. 2529, *in camera*).

379. { [REDACTED] }
{Haas-Wilson, Tr. 2529, *in camera*).
380. { [REDACTED] } (Haas-Wilson, Tr. 2529-30, *in camera*).
381. { [REDACTED] } (Haas-Wilson, Tr. 2531-32, *in camera*). { [REDACTED] }
{ [REDACTED] } (Haas-Wilson, Tr. 2532, *in camera*; CX 6279 at 7, *in camera*).

2. Data Submitted by the Economic Consulting Firm NERA on Behalf of ENH

382. NERA, an economic consulting firm hired by ENH, submitted data to the FTC, on ENH's behalf. (Haas-Wilson, Tr. 2498).
383. The NERA data reported actual negotiated prices for ENH's fiscal years from 1999 through 2001. (Haas-Wilson, Tr. 2498).
384. { [REDACTED] } (Haas-Wilson, Tr. 2498). { [REDACTED] }
{ [REDACTED] } (Haas-Wilson, Tr. 2499; CX 6279 at 4 ({ [REDACTED] })), *in camera*).
385. The NERA data include information only on ENH. There was no data on prices at other hospitals. (Haas-Wilson, Tr. 2498-99).

3. Data Submitted by ENH in Response to a Civil Investigative Demand Issued by the Federal Trade Commission

386. ENH submitted data in response to a CID issued by the Federal Trade Commission. The CID response data was similar to the NERA data. The CID response data reported actual negotiated prices for ENH's fiscal years from 1999 through 2002. (Haas-Wilson, Tr. 2499-500).
387. { [REDACTED] } (Haas-Wilson, Tr. 2498). { [REDACTED] } (CX 6279 at 5 ({ [REDACTED] })), *in camera*).

388. The CID response data, however, have information over a longer period of time than the NERA data, including data for ENH fiscal year 2002. (Haas-Wilson, Tr. 2499-500).

4. Claims Data Submitted by Health Plans

389. { [REDACTED] } (Haas-Wilson, Tr. 2510, *in camera*).

390. The claims data from health plans had data on a patient by patient basis. (Haas-Wilson, Tr. 2496).

391. The claims data contained information about the diagnosis of the patient and the actual amount paid for the procedure. (Haas-Wilson, Tr. 2496-97). { [REDACTED] } (Haas-Wilson, Tr. 2510, *in camera*).

B. There is No Dispute That ENH Raised Prices to Health Plans Following the Merger with Highland Park

392. Regardless of the data source that is used, or the methodology used to “clean” or manipulate the data, all the evidence shows that following the merger with Highland Park, ENH raised the prices of inpatient acute care hospital services to health plans. (CCFF 394-502).

393. All four of the separate data sources show prices to managed care organizations increased at ENH after the merger. (Haas-Wilson, Tr. 2500-01).

1. The Data from the IDPH Universal Dataset and the Data from the Medicare Cost Reports Show That ENH Raised Prices to Health Plans, Taken As a Whole, Following the Merger with Highland Park

394. { [REDACTED] } (Haas-Wilson, Tr. 2530-31, *in camera*).

395. { [REDACTED] } (Haas-Wilson, Tr. 2531-32, *in camera*).

396. { [REDACTED] }

[REDACTED]
[REDACTED]
[REDACTED] } (Haas-
Wilson, Tr. 2532, *in camera*).

397. [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, 2527-29, *in camera*. See also CCFF 376-380).

398. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }
(CX 6279 at 7, *in camera*).

399. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }
(CX 6279 at 7, *in camera*).

400. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }
(CX 6279 at 7, *in camera*).

401. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }
(CX 6279 at 7, *in camera*).

402. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }

[REDACTED]

(CX 6279 at 7, *in camera*).

403. { [REDACTED]

in camera).

404. { [REDACTED]

7012, *in camera*), *in camera*).

2. The Data Provided by NERA Shows That ENH Raised Prices to Most Health Plans, Following the Merger with Highland Park

405. { [REDACTED]

(Haas-Wilson, Tr. 2519, *in camera*).

406. { [REDACTED]

4, *in camera*).

407. { [REDACTED]

(CX 6279 at 4, *in camera*).

408. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*).

409. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*).

410. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }
(CX 6279 at 4, *in camera*).

411. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }
(CX 6279 at 4, *in camera*).

412. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }
(CX 6279 at 4, *in camera*).

413. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*).

414. { [REDACTED]
[REDACTED]
[REDACTED] }

[REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*).

415. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*).

416. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*).

417. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*).

418. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*).

419. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*).

420. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*).

421. { [REDACTED]
[REDACTED]
[REDACTED]

[REDACTED] } (CX 6279 at 4, *in camera*).

422. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*).

423. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*).

424. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*).

425. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*).

426. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*).

427. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*).

428. { [REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*).

429. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*).

430. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2520-22
(referring to DX 7009, *in camera*), *in camera*). [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2521-
22 (referring to DX 7009, *in camera*), *in camera*).

431. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2522-23, *in camera*; Ballengee, Tr. 179).

432. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2519-20,
in camera; CX 6279 at 4, *in camera*).

3. The Data Provided by ENH in Its Response to the Civil Investigative Demand Shows That ENH Raised Prices to Most Health Plans, Following the Merger with Highland Park

433. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2523, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2523-24, *in camera*).

434. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2525, *in camera*; CX 6279
at 5, *in camera*).

435. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, in camera).

436. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, in camera).

437. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, in camera).

438. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, in camera).

439. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, in camera).

440. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, in camera).

441. { [REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED] } (CX 6279 at 5, *in camera*).

442. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, *in camera*).

443. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, *in camera*).

444. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, *in camera*).

445. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, *in camera*).

446. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, *in camera*).

447. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, *in camera*).

448. { [REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, *in camera*).

449. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, *in camera*).

450. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, *in camera*).

451. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, *in camera*).

452. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, *in camera*).

453. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, *in camera*).

454. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, *in camera*).

455. { [REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED] } (CX 6279 at 5, in camera).

456. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, in camera).

457. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, in camera).

458. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, in camera).

459. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, in camera).

460. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, in camera).

461. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, in camera).

462. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 5, *in camera*).

463. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2526
(referring to DX 7007, *in camera*), *in camera*).

464. { [REDACTED]
[REDACTED] } (Haas-Wilson,
Tr. 2524-25, *in camera*; CX 6279 at 4, *in camera*).

4. The Commercial Payer Claims Data Provided by Aetna, Blue Cross, Humana, and United Shows That ENH Raised Prices to Most Health Plans Following the Merger with Highland Park

465. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2510-11, *in camera*).

466. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2511 (referring to DX 7010, *in camera*), *in camera*).

467. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2524-25, *in camera*).

468. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2518, *in camera*).

a. United

469. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2511-12 (referring to DX 7010, *in camera*), *in camera*).

470. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 3, *in camera*).

471. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 3, *in camera*).

472. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 3, *in camera*).

473. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 3, *in camera*).

474. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 3, *in camera*).

475. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }

[REDACTED] } (CX 6279 at 3, *in camera*).

b. Aetna

476. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2512 (referring to DX 7010, *in camera*), *in camera*).

477. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 3, *in camera*).

478. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 3, *in camera*).

479. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 3, *in camera*).

480. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 3, *in camera*).

c. Humana

481. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2511-12 (referring to DX 7010, *in camera*), *in camera*).

482. { [REDACTED]
[REDACTED]
[REDACTED]

[REDACTED] } (CX 6279 at 3, *in camera*).

483. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 3, *in camera*).

484. { [REDACTED]
[REDACTED]
[REDACTED] } (CX
6279 at 3, *in camera*).

485. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 3, *in camera*).

486. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 3, *in camera*).

487. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 3, *in camera*).

d. Blue Cross/Blue Shield

488. { [REDACTED]
[REDACTED] } (Haas-
Wilson, Tr. 2511-2512 (referring to DX 7010, *in camera*), *in camera*).

489. { [REDACTED]
[REDACTED]

[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2511-2512 (referring to DX 7010, *in camera*), *in camera*).

490. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 3, *in camera*).

491. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 3, *in camera*).

492. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 3, *in camera*).

493. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 3, *in camera*).

5. Dr. Baker's Analysis Confirmed That Prices Went Up at ENH After the Merger with Highland Park

494. { [REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4631-32, *in camera*).

495. { [REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4633-34, *in camera*).

496. { [REDACTED]
[REDACTED] } (Baker, Tr. 4635, *in camera*).

a. Dr. Baker's Analysis Showed a Price Increase When He Looked at Individual Payers

497. { [REDACTED]
[REDACTED] }
(Haas-Wilson, Tr. 2564-65 (referring to DX 7022 at 2, *in camera*), *in camera*).

498. { [REDACTED]
[REDACTED] }
(Haas-Wilson, Tr. 2566-67 (referring to DX 7013 at 2, *in camera*), *in camera*; Baker, Tr. 4744-45, *in camera*).

499. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2569 (referring to DX 7014 at 2, *in camera*), *in camera*).

500. { [REDACTED]
[REDACTED] }
(Haas-Wilson, Tr. 2573 (referring to DX 7020 at 2, *in camera*), *in camera*).

b. Dr. Baker's Analysis Showed a Price Increase When He Combined All the Payers Examined by Him

501. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2584). { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }
(Haas-Wilson, Tr. 2584-85 (referring to DX 7050 at 2, *in camera*), *in camera*).

502. { [REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4639-40 (discussing DX 8041, *in camera*), *in camera*).

C. There Is No Dispute That, Following the Merger with Highland Park, ENH Raised Prices to Managed Care Organizations Relative to Other Hospitals in the Chicago Area

1. Relative Price Changes, Not Relative Prices, Is the Appropriate Methodology to Test for Market Power

503. Hospitals services are a differentiated product. (Haas-Wilson, Tr. 2492-93; Noether, Tr. 5910). Consumers are willing and able to pay higher prices for certain aspects of product differentiation. Thus, because prices can vary in the market for a differentiated service for many different reasons, one may not conclude anything about market power by merely using a cross-sectional analysis of hospital prices at a single point in time. (Haas-Wilson, Tr. 2492-93 (example provided in DX 7043)).

504. In contrast, by looking at price changes over time, one can compare the price change at one hospital to the price change at another hospital. Using such an approach, one can conclude there is a change in market power if there is a price increase after having ruled out the other possible explanations for greater price increases at one hospital versus another. (Haas-Wilson, Tr. 2495).

2. Whether ENH's Prices Increased Faster Than Other Hospitals Is Determined by Using a Methodology Called Difference in Differences

505. { [REDACTED] } (Haas-Wilson, Tr. 2546-47 (referring to DX 7027 (showing steps in the process)), *in camera*).

506. { [REDACTED] } (Haas-Wilson, Tr. 2546-47, (referring to DX 7027 (showing steps in the process)), *in camera*).

507. { [REDACTED] } (Haas-Wilson, Tr. 2546-48 (referring to DX 7027 (showing steps in the process)), *in camera*).

508. { [REDACTED] } (Haas-Wilson, Tr. 2548, *in camera*).

509. { [REDACTED] } (Haas-Wilson, Tr. 2938-39, *in camera*).

510. { [REDACTED] } (Haas-Wilson, Tr. 2552, *in camera*).

511. { [REDACTED] } (Haas-Wilson, Tr. 2552-53, *in camera*).

3. Because Multiple Control Groups Assure That the Results Are Not Dependent Upon the Choice of the Control Group, Dr. Haas-Wilson Used Three Control Groups

512. { [REDACTED] } (Haas-Wilson, Tr. 2548, *in camera*).

513. { [REDACTED] } (Haas-Wilson, Tr. 2548-49, *in camera*).

514. { [REDACTED] } (Haas-Wilson, Tr. 2549, *in camera*).

515. { [REDACTED] } (Haas-Wilson, Tr. 2549, *in camera*).

516. { [REDACTED] } (Haas-Wilson, Tr. 2549-50, *in camera*).

517. { [REDACTED] } (Haas-Wilson, Tr. 2550, *in camera*).

518. { [REDACTED]
[REDACTED]
[REDACTED] }
(Haas-Wilson, Tr. 2550-51, *in camera*).

519. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2550-51, *in camera*).

4. Tests of Statistical Significance Allow the Quantification of the Amount of Confidence One Has in the Results

520. { [REDACTED]
[REDACTED]
[REDACTED] }
(Haas-Wilson, Tr. 2553, *in camera*).

521. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2553-54, *in camera*).

5. The IDPH Universal Dataset Shows That Prices to Health Plans Went Up Faster at ENH Than at Other Hospitals After the Merger with Highland Park, Regardless of the Control Group Used and Regardless of the Patient Group Used

522. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2530-31, *in camera*).

523. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2532, *in camera*).

524. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2527-29, *in camera*. See also CCF 376-380).

a. Compared to the Chicago PMSA Hospitals, Prices to Health Plans Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park

525. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 10, in camera).
{ [REDACTED]
[REDACTED] } (CX 6279 at 11, in camera).

526. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 10, in camera). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 11, in camera).

527. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 10, in camera). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 11, in camera).

b. Compared to the Non-Merging Chicago PMSA Hospitals, Prices to Health Plans Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park

528. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 10, in camera). [REDACTED]
[REDACTED] } (CX 6279 at 11, in camera).

529. { [REDACTED]
[REDACTED]

[REDACTED] } (CX 6279 at 10, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 11, *in camera*).

530. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 10, *in camera*).
{ [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 11, *in camera*).

c. Compared to the Chicago PMSA Teaching Hospitals, Prices to Health Plans Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park

531. { [REDACTED]
[REDACTED] } (CX 6279 at 10, *in camera*). { [REDACTED]
[REDACTED] } (CX 6279 at 11, *in camera*).

532. { [REDACTED]
[REDACTED] } (CX 6279 at 10, *in camera*). { [REDACTED]
[REDACTED] } (CX 6279 at 11, *in camera*)

533. { [REDACTED]
[REDACTED] } (CX 6279 at 10, *in camera*). { [REDACTED]
[REDACTED]

[REDACTED]
[REDACTED] } (CX 6279 at 11, *in camera*).

534. The IDPH Universal Dataset shows that prices to health plans went up faster at ENH than at other hospitals after the merger with Highland Park. This result does not change with the different control groups and does not change with the different patient groups identified in the IDPH Universal Dataset. (CCFF 525-533).

6. The Commercial Payer Claims Data Shows That, Except for Blue Cross, Prices to Most Health Plans Went Up Faster at ENH Than at Other Hospitals After the Merger with Highland Park, Regardless of the Control Group Used

a. The United Claims Data Shows That Prices to United Went Up Faster at ENH Than at Other Hospitals After the Merger with Highland Park for All Control Groups

535. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2512 (referring to DX 7010, *in camera*), *in camera*).

(1) Compared to the Chicago PMSA Hospitals, Prices to United Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park

536. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 8, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

537. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 8, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

538. { [REDACTED]
[REDACTED]
[REDACTED] } (CX
6279 at 8, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

(2) **Compared to the Non-Merging Chicago PMSA Hospitals, Prices to United Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park**

539. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 8, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

540. { [REDACTED]
[REDACTED]
[REDACTED] }
(CX 6279 at 8, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

541. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 8, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

(3) **Compared to the Chicago PMSA Teaching Hospitals, Prices to United Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park.**

542. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 8, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

543. [REDACTED]
[REDACTED] } (CX
6279 at 8, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

544. { [REDACTED]
[REDACTED] } (CX 6279 at 8, *in camera*). [REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

b. The Aetna Claims Data Shows That Prices to Aetna Went Up Faster at ENH Than at Other Hospitals After the Merger with Highland Park for All Control Groups

545. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2512 (referring to DX 7010, *in camera*), *in camera*).

(1) Compared to the Chicago PMSA Hospitals, Prices to Aetna Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park

546. { [REDACTED]
[REDACTED] } (CX 6279 at 8, *in camera*). { [REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

547. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 8, in camera). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 9, in camera).

(2) **Compared to the Non-Merging Chicago PMSA Hospitals, Prices to Aetna Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park**

548. [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 8, in camera). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 9, in camera).

549. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 8, in camera). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 9, in camera).

(3) **Compared to the Chicago PMSA Teaching Hospitals, Prices to Aetna Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park**

550. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 8, in camera). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 9, in camera).

551. [REDACTED]
[REDACTED]

[REDACTED] } (CX 6279 at 8, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

c. The Humana Claims Data Shows That Prices to Humana Went Up Faster at ENH Than at Other Hospitals After the Merger with Highland Park for All Control Groups

552. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2511-12 (referring to DX 7010, *in camera*), *in camera*).

(1) Compared to the Chicago PMSA Hospitals, Prices to Humana Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park

553. { [REDACTED]
[REDACTED] } (CX 6279 at 8, *in camera*). { [REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

554. { [REDACTED]
[REDACTED] } (CX 6279 at 8, *in camera*). { [REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

555. { [REDACTED]
[REDACTED] } (CX 6279 at 8, *in camera*). { [REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

(2) Compared to the Non-Merging Chicago PMSA Hospitals, Prices to Humana Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park

556. { [REDACTED]
[REDACTED]
[REDACTED] } (CX
6279 at 8, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

557. { [REDACTED]
[REDACTED]
[REDACTED] } (CX
6279 at 8, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

558. { [REDACTED]
[REDACTED]
[REDACTED] } (CX
6279 at 8, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

(3) Compared to the Chicago PMSA Teaching Hospitals, Prices to Humana Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park

559. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at
8, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

560. { [REDACTED]
[REDACTED]

[REDACTED] } (CX 6279 at 8, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

561. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 8, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 9, *in camera*).

d. The One Health Claims Data Shows That Prices to One Health (Great West) Went Up Faster at ENH Than at Other Hospitals After the Merger with Highland Park for All Control Groups

562. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2511-12 (referring to DX 7010, *in camera*), *in camera*).

(1) Compared to the Chicago PMSA Hospitals, Prices to One Health (Great West) Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park

563. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6282 at 5, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6282 at 5, *in camera*).

(2) Compared to the Non-Merging Chicago PMSA Hospitals, Prices to One Health (Great West) Went Up Faster at ENH Than at the Control Group Hospitals After the Merger With Highland Park

564. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6282 at 5,

in camera). { [REDACTED]
[REDACTED]
[REDACTED] } (CX
6282 at 5, *in camera*).

(3) **Compared to the Chicago PMSA Teaching Hospitals,
Prices to One Health (Great West) Went Up Faster at
ENH Than at the Control Group Hospitals After the
Merger with Highland Park**

565. [REDACTED]
[REDACTED]
[REDACTED] } (CX 6282 at 5, *in
camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6282 at 5, *in camera*).

e. **The Blue Cross Claims Data Does Not Show That Prices to
Blue Cross Went Up Faster at ENH Than at Other Hospitals
After the Merger with Highland Park**

566. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2511-12 (referring to DX 7010, *in
camera*), *in camera*).

567. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2511-12 (referring to DX 7010, *in camera*), *in camera*).

568. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 18, *in camera*).

7. **Professor Baker's Analysis Confirms That Prices Went Up at ENH
Relative to Other Hospitals**

569. { [REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4631-32, *in camera*).

570. { [REDACTED] } (Baker, Tr. 4633-34, *in camera*).

571. { [REDACTED] } (Baker, Tr. 4635, *in camera*).

572. { [REDACTED] } (Baker, Tr. 4637-38; Haas-Wilson, Tr. 2548-49).

a. Dr. Baker Found Price Increases at ENH That Exceeded the Price Increases at His Control Group for United, Aetna, and Humana

573. { [REDACTED] } (Haas-Wilson, Tr. 2564-65 (referring to DX 7022 at 2, *in camera*), *in camera*).

574. { [REDACTED] } (Haas-Wilson, Tr. 2566-67 (referring to DX 7013 at 2, *in camera*), *in camera*; Baker, Tr. 4744-46, *in camera*).

575. { [REDACTED] } (Haas-Wilson, Tr. 2573 (referring to DX 7020 at 2, *in camera*), *in camera*).

576. { [REDACTED] } (Haas-Wilson, Tr. 2569 (referring to DX 7014 at 2, *in camera*), *in camera*).

b. Dr. Baker Found Price Increases at ENH That Exceeded the Price Increases at His Control Group for the Average Price of the Four Payers Analyzed by Him

577. { [REDACTED] } (Haas-Wilson, Tr. 2584). { [REDACTED] }

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2584-85 (referring to DX 7050 at 2, *in camera*), *in camera*).

578. { [REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4640-41 (discussing DX 8041, *in camera*), *in camera*).

8. Summary

579. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CCFF 535-578).

D. Dr. Haas-Wilson Considered Eight Alternative Explanations of the Price Increases Besides Increases in Market Power Arising from the Merger and Learning About Demand

1. Price Increases Alone Do Not Establish the Exercise of Market Power, As Alternative Explanations Must Be Rejected

580. It was not feasible to test directly for whether or not market power is the explanation behind the price increase at ENH. (Haas-Wilson, Tr. 2482).

581. Because market power cannot be tested directly, “the best available method is to develop this sort of list based on theory and what theory would expect to result in a price increase and then use empirical tests based on available data to be able to either cross these items off the list or, if you’re not able with your empirical test to cross them off, then see what you’re left with at the end of the analysis.” (Haas-Wilson, Tr. 2482).

2. There Were Eight Alternative Explanations for the Price Increase to Rule Out Besides Market Power and Learning About Demand

582. It was not possible to test for all possible explanations of the price increase, so it was necessary to look for reasonable explanations that are grounded in economic theory. (Haas-Wilson, Tr. 2481).

583. Dr. Haas-Wilson, drawing upon economic theory, came up with a list of eight potential explanations for the price increase at ENH after the merger other than market power or learning about demand. The "basis for including things in this list was economic theory and what economic theory suggested would be potential explanations for the large post-merger price increase at ENH." (Haas-Wilson, Tr. 2481 (referring to DX 7024)).
584. The eight plausible explanations of the price increase at ENH aside from market power or learning about demand were: (1) cost increases that affect all hospitals; (2) changes in regulations that affect all hospitals; (3) increases in consumer demand for hospital services; (4) increases in quality at ENH; (5) changes in the mix of patients; (6) changes in the mix of customers; (7) increases in teaching intensity; and (8) decreases in outpatient prices. (Haas-Wilson, Tr. 2482-88 (discussing DX 7024)).
585. Dr. Haas-Wilson tested whether any of these potential explanations could explain the price increase at ENH. (Haas-Wilson, Tr. 2481).

3. Dr. Haas-Wilson Was Able to Directly Rule Out Five of the Eight Alternative Explanations of the Price Increase at ENH

586. Dr. Haas-Wilson was able to directly rule out five potential explanations of the price increase at ENH: (1) cost increases; (2) changes in regulations; (3) changes in consumer demand; (4) changes in quality; and (5) declines in outpatient prices. (CCFF 594-595, 597-599, 602-608).

a. Cost Increases

587. Because economic theory suggests that when costs increase in competitive markets, one would expect to see prices increase, Dr. Haas-Wilson tested for whether cost increases in the Chicago area would explain why ENH's prices increased. (Haas-Wilson, Tr. 2482).
588. An example of a kind of cost increase that could take place in the Chicago area that would lead to a price increase is a shortage of nurses in the Chicago area. If a hospital had to pay higher wages in order to hire nurses, that would be an increase in cost that would affect ENH and all of the hospitals in the area, and potentially lead to a price increase. (Haas-Wilson, Tr. 2482-83).

b. Changes in Regulations

589. Because a change in regulation that affected all hospitals in the Chicago area could potentially explain price increases at all hospitals in the Chicago area, Dr. Haas-Wilson tested for whether changes in regulations would explain why ENH's prices increased. (Haas-Wilson, Tr. 2483).

590. An example of a change in regulation that could affect the prices at hospitals is taken from California. In California, where they are particularly prone to earthquakes, there are regulations requiring hospitals to make sure their buildings are able to withstand earthquakes of certain levels. Such a regulation clearly would increase costs at all hospitals in California and would be expected to lead to higher prices. (Haas-Wilson, Tr. 2483-84).

c. Changes in Consumer Demand

591. Because economic theory suggests that if there are increases in demand over a time period, one would expect those increases in demand in the Chicago area to increase prices at all hospitals in the Chicago area, Dr. Haas-Wilson tested for whether increases in demand would explain why ENH's prices increased. (Haas-Wilson, Tr. 2484).

592. An example of what could cause an increase in demand that would subsequently affect prices is "[t]o the extent the elderly consume more hospital services than the young, to the extent the population is aging in the Chicago area, that would likely increase demand for hospital services in the Chicago area and could potentially explain, therefore, price increases at all hospitals in the Chicago area." (Haas-Wilson, Tr. 2484).

d. The Relative Price Increase at ENH, Compared to Control Groups, Rules Out Changes in Costs, Regulations, and Demand As an Explanation of the Price Increase

593. In her analysis, Dr. Haas-Wilson focused on price increases instead of "price levels" because the market for hospital services can be characterized as a market for a differentiated product as opposed to a product that would be characterized as homogenous. Consumers are willing and able to pay higher prices for certain aspects of product differentiation, e.g., convenient location or reputation. Thus, because prices can vary in the market for a differentiated service for many different reasons, one may not conclude anything about market power by merely using a cross-sectional analysis of hospital prices at a single point in time. (Haas-Wilson, Tr. 2492 (*see* example provided in DX 7043)). In contrast, by looking at price changes over time, one can compare the price change at one hospital to the price change at another hospital. Using such an approach, one can conclude there is change in market power if there is a price increase after having ruled out the other possible explanations for greater price increases at one hospital versus another. (Haas-Wilson, Tr. 2495).

594. {

[REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2542-44, *in camera*).

595. Prices at ENH rose relative to the prices at other hospitals. (CCFF 579) [REDACTED] } (Haas-Wilson, Tr. 2562-63, 2565, 2573-74, 2579, 2583, 2586, *in camera*).

596. { [REDACTED] } (Haas-Wilson, Tr. 2562-63, 2565, 2573-74, 2579, 2583, 2586, *in camera*).

e. The Increases in Prices at ENH Relative to Other Hospitals Cannot Be Explained by an Increase in Quality Relative to Other Hospitals

597. If quality is increasing in general, that would lead to potentially higher prices at all hospitals. (Haas-Wilson, Tr. 2485). If quality is increasing at one hospital relative to other hospitals, and the buyers of hospital services value that increase in quality, then that could potentially explain a greater price increase at the first hospital. (Haas-Wilson, Tr. 2485). { [REDACTED] } (Haas-Wilson, Tr. 2586, *in camera*).

598. { [REDACTED] } (Haas-Wilson, Tr. 2586-88, *in camera*. See also CCFF 2032-2496).

599. { [REDACTED] } (Haas-Wilson, Tr. 2587-88, 2615, *in camera*).

f. Decreases in Prices of Outpatient Services at ENH Cannot Explain the Increase In Prices at ENH Relative to Control Group Hospitals

600. Though economic theory does not predict that decreases in outpatient services prices would lead to increases in inpatient service prices, some managed care payers indicated they would be concerned about what they paid for all the products that they were purchasing from a hospital. (Haas-Wilson, Tr. 2487)

601. To the extent that a managed care organization cares about the total price, a managed care organization might be willing to pay higher prices for inpatient services if they were

getting outpatient services at a lower price. It might be willing to trade one off for the other. (Haas-Wilson, Tr. 2487-88).

602. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2607 (referring to DX 7024), *in camera*).

603. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2607-08, *in camera*). [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2608, *in camera*).

604. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2614-15, *in camera*)

605. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2610, *in camera*; CX 6279 at 17, *in camera*).

606. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2614-15, *in camera*).

607. The finding that outpatient prices did not decline is consistent with Dr. Baker's analysis. Dr. Baker estimated that the price increase at ENH for his four payers, relative to his control group, for inpatient and outpatient services combined was 11 to 12%. (Baker, Tr. 4617-4618) Looking at just inpatient services, Dr. Baker that estimated the price increase at ENH for his four payers, relative to the control group was 9-10%. (Baker, Tr. 4620). This implies that the price of outpatient services at ENH for Dr. Baker's four payers increased more than the price of inpatient services. (Baker, Tr. 4797).

608. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2615, *in camera*).

4. Dr. Haas-Wilson Was Not Able to Rule Out Three of the Eight Alternative Explanations of the Price Increase at ENH Without Additional Analysis

609. Dr. Haas-Wilson was not able to rule out three potential explanations of the price increase at ENH: (1) changes in the mix of patients at ENH; (2) changes in the mix of customers at ENH; and (3) changes in the teaching intensity at ENH, without using multiple regression analysis. (CCFF 610-630).

a. **Changes in the Mix of Patients at ENH Cannot Be Ruled Out As a Potential Explanation for the Increase in Prices at ENH Without Additional Analysis**

610. Not all inpatient hospital stays require the same resources to treat. Patients with more complex conditions may require more resources than patients with less complex conditions. For two patients with the same condition, one may be sicker, requiring more resources to treat than the patient who is less sick. (Haas-Wilson, Tr. 2485).

611. The mix of patients that a hospital has will influence the hospital's prices. If the hospital has patients who require more resources to treat than other hospitals, that will impact the hospital's prices. (Haas-Wilson, Tr. 2486).

612. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2589, *in camera*).

613. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2589-90, *in camera*).

614. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2594, *in camera*).

(1) **Commercial Claims Data**

615. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2592-93, *in camera*; CX 6279 at 13, *in camera*).

616. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2590 *in camera*; Haas-Wilson, Tr. 2595-96,

in camera). { [REDACTED] } (Haas-Wilson, Tr.2619-20, *in camera*).

(2) The IDPH Universal Dataset

617. { [REDACTED] } (Haas-Wilson, Tr. 2596-98, *in camera*; CX 6279 at 14, *in camera*).

618. { [REDACTED] } (Haas-Wilson, Tr. 2598-99, *in camera*). { [REDACTED] } (Haas-Wilson, Tr. 2619-20, *in camera*).

b. Changes in the Mix of Customers at ENH Cannot Be Ruled Out As a Potential Explanation for the Increase in Prices at ENH Without Additional Analysis

619. Mix of customers refers to the different types of organizations that pay for patients at a hospital, whether it is commercial insurance or public health insurance programs, such as the Medicare and Medicaid programs. (Haas-Wilson, Tr. 2486).

620. If a hospital has more Medicare and Medicaid patients, that could provide a motivation for the hospital to raise its prices to patients of the managed care organizations, especially when payment under the public programs is lessened. (Haas-Wilson, Tr. 2486).

621. { [REDACTED] } (Haas-Wilson, Tr. 2600, *in camera*).

622. { [REDACTED] } (Haas-Wilson, Tr. 2600, *in camera*).

623. { [REDACTED] } (Haas-Wilson, Tr. 2600, 2602-03, *in camera*). { [REDACTED] } (Haas-Wilson, Tr. 2619-20, *in camera*).

c. Changes in the Teaching Intensity at ENH Cannot Be Ruled Out As a Potential Explanation for the Increase in Prices at ENH Without Additional Analysis

624. Teaching intensity is a measure of how much teaching activity is occurring at a hospital. Some hospitals participate in the training of residents and interns, future doctors. (Haas-Wilson, Tr. 2486-87).
625. There is empirical support for the proposition that hospitals that are involved in teaching activity have higher costs than hospitals that are not involved in teaching activity. (Haas-Wilson, Tr. 2487).
626. Therefore, those hospitals involved in more teaching may have higher costs than those involved with lesser amounts of teaching activity. (Haas-Wilson, Tr. 2487).
627. { [REDACTED] } (Haas-Wilson, Tr. 2603-04, *in camera*).
628. { [REDACTED] } (Haas-Wilson, Tr. 2604, *in camera*).
629. { [REDACTED] } (Haas-Wilson, Tr. 2604, *in camera*).
630. { [REDACTED] } (Haas-Wilson, Tr. 2603-04, 2606, *in camera*). { [REDACTED] } (Haas-Wilson, Tr. 2619-20, *in camera*).

5. Dr. Haas-Wilson Was Able to Eliminate Five of Her Eight Alternative Causes of the Price Increase at ENH

631. Dr. Haas-Wilson was able to eliminate five of her eight potential causes of the price increase at ENH as causes in fact.} (CCFF 586). The three remaining potential causes of the price increase could not be completely eliminated by her initial analysis, so Dr. Haas-Wilson used multiple regression to test the extent to which they could explain the price increases.} (CCFF 632).

E. Multiple Regression Analysis Ruled Out Changes in Patient Mix, Changes in Customer Mix, and Changes in Teaching Intensity As Explanations for the Relative Price Increase Observed at ENH After the Merger with Highland Park

632. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2615,
in camera).

1. Multiple Regression Analysis Allows the Researcher to Measure Simultaneously the Impact of Multiple Independent Variables on a Dependent Variable

633. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr.
2616, *in camera*).

634. [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2616, 2619, *in camera*).

635. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2619-20, *in camera*).

636. { [REDACTED]
[REDACTED]
[REDACTED] } (Dr. Haas-Wilson, Tr. 2620, *in camera*).

637. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2620, *in camera*).

638. { [REDACTED]
[REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2621, *in camera*).

639. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2621-22, *in camera*).

2. The IDPH Universal Dataset Shows That Changes in Patient Mix, Changes in Customer Mix, and Changes in Teaching Intensity Cannot Explain the Relative Price Increase at ENH Following the Merger with Highland Park, Using Any Control Group and Any Grouping of Patients

640. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2631-35, *in camera*; CX 6279 at 20, *in camera*).

641. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2530-31, *in camera*).

642. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }
(Haas-Wilson, Tr. 2622-23, *in camera*).

a. For All Patients in the IDPH Universal Dataset, Changes in Patient Mix, Customer Mix, and Teaching Intensity Cannot Explain the Relative Price Increase at ENH Following the Merger with Highland Park

643. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 20, *in camera*).

644. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 20, *in camera*).

645. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 20, *in camera*).

b. For Commercially Insured and Self Pay Patients in the IDPH Universal Dataset, Changes in Patient Mix, Customer Mix, and Teaching Intensity Cannot Explain the Relative Price Increase at ENH Following the Merger with Highland Park

646. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 20, *in camera*).

647. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 20, *in camera*).

648. { [REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 20, *in camera*).

c. For Commercially Insured, Self Pay, HMO, and Self-Administered Patients in the IDPH Universal Dataset, Changes in Patient Mix, Customer Mix, and Teaching Intensity Cannot Explain the Relative Price Increase at ENH Following the Merger with Highland Park

649. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 20, *in camera*).

650. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 20, *in camera*).

651. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 20, *in camera*).

3. Commercial Payer Claims Data Shows That Changes in Patient Mix, Customer Mix, and Teaching Intensity Cannot Explain the Relative Price Increase at ENH Following the Merger with Highland Park

652. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2622, *in camera*; CX 6279 at 18, *in camera*; CX 6279 at 19, *in camera*).

653. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2623-24, *in camera*, CX 6279 at 18, *in camera*).

654. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson,
Tr. 2624, *in camera*; CX 6279 at 18, *in camera*).

655. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2625, *in camera*).

656. { [REDACTED]
[REDACTED] } (Haas-
Wilson, Tr. 2625, *in camera*).

657. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2625, *in camera*; CX 6279 at 18, *in camera*).

658. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2625, *in camera*; CX 6279 at 18, *in camera*).

659. { [REDACTED] } (Haas-Wilson, Tr. 2628, *in camera*;
CX 6282 at 6, *in camera*).

660. { [REDACTED] } (Haas-Wilson, Tr. 2628-29 (discussing DX 7016, *in camera*), *in camera*).

a. Aetna

661. { [REDACTED] } (Haas-Wilson, Tr. 2512 (referring to DX 7010, *in camera*), *in camera*).

662. { [REDACTED] } (CX 6279 at 18, *in camera*).

663. { [REDACTED] } (CX 6279 at 18, *in camera*).

664. { [REDACTED] } (CX 6279 at 18, *in camera*).

b. Blue Cross

665. { [REDACTED] } (Haas-Wilson, Tr. 2626, *in camera*).

c. Humana

666. { [REDACTED] } (Haas-Wilson, Tr. 2511-12 (referring to DX 7010, *in camera*), *in camera*).

667. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2626-27, *in camera*; CX 6279 at 19, *in camera*).

668. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2626-27, *in camera*; CX 6279 at 19, *in camera*).

669. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 19, *in camera*).

670. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 19, *in camera*).

671. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 19, *in camera*).

d. United

672. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2511-12 (referring to DX 7010, *in camera*), *in camera*).

673. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2626-28, *in camera*; CX 6279 at 19, *in camera*).

674. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2627-28, *in camera*; CX 6279 at 19, *in camera*).

675. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 19, *in camera*).

676. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 19, *in camera*).

677. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 19, *in camera*).

e. One Health (Great-West)

678. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2511-12 (referring to DX 7010, *in camera*), *in camera*).

679. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2628, *in camera*; CX 6282 at 6, *in camera*).

680. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6282 at 6, *in camera*).

681. { [REDACTED]
[REDACTED]

[REDACTED] } (CX 6282 at 6
in camera).

682. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6282 at 6, in camera).

4. Dr. Baker's Regression Results Were Consistent with Dr. Haas-Wilson's Results Showing That Patient Mix Cannot Explain the Relative Price Increase at ENH After the Merger with Highland Park

683. { [REDACTED]
[REDACTED] } (Baker, Tr. 4631-32, in camera).

684. { [REDACTED]
[REDACTED] } (Baker, Tr. 4635, in camera).

685. { [REDACTED]
[REDACTED] } (Baker Tr. 4648-49, in camera). { [REDACTED]
[REDACTED] } (Baker, Tr. 4800, in camera).

686. { [REDACTED] } (Baker, Tr. 4637, in camera). { [REDACTED]
[REDACTED] } (Dr. Baker, Tr. 4638, in camera).

687. The control groups chosen by Dr. Noether were biased. (CCFF 1814-1951).

688. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2635-36 (referring to DX 7019 at 1, in camera), in camera; Baker Tr. 4645 (discussing DX 8042, in camera), in camera).

689. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }

[REDACTED] } (Haas-Wilson, Tr. 2636-37 (referring to DX 7019 at 2, *in camera*), *in camera*; Baker Tr. 4645-46 (discussing DX 8042, *in camera*), *in camera*).

690. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2630-31 (referring to DX 7018, *in camera*), *in camera*).

691. Dr. Baker admitted that the pricing pattern of ENH's prices to Humans, Aetna, and United was consistent with ENH obtaining market power through the merger with Highland Park. (Baker, Tr. 4742-43)

692. Even using Dr. Noether's biased control groups, Dr. Baker's results were consistent with Dr. Haas-Wilson's results. (CCFF 683-691).

5. Conclusion

693. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2637 (referring to DX 7024), *in camera*).

F. The Learning About Demand Theory Does Not Explain the Price Increases at ENH

694. Changes in information, or learning about demand, is a potential explanation that was put forth by the experts hired by ENH in this case. (Haas-Wilson, Tr. 2488). { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2642 (referring to DX 7024), *in camera*).

695. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2643, *in camera*).

1. The Pre-Merger Payment Rates in the Highland Park Contracts with Commercial Payers Would Not Teach ENH About the Demand by Payers for Its Services

696. { [REDACTED] } (Haas-Wilson, Tr. 2645, *in camera*).

697. { [REDACTED] } (Haas-Wilson, Tr. 2645 (referring to DX 7046, *in camera*), *in camera*).

698. { [REDACTED] } (Haas-Wilson, Tr. 2647-48, *in camera*).

699. Learning about contract rates does not necessarily tell one which hospital has the higher prices. (CCFF 696-698).

700. { [REDACTED] } (Haas-Wilson, Tr. 2646 (discussing DX 7047, *in camera*), *in camera*).

701. { [REDACTED] } (Haas-Wilson, Tr. 2646 (discussing DX 7047, *in camera*), *in camera*).

702. { [REDACTED] } (Haas-Wilson, Tr. 2647, *in camera*. See CCFF 700-701).

2. The Academic Control Group, Developed by Dr. Noether and Used by Both Dr. Noether and Dr. Baker, Is an Inappropriate Control Group to Compare with ENH

703. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2697, *in camera*).

704. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2698-2710 (referring to DX 7031, *in camera*), *in camera*).

a. **ENH's Patient Mix Is Very Different from the Patient Mix of Loyola University, Northwestern Memorial, Rush Presbyterian-St. Luke's, and the University of Chicago**

705. { [REDACTED]
[REDACTED] }
(Haas-Wilson, Tr. 2698, *in camera*).

706. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2698, *in camera*).

707. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }
(Haas-Wilson, Tr. 2699-2700 (referring to DX 7057, *in camera*), *in camera*; RX 1912 at 25).

708. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2699-70 (referring to DX 7057, *in camera*), *in camera*; RX 1912 at 26, *in camera*).

709. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2700 (referring to DX 7057, *in camera*), *in camera*).

b. Dr. Noether's Academic Control Group Inappropriately Compares ENH to Hospitals That Perform Quaternary Services

710. { [REDACTED] } (Haas-Wilson, Tr. 2701, *in camera*).

711. { [REDACTED] } (Haas-Wilson, Tr. 2701 (referring to DX 7058, *in camera*), *in camera*).

712. { [REDACTED] } (Haas-Wilson, Tr. 2702 (referring to DX 7058, *in camera*), *in camera*).

c. Most of the Hospitals in Dr. Noether's Academic Control Group Were Not Similar to ENH in Terms of the Overall Inpatient Services They Provide

713. { [REDACTED] } (Haas-Wilson, Tr. 2703-2704, *in camera*).

714. { [REDACTED] } (Haas-Wilson, Tr. 2703, *in camera*).

715. { [REDACTED] }

[REDACTED] } (Haas-Wilson, Tr. 2703, *in camera*; CX 6282 at 7 and 8, *in camera*).

716. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2704-05, *in camera*).

717. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2706, *in camera*).

718. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2707, *in camera*; CX 6282 at 7, 8; *in camera*).

d. Teaching Intensity, Bed Size, and Public Perception Were All Factors That Cut Against Dr. Noether's Control Group Being an Appropriate Control Group

719. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2708 (referring to DX 7061, *in camera*), *in camera*).

720. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2708-09, *in camera*; DX 7060, *in camera*).

721. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2711-2713 (referring to DX 7051, *in camera*), *in camera*).

e. The Testimony of ENH's Customers Undermines Dr. Noether's Control Group

722. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-
Wilson, Tr. 2713-14, *in camera*, citing Ballengee, Tr. at 188-189).

723. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2715, *in camera*, citing Neary, Tr.
Tr. 621).

724. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2716-17, *in camera*, citing Dorsey, Tr. 1443-44).

725. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2718-20, *in camera*, citing Foucre, Tr. 935-36).

726. { [REDACTED]
[REDACTED]
[REDACTED] }
(Haas-Wilson, Tr. 2720, *in camera*).

727. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2698, *in camera*).

**3. Even If One Accepts Dr. Noether's Control Group, Dr. Baker's
Analysis Shows That the Learning About Demand Claim Is
Inconsistent with the Pricing Evidence**

728. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2721 (referring to DX 7046, *in camera*), *in
camera*).

729. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson,
Tr. 2727-28, *in camera*).

730. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2728, *in camera*).

731. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2728 (discussing DX 7062 at 1, *in camera*), *in camera*).

732. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }
(Haas-Wilson, Tr. 2728 (discussing DX 7062 at 1, *in camera*), *in camera*).

733. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2728-29
(discussing DX 7062 at 2, *in camera*), *in camera*).

734. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2728-29
(discussing DX 7062 at 2, *in camera*), *in camera*).

735. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2731-32
(discussing DX 7062 at 3, *in camera*), *in camera*).

736. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2731-32 (discussing DX 7062 at 3, *in camera*), *in camera*).

4. Changes in Information, One of the Potential Explanations for the Price Increase Observed at ENH After the Merger, Does Not Explain the Price Increase

737. { [REDACTED] } (Haas-Wilson, Tr. 2644, *in camera*).

738. { [REDACTED] } (Haas-Wilson, Tr. 2732-33 (referring to DX 7046), *in camera*).

G. Conclusion - The Pricing of ENH to Health Plans Following the Merger with Highland Park Provides Direct Evidence of Anticompetitive Effects

739. The merger on January 1, 2000 between Evanston Hospital and Highland Park Hospital enhanced the market power of ENH, the merged entity, and, after the merger, ENH exercised its market power. (Haas-Wilson, Tr. 2657-58).

740. { [REDACTED] } (Haas-Wilson, Tr. 2733, *in camera*). { [REDACTED] } (Haas-Wilson, Tr. 2734, *in camera*).

1. Other Alternative Explanations Eliminated

741. { [REDACTED] } (Haas-Wilson, Tr. 2733-34, *in camera*).

2. Trial Testimony Supports This Conclusion

742. { [REDACTED] }

[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2734-36 (citing, for example, Ballengee, Tr. 179-80), *in camera*).

743. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2942, *in camera*).

3. Contemporaneous Business Documents Support This Conclusion

744. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2738-39 (referring to CX 13), *in camera*).

745. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2739-40 (referring to CX 17), *in camera*).

**UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION**

In the Matter of

EVANSTON NORTHWESTERN HEALTHCARE CORP.

Docket No. 9315

**COMPLAINT COUNSEL'S PROPOSED FINDINGS
OF FACT, CONCLUSIONS OF LAW, AND ORDER**

(Public Version)

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X. DIRECT EVIDENCE OF ANTICOMPETITIVE EFFECTS: EXPERIENCES OF HEALTH PLANS

A. Overview of 2000 Contract Negotiations and Price Increases

1. Chronology of Key Events and Identification of Key Players from ENH, Bain and Health Plans

746. In July 1999, Evanston and Highland Park Hospital signed the letter of intent to merge. (RX 567 at ENH MN 001365, ENH MN 001390).
747. { [REDACTED] } (Chan, Tr. 833-34, *in camera*; Hillebrand, Tr. 1868-69; Hillebrand 1707).
748. The merger was consummated on January 1, 2000. (Hillebrand, Tr. 1702; Harris, Tr. 4208).
749. The president and chief executive officer of ENH is Mark Neaman. Mr. Neaman became the CEO of Evanston in 1992 and remained CEO of the merged entity after 2000. As CEO, he oversees the development of corporate strategy and also oversees the overall development ENH's relationship and strategy with managed care companies. (Neaman, Tr. 953-54).
750. The chief operating officer of ENH is Jeffrey Hillebrand is the chief operating officer for ENH. (Hillebrand, Tr. 1699). Mr. Hillebrand began supervising contract negotiations for ENH in the mid-80s and became the COO for Evanston in 1998. Mr. Sirabian, who handled the day-to-day contracting duties, reported directly to Mr. Hillebrand on health plan contracting issues. (Hillebrand, Tr. 1699-700). During negotiations with "larger health plans," Mr. Hillebrand became directly involved in face-to-face negotiations. After becoming COO in 1998, he maintained supervisory responsibility for ENH's health plan contracting. (Hillebrand, Tr. 1700-02).
751. Jack Sirabian was responsible for ENH's managed care contracting negotiations from approximately 1990 to 2000. (Sirabian, Tr. 5697-98). During this time, Mr. Sirabian reported to Mr. Hillebrand with respect to managed care contracting. (Sirabian, Tr. 5728-29; Hillebrand, Tr. 1700).
752. In 1999, ENH retained Bain to provide consulting advice related to the Highland Park merger. (Neaman, Tr. 1159-61). The focus of Bain's 1999 merger consulting work for ENH was "growing net income by leveraging contracting and service line opportunities created by the Highland Park merger." (CX 74 at 3). Bain assisted ENH to create a

“unified contracting strategy reflecting the combined entities” of Highland Park and ENH. (CX 66 at 2).

753. Bain’s merger-related engagement began in the fall of 1999. Charles Farkas and Kim Ogden led the Bain team. (CX 2072 at 3). Bain provided contracting strategy advice for ENH’s negotiations with health plans, including individualized plans for each health plan. (CX 67 at 32-44).
754. Bain representatives themselves helped negotiate certain of ENH’s managed care contracts in the renegotiations relating to the Highland Park merger. (Neaman, Tr. 1217-18). Bain issued its final report in the merger project on February 1, 2000. (CX 67 at 1).
755. { [REDACTED] } (Chan, Tr. 834, *in camera*; Hillebrand, Tr. 1868-69).
756. In late 1999, United and ENH reached agreement on the new hospital rates with a contract effective date of January 1, 2000. (Hillebrand, Tr. 1875).
757. Representing United at trial in this proceeding was Jillian Foucre, regional vice-president for United for the Central Region. Ms. Foucre served as vice-president of operations from 1999 to 2001 and then as chief operating officer from 2001 to 2004. As chief operating officer, she had responsibility for all components of network management. (Foucre, Tr. 877-80). During her tenure as COO, she oversaw the negotiation of 30 to 35 hospital contracts annually. (Foucre, Tr. 883-84).
758. In December 1999, PHCS began renegotiations with ENH. (Ballengee, Tr. 173-4; CX 171 at 1).
759. PHCS’s renegotiated contract with ENH went into effect on April 1, 2000. (Ballengee, Tr. 188; CX 5071 at 1).
760. Representing PHCS at trial was Jane Ballengee, regional vice-president for PHCS. Ms. Ballengee was the Chicago territory director for PHCS from 1999 to 2004. As territory director, she was responsible for the contractors that handled the PHCS-provider contract negotiations. (Ballengee, Tr. 146). During most of her employment at PHCS, Ms. Ballengee had direct or supervisory responsibility for negotiations with Highland Park and ENH. (Ballengee, Tr. 165).
761. In December 1999, ENH contacted One Health to request renegotiation of its hospital contract. (Neary, Tr. 595).

762. After negotiations failed and after initially accepting ENH's contract termination, One Health accepted a new agreement with an effective date of January 1, 2001. (Dorsey, Tr. 1439-42; Hillebrand, Tr. 1707-08, 1898; CX 5067 at 4; CX 266 at 1).
763. Representing One Health at trial was Kevin Dorsey, former vice president at One Health. Mr. Dorsey was responsible for developing provider networks during his tenure at One Health. (Dorsey, Tr. 1428-30). Mr. Dorsey was involved in the renegotiations rounds between ENH and One Health in 2000 and 2001. (Dorsey, Tr. 1441-43).
764. Also representing One Health at trial was Patrick Neary, former director of network development and provider relations at One Health. (Neary, Tr. 581-83). He was responsible for State of Illinois contract negotiations from 1999 onwards. (Neary, Tr. 582-83).
765. Aetna's renegotiated contract with ENH became effective June 1, 2000. (CX 5008 at 1).
766. Representing Aetna at trial was Robert Mendonsa, general manager at Aetna's Chicago office. He had responsibility for network contracting and provider maintenance from the time he began in the Chicago office in 1997. (Mendonsa, Tr. 475-76). { [REDACTED] }
(Mendonsa, Tr. 521, *in camera*).
767. { [REDACTED] } (Holt-Darcy, Tr. 1527, *in camera*; CX 124 at 2, *in camera*).
768. { [REDACTED] } (Holt-Darcy, Tr. 1513-14, 62, *in camera*; CX 5075 at 17, *in camera*).
769. Representing Unicare at trial was Lenore Holt-Darcy, regional vice president for network services for Unicare. Ms. Holt-Darcy has been with Unicare since 2000, when Unicare acquired her former employer, Rush Prudential. Throughout her time at Rush Prudential and Unicare, Ms. Holt-Darcy has worked with network services, which involves managing contracts with hospitals and physicians. (Holt-Darcy, Tr. 1412-15).

2. Per Diem Versus Per Case Versus Discount Off Charges

a. Definitions

770. { [REDACTED] } (Holt-Darcy, Tr. 1521, *in camera*; Mendonsa, Tr. 524-25, *in camera*; Ballengee, Tr. 228, *in camera*; Sirabian, Tr. 5740; Chan, Tr. 667).

771. For example, in 1999 Aetna reimbursed Evanston Hospital \$1,010 per day for Medical and Surgical services. (CX 5007 at 4).

772. { [REDACTED]
[REDACTED]
[REDACTED] } (Ballengee, Tr. 229, *in camera*).

773. For example, under the 1998 PHCS contract, the health plan reimbursed Evanston Hospital \$2,652 per case for normal child birth deliveries. (CX 5070 at 30).

774. { [REDACTED]
[REDACTED]
[REDACTED] } (Ballengee, Tr. 227, *in camera*; Chan, Tr. 667).

775. A chargemaster is a list of 15,000 to 20,000 charges showing a hospital's gross charges for all of its services line-by-line. (Neaman, Tr. 1349; Hillebrand, Tr. 1710; Chan, Tr. 674; D. Jones, Tr. 4143).

776. { [REDACTED]
[REDACTED]
[REDACTED] } (Hillebrand, Tr. 1711; Ballengee, Tr. 227, *in camera*; Chan, Tr. 667).

777. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 5075 at 17, *in camera*).

b. Pressure from Health Plans Generally Resulted in Fixed Rate Contracts in the Late 1990s in the Chicago Area

778. { [REDACTED]
[REDACTED] } (Sirabian, Tr. 5739, 5704; Chan, Tr. 671; Chan Tr. 795-96, *in camera*).

779. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1521-22, *in camera*).

780. According to Ms. Schelling who worked for the Northwestern Healthcare Network from 1991 to 1997, the existing contracts for that period between hospitals and payers were predominantly per diem contracts. (CX 6307 at 13-14 (Schelling, Dep.)).

c. Pre-Merger, Health Plans Successfully Pressured Evanston and Highland Park Hospital for Various Fixed Rate Contracts

781. { [REDACTED] } (Chan, Tr. 782-83, 823-24, *in camera*; CX 1095).
782. { [REDACTED] } (Chan, Tr. 785, 787, *in camera*; CX 1095 at 6).
783. { [REDACTED] } (Chan, Tr. 673; Chan, Tr. 787, *in camera*; CX 1095 at 6).
784. Health plan pressure to renegotiate contracts to per diem arrangements did not diminish as time passed. (CX 439 at 8). In a June 1998 report for the Board's finance committee, Ms. Chan repeated the exact same message regarding "continued pressure from payors." (CX 439 at 8; CX 1095 at 6).
785. { [REDACTED] } (Chan, Tr. 794, *in camera*; CX 439 at 8).
786. { [REDACTED] } (Chan, Tr. 794, *in camera*; CX 439 at 8).
787. Prior to the merger, Evanston also "stayed within the standards that were being followed" in the industry as pricing for health plans evolved into per diem and per case pricing. (Sirabian, Tr. 5725).
788. { [REDACTED] } (Holt-Darcy, Tr. 1521, *in camera*; Chan, Tr. 786, *in camera*; CX 5091 at 1, Neary, Tr. 775, *in camera*; CX 5059 at 17; CX 5065 at 17; Ballengee, Tr. 253-54, *in camera*; CX 5068 at 27, *in camera*; CX 5070 at 28).

789. { [REDACTED] } (Holt-Darcy, Tr. 1526, *in camera*; Noether, Tr. 6090, *in camera*).

d. Health Plans Typically Prefer Fixed Rates, in Part Because Fixed Rates Are Predictable

790. { [REDACTED] } (Mendonsa, Tr. 523-25, *in camera*; Ballengee, Tr. 234-35, 255, *in camera*. See RX 1414 at PHCS 000102, RX 1615 at 4 (In its annual reports, PHCS tells its customers that “Fixed costs, such as per diem and per case, are the most advantageous because they allow customers to predict claims costs.”)).

791. Per diem arrangements protect health plans from unexpected increases in the hospital’s chargemaster. (Porn, Tr. 5669-70). Generally, an increase to chargemaster prices will only impact a health care provider’s contracts containing a discount-off-charges provision. (Porn, Tr. 5670).

792. [REDACTED] (Ballengee, Tr. 234-35, 255, *in camera*; Mendonsa, Tr. 524-25; *in camera*).

793. { [REDACTED] } (Mendonsa, Tr. 524, 527-28, *in camera*; Mendonsa, Tr. 488-89).

794. For health plans such as Aetna, the ability to accurately predict expenses is “extremely important” because “about 65-70 percent of the business renews in January,” which locks in a health plan’s revenue stream “for a whole year.” (Mendonsa, Tr. 482-83).

795. Once a health plan’s revenue stream from contract renewals in January is “locked in,” that health plan “really can’t . . . go back [to employer groups] in the middle of the year and say, oops, we need more premium.” (Mendonsa, Tr. 482-83).

796. In fact, in its 2001 and 2004 SEC statements to the public, Aetna marketed itself as a health plan that “typically enters into contracts that provide for all-inclusive per diem and per case rates.” (RX 1047 at 9; RX 1650 at 9).

797. During Evanston contract negotiations pre-merger, Evanston knew that health plans requested per diem and per case rates so that they could fix their costs and price their products accordingly for the coming year. (Sirabian, Tr. 5740).

e. **Health Plans Lose Predictability Under a Discount off Charges Arrangement**

798. { [REDACTED] } (Mendonsa, Tr. 525-27, *in camera*). "
799. { [REDACTED] } (Ballengee, Tr. 235, *in camera*; Mendonsa, Tr. 524-28, *in camera*. See Holt-Darcy, Tr. 1522 ({ [REDACTED] })), *in camera*. See also Sirabian, Tr. 5740-41 (It is "hard for [health plans] to forecast their own costs" under a discount off charges arrangement.); Haas-Wilson, Tr. 2647-48, *in camera*; RX 1414 at PHCS 000102; RX 1615 at 4).
800. { [REDACTED] } (Neary, Tr. 609; Newton, Tr. 366; Holt-Darcy, Tr. 1522, *in camera*; Foucre, Tr. 889. See Mendonsa, Tr. 524-28 ({ [REDACTED] })), *in camera*).
801. Under a discount off charges contract, the higher the chargemaster list price, the more health plans have to pay to the hospital. (Porn, Tr. 5670).
802. { [REDACTED] } (Ballengee, Tr. 235, *in camera*).
803. { [REDACTED] } (Ballengee, Tr. 235, *in camera*; Holt-Darcy, Tr. 1522, *in camera*; Neary, Tr. 609. See RX 1414 at PHCS 000102 (Under a discount off charges arrangement, health plan customers become "susceptible to unpredictable increases in costs."); RX 1615 at 4).

f. **Health Plans Typically Prefer Fixed Rates, in Part Because Health Plans Achieve Lower Rates Through Such Arrangements**

804. Per diem rates are beneficial to health plans in part because they result in greater discounts “up to 50%” for services than do discount off charges arrangements. (Chan, Tr. 675-76).
805. Pre-merger, Evanston and Highland Park’s fixed rate contracts gave health plans “much higher” discounts than the contracts that were structured in a discount off charges arrangement. (Chan, Tr. 675-76).

g. Health Care Providers Prefer Discount off Charges Arrangements Because Such Arrangements Mean Less Risk and More Profit for the Providers

806. Discount off charges arrangements represent “less risk” for a provider and are therefore preferable for the provider over per diem and per case arrangements. (Chan, Tr. 673).
807. Fixed rate contracts with per diem or per case rates limit the amount that the hospital can be reimbursed when a patient is “very sick and incur[s] a lot more charges.” (Chan, Tr. 673).
808. A discount off charges contract is also beneficial to a hospital because it reduces the overall discount that a provider gives health plans and represents an opportunity to increase net revenue. (Chan, Tr. 675-76; Newton, Tr. 366).
809. Once a contract’s reimbursement rate is negotiated as a certain percent discount off charges, a hospital can simply “raise [its] gross charges,” to increase its net revenue. (Newton, Tr. 366). “There’s no limit” on a hospital’s ability to “raise gross prices” under a discount-from-charges arrangement. (Newton, Tr. 366).
810. The rates that health plans pay through a discount off charges arrangement are linked to the hospital’s chargemaster list pricing. (Porn, Tr. 5670).
811. There is “no restraint on a hospital’s ability to raise its list pricing.” (Newton, Tr. 366).
812. The more discount-off-charges contracts a provider has, the more impact a chargemaster increase will have. (Porn, Tr. 5670).

h. With Regard to the Merger, ENH Strategized to Move All Health Plan Contracts to a Discount off Charges Arrangement

813. {

[REDACTED]

[REDACTED] (CX 1373 at 14, *in camera*; RX 2047 at 204-05 (Ogden, Dep.), *in camera*. See also CX 67 at 49; (Bain advised ENH to “Lead with Percent of Charges”); CX 75 at 16).

814. [REDACTED]
[REDACTED]
[REDACTED] (CX 1373 at 14, *in camera*; Chan, Tr. 673-74, *in camera*).

815. In order to “better the terms” of health plan contracts during the post-merger renegotiations, ENH representatives strategized to “shif[t], whenever possible, to a discount from charges from a per diem.” (Newton, Tr. 366; Hillebrand, Tr. 1855. See Hillebrand, Tr. 1705-06 (Mr. Hillebrand’s “first negotiating step” with health plans in 2000 was to “move to discount off charges.”)).

816. By switching from a per diem arrangement to a discount off charges arrangement, ENH ensured that it would be reimbursed based upon its chargemaster list prices. (Pom, Tr. 5670; Chan, Tr. 743-44. See CCFF 791).

i. ENH Achieved Discount off Charges Arrangements with Various Health Plans Through the Merger

817. ENH successfully moved a number of health plans to discount off charges arrangements after the merger. (Hillebrand, Tr. 1706).

818. [REDACTED]
[REDACTED] (Ballengee, Tr. 252, 255, *in camera*; Hillebrand, Tr. 1893; compare CX 116 at 2, *in camera*, CX 117 at 1, *in camera*, and CX 5072 at 23, *in camera*).

819. [REDACTED]
[REDACTED] (Hillebrand, Tr. 1947, *in camera*; compare CX 5067 at 15, *in camera*, CX 5059 at 17, and CX 5065 at 17).

820. [REDACTED]
[REDACTED] (Holt-Darcy, Tr. 1536, 1539, 1563, *in camera*; CX 5075 at 17, *in camera*).

821. { [REDACTED] } (CX 1373 at 14, *in camera*. See CCFF 898, 901, *in camera*).

B. With the Merger, ENH Demanded One Price for All Three Hospitals

1. ENH Wanted All Three Hospitals to Be Put on Whichever Pre-Merger Contract for the Particular Health Plan Had Higher Rates, Evanston's or Highland Park's

a. ENH Moved All Three Hospitals to the Same Health Plan Contract

822. During the winter of 1999, ENH senior management met to discuss strategies for integrating the health plan contracts of the merging parties. (Hillebrand, Tr. 1703; Newton, Tr. 363-65).

823. Senior management decided that the merged entity would put the three ENH facilities on the same contract and charge the same rate for all three facilities. (Hillebrand, Tr. 1703; Newton, Tr. 365. See CX 75 at 12 (Bain advised ENH to “[s]et high targets and preferred structure” for health plan contracts.)).

824. { [REDACTED] } (Holt-Darcy, Tr. 1561, *in camera*; Foucre, Tr. 890; Ballengee, Tr. 176; Neary, Tr. 602; Neary, Tr. 756, *in camera*; Holt-Darcy, Tr. 1528, *in camera*; Dorsey, Tr. 1447; CX 262 at 2, *in camera*).

825. Under ENH's proposed billing system, health plans “can't distinguish between services at the three hospitals” to determine which services were rendered at a particular hospital in the system. (Foucre, Tr. 890-92).

826. United found ENH's insistence on one tax identification number and identical rates for all three hospitals to be “challenging” under the 2000 renegotiated contract. (Foucre, Tr. 890-92).

827. Evanston Hospital, Glenbrook Hospital, and Highland Park hospital did not merit equal reimbursement rates. (Dorsey, Tr. 1446-47).

828. Glenbrook Hospital did not have “the same level of service or the same requirement of service . . . as other hospitals within the ENH network.” (Dorsey, Tr. 1447).

829. Evanston Hospital did not “warran[t] the same reimbursement structure as [the health plan was] giving to Highland Park prior to the merger.” (Dorsey, Tr. 1447).
830. None of the disagreements that health plans had with ENH’s proposed contract structure stopped the merged entity from successfully moving all three facilities to the same health plan contract and equalizing the charges for all three sites post-merger. (See, e.g., CX 5174 at 11 ({}), *in camera*; CX 5072 at 11 ({}), *in camera*; CX 5064 at 15, 17 ({}), *in camera*; CX 5067 at 15 ({}), *in camera*. See Hillebrand, Tr. 1707-08, 1875 (Except for losing One Health for a short period of time, ENH lost no health plan customers over the course of the 2000 renegotiations.); Noether, Tr. 6192-93; CX 5008 at 5 ({}), *in camera*; CX 5075 at 17 ({}), *in camera*; CX 5046 ({}), *in camera*).
831. In December 1999, Evanston’s rates were assigned to all three facilities for Aetna, Blue Cross PPO, and CCN health plans. (CX 5940 at 15-16).
832. In December 1999, Highland Park’s rates were assigned to all three facilities for Preferred Plan, Multiplan PPO, Formost, Admar, Health Marketing, and Beech Street/CAPP Care health plans. (CX 5900 at 1-7; CX 5901 at 1-2; CX 5940 at 15).

b. ENH Moved Health Plans to Whichever Contract Had Higher Rates, the Evanston Contract or the Highland Park Contract

833. In addition to placing all three facilities on the same contract with the same rate structure, ENH senior management also planned to “use the better of the two [hospital] contracts” for health plans post-merger. (Hillebrand, Tr. 1856, 1705; Neaman, Tr. 1031, 1346-47).
834. ENH decided to take whichever was the higher of the two hospital contracts and apply those rates across the board for the post-merger entity. (Hillebrand, Tr. 1705. See CX 75 at 8 (Bain advised ENH to “Identify Superior Contracts” between the two hospital contracts and “notify [health plans] that HP is now assigned to ENH” for those contracts in which “HP [rate] is superior.”)).
835. {}
{}
{}
(CX 1373 at 15, *in camera*).
836. {}
{} (CX 5900 at 2-7; CX 5901; CX 5902, *in camera*; Hillebrand, Tr. 1705).

837. { [REDACTED]
[REDACTED]
[REDACTED] } (Compare CX 5900 at 1
and CX 1373 at 14, *in camera*).

838. “Conver[ting] all payer contracts to the most favorable rates” was an “Opportunity
Ite[m]” for the merged entity that Ernst and Young projected could provide anywhere
from \$500,000 to \$1,000,000 in possible revenue enhancements. (CX 2386 at 2).

839. In fact, as of March 2000, converting the payer contracts to the more favorable rates had
exceeded ENH’s opportunity targets seven-fold. (CX 2386 at 2). Ernst & Young’s
March 2000 update showed that ENH had enhanced its revenue by \$7 million dollars, a
figure that was “ongoing.” (CX 2386 at 2. See CX 2234 at 2 (An April 2000 Ernst &
Young update also showed revenue enhancement achievements from converting the payer
contracts to the most favorable rates to be \$6 million more than the \$1 million target
figure.)).

840. One month later, in May 2000, Ernst and Young reported that converting the payer
contracts to the more favorable of the Highland Park or Evanston contract had increased
ENH’s revenue *another* \$3 million dollars, for a total of \$10 million in revenue
enhancements. (CX 23 at 2 (emphasis added)).

841. The \$10 million revenue enhancement that ENH gained by converting all payer contracts
to the most favorable rates was “ongoing” as of May, 2000. (CX 23 at 2).

842. The question of whether Highland Park should be put on the Evanston pre-merger
contract for a particular health plan or whether Evanston should be put on the Highland
Park pre-merger contract for that health plan arose because of the merger. (Hillebrand,
Tr. 1703-05; CX 30 at 1, 3; Neaman, Tr. 1031). In short, the shift of all three hospitals to
one of the two pre-merger contracts for each health plan and the price increases resulting
from the shift to the more favorable contract were both due to the merger. (Hillebrand,
Tr. 1703-05; CX 30 at 3; Neaman, Tr. 1031).

**c. Some Health Plans Disagreed with the Automatic Assignment
of the Higher-Rate Contract to Cover All Three ENH Hospitals**

843. { [REDACTED]
[REDACTED]
[REDACTED] } (Neary, Tr. 603, 606; Holt-Darcy, Tr.
1560-61, *in camera*).

844. { [REDACTED]
[REDACTED]
[REDACTED] } (Neary, Tr. 603, 644; Neary, Tr. 761, *in camera*).
845. One Health also deemed it inappropriate to increase One Health's rates at Evanston to the level of Highland Park's rates because "the other hospitals that were in Evanston's community were not at that same level [of contract rates] as Highland Park." (Neary, Tr. 606).
846. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1560, *in camera*. See Holt-Darcy, Tr. 1536, 1560-61, ({ [REDACTED]
[REDACTED]
[REDACTED] })), *in camera*).
847. { [REDACTED]
[REDACTED] }
(Hillebrand, Tr. 1705-06; Ballengee, Tr. 174-75; Neary, Tr. 763-64, *in camera*; Dorsey, Tr. 1439-42; Holt-Darcy, Tr. 1563, *in camera*; CX 5900 at 1).

2. In Re-Negotiating Contracts, ENH Demanded the Higher of the Two Contract Rates Plus a Premium

a. ENH Went With the More Favorable Contract and Then Added a Premium to the Higher Rate

848. Using the more favorable of the two hospital contract rates was only ENH's "starting point" in health plan renegotiations after the merger. (Hillebrand, Tr. 1856, 1705).
849. In fact, during the winter of 1999 ENH senior management had decided that "the combined entity would use the better of the Highland Park or Evanston [contract rate] and then add a premium to that." (Newton, Tr. 364 (emphasis added). See Hillebrand, Tr. 1705).
850. As one of the "benefits of the merger," senior management recognized "the additional negotiating power and leverage with the payors." (Newton, Tr. 365; Chan, Tr. 709-10).
851. ENH Negotiators would use this additional leverage to "seek additional price from the health plans" and to "increase the revenue to the combined entity." (Newton, Tr. 364-65. See CX 67 at 49 (ENH strove to "Justify premium pricing (i.e., above the competitive average.")).

852. ENH admitted that the merged entity was successful in 2000 in negotiating prices above the pre-merger rates of either Evanston or Highland Park for numerous payors. (Hillebrand, Tr. 1705).
853. In an October 2000 "Sequential Listing of Accomplishments," Mr. Neaman reported that the merged entity had successfully achieved an additional \$18 million per year through managed care contract renegotiations. (CX 17 at 5-8. *See also* CX 13 at 1 (In July, 2000, Mr. Neaman reported an additional \$16 million per year in total managed care re-negotiation benefits to the board); *plus* CX 17 at 8 (September, 2000, Humana contract renegotiation resulted in \$2 million annualized economic revenue). *See* CCF 855).
854. Among ENH's "accomplishments" were the re-negotiations of the United, PHCS, Aetna, Blue Cross/Blue Shield, and Cigna contracts, which collectively resulted in an annualized economic value of \$15 million for ENH (\$3 million per health plan). (CX 17 at 5-8). ENH realized an additional \$3 million annually from the renegotiation of the Humana contract and from the re-negotiation of other smaller PPO contracts combined (\$2 million for Humana and \$1 million for some "smaller" PPO contracts combined). (CX 17 at 5, 8).
855. Using Mr. Hillebrand's figure of \$3.5 million in annualized economic benefit from the re-negotiation of the United contract instead of Mr. Neaman's \$3 million figure increases ENH's total annualized economic revenue from the re-negotiation of managed care contracts to \$18.5 million. (CX 5 at 5. *See* CX 17 at 5-8 (1/00 "Other (smaller) PPO agreement re-negotiations" (\$1 million), 3/00 "Private Healthcare re-negotiation" (\$3 million), 5/00 "Renegotiated Aetna contract" (\$3 million), 6/00 "Blue Cross Contract re-negotiation" (\$3 million), 6/00 "Cigna Contract re-negotiation" (\$3 million), and 9/00 "Humana Contract Re-negotiations" (\$2 million)).
856. Evanston "had never achieved" a price increase as high as \$18 million before the merger. (Hillebrand, Tr. 1722).
857. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Dorsey, Tr. 1439-42, 57; Hillebrand, Tr. 1708, 1898; Sirabian, Tr. 5717; CX 5067 at 4, *in camera*; CX 266 at 1).
858. This \$18 - \$18.5 million in additional annualized revenue does not take into account additional annualized revenue that ENH achieved through the shifting of health plans to the contract with the highest rate (between Evanston and Highland Park), the adoption of

the higher of the Highland Park or Evanston pre-merger chargemaster rates post-merger, or the chargemaster increases in 2002 and later. (CX 17 at 5-8; CX 5 at 5; CX 13 at 1).

859. Evanston and Highland Park could not have accomplished these annualized revenue increases absent the merger. (CX 17 at 2 (“As stated previously, none of this could have been achieved by either Evanston or Highland Park alone.”); CX 13 at 1 (“Neither Evanston nor Highland Park alone could achieve these results.”)).

b. ENH Charged a Premium Over the Higher Evanston or Highland Park Pre-Merger Rate in Numerous Health Plan Contracts

(1) Aetna

860. { [REDACTED] } (Compare CX 5001 (Highland Park pre-merger contract with Aetna), CX 5007 (Pre-merger Evanston contract with Aetna), and CX 5008 ({ [REDACTED] })), *in camera*. See CCF 863, 865, 868, *in camera*.
861. { [REDACTED] } (Hillebrand, Tr. 1942, *in camera*).
862. { [REDACTED] } (Compare CX 5001 at 4 and CX 5007 at 4; Hillebrand, Tr. 1948-52; Mendonsa, Tr. 550, *in camera*).
863. { [REDACTED] } (Compare CX 5001 at 4, CX 5007 at 4 and CX 5008 at 5-6, *in camera*).
864. For Aetna’s POS product, rates at Highland Park and Evanston for Medical, Surgical, Intensive Care Unit, Coronary Care Unit, OB-Normal, OB-C-section, and Boarder Baby did not differ by more than 50 dollars. (Compare CX 5001 at 6 and CX 5007 at 7).
865. { [REDACTED] } (Compare CX 5001 at 6, CX 5007 at 7 and CX 5008 at 5, *in camera*).

- 866. Prior to the merger, both Highland Park and Evanston's PPO rates to Aetna for Intensive Care, Coronary Care, OB-C-section and Boarder Baby were identical. (*Compare CX 5001 at 8 and CX 5007 at 10*).
- 867. Pre-merger rates at Highland Park and Evanston for Medical and Surgical services under the PPO product differed by only 40 dollars. (*Compare CX 5001 at 8 and CX 5007 at 10*).
- 868. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }
(*Compare CX 5001 at 8, CX 5007 at 10, and CX 5008 at 5-6, in camera*).
- 869. { [REDACTED]
[REDACTED]
[REDACTED] } (*Hillebrand, Tr. 1952, in camera*).

(2) Cigna

- 870. Beginning in 2000, ENH also charged rates that were above both the Highland Park and Evanston pre-merger contract rates for numerous service categories in the post-merger Cigna contract. (CX 5011; CX 5013; CX 5015. *See also CCF 872, 874*).
- 871. Prior to the merger, Cigna's reimbursement rate for Medical and Surgical services was \$1,320 per day to Highland Park and \$1,270 per day to Evanston. (CX 5011 at 1; CX 5013 at 2).
- 872. Instead of simply adopting the higher of Cigna's two hospital rates, ENH sought a per diem that was \$77 more than either hospital's pre-merger rate, and contracted with Cigna to be reimbursed at \$1,397 per day. (CX 5015 at 18).
- 873. Similarly, Evanston's rates pre-merger were higher than Highland Park's for ICU services. (*Compare CX 5013 at 2 (Evanston's ICU per diem of \$1,765) with CX 5011 at 1 (Highland Park's ICU per diem of \$1,320)*).
- 874. Post-merger, ENH adopted an ICU rate of \$1,942 per day, a rate \$177 more than Evanston's pre-merger per diem and \$622 more than Highland Park's pre-merger per diem. (*Compare CX 5015 at 18, CX 5013 at 2, and CX 5011 at 1*).

(3) Humana

875. { [REDACTED] } (CX 5019, *in camera*; CX 5027, *in camera*; CX 5029. *See also* CCF 876-878, *in camera*).

876. { [REDACTED] } (*Compare* CX 5019 at 2-4, *in camera*, CX 5027 at 1, *in camera*, and CX 5029 at 1).

877. { [REDACTED] } (*Compare* CX 5019 at 2-4, *in camera*, CX 5027 at 1, *in camera*, and CX 5029 at 1).

878. { [REDACTED] } (*Compare* CX 5019 at 2-4, *in camera*, CX 5027 at 1, *in camera*, and CX 5029 at 1).

879. Post-merger, the increase in Humana's rates over those charged by either Evanston or Highland Park was consistent with ENH's "premium pricing" strategy. (CX 67 at 49. *See* CCF 849, 852).

880. ENH was only able to impose a premium over pre-merger Evanston and Highland Park contract rates as a result of the merger. (Ballengee, Tr. 176-77, 194-95. *See* CX 13 at 1 (In referring to managed care renegotiations, Mark Neaman told the ENH board of directors that "neither Evanston nor Highland Park alone could achieve these results.")).

3. ENH Set up One Chargemaster for All Three Hospitals, with the Price for Each Product and Service Positioned at the Higher of the Two Pre-Merger Prices, Evanston's or Highland Park's

a. Chargemaster Definition

881. A chargemaster is a line-by-line listing of 15,000 to 20,000 line items showing a hospital's gross charges (i.e. list price) for all of its services. (Neaman, Tr. 1349; Chan, Tr. 674; H. Jones, Tr. 4143; Hillebrand, Tr. 1710-11).

882. { [REDACTED] } (Hillebrand, Tr. 1711; Ballengee, Tr. 227, *in camera*; Chan, Tr. 667).

883. { [REDACTED] } (Neary, Tr. 766, *in camera*).

b. ENH Adopted the Higher of the Evanston or Highland Park Pre-Merger Chargemaster Rates Post-Merger

884. As part of the merger integration process, ENH consolidated the Highland Park and Evanston chargemasters in 2000. (Hillebrand, Tr. 1710; Porn, Tr. 5643).
885. In keeping with ENH's goal to move all three facilities to the same rates, ENH set out to conform the chargemaster rates for all three hospitals. (Hillebrand, Tr. 1704; Porn, Tr. 5643).
886. Mr. Hillebrand was the "principal person" in charge of the chargemaster transition team. (Hillebrand, Tr. 1713).
887. Led by Mr. Hillebrand, ENH's transition team set out to "[e]qualize charges at all three sites," regardless of the different cost-structures at the three ENH hospitals. (Hillebrand, Tr. 1713; CX 2239 at 1). The work began in 1999 and was largely done in January 2000. (See CX 2237 at 1; CX 42 at 2; CX 2462 at 1).
888. In a "fairly simplistic analysis," ENH examined the chargemasters at the two hospitals and adopted the higher of the Highland Park or Evanston chargemaster rates across the board for each line item. (Hillebrand, Tr. 1711, 1714-15; Noether, Tr. 6193. See CX 2240 at 11).
889. For example, in universalizing the Intensive Care Unit line-item rate on the chargemaster, the merged entity chose Evanston's rate of \$1,900 over Highland Park's lower rate of \$1,828. (Hillebrand, Tr. 1715; CX 2240 at 11).
890. Similarly, for a Semi-Private Room, ENH chose Highland Park's chargemaster rate of \$711 over Evanston's lower rate of \$588. (Hillebrand, Tr. 1715; CX 2240 at 11).
891. For service line-items that only existed at one hospital and not the other, ENH automatically adopted the existing price. (Hillebrand, Tr. 1715; CX 2240 at 11).
892. Upon completion of merging the chargemaster items related to renal dialysis, that transition team's report reflected ENH's objective: "Highest charge comparing those of EH and HPH utilized on new Charge Master." (CX 2383 at 2).
893. For renal dialysis alone, ENH's finance department estimated a \$1,324,497 "revenue enhancement" from selecting the higher of the Highland Park and Evanston rates. (CX 2383 at 2).

894. In January 2000, ENH's transition team projected the overall increase in gross revenue from equalizing the charges at the three hospitals to be at least \$100,000,000. (CX 2237 at 1; CX 42 at 2; CX 2462 at 1). Later ENH documents also estimated the overall increase in gross revenues at \$100 million (CX 2238 at 1 (May); CX 2239 at 1 (June); CX 2384 at 2 (July)).
895. With regard to net revenue, as of September 30, 2000, only nine months after the merger, Mr. Neaman reported to ENH's board of directors that ENH's "Unified Pricing Structure" for the chargemaster had already resulted in \$5 million of Annualized Economic Value. (CX 2382 at 6).

c. In Adopting the Higher of the Two Merging Parties' Chargemaster Rates, ENH Raised Its Prices to Health Plans with Discount Off Charges Arrangements

896. Under a discount off charges contract, the price that the health plan must pay to the hospital increases as the chargemaster list price increases. (Porn, Tr. 5670).
897. { [REDACTED] } (Neary, Tr. 609; Newton, Tr. 366; Holt-Darcy, Tr. 1522, *in camera*; Foucre, Tr. 898, 889; Mendonsa, Tr. 524-28, *in camera*. See CCF 799, *in camera*).
898. { [REDACTED] } (CX 1373 at 14, *in camera*; CX 75 at 16; CX 2047 at 61-62 (Ogden, Dep.), *in camera*. See CX 67 at 49 (Bain advised ENH to "Lead with Percent of Charges"))).
899. { [REDACTED] } (CX 1373 at 14, *in camera*).
900. After the merger, ENH's "first negotiating step" with every health plan was to "move to discount off charges" arrangements. (Hillebrand, Tr. 1706; Newton, Tr. 366. See CCF 815).
901. { [REDACTED] } (Hillebrand, Tr. 1706, 1893; Hillebrand, Tr. 1947, *in camera*; Ballengee, Tr. 252, 255, *in camera*; Holt-Darcy, Tr. 1536, 1539, 1563, *in camera*; CX 5075-017, *in camera*; compare CX 116 at 2, *in camera*, CX 117 at 1, *in camera*).

camera, and CX 5072 at 23, *in camera*; compare CX 5067 at 15, *in camera*, CX 5059 at 17, and CX 5065 at 17).

902. By switching from a per diem to a discount off charges arrangement and adopting the higher of the two hospitals' chargemaster rates, ENH ensured that health plans would have to reimburse the hospital system at a higher rate. (Pom, Tr. 5670; Chan, Tr. 743-44).
903. The question of whether Highland Park should be put on the Evanston chargemaster for a particular product or service or whether Evanston should be put on the Highland park chargemaster for that product or service arose because of the merger. (Hillebrand, Tr. 1704). In short, the shift of all three hospitals to one of the two chargemasters for that product or service and the price increases resulting from the shift to the higher of the two chargemaster rates were both due to the merger. (Hillebrand, Tr. 1704).

4. Other Hospital Systems Have Separate Prices for Each Hospital

a. It Is Unusual For a Hospital System to Charge the Same Rates for All Hospitals in the System

904. The ENH system consists of Evanston, Highland Park, and Glenbrook Hospitals. (Neaman, Tr. 954).
905. Highland Park and Glenbrook are community hospitals, while ENH claimed in this litigation to be an academic medical center. (Neaman, Tr. 1286-87).
906. After the merger, ENH senior management renegotiated health plan contracts so that all three of its facilities would be reimbursed at the same rate. (Hillebrand, Tr. 1703. See CCFF 824).
907. { [REDACTED] } (Foucre, Tr. 890-92; See Foucre, Tr. 891-92 (Other than ENH, there are no other systems in United's Chicago network that demand the same rate and contract for all the hospitals in the system.); Ballengee, Tr. 163-65; Dorsey, Tr. 1445-46; RX 1503, *in camera*; Holt-Darcy, Tr. 1528, *in camera*).
908. { [REDACTED] } (Foucre, Tr. 890-92; Ballengee, Tr. 163-65; Dorsey, Tr. 1446-47; RX 1503, *in camera*. See Holt-Darcy, Tr. 1528 ({ [REDACTED] }), *in camera*).

b. The Advocate, Rush, Resurrection and Provena Systems Charge Different Rates for Different Hospitals in Their Systems

909. The Advocate System consists of eight hospitals, all in the Chicago area. (Foucre, Tr. 934; Neaman, Tr. 1297). Advocate Lutheran General is the flagship hospital of the Advocate system. (Neaman, Tr. 1296).
910. { [REDACTED] } (Ballengee, Tr. 163-64; RX 1503 at PHCS 003649-66, *in camera*).
911. { [REDACTED] } (Foucre, Tr. 890-91; Ballengee, Tr. 163-65; Dorsey, Tr. 1446. *See e.g.* RX 1503, *in camera*).
912. Five hospitals make up the Rush system, with Rush Presbyterian-St. Luke's Medical Center as the flagship hospital for the system. (Foucre, Tr. 933).
913. As the academic facility in the system, Rush Presbyterian-St. Luke's is reimbursed at a higher rate than other hospitals in the system that offer a narrower breadth of services. (Dorsey, Tr. 1445-46; Ballengee, Tr. 163-64).
914. One Health and PHCS pay different rates for the hospitals in the Rush system based upon hospital service offerings. (Ballengee, Tr. 163-65; Dorsey, Tr. 1446).
915. When United's attempts to renew a business relationship with the entire Rush System failed in August 2003, the Rush System even allowed United to contract independently with Rush North Shore, only one of the five hospitals in the System. (Foucre, Tr. 935).
916. { [REDACTED] } (Foucre, Tr. 890-91; Ballengee, Tr. 263, *in camera*; RX 1854 at ENHE F16 000426; RX 722, *in camera*).
917. { [REDACTED] } (*See* CCFF 1303, *in camera*).

C. ENH Instituted Major Chargemaster Price Increases in 2002 and 2003

918. { [REDACTED] } (RX 1687 at ENHL BW 027653, *in camera*; CX 44 at 1; CX 43 at 1; CX 45 at 8). { [REDACTED] } (Newton, Tr. 364-65; Neaman, Tr. 1036, 39; Hillebrand, Tr. 1790, 1801-02, 1811-12; CX 68 at 11, 13; CX 86 at 2-3; CX 69 at 1; CX 19; CX 2070 at 3; CX 75 at 12).
919. { [REDACTED] } (CX 44 at 3; CX 45 at 8; RX 1687 at ENHL BW 027653, *in camera*). ENH expected that the April 2002 charge increase would yield ENH between \$20 to \$26 million in net revenue annually (which is roughly 20% net of the gross increase). (CX 45 at 8).
920. { [REDACTED] } (RX 1687 at ENHL BW 027653, *in camera*).
921. { [REDACTED] } (RX 1687 at ENHL BW 027653, *in camera*).
922. { [REDACTED] } (RX 1687 at ENHL BW 027653, *in camera*).
923. { [REDACTED] } (RX 1687 at ENHL BW 027653, *in camera*. See also CCF 1394, *in camera*).
924. { [REDACTED] } (See CCF 817-821, 930, *in camera*).

D. The First Major Chargemaster Increase in 2002 Is an Example of ENH's Ability to Increase Prices Dramatically to Health Plans Without Needing to Re-Negotiate Their Contracts

925. In the spring and summer of 2002, ENH substantially raised prices on its chargemaster, resulting in an overall sustained, net price increase of over 8% to healthcare plans. (Pom, Tr. 5681-82, 85; CX 45 at 8).
926. There was little analysis on the part of ENH management as to the extent or magnitude of these substantial price increases or ENH's ability to raise prices to health plans.

(Hillebrand, Tr. 1718 (decision to raise prices to 90th percentile target based on less than one hour deliberation with business consultant); Porn, Tr. 5681).

927. These price increases resulted in a projected net impact of \$20 million to \$26 million annually. (Porn, Tr. 5685-86; CX 45 at 8).

1. Chargemaster Changes Directly Affect Only Contracts Containing a Discount Off Charges Provision

928. An increase to chargemaster prices will only directly impact a health care provider's contracts containing a discount-off-charges provision. Chargemaster changes will not directly impact payments made under fixed rate contracts. (Porn, Tr. 5670).

929. Chargemaster changes can also indirectly affect payment under fixed rate contracts. { [REDACTED] } (Haas-Wilson, Tr. 2647-48, *in camera*).

930. The more discount off charges contracts a healthcare provider has, the more impact a chargemaster increase will have on net revenue realized by the provider. (Porn, Tr. 5670).

931. Health plans prefer fixed rate contracts, rather than discount off charges, because fixed rate contracts are predictable. (See CCFF 790-797).

932. With discount off charges arrangements, hospitals can set their own prices, and the health plans have little control over costs. (See Mendonsa, Tr. 526, { [REDACTED] }, *in camera*. See CCFF 799-800).

933. In post-merger renegotiations with health plans, ENH strategized "to move to discount off charges as [its] first negotiating step." (Hillebrand, Tr. 1706; Newton, Tr. 366. See CCFF 799).

934. ENH was successful in moving multiple fixed rate contracts to discount off charges arrangements. (Hillebrand, Tr. 1706. See CCFF 817-821).

935. In shifting health plan contract arrangements to discount off charges, ENH ensured that health plans would have to reimburse ENH at a higher rate as the ENH increased its chargemaster. (Porn, Tr. 5670; Chan, Tr. 743-44).

2. ENH, in Deciding to Increase Its Chargemaster Prices, Elected to Set the Prices at a Very High Level

936. In 2001, ENH hired Deloitte to merge and update the ENH and HPH chargemasters. (Porn, Tr. 5643-44).
937. As an outgrowth of the technical chargemaster project, in March 2002, ENH engaged Deloitte to “identify and implement” targeted price increases to ENH’s chargemaster. (Porn, Tr. 5668-69; CX 43 at 1).
938. This Deloitte 2002 chargemaster engagement was known as the “strategic pricing project.” (CX 45 at 1).
939. Although the strategic pricing project officially began in March 2002, Deloitte on its own initiative made some preliminary findings as early as November 2001. (Porn, Tr. 5688).
940. { [REDACTED] } (RX 1687 at ENHL BW 027652, *in camera*).
941. { [REDACTED] } (CX 2070 at 3; RX 1687 at ENHL BW 027652, *in camera*). ENH planned to achieve this goal through its “growth initiatives,” including the merger with Highland Park. (CX 2070 at 3; Hillebrand, Tr. 1811-12; Newton, Tr. 364). Likewise, this “aggressive” stance was consistent with Bain’s negotiating strategy advice for ENH to obtain “premium pricing (*i.e.*, above the competitive average)” after the merger. (CX 75 at 16).

3. The First Major Chargemaster Increase in 2002 Raised ENH’s Net Revenue by \$20 Million to \$26 Million Annually

942. There were two major chargemaster increases in 2002. (See CCF 1393-1394, *in camera*). The first major 2002 chargemaster price increase resulted in a projected net revenue increase of \$20 million to \$26 million annually. (Porn, Tr. 5685-86; CX 45 at 8).
943. By April 2002, ENH had raised 2,065 chargemaster prices. (Porn, Tr. 5684-85; CX 45 at 8).
944. ENH raised prices an average of 31.9% for these 2,065 listings. (Porn, Tr. 5685; CX 45 at 8).
945. The first major chargemaster increase in 2002 raised the overall chargemaster pricing by 8.5%. (Porn, Tr. 5685; CX 45 at 8).

946. This 2002 chargemaster price increase resulted in a projected gross charge impact of \$102.2 million annually, and a net impact of \$20 million to \$26 million annually. (Porn, Tr. 5685-86; CX 45 at 8).
947. The lower range did not include self-pay revenue increases, and the higher range did. (CX 45 at 8).
948. Thus, ENH expected to realize, on a net basis, at a minimum, \$20 million in additional revenue from health plans due to the 2002 chargemaster increases every year on a going forward basis. (Porn, Tr. 5686; CX 45 at 8). Coupled with the \$18 million in additional annualized revenue from the 2000 managed care contract re-negotiations – an increase that was unprecedented for ENH – ENH realized an additional \$38 million in annualized revenue for these two price increase strategies alone. ((Hillebrand, Tr. 1721-22; Porn, Tr. 5686; CX 45 at 8).
949. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2537-38, *in camera*; compare CX 6279 at 4, *in camera*, and CX 6279 at 5, *in camera*). { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2538, *in camera*).
950. { [REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*; Haas-Wilson, Tr. 2537-38). { [REDACTED]
[REDACTED] } (CX 6279 at 5, *in camera*; Haas-Wilson, Tr. 2537).
951. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 4-5, *in camera*).

4. ENH Was Not Concerned That Health Plans Would Switch to Other Hospitals Due to the 2002 Chargemaster Price Increases

952. ENH management did not anticipate any problems in implementing the chargemaster price increase nor did management fear that health plans would leave and switch to other hospitals due to the price increase. (Hillebrand, Tr. 1718-19).

953. Deloitte recognized that certain health plans might have a negative reaction to the 2002 chargemaster price increases. (Porn, Tr. 5683; CX 43 at 2). However, during the course of the 2002 chargemaster project, Deloitte did not have discussions with ENH management about adverse health plans' reactions to the price increases, and Deloitte was unaware of any issues between health plans and ENH due to the chargemaster increases. (Porn, Tr. 5683-84).
954. ENH management also did not factor the reactions of other hospitals into its decision to implement the 2002 chargemaster increase. (Hillebrand, Tr. 1751).

5. Because of the Discount Off Charges Provisions in Health Plan Contracts, ENH Can Unilaterally Institute Large Chargemaster Price Increases Without Even Giving Notice to Most of Its Health Plan Customers

955. After ENH raised its chargemaster prices in April 2002, Tom Hodges, ENH's executive vice-president for finance, wrote to ENH managers that "[f]or a number of reasons we want to be as quiet as possible and there are relatively few people who have seen the scope of the changes." (CX 44 at 1).
956. { [REDACTED] } (Holt-Darcy, Tr. 1523, *in camera*).
957. According to Mr. Hillebrand, for chargemaster increases, "the only notification we make is to Blue Cross." Mr. Hillebrand added, "We should not notify anyone beyond those we have a contractual obligation to do so." (CX 54 at 1).
958. { [REDACTED] } (*see, e.g., Foucre, Tr. 1091, 1093, 1096, in camera; CX 2381 at 4, in camera; CX 6277 at 3, in camera*), but they needed ENH in their network (*see, e.g., Foucre, Tr. 903, 905*).

E. ENH Extracted a Significant Price Increase from United

1. Pre-Merger Experience

959. United – the second largest health plan in the Chicago area – contracted with Highland Park Hospital throughout the 1990s under the names of the health plan's affiliates, including MetLife, Metropolitan Life, Chicago HMO, Travelers, and MetraHealth. (CX 5910 at 36-38; Hillebrand, Tr. 1868).
960. United also had various contracts throughout the 1990s with Evanston Hospital under the names of United affiliates including Share, Metlife, Metropolitan Life, Chicago HMO, Travelers, and MetraHealth. (CX 5910 at 38-42).

2. Post-Merger Experience

2000 Negotiation Experience - ENH Demanded a Price Increase from United

961. { [REDACTED]
[REDACTED]
[REDACTED] } (Hillebrand, Tr. 1873-74; Chan, Tr. 834, *in camera*).
962. Bain targeted the United contract as a "1st Priority" contract with "upside revenue potential" for which the merged entity had "enough leverage to improve terms." (CX 75 at 9-10; CX 74 at 10).
963. In October 1999, Evanston contacted United on behalf of both merging parties to renegotiate their hospital contracts. (Hillebrand, Tr. 1740, 1852).
964. While ENH did not know specifically what price targets it would be seeking for the new contract, ENH did know that the price targets it would set would be "high." (CX 75 at 12; Hillebrand, Tr., 1743).
965. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 1607 at 5, *in camera*).
966. In terms of geography, ENH also knew that it had negotiating leverage due to the fact that "with the Highland Park merger, ENH offers the largest regional network for more convenient access." (CX 75 at 37).
967. { [REDACTED]
[REDACTED] } (CX 21 at 5, *in camera*).
968. During the United renegotiations, representatives from the health plan never threatened to redirect their patients to other hospitals as a result of the price increase. (Chan, Tr. 703).
969. { [REDACTED]
[REDACTED] } (CX 21 at 5, *in camera*).
970. In late 1999, United and ENH reached agreement on the new hospital rates with a contract effective date of January 1, 2000 (the date of the merger). (Hillebrand, Tr. 1875).

ENH Obtained a Significant Price Increase from United

971. { [REDACTED]
[REDACTED]
[REDACTED] } (Foucre, Tr. 890; CX 5174 at 11-12, *in camera*).
972. The 2000 contract between United and ENH also required United to pay the same rates for each of ENH's three hospitals. (Foucre, Tr. 890). ENH's insistence on one tax ID number and identical rates for all three hospitals was "challenging" (Foucre, Tr. 891).
973. Ms. Chan, a negotiator for ENH, knew that, after the contract renegotiation, United "did poorly" and had to pay a lot more. (Chan, Tr. 696).
974. After the renegotiated contract went into effect, Mr. Hillebrand reported to ENH's board of directors that the United contract renegotiation resulted in an "additional 3.5 million dollar benefit" for ENH. (CX 5 at 5; Hillebrand, Tr. 1820).
975. Mr. Neaman further noted that the renegotiated United contract would bring in \$3 million of annualized economic value for the merged entity. (CX 17 at 1, 5).
976. { [REDACTED]
[REDACTED] } (CX 6279 at 19, *in camera*. See also CCFF 672-677, *in camera*).
977. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 19, *in camera*; Haas-Wilson, Tr. 2563, 2612-13, 2627-28, *in camera*).

2002 Renegotiation Experience of United

978. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 21 at 5, *in camera*).
979. In August 2002, United's COO, Jillian Foucre, requested a renegotiation of United's contract with ENH because, since the 2000 contract, ENH had been an "outlier" hospital with "much higher than the average reimbursement." (Foucre, Tr. 888).
980. United was concerned in part because the 2000 contract relied primarily on a discount off charges payment methodology, resulting in higher and higher reimbursements from United as it witnessed "alarmin[g] escalating costs in [ENH's] billed charges" that were "outside of the norms for the market." (Foucre, Tr. 898, 889).

981. { [REDACTED] } (Foucre, Tr. 1078, *in camera*; CX 21 at 8, *in camera*).
982. { [REDACTED] } (Foucre, Tr. 1078, *in camera*; CX 21 at 8, *in camera*).
983. In 2002, United's objectives in the renegotiation talks were to move the hospital to a new contract template, to move to more fixed rates with ENH; and to achieve a reduction in the total reimbursement under the contract so that United's rates would be in line with Blue Cross/Blue Shield, United's primary competitor. (Foucre, Tr. 892-93).
984. Mr. Hillebrand knew that United's renegotiation objectives in August 2002 were to get a "fair deal" and a "price reduction." (Hillebrand, Tr. 1877).
985. The face-to-face renegotiations between United's CEO, Bill Moeller, Ms. Foucre, Mr. Hillebrand, and Mr. Golbus came to a standstill as ENH refused to consider any of United's requests. (Foucre, Tr. 893).
986. { [REDACTED] } (Foucre, Tr. 894-96, 898; CX 2381 at 1, *in camera*).
987. { [REDACTED] } (Foucre, Tr. 1081-82, *in camera*; CX 2381 at 4, *in camera*).
988. { [REDACTED] } (Foucre, Tr. 936; Foucre, Tr. 1083, *in camera*; CX 2381 at 4, *in camera*).
989. { [REDACTED] } (Foucre, Tr. 1082, *in camera*).
990. { [REDACTED] } (CX 2381 at 4, *in camera*). { [REDACTED] }

[REDACTED]
[REDACTED] } (Foucre, Tr. 1082-84, *in camera*; CX 2381 at 4, *in camera*).

991. { [REDACTED]
[REDACTED] } (Foucre, Tr. 1084, *in camera*; CX 2381 at 4, *in camera*). { [REDACTED]
[REDACTED] } (Foucre, Tr. 1084-85, *in camera*; CX 2381 at 4, *in camera*). { [REDACTED]
[REDACTED] } (Foucre, Tr. 1084-85, *in camera*; CX 2381 at 4, *in camera*).

992. { [REDACTED]
[REDACTED]
[REDACTED] }
(Foucre, Tr. 1098-99, *in camera*; CX 6277 at 7, *in camera*).

993. { [REDACTED]
[REDACTED] }
(Foucre, Tr. 1081, *in camera*). { [REDACTED]
[REDACTED] } (Foucre, Tr. 1081, *in camera*; CX 2381 at 3, *in camera*).

994. { [REDACTED]
[REDACTED] } (Foucre, Tr. 1081, *in camera*; CX 2381 at 3, *in camera*).

995. { [REDACTED]
[REDACTED] } (Foucre, Tr. 1096, *in camera*; CX 6277 at 6, *in camera*).

996. { [REDACTED]
[REDACTED] } (Foucre, Tr. 897; CX 57 at 1, *in camera*).

997. { [REDACTED]
[REDACTED] } (Foucre, Tr. 897; CX 57 at 1, *in camera*).

998. In 2002, after exchanging proposals and counter-proposals a second time, United had made no progress towards achieving any of its business goals and considered terminating its existing contract with ENH. (Foucre, Tr. 898-900). { [REDACTED] } (Foucre, Tr. 899-900; CX 5174 at 7, *in camera*).

According to United, Excluding ENH from Its Network Was Not a Viable Choice

999. Nonetheless, United could not terminate its contract with ENH because United “could not have a viable network that would support our sales and growth objectives without the Evanston Northwestern Healthcare system.” (Foucre, Tr. 901-02, 925-26).

1000. A network comprised of United’s other participating hospitals – Lake Forest, Condell, Northwest Community, Advocate Lutheran General and St. Francis Hospitals – would not be viable without ENH. (Foucre, Tr. 900-01, 925-26).

1001. United knew a network without Evanston Northwestern Healthcare would not provide adequate service to the “very heavily populated,” area surrounding the three hospitals because “there are no other facilities” within the geographic triangle formed by the three hospitals. (Foucre, Tr. 902, 933).

United’s Employer Groups Would Not Accept a Network Without ENH

1002. Although United did not want to involve its employer groups in the negotiations with ENH (“they pay [United] to manage the network. They have businesses of their own to run”), United decided in early 2003 that “the situation was extreme enough” that it was time to contact representatives of some of its largest employer groups. (Foucre, Tr. 904-05).

1003. { [REDACTED] } (Foucre, Tr. 903-05; Foucre, Tr. 1085-86, *in camera*; CX 6277 at 4, *in camera*).

1004. { [REDACTED] } (Foucre, Tr. 1089-92, *in camera*; CX 6277 at 3, *in camera*).

1005. { [REDACTED] } (Foucre, Tr. 1086, *in camera*; CX 6277 at 4, *in camera*).

1006. { [REDACTED] } (Foucre, Tr. 1095, *in camera*).
1007. { [REDACTED] } (Foucre, Tr. 1097, *in camera*; CX 6277 at 8, *in camera*).
1008. { [REDACTED] } (Foucre, Tr. 1091, 1096, *in camera*). { [REDACTED] } (Foucre, Tr. 1093, *in camera*; CX 2381 at 4, *in camera*; CX 6277 at 3, *in camera*).
1009. Despite having learned of ENH's escalating rates, United's largest employer groups, comprising the "largest number of dollars flowing through Evanston Northwestern Healthcare," informed United that they did not view a network without ENH as a viable alternative (Foucre, Tr. 903, 905).
1010. United could have had a network that did not include certain hospitals (such as hospitals in the Rush or Advocate system that are spread out over a larger geographic area), but United could not market a network without ENH, a system that "is not geographically dispersed." (Foucre, Tr. 931-34).
1011. Faced with the knowledge that it would not be able to market a network to its largest employer groups without including the three ENH facilities, United decided to abandon its objective of receiving a reduction in reimbursement from ENH in favor of a contract structured with fixed rates. (Foucre, Tr. 907).
1012. United contacted ENH with its new written proposal in the hopes that, with more fixed rates, United would be better able to protect itself from ENH's escalating chargemaster. (Foucre, Tr. 907-08).
1013. On May 13, 2003, United held a meeting involving both ENH and its largest employer groups. (Foucre, Tr. 906). Kraft representatives "question[ed] the current reimbursement structure that was at percentage of charges" and "supported [United's] desire for more predictability on fixed rates." (Foucre, Tr. 909).
1014. Kraft representatives in particular were "pretty vocal about their . . . concern about the increasing trend" in ENH's chargemaster rates and the discount off charges structure of the current contract. (Foucre, Tr. 908).

1015. ENH and United did not resolve the issue of contract structure at the May 13, 2003 meeting. (Foucre, Tr. 921-23).

ENH Compromised with United Only After Learning of the FTC's Scrutiny of the Matter

1016. Over the summer of 2003, the tone of the negotiations between ENH and United changed (Foucre, Tr. 912). New negotiators took over for both ENH and United, and ENH approached United to request a health plan for its employees and to become a customer of United for network services. (Foucre, Tr. 912-14).
1017. During a meeting at ENH to discuss the possible employee-benefit plan, Mr. Hillebrand requested that United representatives "contact the FTC and have a conversation with them about whether—about whether [United] believed that [it] had been . . . financially harmed by the merger of the Evanston hospitals with Highland Park." (Foucre, Tr. 914-15). Mr. Hillebrand also requested that United representatives contact ENH's counsel, Mr. Sibarium, at Winston & Strawn to make a statement that United was "not unreasonably harmed by the merger," and gave Mr. Sibarium's phone number to United representative William Moeller. (Foucre, Tr. 918-19; CX 6283 at 1).
1018. Believing that United, in fact, had been financially harmed by the merger, United did not assist ENH or its counsel. (Foucre, Tr. 919, 927).
1019. Having made some progress on the renegotiation of the hospital contract from spring 2003, United representatives and ENH met again on September 2, 2003. (Foucre, Tr. 921). { [REDACTED] } (Foucre, Tr. 921-23; Hillebrand, Tr. 1928, *in camera*; CX 6284 at 1). Mr. Hillebrand told United representatives that ENH and its attorneys had "taken the liberty of drafting [a] letter pursuant to his conversation that he had had with Bill [Moeller] several weeks earlier." (Foucre, Tr. 923).
1020. Mr. Hillebrand requested that United "consider sending [the] letter or some version of it that [they] were comfortable with" to the Director of the Bureau of Competition at the FTC. (Foucre, Tr. 922-23; CX 6284 at 1).
1021. Disagreeing with the substance of the letter drafted by counsel for ENH, United did not sign it or send it to the FTC. (Foucre, Tr. 924-25, 927).
1022. While the letter drafted by ENH's counsel claimed that "the combination of ENH and HPH has not had any adverse impact on competition for hospital services in the Chicagoland area," United's "own data and information would indicate that there had been an adverse impact to United Healthcare." (Foucre, Tr. 924-25; CX 6284 at 1).

1023. United could not adopt the language of ENH's letter in part because, as of September 2003, Ms. Foucre did not know whether or not the ENH/HPH merger had created an "improved and expanded integrated healthcare delivery system" or whether quality of care had been enhanced at each of the hospitals (as ENH's letter claimed) because she had not been given any information by ENH regarding "re-admission rates, complication rates, [or] average length of stay." (Foucre, Tr. 926-27).

1024. { [REDACTED] } (Foucre, Tr. 921-23; Foucre, Tr. 1101, *in camera*).

1025. { [REDACTED] } (Foucre, Tr. 921-23; Foucre, Tr. 1101, *in camera*; CX 6284 at 1; CX 426 at 1, *in camera*).

1026. The Complaint in this matter was issued by the Commission on February 10, 2004. (Administrative Complaint, In the Matter of *Evanston Northwestern Healthcare*, February 10, 2004).

1027. { [REDACTED] } (Foucre, Tr. 887-88; CX 5176 at 1, 12, *in camera*).

1028. { [REDACTED] } (Foucre, Tr. 1103, *in camera*). { [REDACTED] } (Foucre, Tr. 1103-04, *in camera*).

1029. Mr. Hillebrand admitted that the 2004 negotiation with United did not result in an overall price reduction to the health plan. (Hillebrand, Tr. 1890).

1030. { [REDACTED] } (Foucre, Tr. 1103, *in camera*; Foucre, Tr. 931-32).

F. ENH Extracted a Significant Price Increase from PHCS

1. Pre-Merger Experience

1031. Prior to the merger, PHCS considered Highland Park and Evanston to be “competitors.” (Ballengee, Tr. 166).
1032. PHCS was able to get more competitive pricing from both hospitals when they were separate entities because “if, in fact, the negotiation and the rates were not going well at one hospital . . . we had the alternative.” (Ballengee, Tr. 167).
1033. PHCS understood that it “could choose between the two [hospitals] and work them against each other.” (Ballengee, Tr. 167).
1034. During contract renegotiations prior to the merger, PHCS was able to get Evanston to lower its proposed rate increases to “4-8 percent” due to the “competitive nature of the two hospitals, one with the other.” (Ballengee, Tr. 168-71).
1035. Keeping the rate increases down during contract renegotiations was always important to PHCS because “rate increases at any price [for either Evanston or Highland Park] would have a direct impact on the customer’s premium pricing that they had to pass on to the employers and on to – downstream to the employees.” (Ballengee, Tr. 171-72, 179).

2. Post-Merger Experience

2000 Negotiation Experience - ENH Demanded a Price Increase from PHCS

1036. In November of 1999, Bain identified ENH’s contract with PHCS as a “1st priority” opportunity for which ENH had “enough leverage to improve terms.” (CX 75 at 9-10; Neaman, Tr. 1171-72; CX 1998 at 40, 43)
1037. Although the PHCS contract was already ENH’s “most profitable contract” in October of 1999, Bain advised ENH that it could be more profitable if the merged entity were to “achieve [a] more favorable contract structure.” (CX 74 at 22).
1038. The combination of the three hospitals would give Evanston a powerful bargaining position with PHCS in particular because, as Bain reported, “ENH has significant leverage in negotiations with PHCS as they have strong North Shore presence and need us in their network.” (CX 1998 at 44; Neaman, Tr. 1179; CX 67 at 39).
1039. Bain projected that ENH could use its “significant leverage” to extract “\$3M in net revenue improvement” from PHCS. (CX 1998 at 44; Neaman, Tr. 1178-79; CX 67 at 39).
1040. Upon first hearing about the merger in December 1999, PHCS was “concern[ed]” because the merger would “elimina[te PHCS]’ ability to have more of a competitive environment between the two hospitals.” (Ballengee, Tr. 172-73).

1041. Later in December 1999, ENH representatives contacted PHCS to request a renegotiation of its hospital facility agreement. (Ballengee, Tr. 173-74; CX 171 at 1).
1042. ENH informed PHCS that it would "assign" Highland Park's contract and rates to the merged entity. (Ballengee, Tr. 174-75; Ballengee, Tr. 232, *in camera*; CX 171 at 1).
1043. { [REDACTED]
[REDACTED] }
(CX 1539 at 2, *in camera*; CX 172 at 1, *in camera*).
1044. { [REDACTED]
[REDACTED] } (CX 1539 at 2, *in camera*).
1045. { [REDACTED]
[REDACTED] } (CX 172 at 1, *in camera*; Ballengee, Tr. 233, *in camera*).
1046. { [REDACTED]
[REDACTED] } (CX 172 at 2, *in camera*; Ballengee, Tr. 253-54, *in camera*; compare CX 5068 at 27, *in camera*, and CX 5070 at 28).
1047. { [REDACTED]
[REDACTED]
[REDACTED] } (Ballengee, Tr. 234-35, 255, *in camera*. See RX 1414 at PHCS 000102 ("Fixed costs, such as per diem and per case, are the most advantageous because they allow customers to predict claims costs.")).
1048. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 113 at 1, *in camera*; Ballengee, Tr. 234, *in camera*).
1049. { [REDACTED]
[REDACTED]
[REDACTED] } (Ballengee, Tr. 234, *in camera*; CX 113 at 2, *in camera*).
1050. { [REDACTED]
[REDACTED]
[REDACTED] } (Ballengee, Tr. 235, *in camera*).

1051. { [REDACTED]
[REDACTED]
[REDACTED] } (Ballengee, Tr. 235, *in camera*).

1052. { [REDACTED]
[REDACTED] } (Ballengee, Tr. 235, *in camera*).

1053. { [REDACTED]
[REDACTED] } (CX 115 at 1, *in camera*).

1054. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 116 at 1, *in camera*; Ballengee, Tr. 236, *in camera*).

1055. { [REDACTED]
[REDACTED] } (Ballengee, Tr. 236, *in camera*; CX 116 at 2, *in camera*).

1056. { [REDACTED]
[REDACTED] } (Ballengee, Tr. 237, *in camera*; CX 176 at 2, *in camera*).

1057. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Ballengee, Tr. 239-40, *in camera*).

Eliminating ENH from Its Network Would Have Been Cheaper for PHCS

1058. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Ballengee, Tr. 184; Ballengee, Tr. 242, *in camera*; CX 46 at 1, *in camera*).

1059. { [REDACTED]
[REDACTED] } (Ballengee, Tr. 184,
242; CX 46 at 1, *in camera*).

1060. { [REDACTED]
[REDACTED]
[REDACTED] } (Ballengee, Tr. 244-45, *in camera*; CX 46 at 1, *in camera*).

1061. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 46 at 1, *in camera*).

1062. { [REDACTED]
[REDACTED] } (Ballengee, Tr. 246-7,
in camera; CX 46 at 1, *in camera*). { [REDACTED]
[REDACTED] } (Ballengee, Tr. 246-47, *in camera*; CX 46 at 1, *in camera*).

1063. { [REDACTED]
[REDACTED] } (Ballengee,
Tr. 246, *in camera*; CX 46 at 1, *in camera*).

1064. { [REDACTED]
[REDACTED]
[REDACTED] } (Ballengee, Tr. 246, 248, *in camera*;
CX 46 at 1, *in camera*).

1065. Overall, PHCS's calculations showed that "the elimination of Evanston and Highland Park financially would be the best overall in impacting [PHCS's] costs," and that scenarios eliminating other hospitals and keeping the ENH system did not show "as significant" cost savings as eliminating the ENH system altogether. (Ballengee, Tr. 185).

ENH Would Not Compromise with PHCS on Rates

1066. { [REDACTED]
[REDACTED]
[REDACTED] } (Ballengee, Tr. 175; CX 116 at 1, *in camera*).

1067. Mr. Hillebrand demanded higher rates from PHCS because the three hospitals were "now one system" that "controlled the marketplace." (Ballengee, Tr. 176-77, 194).

1068. As evidence of ENH's "control" over the marketplace, Mr. Hillebrand cited market share figures, noting that the three hospitals combined "already had the market share for these [North Shore] communities." (Ballengee, Tr. 176-77, 194).
1069. Mr. Hillebrand informed Ms. Ballengee that ENH's market share in the North Shore area was 60%. (Ballengee, Tr. 177).
1070. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Ballengee, Tr. 164, 76; Ballengee, Tr. 225, *in camera*; RX 1503 at PHCS 003654-65, *in camera*).
1071. ENH assured PHCS that all of the other health plans would also have to acquiesce to ENH's pricing demands. (Ballengee, Tr. 176-77 ("these were the rates, everybody was going to do it.")).
1072. In a "take it or leave it type – type [*sic*] presentation," Mr. Hillebrand told Ms. Ballengee that the PHCS representatives should "go down the hall for 15 minutes," that Ms. Ballengee should "talk it over with [her] boss," and that when the ENH representatives returned, "they wanted a decision at that time." (Ballengee, Tr. 177, 194).
1073. Ms. Ballengee was "concerned" about the impact that the price increase was going to have on PHCS and its customers. (Ballengee, Tr. 178).
1074. Feeling the "heavy responsibility" of "having some sort of arrangement that would work in a beneficial way for our customers," PHCS did not immediately agree to ENH's demands on the price increases. (Ballengee, Tr. 178).
1075. Instead, PHCS focused on finding terms that would persuade ENH to lower its rates to PHCS. (Ballengee, Tr. 178-79).
1076. PHCS offered to "eliminat[e] competitive hospitals" in exchange for "more enhanced rates." (Ballengee, Tr. 178). Identifying St. Francis, Rush North Shore, and Condell as "competitive hospitals" to ENH, PHCS prepared scenarios in which it would eliminate those hospitals from its network in the hopes that it would prompt ENH to lower its hospital contract rates. (Ballengee, Tr. 178-79, 181-82).
1077. Mr. Hillebrand rejected PHCS's offer on the grounds that he did not view St. Francis, Rush North Shore, or Condell as "competitors that would be worth any additional rates." (Ballengee, Tr. 182; Hillebrand, Tr. 1746-47).

1078. The only hospital that Mr. Hillebrand “considered possibly might be worth something” in lower ENH rates was Advocate Lutheran General. In exchange for eliminating that hospital from PHCS’s network, ENH was willing to lower PHCS’s rate “only . . . five points.” (Ballengee, Tr. 182).

1079. ENH and PHCS did not reach an agreement on rates at the February 2000 meeting. (Ballengee, Tr. 179).

PHCS Found that Alternative Networks Excluding ENH Were Not Viable

1080. PHCS next consulted its customers about the possibility of eliminating ENH from its network, but found that the insurance companies, third party administrators, and direct employers that contracted with PHCS “would not find it acceptable” to redirect enrollees to hospitals outside of the geographic triangle formed by the three ENH facilities. (Ballengee, Tr. 183-84). Those customers “made it very clear . . . that they didn’t believe that they could have a marketable network . . . without having the new ENH entity in it.” (Ballengee, Tr. 180-81, 183-84).

1081. Eliminating the ENH system from PHCS’s network would have left “a large area that would be uncovered.” (Ballengee, Tr. 181).

1082. Other hospitals in PHCS’s network, such as Rush North Shore, Lake Forest or Lutheran General Hospitals, were not considered to be “viable alternatives” to ENH because “there would be a large area that would be not served by the community hospitals.” (Ballengee, Tr. 181, 183-84).

PHCS Could Not Walk Away from ENH

1083. Notwithstanding the “significantly higher” rates proposed by ENH, the fact that “the elimination of Evanston and Highland Park financially would be the best overall in impacting [PHCS’s] costs,” and the fact that PHCS had 72 other hospitals in its network, PHCS reached the conclusion that it “needed to finalize some rates” and “go on with our contract with Evanston.” (Ballengee, Tr. 154, 179, 185).

1084. { [REDACTED]
[REDACTED]
[REDACTED] } (Ballengee, Tr. 155, 180; Ballengee, Tr. 249, *in camera*).

ENH’s Price Increase to PHCS Resulted in “Significantly Higher” Rates for PHCS

1085. After the February meeting, PHCS and ENH came to agreement on rates that were “significantly higher” than what PHCS had been paying pre-merger. (Ballengee, Tr. 179).
1086. { [REDACTED] } (Ballengee, Tr. 252, 255, *in camera*; Hillebrand, Tr. 1893; CX 116 at 2, *in camera*, CX 117 at 1, *in camera*; CX 5072 at 23, *in camera*).
1087. { [REDACTED] } (CX 5072 at 23, *in camera*; CX 1998 at 44).
1088. { [REDACTED] } (Ballengee, Tr. 252, *in camera*; compare CX 5068 at 27, *in camera*, and CX 5070 at 28).
1089. { [REDACTED] } (CX 5072 at 23, *in camera*; RX 1414 at PHCS 000102).
1090. If ENH increases its chargemaster rates, “the amount the customer pays also increases, based on the discount percentage.” (RX 1414 at PHCS 000102).
1091. { [REDACTED] } (Ballengee, Tr. 268-70, *in camera*).
1092. { [REDACTED] } (CX 5070 at 28; Ballengee, Tr. 268, *in camera*). { [REDACTED] } (CX 5068 at 27, *in camera*; Ballengee, Tr. 269, *in camera*). { [REDACTED] } (Ballengee, Tr. 269-70, *in camera*).
1093. While PHCS’s average rate increases prior to the merger ranged from 4-8%, post-merger, PHCS showed a 60% increase in the rates that it had to pay under the new contract. (Ballengee, Tr. 179, 196).

1094. The new rates for ENH's contract with PHCS went into effect April 1, 2000. (Ballengee, Tr. 188; CX 5071 at 1, *in camera*).
1095. ENH's victory in imposing higher rates on PHCS was large, as PHCS represents "a significant part of [ENH's] business." (Hillebrand, Tr. 1891-92).
1096. In October 2000, Mr. Neaman told ENH's board of directors that he estimated the annualized economic value of the renegotiation of the PHCS contract to be 3 million dollars. (CX 17 at 6). In achieving an annualized economic value of 3 million dollars, ENH had met the net revenue target set by Bain nine months earlier. (*Compare* CX 17 at 6 and CX 1998 at 44).
1097. After the rate increases went into effect, PHCS learned the downstream effect of ENH's price increases on employer premiums. (Ballengee, Tr. 197). PHCS's customers "had to raise their rates significantly in – the premiums to accommodate the increased rates at Evanston." (Ballengee, Tr. 197).
1098. { [REDACTED] } (Haas-Wilson, Tr. 2535-36, *in camera*. See also CCF 424-425, 453-454, *in camera*).
1099. { [REDACTED] } (CX 6279 at 4-5 ({ [REDACTED] }), *in camera*; Haas-Wilson, Tr. 2522, *in camera*).
1100. { [REDACTED] } (Haas-Wilson, Tr. 2522, *in camera*; CX 6279 at 4-5, *in camera*; Ballengee, Tr. 196).

G. ENH Extracted a Significant Price Increase from One Health/Great-West

1. Pre-Merger Experience

1101. Prior to the merger, One Health considered Highland Park Hospital, the "next hospital to the north" of Evanston, to be Evanston's "main competitor." (Neary, Tr. 600-02).
1102. Both hospitals "drew patients from the same general area" in the affluent communities between the two hospitals. (Neary, Tr. 601-02).

1103. Highland Park Hospital was also Evanston's "main competitor" pre-merger because the two hospitals offered "comparable" services. (Neary, Tr. 601-02).
1104. The area surrounding Highland Park Hospital was especially important to One Health prior to the merger because the hospital was located in "a more affluent" neighborhood with a "number of leaders from the business community." (Neary, Tr. 604). These leaders are the purchasers of care for their own businesses, and they "would want to have the hospital that's in their community in the network." (Neary, Tr. 604-05).

2. Post-Merger Experience

2000 Negotiation Experience - ENH Demanded a Price Increase from One Health

1105. In December of 1999, ENH contacted One Health to request the renegotiation of its hospital contract—a contract that Bain had identified as one with "significant upside potential." (Neary, Tr. 595; CX 75 at 9-10).
1106. Bain instructed ENH to "Achieve HP terms or better" in its negotiations with One Health. (CX 1998 at 43).
1107. One Health knew that "[they] were not in a strong negotiating position" because "Evanston had purchased their main competitor," Highland Park. (Neary, Tr. 600-01).
1108. ENH's initial demand was to convert "every single service" to a discount-off-charges basis. (Neary, Tr. 607-08).
1109. Knowing that One Health would "have less control . . . over what will ultimately be paid" to the hospital under a percent of charges arrangement, Mr. Neary resisted changing the structure of the contract. (Neary, Tr. 609).
1110. If One Health were to accept ENH's proposal, the health plan would lose the ability to accurately predict hospital charges because, under a discount-off-charges contract, "a hospital could potentially raise their rates as they saw fit, which would ultimately increase the payments that went out the door." (Neary, Tr. 609).
1111. { [REDACTED] } (CX 262 at 1, *in camera*; Neary, Tr. 756, *in camera*; Dorsey, Tr. 1436-37).
1112. { [REDACTED] } (Neary, Tr. 602; Neary, Tr. 757, *in camera*; CX 262 at 2-3, *in camera*).

1113. { [REDACTED] } (Neary, Tr. 757, *in camera*; CX 262 at 2-3, *in camera*).

1114. { [REDACTED] } (Neary, Tr. 757-58, *in camera*; CX 5064 at 17, *in camera*).

1115. { [REDACTED] } (Neary, Tr. 758-59, *in camera*).

1116. { [REDACTED] } (Neary, Tr. 759, *in camera*; CX 262 at 2-3, *in camera*).

1117. { [REDACTED] } (Neary, Tr. 756, *in camera*; CX 262 at 2, *in camera*).

1118. { [REDACTED] } (CX 262 at 1, *in camera*).

1119. Having last renegotiated the Highland Park and Evanston contracts in 1996 and 1995, One Health “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. 596, 608). { [REDACTED] } (Neary, Tr. 763, *in camera*; CX 2085 at 1, 6, *in camera*. See CCF 1188, 1194, *in camera*).

ENH’s Proposed Price Increase to One Health Was “Excessive”

1120. { [REDACTED] } (Neary, Tr. 762, *in camera*; Neary, Tr. 609).

1121. One Health's analysis of ENH's best and final offer showed "excessive" price increases. (Neary, Tr. 609).

1122. { [REDACTED] } (Neary, Tr. 762, *in camera*; CX 2085 at 1, *in camera*).

ENH Rejected One Health's Counter-Proposal

1123. One Health believed that ENH was "shooting for the stars" with its "extreme" reimbursement request and viewed ENH's proposal as "an opportunity to counter and an opportunity to begin negotiations of a final agreement." (Dorsey, Tr. 1437-38).

1124. { [REDACTED] } (Neary, Tr. 609; Neary, Tr. 760, 763, *in camera*; Dorsey, Tr. 1438; CX 2085 at 1, *in camera*).

1125. { [REDACTED] } (CX 2085 at 2, *in camera*).

1126. Because it had been paying higher rates to Highland Park prior to the merger, One Health also proposed a "fair increase to both hospitals," but wanted to assign a separate rate to Highland Park from the rates for Evanston and Glenbrook. (Neary, Tr. 603; Neary, Tr. 760, *in camera*; Dorsey, Tr. 1446-47).

1127. For other hospitals systems such as Rush and Advocate, One Health typically paid different rates for hospitals based upon varying levels of service. (Dorsey, Tr. 1446). Academic facilities, such as Rush Presbyterian-St. Lukes, were reimbursed at a higher rate than a smaller community or tertiary facility in the same system. (Dorsey, Tr. 1466).

1128. Glenbrook Hospital did not have "the same level of service or the same requirement of service from [One Health's] members as other hospitals within the ENH network." (Dorsey, Tr. 1447).

1129. Moreover, One Health "didn't see that [ENH's] facility and that list of services warranted the same reimbursement structure as we were giving in the Highland Park system." (Dorsey, Tr. 1447).

1130. One Health also "didn't think it was appropriate" to bring the rates at Evanston up to the level of the rates at Highland Park because the other hospitals in the Evanston community did not have rates as high as Highland Park's rates. (Neary, Tr. 606).

1131. Automatically increasing Evanston's level of reimbursement to that of Highland Park "would represent what [One Health] deemed to be an excessive increase in the rates" for a hospital whose rates were not below market prior to the merger. (Neary, Tr. 603, 644; Neary, Tr. 761, *in camera*).

1132. ENH dismissed One Health's proposal and demanded that all three hospitals be reimbursed at the same rate. (Neary, Tr. 602).

One Health Dropped ENH from Its Network for a Short Period of Time

1133. In the first half of 2000, ENH and One Health did not reach agreement on the renegotiation of the PPO and HMO contracts, and ENH invoked the termination clause in its contract. (Neary, Tr. 598, 609-10; Dorsey, Tr. 1438).

1134. On May 23, 2000, One Health received a letter from ENH stating that the PPO and HMO contracts would terminate on August 31, 2000, if an agreement on rates could not be reached. (CX 5062 at 1; Neary, Tr. 609-10; Dorsey, Tr. 1438-39, 1441-42).

1135. One Health knew that terminating the ENH contract could mean "los[ing] the employer groups because we didn't have [ENH] in the network." (Dorsey, Tr. 1450).

1136. On the other hand, if One Health were to acquiesce to ENH's higher prices, One Health would "lose the employer groups because they couldn't afford to continue to pay the high cost in their overall medical cost ratio." (Dorsey, Tr. 1450).

1137. One Health decided to explore the strength of its "alternative networks" before accepting the termination of the ENH contract. (Dorsey, Tr. 1450).

1138. Mr. Neary met with his sales staff to "determine whether or not we would have a network that would be sellable" without the merged entity. (Neary, Tr. 613).

1139. While Mr. Neary knew that "it would be risky" to terminate the ENH system from One Health's network, he "thought that it perhaps could be done . . . the company would have a sellable network, that was my judgment." (Neary, Tr. 615).

1140. As a final response to ENH's May 23, 2000, termination letter, Patricia Moldovan, the president of One Health's Midwest region placed a call to Jeffrey Hillebrand to make a "last-ditch effort to try and salvage the relationship." (Dorsey, Tr. 1449).

1141. One Health explained to Mr. Hillebrand that "the price increases were just too high for [One Health] to pass on to the employer groups." (Dorsey, Tr. 1450).

1142. At the conclusion of the call, One Health realized that its “last-ditch effort” to “salvage the relationship” had failed and that the termination would proceed. (Dorsey, Tr. 1449-50).
1143. After giving the matter careful consideration and sending the issue “up through the entire organization,” the collective decision of Mr. Neary, Kevin Dorsey, the regional president of One Health, and Pat Moldovan, the vice president of sales for the region, was to accept ENH’s termination and allow the contract to lapse. (Neary, Tr. 611, 616; Dorsey, Tr. 1449-50).
1144. In July 2000, One Health accepted ENH’s termination. (CX 266 at 1).

ENH Raised Its Rates for Pregnant Women Soon to Give Birth and Refused to Deal with Transitioning Other One Health Customers After the Termination

1145. In order to ensure a smooth transition for its employer groups away from ENH, One Health “tried to arrange a meeting with utilization management staff at ENH . . . to come up with a plan for members who were going to be in the hospital as of the termination date.” (Neary, Tr. 619).
1146. ENH disregarded One Health’s request and would not agree to meet with the health plan’s medical director. (Neary, Tr. 619). In other words, One Health patients whose stay in the hospital went past the contract termination would not have their post-termination charges limited by EHN to the amount specified on the One Health Contract. (Neary, Tr. 619).
1147. One Health also tried to make provisions for women “who were in the third trimester of pregnancy” at the time of the contract termination. (Neary, Tr. 619-20).
1148. These expecting mothers “would need to have their babies at one of the ENH hospitals regardless of whether or not they were in network” because “if their OB had only admitting privileges to one of those hospitals, the mother could not switch OBs in the third trimester of her pregnancy. Another OB would not take that person as a patient.” (Neary, Tr. 619-20).
1149. Knowing that One Health had no other provider options for those expecting mothers, ENH used its negotiating leverage to increase One Health’s prices to a 10% discount-off-charges arrangement for those OB services. (Neary, Tr. 620, 637; CX 5063 at 1).
1150. While One Health was able to negotiate a continuation of benefits for those expecting mothers, ENH charged the health plan rates that were even “higher” than contract rates that were in place under the pre-merger One Health contract. (Neary, Tr. 620, 37; CX 5063 at 1).

1151. One Health's contract with ENH terminated on August 31, 2000. (Neary, Tr. 610-11; Hillebrand, Tr. 1707-08, 1898; CX 5062 at 1).

One Health Lost Membership and Could Not Market a Network
Without ENH After Its Contract with ENH Terminated

1152. Shortly after the termination of the ENH contract went into effect, Mr. Neary realized that he "was wrong" in thinking that One Health could market and sell a network without the three ENH facilities. (Neary, Tr. 617).
1153. One Health "immediately started receiving complaints from our sales staff about the termination." (Neary, Tr. 617).
1154. The sales staff tried to market its network to employer groups. However, Lake Forest, Condell, Northwest Community, Advocate Lutheran General, Holy Family, Rush North Shore, St. Francis, St. Therese and Victory Memorial – all hospitals in One Health's network at the time of the termination of ENH's contract – could not provide adequate access to the health plan's customers in the North Shore. (Neary, Tr. 611, 617, 618-19; Dorsey, Tr. 1459, 1467, 1479).
1155. The sales staff urged network development management to "try to re-open negotiations with ENH" because One Health was "losing membership" and "losing employer groups" without the three ENH facilities. (Neary, Tr. 617; Dorsey, Tr. 1452).
1156. In the months following the termination of the ENH contract, One Health's monthly membership reports also began to reflect a "loss of membership within [the] network." (Dorsey, Tr. 1488).
1157. In response to declining membership figures and lost employer groups, One Health held a meeting with regional vice presidents and the president of the One Health Midwest region to reassess One Health's "ability to continue without ENH in our network." (Dorsey, Tr. 1455, 1488).
1158. One Health management concluded that they "wanted a face-to-face" with ENH so that the health plan could establish a new contractual agreement. (Dorsey, Tr. 1455-57).

One Health Soon Re-Opened Negotiations with ENH and Came to an Agreement

1159. After only a few months of attempting to market a network without ENH, One Health requested a "face-to-face" with ENH and re-opened negotiations on November 15, 2000. (Neary, Tr. 617-18; Hillebrand, Tr. 1708; Dorsey, Tr. 1439, 1441-42, 1456-57; CX 266 at 1).

1160. One Health approached the negotiating table a second time knowing that they “were not in a strong negotiating position” because they “were going back to a . . . hospital system that had terminated with us, and . . . we are going there because our sales staff could not sell the network without having this hospital system in our network.” (Neary, Tr. 618-19).
1161. One Health was vulnerable to ENH’s price demands because “we knew that we had to get a contract with the hospital . . . essentially regardless of what the ultimate price was.” (Neary, Tr. 619).
1162. One Health’s meeting with ENH representatives resulted in a new agreement with an effective date of January 1st 2001. (Dorsey, Tr. 1439-42, 1457; Hillebrand, Tr. 1708, 1898; CX 5067 at 4, *in camera*; CX 266 at 1).

One Health Surrendered to ENH’s Pricing Demands and Contract Terms

1163. { [REDACTED] } (Neary, Tr. 763-64, *in camera*; Dorsey, Tr. 1439-42; CX 2085 at 1, *in camera*).
1164. ENH achieved the same rates for all three facilities in the renegotiated One Health contracts. (Dorsey, Tr. 1447).
1165. { [REDACTED] } (Hillebrand, Tr. 1947, *in camera*; compare CX 5067 at 15, *in camera*, CX 5059 at 17, and CX 5065 at 17, *in camera*).
1166. { [REDACTED] } (CX 5067 at 15, *in camera*).
1167. { [REDACTED] } (Neary, Tr. 765, *in camera*).
1168. { [REDACTED] } (Neary, Tr. 765-66, *in camera*; Hillebrand, Tr. 1944, *in camera*; CX 5064 at 17, *in camera*).
1169. { [REDACTED] }

[REDACTED] } (Hillebrand, Tr. 1944, *in camera*; CX 5064 at 17, *in camera*).

1170. { [REDACTED]
[REDACTED] } (Neary, Tr. 765-66, *in camera*, Hillebrand, Tr. 1944, *in camera*).

1171. { [REDACTED]
[REDACTED] } (Neary, Tr. 767, *in camera*; compare CX 5064 at 17, *in camera*, and CX 5058 at 18).

1172. { [REDACTED]
[REDACTED]
[REDACTED] } (Neary, Tr. 767, *in camera*; CX 5058 at 18 (emphasis added)).

1173. [REDACTED]
[REDACTED]
[REDACTED] } (Neary, Tr. 766-67, *in camera*; compare CX 5064 at 17, *in camera*, and CX 5058 at 18 (emphasis added)).

ENH Obtained a Significant Price Increase from One Health

1174. { [REDACTED]
[REDACTED] } (CX 6282 at 6, *in camera*; Haas-Wilson, Tr. 2576-79, *in camera*. See CCFF 678-682, *in camera*).

1175. Over the course of the period in 2000 in which One Health had no contract with ENH (due to the contract termination), One Health learned through natural experiment that it could not market a network and maintain membership without the ENH system. (Dorsey, Tr. 1488; Neary, Tr. 617-19. See CCFF 1152-1158).

1176. Except for the short period of a few months when One Health had no contract with ENH, the hospital system lost no health plan customers over the course of the contract renegotiations in 2000. (Neary, Tr. 617-18; Dorsey, Tr. 1439, 1441-42, 1456; Hillebrand, Tr. 1707-08).

1177. One Health proved that ENH could “drop” a health plan’s contract and that the termination would “serve as [a] good example to [the] market.” (CX 75 at 9).

H. ENH Extracted a Significant Price Increase from Aetna

1. Pre-Merger Experience

1178. { [REDACTED] } (Mendonsa, Tr. 569, *in camera*).
1179. { [REDACTED] } (Mendonsa, Tr. 529, *in camera*).
1180. { [REDACTED] } (Chan, Tr. 690, *in camera*; CX 30 at 2).
1181. These substantial effective discounts ranged between 54% and 62% for Aetna's HMO and PPO products. (Chan, Tr. 688-89; CX 30 at 2).
1182. Aetna was also able to get favorable compromises on contract terms from Evanston pre-merger, such as reductions in rates for services that "were of greatest concern" to Aetna. (RX 84 at ENHL JL 001097; CX 2045 at 1).
1183. { [REDACTED] } (Mendonsa, Tr. 530, *in camera*).

2. Post-Merger Experience

2000 Negotiation Experience - ENH Demanded a Price Increase from Aetna

1184. In November 1999, Bain targeted the Aetna contract as one with "significant upside potential." (CX 75 at 10).
1185. { [REDACTED] } (Mendonsa, Tr. 529-30, *in camera*).
1186. In February 2000, having achieved an additional \$3.5 million per year on the United contract, Bain recommended that ENH give "immediate focus" to the "successful renegotiation" of the Aetna contract. (CX 67 at 2; CX 5 at 5; Hillebrand, Tr. 1820).
1187. Bain estimated that ENH would be able to extract \$1 million in additional net revenue per year from Aetna post-merger. (CX 67 at 32).

1188. { [REDACTED]
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 530, *in camera*).

1189. { [REDACTED]
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 531, *in camera*; CX 123 at 1, *in camera*).

1190. { [REDACTED]
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 547, *in camera*).

1191. { [REDACTED]
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 548, *in camera*).

1192. { [REDACTED]
[REDACTED] } (Mendonsa, Tr. 532-33, *in camera*; CX 123 at 1, *in camera*).

1193. { [REDACTED]
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 532-33, *in camera*).

1194. { [REDACTED]
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 533-34, *in camera*).

1195. { [REDACTED]
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 531-34, *in camera*).

ENH Would Not Compromise with Aetna

1196. { [REDACTED]
[REDACTED] } (Mendonsa, Tr. 534, 536, *in camera*; CX 2447 at
1, *in camera*).

1197. { [REDACTED]
[REDACTED]

[REDACTED] (Mendonsa, Tr. 535-36, *in camera*).

1198. { [REDACTED] } (Mendonsa, Tr. 536, *in camera*).

1199. { [REDACTED] } (Mendonsa, Tr. 536, *in camera*).

1200. { [REDACTED] } (Mendonsa, Tr. 536, *in camera*).

1201. { [REDACTED] } (Mendonsa, Tr. 536-37, *in camera*.
See Mendonsa, Tr. 537 ({ [REDACTED] }), *in camera*).

1202. Knowing the futility of walking away from ENH when it might cause Aetna to lose business, health plan representatives did not tell Ms. Chan that Aetna would redirect patient flow to other hospitals as a result of the price increase. (Chan, Tr. 703).

1203. Aetna's renegotiation meeting with ENH was "fairly brief." (Hillebrand, Tr. 1895-96).
{ [REDACTED] }
(Hillebrand, Tr. 1895-97; Mendonsa, Tr. 539, *in camera*; CX 2447 at 1, *in camera*).

Aetna Could Not Walk Away from ENH

1204. { [REDACTED] } (Mendonsa, Tr. 518, 520, 530, *in camera*).

1205. { [REDACTED] } (Mendonsa, Tr. 516-18, 520, 530, *in camera*).

1206. { [REDACTED]
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 516-18, 520, 530, *in camera*).

1207. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 517-18, 530, *in camera*).

1208. { [REDACTED]
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 543-44, 568-69, *in camera*).

1209. { [REDACTED]
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 541, *in camera*).

1210. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 568, *in camera*).

Aetna Acquiesced to ENH's Price Increase

1211. { [REDACTED]
[REDACTED] } (Mendonsa, Tr. 539, *in camera*; Hillebrand, Tr. 1948, *in camera*; CX 2447 at 1, *in camera*).

1212. { [REDACTED]
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 533-34, *in camera*).

1213. { [REDACTED]
[REDACTED] } (Mendonsa, Tr. 540, *in camera*).

1214. { [REDACTED]
[REDACTED] } (Mendonsa, Tr. 538-39, 570-71, *in camera*).

1215. { [REDACTED] } (Mendonsa, Tr. 539-40, *in camera*; Mendonsa, Tr. 478).
1216. { [REDACTED] } (Mendonsa, Tr. 534, *in camera*).
1217. { [REDACTED] } (Hillebrand, Tr. 1952, *in camera*).
1218. { [REDACTED] } (Mendonsa, Tr. 545, *in camera*).
1219. { [REDACTED] } (Mendonsa, Tr. 546, *in camera*).
1220. { [REDACTED] } (*Compare CX 5001 at 8, CX 5007 at 10, and CX 5008 at 5, in camera. See CCFF 860-869, in camera*).
1221. { [REDACTED] } (CX 5008 at 1, *in camera*).

ENH Obtained a Significant Price Increase from Aetna

1222. In Mr. Neaman's October 2000 report to the board of directors, he estimated the annualized economic value of the renegotiation of the Aetna contract to be \$3 million. (CX 17 at 7).
1223. Mr. Neaman's figure of \$3 million was \$2 million more than even Bain's February 2000 prediction of the increase in annual net revenue per year from the Aetna contract. (CX 17 at 7; CX 67 at 32. *See CCFF 1187*).
1224. { [REDACTED] }

[REDACTED] } (CX 6279 at 18, *in camera*; Haas-Wilson, Tr. 2625, *in camera*. See CCF 661-664, *in camera*).

1225. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 18, *in camera*; Haas-Wilson, Tr. 2565, 2625-26, 2612-13, *in camera*).

I. ENH Extracted a Significant Price Increase from Unicare

1. Pre-Merger Experience

1226. In 2000 Unicare acquired Rush Prudential, another health plan. (Holt-Darcy, Tr. 1413).
{ [REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1504-05, *in camera*).

1227. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1505-07, *in camera*).

1228. { [REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1506-07, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1506-07, *in camera*).

1229. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1509, *in camera*).

1230. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1603, *in camera*).

1231. { [REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1602, *in camera*)

1232. { [REDACTED] } (Holt-Darcy, Tr. 1520, *in camera*).

1233. { [REDACTED] } (Holt-Darcy, Tr. 1521, *in camera*).

1234. { [REDACTED] } (Holt-Darcy, Tr. 1520, *in camera*; CX 75 at 6. See Holt-Darcy, Tr. 1597 ({ [REDACTED] })), *in camera*).

1235. { [REDACTED] } (Holt-Darcy, Tr. 1519-20, *in camera*).

1236. { [REDACTED] } (Holt-Darcy, Tr. 1520, *in camera*; CX 5091 at 1).

1237. { [REDACTED] } (Holt-Darcy, Tr. 1520, *in camera*; CX 5091 at 1).

2. Post-Merger Experience

2000 Negotiation Experience - ENH Demanded a Price Increase from Unicare

1238. { [REDACTED] } (Holt-Darcy, Tr. 1547-48, 1597, 1599-1600, *in camera*; CX 216 at 1, *in camera*).

1239. { [REDACTED] } (Holt-Darcy, Tr. 1548-49; compare CX 216 at 1, 15, *in camera*, and CX 5091 at 1).

1240. In fact, Rush Prudential had been paying Evanston higher rates than many health plans prior to the merger. (CX 74 at 9). In 1999, Rush Prudential paid higher per diems for

ICU, medical, and surgical services than Blue Cross/Blue Shield, Aetna, PHCS, United, Preferred, and Cigna. (CX 74 at 9).

1241. { [REDACTED] } (Holt-Darcy, Tr. 1527, 1535, *in camera*; CX 124 at 2, *in camera*).
1242. { [REDACTED] } (Holt-Darcy, Tr. 1527, *in camera*; CX 124 at 1-2, *in camera*. See Holt-Darcy, Tr. 1535 ({ [REDACTED] })), *in camera*).
1243. { [REDACTED] } (CX 124 at 1, *in camera*).
1244. { [REDACTED] } (Holt-Darcy, Tr. 1533, *in camera*).
1245. { [REDACTED] } (Holt-Darcy, Tr. 1533-35, *in camera*; CX 124 at 1-2, *in camera*).
1246. { [REDACTED] } (Holt-Darcy, Tr. 1528, *in camera*).
1247. { [REDACTED] } (Holt-Darcy, Tr. 1528-29, *in camera*). [REDACTED] } (Holt-Darcy, Tr. 1528-29, *in camera*).
1248. { [REDACTED] } (Holt-Darcy, Tr. 1527, 1535-36, *in camera*; CX 124 at 2-3, *in camera*).
1249. { [REDACTED] }

[REDACTED] } (Holt-Darcy, Tr. 1527, 1535-36, *in camera*;
Hillebrand, Tr. 1944, *in camera*; CX 124 at 2-3, *in camera*).

1250. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-
Darcy, Tr. 1527, 1536, *in camera*; CX 124 at 2-3, *in camera*; CX 5091 at 1).

Unicare's Analysis Showed a Significant Price Increase over Pre-Merger Contracts

1251. { [REDACTED]
[REDACTED] }
(Holt-Darcy, Tr. 1503-04, *in camera*).

1252. { [REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1536, 1543, *in camera*).

1253. { [REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1536, 1539, *in camera*).

1254. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1502-03, *in camera*. See Holt-
Darcy, Tr. 1503 ({ [REDACTED]
[REDACTED] }, *in camera*. See
CCFF 1238, *in camera*).

1255. { [REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1503, 1597,
1599-1600, *in camera*. See CCFF 1238, *in camera*).

1256. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1536-37, 1542, *in camera*).

1257. { [REDACTED] } (Holt-Darcy, Tr. 1541, in camera).

Unicare Felt It Necessary to Involve Senior Network Managers in the ENH Negotiations

1258. { [REDACTED] } (Holt-Darcy, Tr. 1501-02, in camera).

1259. { [REDACTED] } (Holt-Darcy, Tr. 1540, in camera).

1260. { [REDACTED] } (Holt-Darcy, Tr. 1540, in camera)

1261. { [REDACTED] } (Holt-Darcy, Tr. 1540, in camera)

ENH Would Not Compromise with Unicare on Rates

1262. { [REDACTED] } (Holt-Darcy, Tr. 1530, 1544, in camera).

1263. { [REDACTED] } (Holt-Darcy, Tr. 1545-46, in camera).

1264. { [REDACTED] } (Holt-Darcy, Tr. 1530, in camera).

1265. { [REDACTED] } (Holt-Darcy, Tr. 1529-30, 1544-45, in camera).

1266. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1545, *in camera*).
1267. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1546, *in camera*).
1268. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1547, *in camera*).
1269. { [REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1547, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1547, *in camera*).
1270. { [REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1546, *in camera*).
1271. Unicare representatives did not threaten to walk away from ENH's price demands and redirect patient flow to other facilities during the meeting. (Chan, Tr. 703).
1272. { [REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1550, *in camera*).
1273. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1550-51, *in camera*).
1274. { [REDACTED]
[REDACTED] } (CX 129 at 1, *in camera*).
1275. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 129 at 1, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1560, *in camera*; CX 129 at 1, *in camera*).

1276. { [REDACTED] } (Holt-Darcy, Tr. 1551, *in camera*).

1277. { [REDACTED] } (Holt-Darcy, Tr. 1551, *in camera*; CX 5907 at 1, *in camera*). { [REDACTED] } (CX 5907 at 1; *in camera*). { [REDACTED] } (Holt-Darcy, Tr. 1525, *in camera*).

1278. In response to Unicare’s counter-proposal, Mr. Gilbert recommended that Mr. Hillebrand send a termination letter to Unicare so that the health plan would “take [ENH’s] proposals more seriously.” (RX 885 at ENH JL 005396).

1279. On June 14, 2000, Mr. Hillebrand took Mr. Gilbert’s advice and sent a letter to Unicare stating that the hospital system could not accept the rates as proposed and providing “written notice of termination for both hospital and physician agreements with Unicare effective September 15, 2000.” (RX 885 at ENH JL 005396; CX 2063 at 1).

1280. [REDACTED]
(CX 2063 at 1, *in camera*).

Unicare Could Not Walk Away from ENH

1281. { [REDACTED] } (Holt-Darcy, Tr. 1552-53, 1568, *in camera*).

1282. { [REDACTED] } (Holt-Darcy, Tr. 1552, 1554, *in camera*).

1283. { [REDACTED] } (Holt-Darcy, Tr. 1552-53, *in camera*. See Holt-Darcy, Tr. 1602 ({ [REDACTED] })), *in camera*).

1284. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1552, *in camera*).

1285. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1552-53, *in camera*).

1286. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1552-53, *in camera*).

1287. { [REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1554, *in camera*).

1288. { [REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1513-14, 1562, *in camera*; CX 5075 at 17, *in camera*).

ENH Obtained a Significant Price Increase from Unicare

1289. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1536, 1539, 1563, *in camera*; CX 5075 at 17, *in camera*; CX 124 at 1, *in camera*).

1290. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1536, 1543, 1563, *in camera*).

1291. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1563, 1600, *in camera*; CX 5907 at 1, *in camera*).

1292. { [REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1564-65, *in camera*).

1293. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1565, *in camera*).

1294. { [REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1565, *in camera*).

1295. [REDACTED]
[REDACTED]
[REDACTED] } (CX 6279 at 4, *in camera*; Haas-Wilson, Tr. 2536 (citing DX 7009 at 1, *in camera*), *in camera*).

1296. { [REDACTED]
[REDACTED] (Haas-Wilson, Tr. 2536, *in camera*).
[REDACTED]
[REDACTED] } (CX 6279 at 5, *in camera*).

The Merger Strengthened ENH's Negotiating Position in the North Shore with Health Plans

1297. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1518-19, *in camera*).

1298. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1518-19, *in camera*).

1299. { [REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1510, *in camera*)

1300. { [REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1511, *in camera*. See Holt-Darcy, Tr. 1510 ({ [REDACTED]
[REDACTED] })), *in camera*).

1301. { [REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1529, *in camera*).

1302. { [REDACTED] } (Holt-Darcy, Tr. 1561, *in camera*).

1303. { [REDACTED] }
(Holt-Darcy, Tr. 1528, 1560-61, *in camera*).

1304. { [REDACTED] } (Holt-Darcy, Tr. 1560-61, *in camera*).

J. ENH Also Extracted a Significant Price Increase from Other Health Plans That Did Not Testify at Trial

1305. { [REDACTED] } (See Chan, Tr. 697-98; CX.17 at 8; CX 24 at 8-10, *in camera*; CX 121 at 1, *in camera*).

1306. Cigna also did poorly in its 2000 contract renegotiations with ENH. (Chan, Tr. 697-8). In an October 2000 report to ENH's board of directors, Mr. Neaman estimated the June 2000 renegotiation of the Cigna contract to be worth \$3 million in annualized economic value. (CX 17 at 8).

1307. In that same report to the board, Mr. Neaman also noted that the Humana contract renegotiation had resulted in \$2 million of additional annualized economic value. (CX 17 at 8).

1308. { [REDACTED] } (CX 24 at 8, *in camera*; CX 121, *in camera*).

1309. { [REDACTED] } (CX 24 at 9, *in camera*).

1310. { [REDACTED] } (CX 24 at 10, *in camera*).

1311. In October 2000, Mr. Neaman reported to ENH's board of directors that the renegotiation of some other small PPO agreements in January 2000 alone had resulted in \$1 million in estimated annualized economic value. (CX 17 at 5).

1312. Mr. Neaman's October 2000 memo to the board of directors noted that, through the merger, "some \$24 million of revenue enhancements have been achieved – mostly via managed care renegotiations" (CX 17 at 1).

K. ENH's Price Increases Were Contrary to Market Trends to Hold Pricing Flat or to Discount Further

1313. ENH's price increases occurred in an environment where the price trend for hospitals has been flat at best. Before the merger, Evanston and Highland Park leadership believed that health plans would increase pricing pressures on hospitals. (Neaman, Tr. 1042; CX 442. See CCFF 778-789).

1314. { [REDACTED] } (Chan, Tr. 688-90, 716-20; CX 30 at 2; Chan, Tr. 824-26, *in camera*). { [REDACTED] } (Chan, Tr. 824-26, *in camera*; Chan, Tr. 716-20; CX 30 at 2).

1315. For example, as early as the beginning of 1998, Mr. Hillebrand lamented to Evanston's board of directors that the hospital was experiencing "significant reductions in reimbursement" from both Blue Cross and Humana. (CX 2037 at 2-3; Neaman, Tr. 1151-52).

1316. { [REDACTED] } (Chan, Tr. 688-90, 716-20; CX 30 at 2; Chan, Tr. 824-26, *in camera*). { [REDACTED] } (Chan, Tr. 688-90, 716-20; CX 30 at 2; Chan, Tr. 824-26, *in camera*).

1317. { [REDACTED] } (Chan, Tr. 688-90, 716-20; CX 30 at 2; Chan, Tr. 824-26, *in camera*). { [REDACTED] } (Chan, Tr. 688-90, 716-20; CX 30 at 2; Chan, Tr. 824-26, *in camera*).

1318. { [REDACTED] } (Chan, Tr. 823-24, *in camera*. See also Chan, Tr. 782-83, *in camera*; CX 1095 at 6; CX 439 at 8. See CCFF 778-789).

1319. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 1095 at 6; Chan, Tr. 673; Chan, Tr. 787, *in camera*. See CX 439 at 8).
1320. { [REDACTED]
[REDACTED]
[REDACTED] } (Chan, Tr. 794, *in camera*; See CX 439 at 8 (June, 1998 presentation to the Highland Park board of directors finance committee showing Highland Park's projected 1998 effective discount to health plans increasing from 34.3% to 34.9%).
1321. { [REDACTED]
[REDACTED] } (Chan, Tr. 819-20, *in camera*; CX 1099 at 1-67, *in camera*).
1322. Highland Park's own executives admitted that Highland Park could not have achieved price increases with health plans prior to the merger. (Spaeth, Tr. 2201-02, 2172-73).
1323. Highland Park executives knew that the hospital could not sustain a strategy in which it would lose contracts or be eliminated from a health plan's network. Such a strategy would have proved very difficult for the hospital to stick to. (Spaeth, Tr. 2172-73, 2178).
1324. { [REDACTED]
[REDACTED] } (Hillebrand, Tr. 1704-07. See CCF 817-821, 822-842, 848-859, 884-903, 918-924, 936-951).
1325. Mr. Spaeth does not believe that the downward trend in pricing before the merger has changed after the merger. (Spaeth, Tr. 2201-02).
1326. Similarly, both Mr. Neaman and Mr. Hillebrand claimed that health plans' bargaining positions have *increased* since the merger. (Neaman, Tr. 1269-71; Hillebrand, Tr. 1725-26 (emphasis added)).
1327. { [REDACTED]
[REDACTED]
[REDACTED] } (Hillebrand, Tr. 1704-07. See CCF 652-692).
1328. { [REDACTED]
[REDACTED]
[REDACTED] }

(Hillebrand, Tr. 1708-09 (admitting that health plan attempts to take away post-merger price increases obtained in 2000 failed); Chan, Tr. 710 (Ms. Chan testified that ENH had more "leverage" after the merger); Chan, Tr. at 839 ({ [REDACTED] [REDACTED] })), *in camera*. See CCF 652-692, 817-842, 848-859, 884-903, 918-924, 936-951, *in camera*).

L. ENH Increased Its Net Revenues from Health Plans by a Minimum of \$18 Million Annually Due Just to the 2000 Managed Care Contract Re-Negotiations

1329. With the exception of losing One Health for a short period of time, ENH did not lose a single health plan over the course of the 2000 contract renegotiations. (Neary, Tr. 617-18; Dorsey, Tr. 1438-39, 1441-42, 1456; Hillebrand, Tr. 1707-08).
1330. In October 2000, Mr. Neaman sent a memorandum to the board of directors with an attached "Sequential Listing of Accomplishments" of the merger. (CX 17 at 1, 5). Mr. Neaman reported that the re-negotiation of the United, PHCS, Aetna, Blue Cross/Blue Shield, and Cigna contracts had resulted in an annualized economic value of \$15 million (\$3 million per health plan). (CX 17 at 5-8). ENH realized an additional \$3 million annually from the re-negotiation of the Humana contract and from the re-negotiation of other smaller PPO contracts (\$2 million for Humana and \$1 million for some smaller contracts combined). (CX 17 at 5, 8). As of October, ENH's had achieved this additional \$18 million per year through the managed care contract renegotiations. (CX 17 at 5-8; Hillebrand 1708-09. See CX 13 at 1 (In July 2000, Mr. Neaman reported an additional \$16 million/year in total managed care re-negotiation benefits to the board); CX 17 at 8 (September 2000 Humana contract re-negotiation resulted in \$2 million annualized economic revenue)).
1331. Using Mr. Hillebrand's January 2000 report of a \$3.5 million annualized economic benefit from the United contract instead of Mr. Neaman's \$3 million figure, ENH's total annualized economic revenue from the re-negotiation of managed care contracts increases from \$18 million to \$18.5 million. (CX 5 at 5; Hillebrand, Tr. 1820. See CX 17 at 5-8 (1/00 "Other (smaller) PPO agreement re-negotiations" (\$1 million), 3/00 "Private Healthcare re-negotiation" (\$3 million), 5/00 "Renegotiated Aetna contract" (\$3 million), 6/00 "Blue Cross Contract re-negotiation" (\$3 million), 6/00 "Cigna Contract re-negotiation" (\$3 million), and 9/00 "Humana Contract Re-negotiations" (\$2 million)).
1332. Evanston alone "had never achieved" a price increase as high as \$18 million before the merger. (Hillebrand, Tr. 1722).
1333. { [REDACTED]
[REDACTED]
[REDACTED]

[REDACTED] } (Dorsey, Tr. 1439-42, 1457; Hillebrand, Tr. 1707-08, 1898; Sirabian, Tr. 5717; CX 5067 at 4, *in camera*).

1334. This \$18 - \$18.5 million in additional annualized net revenue does not include any additional revenue achieved through the shifting of health plans to the higher (in terms of rates) of the Evanston or Highland Park pre-merger contracts. (CX 17 at 5-8; CX 5 at 5; CX 13 at 1).
1335. This \$18 - \$18.5 million in additional annualized net revenue does not include any additional revenue achieved through ENH's adoption in 2000 of the higher of the Highland Park or Evanston pre-merger chargemaster rates. (CX 17 at 5-8; CX 5 at 5; CX 13 at 1).
1336. This \$18 - \$18.5 million in additional annualized net revenue does not include any additional revenue achieved through ENH's chargemaster increases in 2002 and later. (CX 17 at 5-8; CX 5 at 5; CX 13 at 1).
1337. None of ENH's annualized revenue increases "could have been achieved by either Evanston or Highland Park alone." (CX 17 at 2. See CX 13 at 1 ("Neither Evanston nor Highland Park alone could achieve these results.")).

M. When Hospitals Increase Their Prices, Health Plans Pass the Price Increases on to Their Customers

1338. { [REDACTED] } (Ballengee, Tr. 239, *in camera*; Mendonsa, Tr. 483; Dorsey, Tr. 1450).
1339. Unexpected price increases adversely affect the profitability of the self-insured's business because these price increases have a "direct impact" the business' "bottom line." (Mendonsa, Tr. 483).
1340. { [REDACTED] } (Mendonsa, Tr. 483-84; Mendonsa, Tr. 549, *in camera*; Ballengee, Tr. 239, *in camera*; Dorsey, Tr. 1450).
1341. { [REDACTED] } (Mendonsa, Tr. 549, *in camera*).
1342. In response to ENH's rate increases to PHCS in 2000, PHCS's customers "had to raise their rates significantly in – the premiums to accommodate the increased rates at Evanston." (Ballengee, Tr. 196-97).

1343. { [REDACTED]
[REDACTED] }
(Mendonsa, Tr. 483-84; Mendonsa, Tr. 549, *in camera*).

1344. { [REDACTED]
[REDACTED]
[REDACTED] } (Newton, Tr. 365; CX 17 at 5-8; CX 5 at 5; CX 13 at 1;
Hillebrand, Tr. 1704-09; Chan, Tr. 709-10, *in camera*. See CCF 652-692, 817-842,
848-859, 884-859, 884-903, 918-924, 936-951).

1345. ENH would not have possessed the leverage needed to extract these terms absent the merger. (See CX 13 at 1 (In referring to managed care renegotiations, Mark Neaman told the ENH board of directors that “neither Evanston nor Highland Park alone could achieve these results.)).

XI. DIRECT EVIDENCE OF ANTICOMPETITIVE EFFECTS: PARTY ADMISSIONS

A. Party Documents Regarding Merger Creating Market Power

1346. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 3 at 2; CX 1879 at 3-4; CX 1 at 3; CX 2 at 7; CX 4 at 1-2, 9; CX 1566 at 9; Neaman, Tr. 1138, *in camera*),
{ [REDACTED]
[REDACTED] } (CX 5 at 5; CX 6 at 7; CX 2070 at 3; CX 12 at 2; CX 13 at 1; CX 16 at 1; CX 17 at 2), { [REDACTED]
[REDACTED] } (CX 1519 at 1-2; CX 30 at 1; CX 23 at 2; CX 24 at 2, *in camera*; CX 26 at 1; CX 25 at 9; CX 31 at 1).

1. Evanston and Highland Park Sought Market Power Through the Merger

1347. { [REDACTED]
[REDACTED] } (CX 3 at 2; CX 1879 at 3-4; CX 1 at 3; CX 2 at 7; CX 4 at 1-2, 9; CX 1566 at 9; Neaman, Tr. 1138, *in camera*).

Highland Park Sought Market Power Through the Merger

1348. As early as the fall of 1998, Highland Park leadership “had been approached and approached again by [Evanston]” to discuss the possibility of a relationship between the two institutions. (CX 3 at 1).
1349. Transcript remarks from a fall 1998 meeting of Highland Park leadership lament that no hospital “is able to apply or assemble enough power to deal with managed care areas.” (CX 3 at 2).
1350. Highland Park recognized the potential “power” that could be gained from an affiliation with Evanston. The affiliation “would enable [Highland Park] to exploit an area of the market in a meaningful way – Evanston has a large effect.” (CX 3 at 1-2; Spaeth Tr. at 2207).
1351. In November 1998, Highland Park Hospital responded to Evanston’s merger proposal. (CX 1879 at 1; CX 3 at 2). With respect to “competition and signals,” Neele Stearns, Highland Park Hospital’s board chairman, recognized that a merger would allow the two health care providers to “[s]top competing with each other.” (CX 1879 at 3-4).

1352. Sometime between April 16, 1999 and January 1, 2000 (after a “Notice of Intent to Merge” had been established and before the merger), Highland Park board members and doctors met to discuss the possible merger. During this meeting, Ronald Spaeth, the president of Highland Park, stated: “[T]here are ways to at least I think to push back on the managed care phenomenon and get the rates back where they ought to be if you are a big enough concerted enough entity which is important enough to the employers in the community.” (CX 4 at 1-2; Spaeth, Tr. 2210-11 (emphasis added)).
1353. At that same meeting, another Highland Park representative echoed Mr. Spaeth’s concerns regarding the “the relative negotiating power of the payers,” which had become an “economic issue” for the hospital. (CX 4 at 9; Spaeth, Tr. 2211-12).
1354. This same Highland Park representative went on to distinguish the unique market concentration opportunities associated with a Highland Park/Evanston merger. “What Evanston does is provide total concentration. . . If one of your key objectives is to get geographic leverage on the employers in this area getting Northwestern [Memorial] doesn’t do much for you.” (CX 4 at 9; Spaeth, Tr. 2211-12. See also CX 4 at 9 (The transcript entry also shows that the board member stated that a merger with Northwestern Memorial would not provide “critical mass in the same area.”)).
1355. According to Mr. Spaeth, “everybody” perceived that the merged hospitals would reap the “economic benefit of not being out there doing battle with one another in what will be a common battle ground.” (CX 4 at 1).
1356. With the merger, Evanston and Highland Park would no longer have to “d[o] battle” with each other against health plans. At the post “Notice of Intent to Merge” meeting, Mr. Spaeth concluded that “it would be real tough for any of the Fortune 40 companies in this area whose CEOs use either this place or that place to walk from Evanston, Highland Park, Glenbrook, and 1700 of their doctors.” (CX 4 at 1-2; Spaeth, Tr. 2210-11 (emphasis added)).

Evanston Sought Market Power Through the Merger

1357. At a January 4, 1999, meeting between Evanston and Highland Park board members and medical staff leaders, Evanston suggested “do not compete with self” in covered zip codes (e.g., 60-70% market share) such as Evanston, Glenview, Highland Park, and Deerfield.” (CX 1 at 3).
1358. At that same January 4, 1999, meeting, Evanston representatives identified the opportunity to “strengthen negotiation capability with managed care companies through merged entities.” (CX 1 at 3).

1359. At an April 5, 1999, meeting of the medical staff executive committee at Highland Park, Mr. Neaman commented on the “geographic advantages” of a merger between Evanston and Highland Park. (Spaeth, Tr. 2213-14; CX 2 at 7).
1360. Like Highland Park, Evanston representatives also perceived the potential benefits of eliminating a competitor through the merger. The minutes of the April 5, 1999, meeting record another Evanston representative as saying that the merger “would be an opportunity to join forces and grow together rather than compete with each other.” (CX 2 at 7).
1361. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 1566 at 9;
Neaman, Tr. 1138, *in camera*).
1362. Mr. Neaman’s November 18, 1999, speech to the board of directors emphasized the same potential to increase leverage and enhance the negotiating posture with managed care players through the merged entity. (*Compare* RX 2015 at ENHL MO 003485, and CX 1566 at 9).

2. ENH Employed the Market Power of the Combined Evanston and Highland Park After the Merger

1363. Numerous ENH documents illustrate that ENH employed the market power of the combined Evanston and Highland Park after the merger. (CX 5 at 5; CX 6 at 7; CX 2070 at 3; CX 12 at 2; CX 13 at 1; CX 16 at 1; CX 17 at 1-2).
1364. At a January 6, 2000, ENH board of directors executive committee meeting, Mr. Neaman asked Mr. Hillebrand “to comment on the recent renegotiation of managed care contracts, one of the tactics of system integration.” (CX 5 at 5).
1365. In his January 6, 2000, update to the ENH executive committee, Mr. Hillebrand reported that “as a result of combining the medical staffs and Hospitals of the merger, [ENH] was able to renegotiate a managed care contract that resulted in an additional \$3.5 million benefit.” (CX 5 at 5).
1366. Mr. Hillebrand further informed the ENH executive committee at the January 6, 2000, meeting that “other managed care contracts will be renegotiated over the next 100 days.” (CX 5 at 5).
1367. One month later, at a February 3, 2000, ENH board meeting, Mr. Neaman highlighted accomplishments related to the system integration of Highland Park and Evanston. (CX 6 at 6).

1368. Mr. Hillebrand gave another update at the February 3, 2000, ENH board meeting. He “commented on the recent re-renegotiation of managed care contracts and the ‘added value’ as a result of combining the medical staffs and hospitals.” (CX 6 at 7). Mr. Hillebrand again reported to the board (as he had the month before) that other managed care contracts were in the process of being renegotiated. (*Compare CX 6 at 7 and CX 5 at 5*).
1369. One month later, on March 14, 2000, Mr. Hillebrand drafted ENH’s 2001-2003 Strategic Plan. In the Strategic Plan, Mr. Hillebrand stated that ENH’s growth initiatives, including the merger with Highland Park, would be used to “provide leverage to [ENH’s] market position as it negotiates with the purchasers of care.” (CX 2070 at 3).
1370. According to Mr. Hillebrand’s March 2000 ENH Strategic Plan draft, ENH’s “goal” in gaining leverage would be “to receive superior pricing” from purchasers of care. (CX 2070 at 3).
1371. At a June 16, 2000, meeting of the health care services committee at Highland Park, “Mr. Neaman reviewed the list of merger accomplishments,” including the “important successes [that] have been accomplished in managed care contracting.” (CX 12 at 2).
1372. At that same meeting, Mr. Neaman reported to the Highland Park health care services committee that “[t]here has been a \$12 million improvement on the Hospital side and \$8 million to physicians’ practices to date. The total improvements as a result of the merger are \$29.5 million.” (CX 12 at 2).
1373. The \$29.5 million total revenue improvement reported by Mr. Neaman at the June 16, 2000, meeting “greatly exceed[ed] the Board approved \$19 million goal over three years.” (CX 12 at 2).
1374. In a July 3, 2000, “Interdependence Day” memorandum to the ENH board, Mr. Neaman updated the board on the status of merger integration activities, including contract renegotiations with managed care plans. (Neaman, Tr. 1200; CX 13 at 1).
1375. While only one month earlier, Mr. Neaman had reported \$12 million in revenue improvement from managed care renegotiations to the health care services committee at Highland Park, Mr. Neaman’s July 3, 2000, “Interdependence Day” memorandum to the board reported that additional benefits from managed care renegotiations to that date totaled \$16 million on an annualized basis. (CX 13 at 1; CX 12 at 2).
1376. In that July 2000 memorandum, Mr. Neaman reported the successes in the merger integration efforts were the result of Evanston’s and Highland Park’s “interdependence.” Mr. Neaman stressed that “*neither Evanston nor Highland Park alone could achieve these results.*” (CX 13 at 1 (emphasis added)).

1377. At a September 27, 2000, meeting of the ENH board's finance committee, Mr. Neaman emphasized the link between the merger and the managed care renegotiations. Mr. Neaman stressed that "the larger market share created by adding Highland Park Hospital has translated to better managed care contracts." (CX 16 at 1).
1378. Mr. Neaman's October 2, 2000, "Final Report – Merger Integration Activities" memorandum to the ENH board reported that "some \$24 million of revenue enhancements have been achieved – mostly via managed care renegotiations." Mr. Neaman further reported that ENH's "net income from operations will go from a budgeted \$4 million to in excess of \$20 million for Fiscal Year 2000." (CX 17 at 1).
1379. In his October 2, 2000, "Final Report," Mr. Neaman repeated his "Interdependence Day" message to the board, concluding that "[a]s stated previously, none of this could have been achieved by either Evanston or Highland Park alone. The 'fighting unit' of our three hospitals and 1600 physicians was instrumental in achieving these ends." (Compare CX 17 at 2, and CX 13 at 1 (emphasis added)).

3. ENH Achieved Substantial Post-Merger Price Increases Through the Merger

1380. The record shows that ENH exercised its market power, attained through the merger, to raise prices. At least five mechanisms were employed to raise prices, including: (1) moving health plans to one contract for all three ENH facilities, i.e., the Evanston or Highland Park pre-merger contract, whichever had the higher rates; (2) adding a premium to the higher of the Evanston or Highland Park contract rates; (3) moving health plans from a fixed price contract to a discount off charges contract or to a contract that contained more discount off charges provisions than the pre-merger contract; (4) adopting in 2000 the higher of the Evanston or Highland Park chargemaster list prices; and (5) increasing ENH's chargemaster list prices on numerous occasions following the merger. (See, e.g., CX 30 at 1, 3; CX 23 at 2; CX 26 at 1; CX 25 at 9; CX 31 at 1. See also CCFF 822-842, 848-880, 813-821, 881-903, 918-927, 942-958).

ENH Moved Health Plans to One Contract for All Three ENH Facilities

1381. During the winter of 1999, ENH senior management decided that the merged entity would put the three ENH facilities on the same contract and charge the same rate for all three facilities. (Hillebrand, Tr. 1703; Newton, Tr. 363-65).
1382. { [REDACTED] } (Holt-Darcy, Tr. 1528, 1560-61, *in camera*; Foucre, Tr. 890; Ballengee, Tr. 176; Neary, Tr. 602; Neary, Tr. 756, *in camera*; Dorsey, Tr. 1447; CX 262 at 2, *in camera*).

ENH Moved Health Plans to the Higher (in Terms of Rates) of the Evanston or Highland Park Contracts

1383. In a September 24, 1999, memorandum, Terry Chan of Highland Park compared ENH and HPH inpatient rates, and observed that “there could be great potentials [sic] in improving payment rates for both hospitals and physicians.” (CX 30 at 3).
1384. Ms. Chan reported that ENH’s “potentia[l]” rate improvements could be achieved if the merged entity renegotiated “rates that are more favorable than the current Highland Park or ENH rates, (*whichever is higher*).” (CX 30 at 3 (emphasis added)).
1385. During the post-merger contract renegotiations, ENH successfully moved health plans to the higher of the Evanston or Highland Park contracts, which resulted in at least \$10 million in revenue enhancements for the merged entity. (Hillebrand, Tr. 1705; CX 23 at 2. See CCF 833-842).

ENH Added a Premium in Addition to Adopting the Higher of the Evanston or Highland Park Contract Rates

1386. Moving health plans to the higher of the Evanston or Highland Park contract rates was only the “starting point” for ENH’s health plan renegotiations after the merger. (Hillebrand, Tr. 1856, 1705).
1387. Recognizing ENH’s “additional negotiating power and leverage with the payors”– one of the “benefits of the merger” – during the winter of 1999, ENH senior management decided that “the combined entity would use the better of the Highland Park or Evanston [contract rate] *and then add a premium to that.*” (Newton, Tr. 364-65; Hillebrand, Tr. 1705; Chan, Tr. 709-10 (emphasis added)).
1388. The merged entity successfully negotiated prices above the pre-merger rates of either Evanston or Highland Park for numerous payors. (Hillebrand, Tr. 1705. See CCF 848-880).

ENH Moved Health Plans from Fixed Rates to Discount Off Charges Arrangements

1389. { [REDACTED]
[REDACTED]
[REDACTED] } (RX 663 at ENHL TC 016939, *in camera*).
1390. { [REDACTED]
[REDACTED]
[REDACTED] } (Hillebrand, Tr. 1706; Chan, Tr. 795-96; *in camera*. See CCF 813-821).

ENH Adopted the Higher of the Evanston or Highland Park Chargemaster Rates

1391. { [REDACTED] } (RX 663 at ENHL TC 016939, *in camera*).
1392. During the post-merger contract renegotiations, ENH consolidated the Highland Park and Evanston chargemaster by selecting the higher of the Evanston or Highland Park rate for each gross charge listing, resulting in at least an additional \$5 million in annualized economic value for Evanston. (Hillebrand, Tr. 1711, 1714-15; CX 17 at 5; CX 2240 at 11. *See* CCFF 881-903).

ENH Increased Its Chargemaster Rates in the Years Following the Merger

1393. { [REDACTED] } (RX 1687 at ENH BW 027653, *in camera*). { [REDACTED] } (RX 1687 at ENHL BW 027653, *in camera*).
1394. { [REDACTED] } (See RX 1687 at ENHL BW 027653 ({ [REDACTED] }, *in camera*).

ENH Attributed Its Successes in Raising Prices to Health Plans to the Merger Itself

1395. Despite Mr. Neaman and Mr. Hillebrand's claims that health plans' bargaining positions have actually *increased* since the merger, ENH was able to increase its prices post-merger to health plans and achieve at least \$18 million in increased annual revenues. None of the initial post-merger price increases obtained by ENH from health plans were taken away in subsequent years, with the exception of a partial price decrease to Humana. (Hillebrand, Tr. 1709-10, 1725-26; Neaman, Tr. 960-61, 1269-71).
1396. A worksheet entitled "Economic Measures of Success: ENH/HPH Merger/FY 2000," dated August 31, 2000, shows that ENH's initial forecast of income from operations for fiscal year 2000 was just \$4 million, but that the fiscal year 2000 actual income from operations was \$24 million, which is \$20 million more than projected. (CX 31 at 1; CX 2382 at 2).
1397. On October 2, 2000, Mr. Neaman issued a "Final Report" to ENH's board of directors on "Merger Integration Activities." (CX 17 at 1). In it, Mr. Neaman reports that "[S]ome

\$24 million of revenue enhancements have been achieved - mostly via managed care renegotiations.” (CX 17 at 1).

1398. Mr. Neaman’s October 2, 2000, memorandum to the board of directors included an attached “Sequential Listing of Accomplishments” of the merger. (CX 17 at 1, 5). Mr. Neaman reported that the re-negotiation of payor contracts had resulted in an annualized economic value of \$18 million. (CX 17 at 5-8 (\$3 million each for the United, PHCS, Aetna, Blue Cross/Blue Shield, and Cigna contracts, \$2 million for the Humana contract, and \$1 million from the renegotiation of other smaller PPO contracts combined)). (CX 17 at 5-8; Hillebrand, Tr. 1708-09. *See* CX 13 at 1 (In July 2000, Mr. Neaman reported an additional \$16-million/year in total managed care re-negotiation benefits to the board); *See also* CX 25 at 9, 11 (September 13, 2000 memo reporting the same “Merger Accomplishments” in the form of increased revenue through renegotiated contracts).

1399.

{
[REDACTED]
[REDACTED]
[REDACTED]} (Chan, Tr. 820, *in camera*;
CX 1099, *in camera*).

1400. Mr. Spaeth also testified that at the time of the merger Highland Park would not have been successful in raising its rates because the hospital could not sustain a strategy where it kept losing contracts. (Spaeth, Tr. 2178-79). He did not see an opportunity to raise the rates before the merger. (Spaeth, Tr. 2172-73).

B. Testimony of Present ENH Executives Regarding Merger Creating Market Power

1. Assessments in Contemporaneous Documents of the Anticompetitive Consequences of the Merger Are a Reliable and Accurate Reflection of Discussions

1401. Present and former ENH executives testified that the contemporaneous assessment of the consequences of the merger found in ENH documents is an accurate reflection of contemporaneous discussions in the pre- and post-merger period. (Neaman, Tr. 1192-95, 1196-97, 1200, 1203-05, 1207, 1209; Hillebrand, Tr. 1811-12; Spaeth, Tr. 2210-11; Newton, Tr. 369-70; Newton, Tr. 372-73). This testimony confirms that ENH’s documents provide trustworthy and reliable evidence that ENH’s post-merger price increases are the product of anticompetitive behavior and market power.

1402. ENH’s board meeting minutes were reviewed by key personnel, including Mr. Neaman, and accurately represented what occurred at the meetings. Attendees were free to speak candidly and honestly. (Neaman, Tr. 1192-95).

1403. Consistent with the language of the merger documents, Mr. Neaman admitted that one of the goals of the merger with Highland Park was to get better prices and terms from health plans for ENH. (Neaman, Tr. 1036). In the late 1990's health plans were decreasing rates for hospital services. (Neaman, Tr. 1037-38). ENH and Highland Park hoped that the merged entity could strengthen the negotiating position of the hospitals with health plans. (Neaman, Tr. 1039; CX 19).
1404. Mark Newton, a former Highland Park and ENH executive, attended the January 6, 2000, board meeting at which Jeff Hillebrand reported on renegotiations with health plans. The minutes from that meeting (CX 5 at 5) accurately reflect the statements made by Mr. Hillebrand at that meeting. (Newton, Tr. 369-70).
1405. Mark Newton also attended the February 2000 board meeting at which Jeff Hillebrand reported on renegotiations with health plans. The minutes from that meeting (CX 809) accurately reflect the statements made by Mr. Hillebrand at that meeting. (Newton, Tr. 372-73).

2. ENH Executives Testified That Pre-Merger There Were Significant Pricing Pressures and the Threat of Increased Competition from Highland Park

1406. Before the merger, ENH leadership believed that the government and health plans would increase pricing pressures on hospitals. (Neaman, Tr. 1042; CX 442 at 4).
1407. { [REDACTED]
[REDACTED]
[REDACTED] } (Neaman, Tr. 1134-35, *in camera*; CX 1566 at 3-4). { [REDACTED]
[REDACTED]
[REDACTED] } (Neaman, Tr. 1138, *in camera*; CX 1566 at 9).
1408. In December 1997, Mr. Neaman authored the ENH strategic plan, "Achieving our Strategic Goals: The Financial Roadmap for Our Future, 1998-2002." ENH management also authored a 1996 to 2000 strategic plan. Mr. Neaman forwarded excerpts from these plans to Bain in February 1998. (Neaman, Tr. 1149-51; *see also* CX 2037).
1409. As he wrote in the December 1997 Financial Roadmap, Mr. Neaman believed that "[p]ricing pressures, as anticipated five years ago, have continued to grow." (Neaman, Tr. 1151; CX 2037 at 2). Thus, ENH management recognized from the early 1990s that declining managed care prices would continue to exert pressure on ENH's bottom line.
1410. As early as the beginning of 1998, ENH experienced "significant reductions in reimbursement" from both Blue Cross and Humana. (CX 2037 at 2-3; Neaman, Tr. 1151-52).

1411. In December 1998, ENH viewed the pricing pressures as a “significant threat” to Evanston. (CX 2037 at 3; Neaman, Tr. 1152).
1412. In its 1996 to 2000 Strategic Plan, ENH sought to increase market share for each segment of its business, including inpatient services. (CX 2037 at 9; Neaman, Tr. 1153). Part of that growth strategy included the strategy of acquiring other hospitals. (Neaman, Tr. 1154; CX 2037 at 9).
1413. According to Mr. Hillebrand, Mark Neaman believes that the reason Evanston’s prices pre-merger were lower than those at Highland Park was because Evanston had a much greater volume of business for commercial payers. Neaman believes that “since Highland Park was so much smaller than Evanston, the managed care companies weren’t as particular about what they paid them.” (Hillebrand, Tr. 1706-07).
1414. Prior to the merger, United, which had recently purchased a number of other health plans, was attempting to exert market power on ENH. Mr. Hillebrand believes that in the 1990s ENH was at a disadvantage in negotiations with Blue Cross, Aetna, and United because of the substantial collective market share of these three payers. (Hillebrand, Tr. 1725).
1415. At the time of the merger, Blue Cross, United, Aetna, and Humana collectively comprised 75% of the managed care market in Chicago. (Hillebrand, Tr. 1725).
1416. One of the ways that Highland Park competed with other hospitals was to negotiate contracts with health plans. Mr. Spaeth of Highland Park testified that health plans were looking for hospitals that would take care of the patient volume for the lowest possible rate. (Spaeth, Tr. 2185-86).
1417. Mr. Spaeth testified that, before the merger, Evanston and Highland Park were competitors of each other, and health plans might have gotten a better deal from one hospital over the other or contracted with only one hospital and not the other. (Spaeth, Tr. 2188-89).
1418. During the period 1994 forward, Mr. Spaeth had heard that every major insurer in the Chicago area had threatened to or had actually left hospitals out of its network contracts. (Spaeth, Tr. 2193).
1419. The price trend before the merger was down, and in Mr. Spaeth’s view that has not changed. (Spaeth, Tr. 2201-02).
1420. Before the merger, Highland Park would sometimes propose a rate to a health plan that the health plan would say was too high. Sometimes health plans would not contract with Highland Park. That included both small HMOs and at least one large health plan like Aetna or Humana. (Spaeth, Tr. 2170-71).

1421. Mr. Spaeth testified that, before the merger, health plans sometimes walked away from hospitals. Mr. Spaeth did not believe that Highland Park was an absolute necessity in any health plan contract. He testified that health plans walk when they have the opportunity to go down the street and contract with another hospital at a better rate. Consequently, Highland Park was afraid that it would lose patients if health plans did not contract with the hospital. (Spaeth, Tr. 2171-72).
1422. Mr. Spaeth testified that when Highland Park turned down a contract, this would reduce Highland Park's patient volume, and that Highland Park would begin to reduce its bottom line. (Spaeth, Tr. 2172).
1423. Mr. Spaeth believed that at the time of the merger Highland Park would not have been successful in raising its rates. He did not see an opportunity to raise the rates before the merger. (Spaeth, Tr. 2172-73). The hospital could not sustain a strategy where it kept losing contracts, as such a strategy would have proved very difficult to stick to. (Spaeth, Tr. 2178-79).
1424. Before the merger, normally it was very difficult for Highland Park to get an increase from a health plan in its contract rates. (Spaeth, Tr. 2180-82).
1425. Before the merger, Highland Park had some contracts with prices that rolled over and others that had "a stipulated end at which then it was agreed to that there would be renegotiation." When the contract was "evergreen" and rolled over, the parties sometimes did not seek an adjustment of the current contract rates, and it was understood that the rate would continue to the following year. Highland Park had staff negotiating with the payers and trying to maximize the reimbursement from them, but in the pre-merger period, "every time we tried to negotiate for a higher rate, it was very difficult to achieve." (Spaeth, Tr. 2182-85).
1426. Mr. Spaeth viewed the merger of Highland Park and Evanston as providing a unified face to managed care. Evanston now has the final say for all three hospitals in matters of contracting. (Spaeth, Tr. 2188).

3. Merger-Related Negotiations Headed by Jeff Hillebrand Were Successful for ENH

1427. Mr. Hillebrand agreed that "\$36 million in economic value on an annualized basis" achieved by October 2, 2000, by ENH could not "have been achieved by Evanston and Highland Park alone." This \$36 million included \$24 million derived mostly from managed care renegotiations. (Hillebrand, Tr. 1817-18; CX 17 at 2).
1428. On an "annualized basis," Mr. Hillebrand testified that the ENH post-merger price increases from the health plan contract re-negotiation alone yielded \$18 million in increased revenues. None of the initial post-merger price increases ENH obtained from

health plans were taken away in subsequent years, with the exception of a partial price decrease with Humana. (Hillebrand, Tr. 1709-10).

1429. The 2000 negotiations led to a termination of the hospital contract between ENH and One Health on August 31, 2000. A number of months later, ENH and One Health came to terms on a new hospital contract. Other than One Health's termination period, ENH lost no other health plan customers. (Hillebrand, Tr. 1707-08).
1430. In the process of setting its prices for the 2000 negotiations with health plans, and the 2002 increases to its chargemaster, ENH did not factor in whether patients or the health plans would switch to other hospitals in response to the increases. In his 26 years of experience, Mr. Hillebrand has never seen steerage by health plans work effectively in the Chicago area. (Hillebrand, Tr. 1765).
1431. In the process of setting its prices for the 2000 negotiations with health plans, and the 2002 increases to its chargemaster, ENH did not consider what actions other hospitals would take in response. (Hillebrand, Tr. 1764-65).
1432. When setting its prices in 2000, ENH was not concerned with and did not factor in whether Lutheran General, Rush North Shore, St. Francis, Lake Forest or any other hospital raised or lowered their prices in response. (Hillebrand, Tr. 1753-55).
1433. Mr. Hillebrand did not write and does not recall seeing any analysis of the possibility that ENH's 2000 price increases would lead to ENH losing health plans to other hospitals. (Hillebrand, Tr. 1757-58).
1434. Mr. Hillebrand does not recall anyone at ENH recommending against the 2000 ENH price increases on the ground that they would lead to ENH losing health plans to other hospitals. (Hillebrand, Tr. 1758).
1435. Mr. Hillebrand believes that employers with insurance access to the three ENH hospitals would balk at the idea of a health plan telling the employer's enrollees that they have to go to another hospital system, instead of ENH. (Hillebrand, Tr. 1764).
1436. According to ENH, Evanston and Highland Park could not have achieved the increased revenues from the post-merger health plan negotiations if they had been independent hospitals. (Hillebrand, Tr. 1816-17; CX 13 at 1).
1437. With the exception of capitation contracts, health plans in Chicago have not successfully engaged in steering their enrollees from one hospital to another in exchange for better rates. Mr. Hillebrand testified that it would be difficult for health plans to steer patients away from ENH. (Hillebrand, Tr. 1760-63).

1438. { [REDACTED]
[REDACTED]
[REDACTED] } (Hillebrand, Tr. 1927, *in camera*; CX 20).

1439. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }
(Hillebrand, Tr. 1923-24, *in camera*; CX 57 at 1, *in camera*).

4. ENH's Executives Affirmed Respondent's Documents' Assertions About Price Increases Related to Post-Merger Re-Negotiations with Health Plans

1440. Mr. Neaman admitted that one of the goals of the merger with Highland Park was to get better prices and terms from health plans for ENH. (Neaman, Tr. 1036). In the late 1990s health plans were decreasing rates for hospital services. (Neaman, Tr. 1037-38). ENH and Highland Park hoped that the merged entity could strengthen the negotiating position of the hospitals with health plans. (Neaman, Tr. 1039; CX 19).

1441. Mr. Neaman affirmed that, according to the January 2000 board meeting minutes, Mr. Hillebrand reported that ENH was able to gain an additional \$3.5 million benefit from a managed care contract renegotiation "as a result of combining the medical staffs and Hospitals of the merger." (CX 5 at 5). This was the United renegotiation. (Neaman, Tr. 1196-97).

1442. Mr. Hillebrand confirmed that a March 14, 2000, draft Evanston Northwestern Healthcare, 2001-2003 Strategic Plan, which he wrote, states that ENH's growth initiatives, including the merger with Highland Park, would be used to provide leverage to ENH's market position as it negotiates with managed care and to receive superior pricing. (CX 2070 at 3, Hillebrand, Tr. 1811-12).

1443. Mr. Neaman testified that in his July 3, 2000, "Interdependence Day" memorandum to the ENH board, he reported to the board on the status of merger integration activities. Mr. Neaman reported that the successes in the merger integration efforts were the result of Evanston's and Highland Park's "interdependence." Mr. Neaman noted, "Neither Evanston nor Highland Park alone could achieve these results." (Neaman, Tr. 1201-02; CX 13 at 1).

1444. Mr. Neaman testified that at the September 27, 2000, finance committee meeting of the board, he noted that the "larger market share created by adding Highland Park Hospital has translated to better managed care contracts." (CX 16 at 1; Neaman, Tr. 1202-03).

1445. Mr. Neaman testified that in an October 2, 2000, memorandum, he provided the board with his final report on the merger integration activities for the Highland Park merger. (CX 17; Neaman, Tr. 1203).
1446. Mr. Neaman testified that in his October 2, 2000, memorandum he reported that all of ENH's managed care contracts "have been successfully renegotiated." To that date, ENH had achieved, since the merger, \$24 million in "revenue enhancements," the majority of which came from contract renegotiations. This \$24 million figure was a "big number" relative to prior years. (CX 17 at 1; Neaman, Tr. 1203-04).
1447. Mr. Neaman acknowledged that in his October 2, 2000, report he reiterated that "none of [the revenue enhancements and cost improvements] could have been achieved by either Evanston or Highland Park alone." (CX 17 at 2; Neaman, Tr. 1205-06).
1448. Mr. Neaman admitted that he was the primary drafter of the 2001-2003 Corporate Strategy presentation made to the board in approximately late 2000 or early 2001. (CX 68; Neaman, Tr. at 1206-07).
1449. Mr. Neaman admitted that one of ENH's strategic goals was to "protect the 'core.'" In the zip codes immediately surrounding its facilities, ENH wanted to increase its market share from 55 to 60% market share in the zip codes immediately surrounding its facilities. (CX 68 at 11; Neaman, Tr. 1208-09).
1450. Mr. Neaman acknowledged that another of ENH's strategic goals was "market place leadership," partly through "leverage with payors." (CX 68 at 13; Neaman, Tr. 1209).

5. ENH Executive After-the-Fact "Explanations" of Leverage Are Factually Implausible

1451. ENH executives do not deny that they made various key statements concerning leverage. However, several of them claim that the statements in the documents concerning "leverage" do not reflect admissions of market power or are not connected to the merger with Highland Park. Such assertions are not credible and are contradicted by certain record admissions in light of numerous documents and supporting testimony. (Neaman, Tr. 1036- 39; Hillebrand, Tr. 1790, 1801-02, 1811-12; Spaeth, Tr. 2188; 2211-14; CX 2 at 7; CX 86 at 2; CX 69 at 1; CX 19 at 1; CX 4 at 1, 2, 9; CX 394 at 3; CX 2070 at 3).
1452. { [REDACTED]
[REDACTED]
[REDACTED] }
(CX 1566 at 9; Neaman, Tr. 1138, *in camera*); *see also*, RX 2015 at 3487 ("leverage with managed care").

1453. Mr. Neaman admitted that one of the goals of the merger with Highland Park was to get better prices and terms from health plans for ENH. (Neaman, Tr. 1036). In the late 1990s health plans were decreasing rates for hospital services. (Neaman, Tr. 1037). ENH and Highland Park hoped that the merged entity could strengthen the negotiating position of the hospitals with health plans. (Neaman, Tr. 1039; CX 19 at 1).
1454. Mr. Hillebrand admitted that the phrase “increase market leverage,” includes the potential to get higher prices from health plans and to increase bargaining power. (Hillebrand, Tr. 1790-91, 1801-02, 1811-12; CX 394 at 3; CX 2070 at 3).
1455. Mr. Spaeth viewed the merger of Highland Park and Evanston as providing a unified face to managed care. Evanston now has the final say for all three hospitals in matters of contracting. (Spaeth, Tr. 2188).
1456. Mr. Spaeth admitted that on April 5, 1999, at a meeting of the medical staff executive committee at Highland Park, Mr. Neaman of Evanston made a presentation related to the hospital merger. Mr. Spaeth understood that in the presentation Mr. Neaman “refers to the geographic advantages of two institutions” through the merger. (Spaeth, Tr. 2213-14; CX 2 at 7). The minutes also state that “[t]his would be an opportunity to join forces and grow together rather than compete with each other.” (CX 2 at 7).
1457. Mr. Spaeth further admitted to making statements about gaining leverage over large employers after the merger. He testified that sometime after April 16, 1999, when a letter of intent was signed by Highland Park and Evanston regarding the merger, Mr. Spaeth told his board members that “it would be real tough for any of the Fortune 40 companies in this area whose CEOs either use this place or that place to walk from Evanston, Highland Park, Glenbrook and 1700 of their doctors.” (CX 4 at 2; Spaeth, Tr. 2210-11). When Mr. Spaeth referred to “this place,” he was referring to the three hospitals. (Spaeth, Tr. 2211).
1458. Mr. Spaeth admitted that at the same meeting where he made his comment about gaining leverage over large employers, Mr. Patience, a board member of Highland Park Hospital, expressed the view that the economic issue being dealt with was the relative negotiating power of the health plans versus the hospitals and that, if one of the objectives was to get geographic leverage on the employers in the area, Northwestern Memorial would not help much. (CX 4 at 9; Spaeth, Tr. 2211-12).
1459. The leadership of both Evanston and Highland Park wanted to make ENH “indispensable” to the market. (CX 19 at 1).
1460. In a May 2000 planning document, ENH recognized that achieving “a leadership position (#1 or #2) and significant market share (>30%)” even in small market areas, “increases contracting leverage with health plans and employers.” (CX 86 at 2-3).

1461. In a document with a time period January 1, 2000 – December 31, 2000, titled “Effective Communications During a Hospital Merger,” ENH stated that the boards of Evanston and Highland Park Hospital decided to merge to obtain, among other things, “increased leverage in the managed care marketplace.” (CX 69 at 1).

C. Testimony of Former ENH Executives Regarding Merger Creating Market Power

1462. Two former executives of ENH testified that ENH officials were aware that the merger created leverage and market power with health plans. Those two executives are Mark Newton and Terry Chan, and each held management positions with the merging hospitals. (Newton, Tr. 279, 295, 363-64; Chan, Tr. 652-62).

1463. { [REDACTED] } (Newton, Tr. 351-53, 54, 59-60, 61-62; Chan, Tr. 839, *in camera*; Chan, Tr. 709-10); { [REDACTED] } (Newton, Tr. 363-64, 365, 66-67; Chan, Tr. 705-06; Chan, Tr. 839-41, *in camera*); { [REDACTED] } (Newton, Tr. 369-70; Chan, Tr. 696-97; 703).

1464. { [REDACTED] } (CX 129 at 1, *in camera*); { [REDACTED] } (Holt-Darcy Tr. at 1559-60 *in camera*). ENH indicated to PHCS that ENH was an “entity controlling all of these communities.” (Ballengee, Tr. 176-77 (“they indicated that they already had the market share for these communities.”)).

1. Background of the Two Former ENH Executives

1465. During the period 1988 to April 2000, Mark Newton was employed at Highland Park and post-merger at ENH. (Newton, Tr. 279, 295). Mr. Newton’s first position at Highland Park Hospital was vice president of planning and marketing. He subsequently took over the duties of senior vice president of business development. (Newton, Tr. 279). Mr. Newton also was involved in meetings on post-merger contract renegotiations between ENH and health plans. Specifically, he participated in several meetings with Bain and senior management of the former Highland Park. (Newton, Tr. 295). Mark Newton was involved in contract renegotiation strategy discussions in the winter of 2000. At least three meetings occurred during this time period. (Newton, Tr. 363-64).

1466. From January 1, 2000, to September 1, 2000, Teresa Chan worked for ENH as assistant vice-president for finance. In this role, Ms. Chan was a member of the managed care

contracting team that conducted post-merger negotiations with commercial payers. (Chan, Tr. 651-52). Ms. Chan's involvement during the 2000 post-merger negotiations included contacting health plans, drafting proposals, and analyzing the impact of every contract proposal and negotiation. (Chan, Tr. 663).

2. Former ENH Executives Also Testified That Highland Park and Evanston Faced Pricing Pressures Before the Merger

1467. Pre-merger, Highland Park management was "routinely concerned" about being excluded from a health plan's network. (Newton, Tr. 303).
1468. MCOs would continually inform Highland Park during negotiations that "other hospitals will fill that bill." (Newton, Tr. 303).
1469. Highland Park management's "fundamental business tenet" was that Highland Park needed to be included in all products for all payors. Exclusion would "diminish [Highland Park's] ability to be successful in the market, would diminish [Highland Park's] ability for patients to come to [Highland Park]." (Newton, Tr. 303-04).
1470. In order to avoid exclusion, Highland Park management had to be "constrained" in its pricing negotiations. (Newton, Tr. 304).
1471. Highland Park management believed that one benefit of growing via merger was that such a strategy "builds negotiating strength with payers." (CX 1869). "[B]y being part of a larger entity, a larger contracting entity, [the merged entity] would collectively have strength with payors." (Newton, Tr. 349).
1472. In the mid to late 1990s, Highland Park generally received single digit price increases from health plans. These price increases were less than what Highland Park had requested in negotiations. (Newton, Tr. 356-57).
1473. In the mid to late 1990s, Highland Park could not obtain higher price increases because health plans could substitute other hospitals for Highland Park in their networks. These substitute hospitals included Evanston, Rush North Shore, and Lutheran General, among others. (Newton, Tr. 358).
1474. Prior to the merger, health plans indicated to Ms. Chan that Evanston was a nearby option if they were unsatisfied during rate negotiations with Highland Park Hospital. Before the merger, Evanston was a competitor of Highland Park Hospital. (Chan, Tr. 745).
1475. Before the merger, Highland Park perceived health plans to have greater leverage than Highland Park Hospital. (CX 1908 at 4).

1476. In the late 1990s there was a trend of health plans to “convert any discount off charge contract to per diems.” (Chan, Tr. 671).
1477. Ms. Chan believes that the higher a hospital increased its rates, the less likely a health plan was to desire that hospital to remain in its network. (Chan, Tr. 699-700).
1478. { [REDACTED] } (Chan, Tr. 823-24, *in camera*).
1479. { [REDACTED] } (Chan, Tr. 782-83, *in camera*; CX 1095 at 6, *in camera*).
1480. { [REDACTED] } (Chan, Tr. 785-87, *in camera*; CX 1095 at 6, *in camera*).
1481. { [REDACTED] } (Chan, Tr. 791-92, *in camera*; CX 439 at 8).
1482. { [REDACTED] } (Chan, Tr. 794, *in camera*; CX 439 at 8).
1483. { [REDACTED] } (Chan, Tr. 795-96, *in camera*).
1484. { [REDACTED] } (Chan, Tr. 820, *in camera*; CX 1099 at 1-67, *in camera*).
1485. Before the merger, Highland Park felt that a merger or acquisition with another hospital could increase Highland Park’s “negotiating strength” with health plans. (CX 1869 at 7 (LHS Strategic Planning Retreat, 9/2/98)).

3. Former ENH Executives Admitted That Market Power and Leverage over Health Plans Were Attributable to the Merger

1486. At the time of the merger, the merging parties' executives believed that the proposed Evanston merger would increase the merged entity's negotiating leverage with the health plans. (Newton, Tr. 359-60). The merging parties' executives believed that the merged entity's negotiating leverage would increase despite the existence of non-ENH facilities relatively nearby. Employers with employees in the merged entity's communities would find it "very difficult" to notify their employees that the ENH facilities were not in the network. (Newton, Tr. 362).

1487. From Highland Park's perspective, Evanston presented the best combination to generate negotiating strength. Evanston's two hospitals and Highland Park "form a triangle . . . within this market of these really affluent communities . . . These organizations together would have a significant market penetration in these very affluent, attractive communities." (Newton, Tr. 351-52). Highland Park believed this would lead to increased prices from health plans. (Newton, Tr. 359-60).

1488. The combination of Highland Park and Evanston would have more bargaining strength as compared to combinations of Highland Park and other institutions. The factors pushing in this direction include proximity of institutions, cultural relationships existing in the community, and placement of medical staffs, among others. (Newton, Tr. 354).

1489. According to Mr. Newton, "essentially, what we were looking for here is how concentrated could this market be for us." (Newton, Tr. 353-54).

1490. The geographic placement of ENH's three hospitals, which are concentrated in the North Shore's extremely affluent communities, gave ENH immense influence and power with the health plans. (Newton, Tr. 361-62). The merger between Evanston and Highland Park gave ENH "more power than it had before the merger." (Chan, Tr. 705-06).

1491. Terry Chan testified that ENH insisted on certain rates after the merger, because it increased its negotiation power through the merger, and had more leverage. (Chan, Tr. 710). She believes that ENH had "more leverage" to insist on certain rates from health plans because of the merger. (Chan, Tr. 709-10).

1492. { [REDACTED] } (CX 1607 at 5, *in camera*). { [REDACTED] }
{ [REDACTED] }
{ [REDACTED] }
(Chan, Tr. 839-40, *in camera*).

1493. { [REDACTED] }
{ [REDACTED] } (Chan, Tr. 839, *in camera*). { [REDACTED] }
{ [REDACTED] }

[REDACTED] } (Chan, Tr. 840-41, *in camera*;
CX 1607 at 5, *in camera*)

1494. Ms. Chan did not hear any health plans say during negotiations that they would not pay the ENH post-merger increase, or that they would move patients to St. Francis or Rush North Shore hospitals. (Chan, Tr. 703).

1495. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CX 129 at 1, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr.1559-60; *in camera*).

1496. ENH indicated to PHCS that ENH was an “entity controlling all of these communities.” (Ballengee, Tr. 176-77 (“they indicated that they already had the market share for these communities.”)).

4. Former ENH Executives Admitted That a Merger Plan Was to Use Power Attributable to the Merger to Increase Prices

1497. { [REDACTED]
[REDACTED]
[REDACTED] } (Chan, Tr. 834, *in camera*; Hillebrand, Tr. 1868).

1498. The pricing strategy was based on the “additional negotiating power and leverage with the payors” due to the ENH-Highland Park merger. (Newton, Tr. 365).

1499. Bain representatives participated in contract renegotiation strategy discussions, along with Mark Neaman, Jeff Hillebrand, Ray Grady, Joseph Golbus, Ron Spaeth, William Luehrs, and Mark Newton. (Newton, Tr. 363-64).

1500. At these renegotiation strategy meetings, the participants established a strategy that the merged entity would seek the higher of the Highland Park and Evanston contract rates and “add a premium.” No one at the meetings disagreed with this overall pricing strategy. (Newton, Tr. 364-65).

1501. At these contract renegotiation meetings, no one expressed a concern that health plans would walk away from ENH rather than accept changes to the contracts. Mr. Newton believed that having a health plan walk away was not a concern because the plans “really needed this combined entity.” (Newton, Tr. 367).

1502. Another component of the pricing strategy that emerged from these renegotiation strategy discussions was to shift, whenever possible, to a discount off charges structure from per diem contracts. No one at the meetings disagreed with this strategy. (Newton, Tr. 366-67).
1503. The merged ENH entity preferred discount off charges contracts because the hospital was not constrained in its ability to raise list prices, thereby increasing net revenue. (Newton, Tr. 366).
1504. { [REDACTED] } (Chan, Tr. 834, *in camera*; CX 1607 at 2, *in camera*). ENH negotiators planned to use the results of the United negotiation in late 1999 (of a contract effective January 1, 2000) as a benchmark for hospital rates that ENH would use in subsequent negotiations with health plans. (Hillebrand, Tr. 1740-41).

5. Former ENH Executives Admitted That ENH's Plan to Use Power From the Merger to Increase Prices Succeeded

1505. Mr. Newton testified that Mr. Hillebrand summarized at board meetings the success that ENH had had renegotiating a number of contracts with managed health plans. (Newton, Tr. 369-70; CX 5 at 5; CX 809 at 7).
1506. { [REDACTED] } (Chan, Tr. 844-46, *in camera*; CX 5906 at 2).
1507. Ms. Chan testified that a number of health plans, such as United, Cigna, and PHCS, fared "poorly" in the post-merger negotiations with ENH. Faring "poorly" means that United, Cigna, and PHCS had to pay a lot more in rates to ENH after the post-merger negotiations. (Chan, Tr. 696-97).
1508. Ms. Chan never heard health plan representatives threaten to redirect their patient flow to other hospitals as a result of ENH's price increases. (Chan, Tr. 703).

D. Testimony and Documents from ENH Consultants Regarding Merger Creating Market Power

1509. Through the end of 1999 and early 2000, Bain provided contracting strategy advice to ENH relating to the Highland Park merger. (Neaman, Tr. 1160-61 (describing Bain's work); CX 2072 at 1 (Bain's engagement letter)). The focus of Bain's project was to "gro[w] net income by leveraging contracting and service line opportunities created by the Highland Park merger." (CX 74 at 3). Bain consistently advised ENH to "leverage"

the addition of Highland Park against healthcare plans during renegotiations in order to obtain more favorable rates. (See, e.g., CX 74 at 22 (ENH should “leverage HP” to “maximize scale benefits”); CX 74 at 19 (“the addition of Highland Park will substantially improve ENH’s leverage”)). Bain provided specific contracting advice by health plan to maximize rate increases and based its recommendations on the amount of “leverage” the post-merger ENH had. (See, e.g., CX 67 at 39 (ENH had “required leverage to gain PHCS’s agreement to improved terms” because PHCS was heavily reliant on combined ENH/HP entity for admissions)). Through these tactics, ENH successfully negotiated higher rates from health plans in late 1999 and through 2000. (CX 67 at 32 (projecting annual increase of nearly \$15 million in net revenue due to renegotiations)).

1. In 1999, ENH Engaged Bain to Provide Merger-Related Contracting Strategy

1510. In March 1999, Bain set forth, at the request of ENH, a number of proposals on how Bain “might help [ENH] with the Highland Park merger that is under discussion.” (CX 66 at 1). Bain believed that the merger “significantly enhances ENH’s competitive and operating position.” (CX 66 at 1).
1511. ENH also agreed with Bain’s conclusion that, “Evanston, Glenbrook and Highland Park all enjoy relatively high market shares in the core markets around each hospital.” (Neaman, Tr. 1156-57; CX 66 at 1).
1512. ENH agreed with Bain’s view that the Highland Park merger would provide an opportunity for ENH to improve its strategic position and improve operating results. (Neaman, Tr. 1156-57).
1513. Bain proposed, among other projects, creating “a unified contracting strategy reflecting the combined entities” of Highland Park and ENH. (CX 66 at 2).
1514. Around August 1999, ENH officially retained Bain to provide advice on the Highland Park merger. The principal Bain representatives leading the team were Chuck Farkas and Kim Ogden. (Neaman, Tr. 1160-61; CX 2072 at 3).
1515. For the Highland Park merger, ENH engaged Bain to provide advice on contracting strategy with managed care plans and on how best to improve, rationalize and consolidate service lines. (Neaman, Tr. 1169). ENH believed Bain’s analysis was accurate and provided useful information and direction for ENH in the context of the Highland Park merger. (Neaman, Tr. 1161).

2. Bain Advised ENH to Use in Contracting the Increased Market Leverage Due to the Addition of Highland Park

1516. Bain advised ENH that the “merger provides the opportunity to . . . negotiate contracts with payors from a stronger position.” (CX 2072 at 1).
1517. The focus of Bain’s 1999 through 2000 merger consulting work for ENH was “growing net income by leveraging contracting and service line opportunities created by the Highland Park merger.” (CX 74 at 3).
1518. Bain consistently advised ENH that ENH’s “negotiating leverage [with health plans] should increase with increased scale.” Thus, ENH should “leverage HP” to “maximize scale benefits.” (CX 74 at 22). Bain counseled that “the addition of Highland Park will substantially improve ENH’s leverage.” (CX 74 at 19).
1519. Bain advised ENH that ENH had “significant leverage” with managed care plans because the combined ENH/Highland Park entity would be the largest in admissions volume in the Chicago area. (CX 74 at 15).
1520. ENH understood that Bain’s use of the term “leverage” incorporated the concept of bargaining power in contract negotiations with health plans. (Hillebrand, Tr. 1801-02).
1521. Bain advised ENH that the post-merger ENH had a “good position” in the marketplace for negotiating better rates in managed care contracts. (RX 2047 at 156 (Ogden, Dep.)).
1522. This “good position” was attributable to the post-merger ENH’s “size and quality in the marketplace.” (RX 2047 at 156 (Ogden, Dep.)).
1523. According to Bain, one of the important factors in establishing this “good position” post-merger was the post-merger market share. Bain advised ENH that “[w]ith the Highland Park merger ENH now commands a 55 percent market share.” (RX 2047 at 156 (Ogden, Dep.); CX 1607 at 5).
1524. Bain advised prioritizing in the renegotiations large, poor-performing managed care contracts for which ENH had “enough leverage to improve terms.” (CX 75 at 9).
1525. Bain advised ENH to “sell ENH’s benefits to payor” in order to “justify premium pricing (i.e., above the competitive average).” (CX 75 at 16).
1526. Bain provided ENH with “action plans” for individual health care plan negotiations. (CX 1998 at 44, 49).
1527. For the PHCS negotiations in early 2000, Bain concluded that ENH could negotiate better terms because “ENH has significant leverage in negotiations with PHCS as they have strong North Shore presence and need [ENH] in their network.” (CX 1998 at 44).

1528. Bain advised ENH that it had “the required leverage to gain PHCS’s agreement to improved terms.” This was because PHCS was heavily reliant on the combined ENH/HP entity, with ENH/HP constituting “over 30% of [PHCS] North Shore admissions.” (CX 67 at 39).
1529. Blue Cross was an exception, in terms of ENH’s negotiating leverage. ENH management agreed that ENH had less opportunity to negotiate successfully with Blue Cross than with other payors because of Blue Cross’s large size. (Neaman, Tr. 1182-83).
1530. For the early 2000 negotiations with Blue Cross’s HMO (HMO Illinois), Bain concluded that “negotiations will be challenging given their strong strategic positions in [Illinois].” According to Bain, HMO Illinois at that time had the largest market share of any HMO in Illinois. (CX 1998 at 49). Bain noted that “[t]his negotiation will be challenging because ENH’s relative leverage with HMO IL is less than with most payors.” (CX 67 at 36).

3. Following Bain’s Advice, ENH Successfully Utilized the Market Power Generated by the Merger to Extract More Money from Health Plans

1531. Bain representatives themselves assisted in negotiating certain of ENH’s managed care contracts in the renegotiations relating to the Highland Park merger. (Neaman, Tr. 1217-18).
1532. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 1991 at 3, *in camera*).

1533. By February 2000, Bain targeted an increase of \$14.8 million in annual net revenue attributable to the contract renegotiations by ENH. (CX 67 at 32).
1534. As it turned out, ENH, according to its own estimates, surpassed this expectation by the fall of 2000. In September 2000, ENH management estimated that the health plan renegotiations had added an additional \$21 million in annual net revenue. (CX 25 at 9, 11).

E. Prior to the Highland Park Merger, Evanston and Highland Park Sought Market Power

1. Northwestern Healthcare Network

1535. The Northwestern Healthcare Network (“NHN”) was an association of hospitals formed in the early 1990s and disbanded in the late 1990s. The purpose of the network was to create an integrated healthcare delivery system. (CX 6306 at 2 (Mecklenburg Dep.)).

NHN's founding members included Evanston Hospital, Highland Park Hospital, Northwestern Memorial Hospital, and Children's Hospital. (Hillebrand, Tr. 1785).

1536. Through the formation of NHN, its members, including ENH and HPH, aimed to increase bargaining power versus healthcare plans by negotiating jointly and combining the bargaining strength of the individual members. (Neaman, Tr. 965 (unified contracting through NHN hopefully would result in better terms than individual negotiations)). This was a specific goal discussed by Mr. Neaman of ENH and Mr. Spaeth of HPH at NHN meetings and internally. (Spaeth, Tr. 2194; CX 1802 at 2 (HPH joined NHN for "leverage"); CX 1802 at 3 (ENH belief that reason for joining network was to get better pricing than negotiating alone)). However, the members did not want to give up individual autonomy in contracting (Neaman, Tr. 966), and the network eventually dissolved. (CX 2231 at 4 (NHN board voting for dissolution)).

a. A Central Purpose of the Northwestern Healthcare Network Was to Negotiate Collectively and Eliminate Competition Between Member Hospitals to Obtain Better Contract Terms

1537. A primary goal of NHN was to grow enough for member hospitals to successfully negotiate as a group with health plans. (Neaman, Tr. 963).

1538. According to Mr. Neaman, the NHN members understood that one of the problems that NHN's member hospitals faced was that health plans had greater bargaining power than the hospitals. (Neaman, Tr. 964). Through the network, the members aimed to get better pricing and terms from health plans. (Neaman, Tr. 964).

1539. By increasing NHN's market share to 30%, NHN members hoped "to build towards becoming indispensable to payors." (CX 381 at 2). This "market growth strategy" building "towards becoming indispensable to payors" was a central component of NHN's strategic plan. (CX 2231 at 3).

1540. ENH believed that if NHN's members did not stand united against managed care companies, NHN's benefits would be diminished. (Neaman, Tr. 965).

1541. ENH hoped that unified contracting among members would result in better terms than individual members could obtain by contracting on their own. (Neaman, Tr. 965).

1542. NHN's goals included "trying to achieve a global contract price and exclusivity with certain payors." (Newton, Tr. 308).

1543. ENH hoped to "level the playing field" by collectively negotiating with NHN in the 1990s in order to get better rates from health plans. (Hillebrand, Tr. 1726).

1544. Mr. Spaeth acknowledged discussing the idea of having leverage over health plans as a by-product of the unity of the network. (Spaeth, Tr. 2194)
1545. The chief executives of the NHN members met in July 1994. Attending that meeting were, among others, Mr. Neaman of ENH and Mr. Spaeth of Highland Park. (CX 1802 at 1).
1546. According to the minutes of that meeting, Mr. Spaeth “remarked that HPH joined NHN for leverage, and that if the member Institutions are not going to stand united, then he is not sure where the value is.” (CX 1802 at 2). Mr. Spaeth continued that “he hoped NHN would get to the point that when a situation presented itself, an Institution would be willing to ‘act in a manner that allows for best leverage.’” (CX 1802 at 2). Mr. Spaeth acknowledged that “best leverage” as he used the term in the July 1994 meeting included getting better prices from health plans. (Spaeth, Tr. 2195).
1547. At that same July 1994 meeting, Mr. Neaman agreed with Mr. Spaeth’s sentiments. “Mr. Neaman responded that Mr. Spaeth’s comments are the absolute heart of what NHN is about. He [Mr. Neaman] would expect NHN to get better pricing than the hospital, and that is the benefit of being in the network.” (CX 1802 at 3).

b. Bain Recommended Joint Bargaining by Hospitals in the Northwestern Healthcare Network

1548. In 1996, NHN hired Bain to assess its managed care contracting strategies and to make recommendations. (Neaman, Tr. 987).
1549. In its 1996 recommendations to NHN, Bain made the case for “network scale/solidarity” by comparing the fragmented Chicago healthcare market to that of Indianapolis. In support of its recommendations, Bain quoted a Humana vice-president as stating, “[i]t’s trickier to negotiate with providers in the Indianapolis market because hospital networks stick together and comprise such a large proportion of the beds in that area. Our bargaining power in Indianapolis is far less than our bargaining power in the Chicago market.” (CX 1860 at 54) (comparing market shares of independent hospitals in Indianapolis (30%) to Chicago (60%)).
1550. Bain advised that NHN should gain “market influence” through “significant share (20-25%) of physician/hospital market.” (CX 1860 at 48).
1551. One of Bain’s recommendations for NHN to get better contract terms from managed care companies was to centralize the hospital members’ contracting through the network. (Neaman, Tr. 989; CX 1860 at 52).
1552. Mr. Neaman agreed that the network would have done a better job on contracting if it had “gone with a strong, central contracting methodology.” (Neaman, Tr. 989).

c. **The Northwestern Healthcare Network Failed for a Number of Reasons**

1553. As early as 1994, some saw NHN as a weak, non-cohesive organization, (Neaman, Tr. 977-78), without a strong brand identity. (CX 6307 at 25 (Schelling Dep.)).
1554. NHN disbanded because it was “not fulfilling its purposes.” Members were incurring overhead but could not attribute volume coming from the network, and NHN “was not making collective decisions.” (Newton, Tr. 310-11).
1555. NHN “didn’t do very much. I think that’s the problem.” (CX 6304 at 2 (Livingston, Dep.)). NHN dissolved because “it didn’t do anything.” (CX 6304 at 4 (Livingston, Dep.)).
1556. In order for NHN to have gone forward rather than dissolving, NHN would have needed more central authority and less local authority. (CX 6306 at 18 (Mecklenburg, Dep.)).
1557. NHN was ineffective on the managed care contracting front. (Neaman, Tr. 966).
1558. The network failed in getting better prices and terms from health plans because the hospital members would not act collectively in negotiations with health plans. (Neaman, Tr. 965-66).
1559. Giving up autonomy was necessary to achieve NHN’s goal of “single signature contracting.” (CX 6305 at 6 (Stearns, Dep.)). NHN was not effective because “there was not a willingness of the institution to give up any of their autonomy.” (CX 6305 at 6 (Stearns, Dep.)).
1560. From 1991 to 1997, NHN was never able to have a centralized capitation program, in part due to lack of cohesion among member hospitals on issues, including managed care. (CX 6307 at 27 (Schelling, Dep.)).
1561. By 1998, NHN had evolved into more of a general grouping of hospitals, like a trade association, rather than a centralized organization. (Neaman, Tr. 1008).
1562. In an August 3, 1999, internal memorandum, ENH again concluded that the “results for the Network . . . have been disappointing . . . [p]articularly . . . the lack of improved managed care contracts through NHN – the key goal for ENH and reason for the ‘tightly controlled’ organizational model developed by NHN – that is, the ability to jointly bid managed care contracts.” (CX 2231 at 3; *see also* CX 381 at 3).

1563. The members decided to terminate NHN in the late 1990s. In the absence of full integration, the Network members decided NHN's future was not necessary. (CX 6306 at 7 (Mecklenburg Dep.)).
1564. The NHN board voted to dissolve the network on June 24, 1999 and implemented plans to "close-down" the network by October 31, 1999. (CX 2231 at 4).

2. Northwestern Healthcare-North Proposed Merger of Highland Park, Evanston and Northwest Community

1565. During NHN's struggles, ENH, HPH and Northwest Community Hospital attempted to form Northwestern Healthcare-North, a "sub-regional" merger. (CX 394 at 2 (outlining sub-regional merger proposal)). Although NH-North was conceived of as a merger rather than just a network, one of the main purposes of its proposed existence, as with NHN, was to negotiate collectively with healthcare plans for the purpose of obtaining better rates. (Hillebrand, Tr. 1726 (NH-North's key goal to get better contracts by negotiating as one entity)). However, the merger never occurred. (Neaman, Tr. 1035).

a. Background of NH-North

1566. In approximately 1996 and 1997, Evanston pursued a potential merger with two other members of NHN: Highland Park Hospital and Northwest Community Hospital. (Neaman, Tr. 1017-18; CX 394 at 2).
1567. This proposed "sub-regional" merger was called "NH-North." (CX 394 at 2).

b. Increasing Market Share and Joint Negotiations Were Important Goals of NH-North

1568. According to ENH management, key goals for NH-North was to get better contracts by negotiating as one entity, (Hillebrand, Tr. 1726), as well as to gain "market influence." (Neaman, Tr. 1020; CX 394 at 2).
1569. Part of the "market influence" goal was for NH-North to capture "30-40% of key health plans" and achieve a level of "indispensability." (CX 394 at 13). NH-North aimed to become "indispensable to the marketplace." (CX 395 at 2).
1570. A revenue-side goal for NH-North was to "increase market leverage." (CX 394 at 3; Hillebrand, Tr. 1790). Increasing market leverage would provide the potential for ENH to obtain higher prices from health plans. (Hillebrand, Tr. 1790-91).
1571. Through the proposed NH-North merger, ENH aimed "to increase market share and obtain premium sustainable pricing through managed care contracting." (CX 395 at 1).

c. Bain Advised Anticompetitive Measures for Contracting by NH-North

1572. Bain provided consulting advice to ENH relating to the proposed NH-North alternative during the time ENH was considering the option. (CX 393; CX 1860).
1573. In its advice to ENH on the NH-North strategy, Bain counseled ENH to “take share from independents (e.g., Condell).” Bain specifically recommended that ENH be prepared “to act aggressively when opportunity presents itself to buy and close a weak competitor.” (CX 66 at 17).
1574. Bain also recommended “unified contracting” by ENH, Northwest Community, and Highland Park in order “to squeeze out independent hospitals” and “to obtain capitation/price premiums.” (CX 66 at 23).
1575. Bain noted that ENH, HP and Northwest Community had significant market share in certain regions of the north suburbs of Chicago, including 39% of “Near North Shore,” 39% of “Northwest,” and 56% of “North.” These were regions immediately surrounding the various facilities of the three proposed partners. (CX 66 at 9, 28).
1576. Bain advised that a “key need” for the merger was “marketshare ‘clout’ (30-50%).” (CX 393 at 1).
1577. Bain believed that its advice to ENH relating to NH-North was “equally relevant to [the 1999 Highland Park-ENH merger].” (CX 66 at 6).

d. The Proposed NH-North Merger Ultimately Failed to Occur

1578. The NH-North merger discussions never resulted in the proposed merger. (Neaman, Tr. 1035).

3. Evanston-Highland Park Merger

1579. After the failed experiments of NHN and NH-North, Evanston and Highland Park re-engaged in bilateral merger discussions in late 1998. (CX 1879 (Highland Park’s November 1998 response to ENH’s merger proposal)). The leadership of both ENH and Highland Park believed that the merged entity could “strengthen negotiating positions with managed care through merged entities and one voice.” (CX 19 at 1; Neaman, Tr. 1039). From Highland Park’s perspective, one merger benefit was that such a strategy “builds negotiating strength with payers.” (CX 1869 at 7). Evanston and Highland Park presented the best combination to generate negotiating strength because the three facilities “form a triangle . . . within . . . affluent communities . . . [and] together would have a significant market penetration.” (Newton, Tr. 351-52).

a. Viewpoint of Evanston

1580. As early as December 12, 1996, Mark Neaman of Evanston proposed a merger of Highland Park Hospital with Evanston and Glenbrook hospitals. (Spaeth, Tr. 2202-03; CX 1861 at 2-4).
1581. In the late 1990's health plans were decreasing rates for hospital services. (Neaman, Tr. 1037-38).
1582. In 1997, ENH believed that “[p]ricing pressures, as anticipated five years ago, have continued to grow.” ENH noted that “[i]n the last 12 months, in particular, three major payers have instituted significant reductions in reimbursement.” (CX 2037 at 2).
1583. ENH viewed these “pricing pressures” as a “significant threat.” (CX 2037 at 3).
1584. One of the goals of the merger with Highland Park was to get better prices and terms from health plans for ENH. (Neaman, Tr. 1036).
1585. ENH and Highland Park hoped that the merged entity could “strengthen negotiating positions with managed care through merged entities and one voice.” (CX 19 at 1; Neaman, Tr. 1039).
1586. The leadership of both ENH and Highland Park wanted to make their hospitals “indispensable to marketplace.” (CX 19 at 1; CX 442 at 5).
1587. The merger was seen as an opportunity for the hospitals to “join forces and grow together rather than compete with each other.” (CX 2 at 7).
1588. The combined market share was as high as 60%-70% in the “Evanston, Glenview, Highland Park, and Deerfield” markets. (CX 442 at 5). One object of the merger was to “not compete with self” in these high market share areas. (CX 442 at 5).
1589. In June 1999, ENH warned its board that the risk of not undertaking the merger was a repetition of the phenomenon of “Skokie Valley Becomes Rush North Shore.” (CX 84 at 58). As explained by Mr. Hillebrand, the Rush system of hospitals affiliated with Skokie Valley Community Hospital and expanded its staff and services. It was renamed Rush North Shore, and it ultimately became a stronger direct competitor to Evanston. (Hillebrand, Tr. 1795-97). Mr. Hillebrand confirmed that ENH viewed the possibility of another hospital system besides ENH affiliating with Highland Park and creating a stronger Highland Park was a perceived risk of not undertaking the merger. (Hillebrand, Tr. 1797).

b. Viewpoint of Highland Park

1590. Pre-merger, Highland Park management was “routinely concerned” about being excluded from a health plan’s network. (Newton, Tr. 303).
1591. Health plans continually informed Highland Park during negotiations that there were “other hospitals will fill that bill.” (Newton, Tr. 303).
1592. Highland Park management’s “fundamental business tenet” was that Highland Park needed to be included in all products for all health plans. Mark Newton, HPH’s former senior vice-president for business development, testified that exclusion would “diminish [HPH’s] ability to be successful in the market, would diminish [HPH’s] ability for patients to come to [HPH].” (Newton, Tr. 303-04). In order to avoid exclusion, Highland Park’s management had to be “constrained” in its pricing negotiations. (Newton, Tr. 304).
1593. Highland Park management believed that one benefit of growing via merger was that such a strategy “builds negotiating strength with payers.” (CX 1869 at 7).
1594. Highland Park management believed that “by being part of a larger entity, a larger contracting entity, [the merged entity] would collectively have strength with payors.” (Newton, Tr. 349).
1595. Although one option for Highland Park was a merger, another option Highland Park considered was a joint venture for specific services including cardiac and oncology services. (Spaeth, Tr. 2205).
1596. As early as September 5, 1997, Evanston offered to help Highland Park with new clinical programs, including cardiac surgery and oncology programs Evanston offered, short of a merger. Mr. Neaman indicated that he had the support of Evanston’s board. (CX 1865 at 1; CX 1866 at 1; Spaeth, Tr. 2222-25).
1597. Highland Park sent out a request for proposal regarding an oncology program to Evanston and Northwestern Memorial Hospital. (CX 1862 at 1; Spaeth, Tr. 2227).
1598. In September 1998, Highland Park contemplated mergers with Evanston, Northwest Community, Lake Forest and Condell. (Newton, Tr. 350; CX 1869 at 6).
1599. Of these merger options, the combination of Evanston and Highland Park would generate the greatest negotiating strength versus health plans because 1) Northwest Community was “relatively distant” from Highland Park; 2) Lake Forest did not have as “sophisticated an array” of services as Highland Park, and 3) Condell would present some cultural and medical staff integration difficulties. (Newton, Tr. 350-51).
1600. A combination of Highland Park and Evanston would have more bargaining strength as compared to combinations of Highland Park and other institutions. The factors pushing

in this direction included, among others, proximity of institutions, cultural relationships existing in the community, and placement of medical staffs. (Newton, Tr. 354).

1601. From Highland Park's perspective, Evanston presented the best combination to generate negotiating strength. Evanston's two hospitals and Highland Park "form a triangle . . . within this market of these really affluent communities. . . . These organizations together would have a significant market penetration in these very affluent, attractive communities." (Newton, Tr. 351-52).
1602. HPH management believed that the proposed Evanston merger would benefit Highland Park through increased volume and increased price for health plan patients. (Newton, Tr. 359-60). The proposed Evanston merger would increase the merged entity's negotiating leverage with the health plans. (Newton, Tr. 359-60).
1603. Mr. Newton testified that the merged entity's negotiating leverage would increase despite the existence of non-ENH facilities relatively nearby. Employers with employees in the merged entity's communities would find it "very difficult" to notify their employees that the ENH facilities were not in the network. (Newton, Tr. 362).
1604. In November 1998, Highland Park Hospital responded to the Evanston Northwestern Healthcare proposal for a merger. (CX 1879). With respect to "competition and signals," Neele Stearns, Highland Park's chairman of the board, commented that a merger would allow the two health care providers to "[s]top competing with each other. (CX 1879 at 3-4).
1605. Highland Park management discussed their motivations for the merger in a spring 1999 board meeting called to discuss the merger. At that meeting, Mr. Spaeth stated, "The reality in my view is that we are not looking at a rosie [*sic*] future economically on this site. Neither are they. We are not looking at the opportunity to control this market individually. The largest again [*sic*] payors in this arena have consolidated and are big enough, strong enough, and probably bent on assuring that the physicians who practice here and at Evanston and the institutions don't make a hell of a lot of money." (CX 4 at 1-2). Mr. Spaeth stated that the solution was a merger. "There are ways to at least I think to push back on the managed care phenomenon and get the rates back where they out to be if you are a big enough concerted enough entity which is important enough to the employers in this community. I think it would be real tough for any of the Fortune 40 companies in this area whose CEOs either use this place or that place to walk from Evanston, Highland Park, Glenbrook and 1700 of their doctors." (CX 4 at 2). When Mr. Spaeth referred to "this place," he was referring to the hospitals covered by the merger. (Spaeth, Tr. 2211).
1606. At that same meeting, another board member noted the problems of not unifying, stating, "I'll tell you can put in the bank now Dr. and that is that the Fortune 40 are gonna win they have the economic power and as long as we maintain the divided front on the

provider side you're gonna get hammered its just economics always work [*sic*]." (CX 4 at 11). Another Highland Park board member, Mr. Patience, stated his view that the economic issue being dealt with was the relative negotiating power of the health plans versus the hospitals and that, if one of the objectives was to get geographic leverage on the employers in the area, Northwestern Memorial did not help much. (CX 4 at 9; Spaeth, Tr. 2211-12).

1607. On April 5, 1999, at a meeting of the medical staff executive committee at Highland Park, Mr. Neaman of Evanston made a presentation related to the hospital merger. According to the meeting minutes, Mr. Neaman saw "geographic advantages, growth opportunities and program opportunities" in the merger. (CX 2 at 7). Mr. Neaman also stated that "[t]his would be an opportunity to join forces and grow together rather than compete with each other." (CX 2 at 7).
1608. The Highland Park management and board were aware that partnering with another hospital would increase the merged entity's negotiating strength vis-a-vis health plans. A merged entity "would bring more weight to the table in discussing the terms of contracts that involved third-party payors." (CX 6305 at 14 (Stearns Dep.)).

XII. THE STRUCTURE OF THE MARKET GIVES RISE TO THE LIKELIHOOD OF ANTICOMPETITIVE EFFECTS

A. Introduction to Market Structure Analysis

1. For a Consummated Merger Where Pricing Data Exists, the Emphasis Is on Analysis of the Pricing Data, Not on Elzinga-Hogarty Type Analysis

1609. After a merger has been consummated, an economist can rely on direct evidence, such as price behavior in the marketplace since the merger was consummated, evidence from the merging parties themselves after the merger took place, (*i.e.*, *how they assessed the merger*), and the assessment of the consequences of the merger by people who buy in the marketplace, rather than inferential data based on market definition and share. (Elzinga, Tr. 2362).
1610. In the instant case, the merger took place effective January 1, 2000. There were several years of market-determined prices post-merger before there was any knowledge or reason to know that the FTC would challenge the merger. The “years of data on the actual competitive effects of this merger” are available to inform “a very different type of analysis” from that of the Merger Guidelines. (Haas-Wilson, Tr. 2468)
1611. The best available method for determining whether the merger created or enhanced market power is to test possible explanations based on economic theory to rule the explanation either in or out. At the end of this methodical analysis, the explanations that have not been ruled out would reflect the most likely cause of the price increases found. (Haas-Wilson, Tr. 2482).
1612. Where an analyst has persuasive post-merger evidence about the consequences of a merger, it is not necessary to define a relevant product or geographic market. If one has direct evidence that a merger is anticompetitive, one would rely on that evidence rather than rely on the inferential evidence based on market definition and share. (Elzinga, Tr. 2355, 2363).

2. Application of the SSNIP Test to Identify Smallest Relevant Product and Geographic Markets

1613. For the product market, in terms of the demand side, the relevant inquiry is whether, “if ENH were to raise its prices for inpatient services, would the relevant customers be able to substitute other services” in place of those inpatient services. (Haas-Wilson, Tr. 2659-60). From the supply side, the relevant inquiry is whether, “if ENH were to raise its prices for inpatient services, could managed care organizations, the relevant customers in this

market, substitute those facilities that provide outpatient services only, such as physician offices or other types of clinics.” (Haas-Wilson, Tr. 2660).

1614. For the geographic market, the relevant inquiry using the Merger Guideline’s SSNIP test is whether, if ENH were to raise its prices in a significant way over the long term, the relevant customers would be able to turn to alternative sellers located outside of the geographic area. (Haas-Wilson, Tr. 2667).
1615. ENH successfully raised its prices in a significant way over the long term, and customers did not turn to alternative sellers located outside of the geographic area. (Haas-Wilson, Tr. 2667).

B. Product Market: In-Patient Hospital Services (Except Quaternary) Sold to Health Plans

1. Documents and Testimony Support the Conclusion That Inpatient Hospital Services (Except Quaternary) Sold to Health Plans Is a Relevant Product Market

1616. The relevant product market is the market for “general acute care inpatient services sold to managed care organizations.” (Haas-Wilson, Tr. 2451-52). Primary, secondary and tertiary services are included in the relevant product market. (Haas-Wilson, Tr. 2661. *See also* Newton, Tr. 302; Neaman Tr. 1210; Hillebrand, Tr. 1756; Holt-Darcy, Tr. 1422-1423).
1617. ENH successfully over the long term raised the prices of inpatient services. Applying the principles of the hypothetical monopolist and SSNIP test, found in the Merger Guidelines, this also justifies a definition of the product market. (Haas-Wilson, Tr. 2666-67). { [REDACTED] } (CCFF 959-1304, *in camera*).
1618. Acute Care Hospital Services are “[s]ervices furnished to patients with acute needs for health care services, as distinguished from services furnished for chronic physical conditions through the provision of long-term inpatient care.” (Amended Glossary of Terms at 1, April 22, 2005).
1619. Hospitalized patients generally require an overnight stay in the hospital. Ballengee, Tr. 144 (“inpatient are those that are requiring an overnight stay”); Neary, Tr. 590 (“services that you stay in the hospital for overnight generally”).
1620. During that overnight stay, a hospital houses a patient in an environment that has the safety of nurses, where there is the requirement of gases, where there is constant

medication, and where there is time for the patient's recuperation. (Spaeth, Tr. 2075-76).

1621. Before the merger, both Highland Park Hospital and Evanston had, among other things, operating rooms, pediatric services, obstetrical services, radiation therapy, cancer services, and psychiatric services. (Spaeth, Tr. 2083-2088). Evanston also had all of the services that one would expect within a community hospital, as well as some tertiary services. (Ballengee, Tr. at 159) Evanston provided tertiary services before the merger while Highland Park generally did not. (Haas-Wilson, Tr. 2491)
1622. After the merger, when analyzing investments for its clinical "rationalization of services" plan, Mark Neaman referred to the "return on sales" primarily from a cluster of inpatient related hospital services (including cardiac surgery, emergency room, radiology and diagnostics, psychiatry, pediatrics, total joints, and plastic surgery), services that Neaman stated were "tied directly to our strategy and the economics of the Corporation going forward." (CX 373 at 6-7).
1623. Bain also analyzed ENH's services as a cluster of inpatient service lines (including orthopedics, general medicine, gastroenterology, cardiac surgery, oncology, OB/neonatology, radiology, psychiatry, pediatrics, surgical services and lab). (CX 67 at 4).
1624. From the perspective of health plans, the core services of the hospital are medical/surgical services. Most hospitals also provide OB and pediatric services (Holt-Darcy, Tr. 1422-1423).

2. Application of the SSNIP Test Supports the Conclusion That Inpatient Hospital Services (Except Quaternary) Sold to Health Plans Is a Relevant Product Market

1625. Hospitals offer inpatient and outpatient services, but they are not demand side or supply side substitutes. When faced with a price increase for inpatient care from a hospital, the demand side issue is to ask, when that price increase occurs could the relevant customer – the managed care organization – turn to alternative suppliers. Managed care plans could not add to the network outpatient-only providers and exclude the higher priced hospitals. (Haas-Wilson, Tr. 2663).
1626. { [REDACTED] } (Haas-Wilson, Tr. 2615, *in camera*).
1627. Dr. Haas-Wilson concluded that a managed care plan could not sell a health plan that provided coverage that only included outpatient services, but did not include inpatient services. (Haas-Wilson, Tr. 2660). A managed care organization would not be able to

sell a managed care plan that included a network of providers that provided outpatient services only. (Haas-Wilson, Tr. 2660).

1628. Testimony concerning health plans accepting higher prices for inpatient services in return for lower prices for outpatient services is consistent with Dr. Haas-Wilson's exclusion of outpatient services from the market. Many sellers offer multiple products, and even if they trade one product off on price for the other, that does not mean here that the two products are in the same product market. (Haas-Wilson, Tr. 2663-65).

3. Quaternary Services Are Not in the Product Market

1629. The term "[q]uaternary services" dates back at least to the 1980s and refers to high-end services that are performed at some hospitals and not others. Examples include burn units and cardiac transplants. (Neaman, Tr. 1294).

1630. Tertiary services are more complicated services than primary or secondary, but less complicated services than quaternary services (quaternary services include solid organ transplants and extensive burn treatments that only a handful of hospitals with very specialized nurses and physicians could provide). (Haas-Wilson, Tr. 2491).

1631. Quaternary services are not in the relevant product market, because they require the use of very specialized doctors, nurses and equipment, and, from the supply side, there is not easy supply-side substitution for quaternary services by hospitals offering less than that. (Haas-Wilson, Tr. 2665-66).

1632. Health plans testified that ENH did not offer the advanced services one would expect at a quaternary facility. For example, Ms. Ballengee of PHCS identified the "advanced teaching hospitals" in Chicago as Northwestern Memorial Medical Center, Rush-Presbyterian Hospital, Loyola Medical Center, the University of Chicago and the University of Illinois. Ms. Ballengee does not consider ENH to be an advanced teaching hospital. (Ballengee, Tr. at 188-189).

1633. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Dorsey, Tr. 1443-44,
in camera).

1634. United also testified that Loyola University Medical Center, the University of Chicago, and Northwestern Memorial are academic hospitals, but not Evanston Hospital, Highland Park Hospital or Glenbrook Hospital. (Foucre, Tr. 935-36).

4. Outpatient Services Are Not a Substitute for Inpatient Services

1635. Outpatient services are not part of the relevant product market. (Haas-Wilson, Tr. 2660). Hospitals offer inpatient and outpatient services, but they are not demand side or supply side substitutes. When faced with a price increase for inpatient care from a hospital, the demand side issue is to ask, when that price increase occurs could the relevant customer – the managed care organization – turn to alternative suppliers. Managed care plans could not add to the network outpatient-only providers and exclude the higher priced hospitals. (Haas-Wilson, Tr. 2663).
1636. None of the outpatient centers in the Evanston area have 24 hour nursing or lodging of patients. (Spaeth, Tr. 2076).
1637. Outpatient centers would require Certificate of Need approval from the state to have beds for patients. (Spaeth, Tr. 2077).
1638. The physician determines whether a patient should be admitted to the hospital. (Hillebrand, Tr. 1756; Spaeth, Tr. 2076; Newton, Tr. 302).
1639. Ronald Spaeth never heard of a health plan threatening to send all patients to an outpatient center rather than to a hospital for a particular procedure. (Spaeth, Tr. 2078). There is a trend on the part of consumers to not want to see their health care benefits cut back, and that includes consumers not wanting to get less hospital care than they think they should. (Spaeth, Tr. 2079). Any shift toward outpatient services from inpatient services is a factor of a change in medicine and other factors, rather than pricing. (Hillebrand, Tr. 1756).
1640. Changes in inpatient pricing have no impact on patients switching from inpatient services to outpatient prices. (Neaman Tr. 1210; Hillebrand, Tr. 1755-56).
1641. During the course of the year 2000 negotiations, ENH management did not believe that patients would switch from inpatient services to outpatient services as a result of the inpatient price changes. ENH management did not request written analysis on any potential switching from inpatient to outpatient. (Neaman, Tr. 1210-11).
1642. When ENH developed its plan to negotiate higher prices, Hillebrand did not prepare or ask for any documents analyzing whether more patients would switch from inpatient to outpatient services as a result of changes in inpatient prices. (Hillebrand, Tr. 1756).
1643. Testimony concerning health plans accepting higher prices for inpatient services in return for lower prices for outpatient services is consistent with Dr. Haas-Wilson's exclusion of outpatient services from the market. Many sellers offer multiple products, and even if

they trade one product off on price for the other, that does not mean here that the two products are in the same product market. (Haas-Wilson, Tr. 2663-65).

1644. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2615, *in camera*).

C. Geographic Market: Triangle Formed by Evanston, Glenbrook and Highland Park

1645. The relevant geographic market is a triangle formed by Evanston, Glenbrook, and Highland Park, including their campuses, the area in-between, and some additional area around them. This area is established through a range of evidence including post-merger pricing studies, testimony of payers and others, and documents of the parties. (Haas-Wilson, Tr. 2452, 2667; Newton, Tr. 351-52; Foucre, Tr. 901-903; Ballengee, Tr. 167-68; Holt-Darcy, Tr. 1425-1427).

1646. Employing the principles of the Merger Guidelines, in particular the hypothetical monopolist and SSNIP test, the triangle is the appropriate geographic market. ENH successfully raised its prices in a significant way over the long term, and customers did not turn to alternative sellers located outside of the triangle that included the three hospitals. (Haas-Wilson, Tr. 2452, 2667). It was not necessary to use patient flow information and zip codes to define the geographic market because managed care insurers are the relevant customers at the first stage of competition where price is determined. (Haas-Wilson, Tr. 2668).

1. General Definition of the Triangle Area

1647. The relevant geographic market is a triangle adjacent or contiguous to the three hospital campuses that make up ENH: Evanston Hospital, Highland Park Hospital and Glenbrook Hospital. The triangle includes the area within the contiguous three points of the hospitals. (Haas-Wilson, Tr. 2452, 2667; *see also* Newton, Tr. 351-52; Foucre, Tr. 901-903; Ballengee, Tr. 167-68; Holt-Darcy, Tr. 1425-1427; Mendonsa, Tr. 543-44 (referring to ENH's concentration in one area)).

1648. The triangle market is consistent with various witnesses' testimony who testified that the North Shore, covered by ENH's three hospitals – Evanston, Glenbrook and Highland Park – may be characterized as a “triangle.” (Newton, Tr. 351-52; Foucre, Tr. 901-903; Ballengee, Tr. 167-68; Holt-Darcy, Tr. 1425-1427; Mendonsa, Tr. 543-44 (referring to ENH's concentration in one area)).

1649. { [REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2734-36, *in camera*, citing for example Ballengee, Tr. 179-80, Neary, Tr. 617, and Mendonsa, Tr. 520, *in camera*).

1650. The closest proxy for ENH's relevant geographic market, based on ENH documents, is a larger 19 zip code area that ENH documents describe as its "Combined Core Service Area." (CX 348 at 2). Evanston and Highland Park presented a post-merger "market share" estimate of 55% (Evanston and Glenbrook 44% and Highland Park 11%) based on the CCSA to the boards of the merging hospitals when they were approving the merger. (CX 84 at 21; CX 1876 at 18; CX 359 at 16; RX 1886 at ENHE DL 009270).
1651. In the 2000 contract renegotiations, ENH management did not believe that other hospitals would change their prices as a result of ENH's price setting nor did they consider the risk of health plans switching to other hospitals. (Neaman, Tr. 1212; Hillebrand, Tr. 1764-65; Newton, Tr. 367).
1652. Mr. Hillebrand did not write and did not recall seeing any analysis of the possibility that ENH's 2000 price increases would lead to ENH losing health plans to other hospitals. (Hillebrand, Tr. 1757-58).
1653. ENH did not see a decrease in the number of managed care admissions as a result of ENH's price increases in 2000. (Neaman, Tr. 1211-12).

2. SSNIP Test Supports the Conclusion That the Triangle Is a Relevant Geographic Market

1654. For the geographic market, the relevant inquiry using the Merger Guideline's SSNIP test is whether, if ENH were to raise its prices in a significant way over the long term, the relevant customers would be able to turn to alternative sellers located outside of the geographic area. (Haas-Wilson, Tr. 2667).
1655. Dr. Haas-Wilson employed the principles of the Merger Guidelines, in particular the hypothetical monopolist test, to find that ENH successfully raised its prices in a significant way over the long term and that customers did not turn to alternative sellers located outside of the geographic area. (Haas-Wilson, Tr. 2667).
1656. The health plans stated clearly that they understood the market and could not have a marketable health plan that excluded ENH, and further, Great West (One Health) "was one payer in the market that did the market experiment. It tried to exclude post-merger the three ENH hospitals, and what it discovered was that it could not. [One Health] had to

go back to the negotiating table with ENH and begin to again include the three-hospital ENH in its provider network.” (Haas-Wilson, Tr. 2942).

1657. In the 2000 contract renegotiations, ENH management did not believe that other hospitals would change their prices as a result of ENH’s price setting nor did they consider the risk of health plans switching to other hospitals. (Neaman, Tr. 1212; Hillebrand, Tr. 1764-65; Newton, Tr. 367).
1658. Mr. Hillebrand did not write and did not recall seeing any analysis of the possibility that ENH’s 2000 price increases would lead to ENH losing health plans to other hospitals. (Hillebrand, Tr. 1757-58).
1659. ENH did not see a decrease in the number of managed care admissions as a result of ENH’s price increases in 2000. (Neaman, Tr.1211-12).
1660. With regard to pricing decisions in 2000, Jeff Hillebrand did not factor in the possibility of a competitive pricing response by any other hospital. (Hillebrand, Tr. 2036. *See* Hillebrand 2036-37 (Mr. Hillebrand specified that he did not factor in the possibility of a competitive pricing response from Lake Forest, Northwestern Memorial and Condell.)).

3. Patient Flow Analysis and the Elzinga-Hogarty Test Are Inappropriate Tools for Defining Geographic Markets for General, Inpatient Acute Care Hospital Services

1661. Dr. Kenneth G. Elzinga is the Robert C. Taylor Professor of Economics at the University of Virginia. Dr. Elzinga, together with Dr. Thomas Hogarty, developed what is now known as the “Elzinga-Hogarty test” in the early 1970s, when Dr. Elzinga was the Special Economic Advisor to the Assistant Attorney General, Antitrust Division, Department of Justice. (CX 6294 at 1; Elzinga, Tr. 2370-71).
1662. The Elzinga-Hogarty test generally was developed to examine the flow of products into or out of a particular area to determine whether that area is a stand-alone geographic market. (Elzinga, Tr. 2372-73).
1663. In general, under the Elzinga-Hogarty test, if a significant portion of a product produced in an area is shipped to buyers outside the area, or if a significant portion of the product consumed in that area is shipped from sellers outside the area or both, then it is appropriate to conclude that the area is not the “geographic market” for the product in question. (Elzinga, Tr. 2372-73). Products produced in an area that are currently shipped outside the area could be sold within the area to “thwart” an increase in prices for the products currently sold in that area. (Elzinga, Tr. 2374). If producers from outside the area currently sell a substantial amount of the product consumed in the area, then those

producers could increase their sales in the area to “thwart” an increase in prices for the products currently sold in that area. (Elzinga, Tr. 2373-74).

1664. The Elzinga-Hogarty test was developed before the Merger Guidelines were issued by the Department of Justice in 1982. (Elzinga, Tr. 2376). The Merger Guidelines utilize a “hypothetical monopolist” test for defining geographic markets. (Elzinga, Tr. 2376-77). Under the hypothetical monopolist test it is necessary to ask whether, in a geographic area, a seller could profitably impose a small but significant and nontransitory increase in price – “SSNIP” – for the product in the product market. If the hypothetical monopolist could impose a SSNIP, then the geographic area is considered a geographic market for the product in question. On the other hand, if due to its buyers’ response to the SSNIP, the hypothetical monopolist’s reduction in sales makes the price increase unprofitable, then the geographic area is too small to be considered a geographic market for the product in question. (Elzinga, Tr. 2377-78. *See* Merger Guidelines § 1.21).
1665. The Elzinga-Hogarty test is a different and less reliable method for defining geographic markets than the hypothetical monopolist test under the Merger Guidelines. (Elzinga, Tr. 2378). Further, the Elzinga-Hogarty test would have been unnecessary if the Merger Guidelines and the hypothetical monopolist test had been in effect at the time Dr. Elzinga and Dr. Hogarty did their research. (Elzinga, Tr. 2378-79).
1666. The Elzinga-Hogarty test was developed to define geographic markets for products such as coal or beer by analyzing the shipments of those products from the place of production to the point of consumption. (Elzinga, Tr. 2375). Yet, the Elzinga-Hogarty test has been used in past hospital merger cases to define the geographic markets for hospital services. (Elzinga, Tr. 2379-82). When the Elzinga-Hogarty test was used to define geographic markets for hospital services, it was based on “patient migration” or “patient flow,” *i.e.*, whether hospital patients, as consumers, would travel to hospitals, as the place of production, to obtain hospital services. (Elzinga, Tr. 2375).
1667. The use of patient flow analysis and the Elzinga-Hogarty test in past hospital cases had assumed that there is a high correlation between the existing patient migration at the existing prices for hospital services and the change in patient flow in response to a change in the prices for those hospital services. (Elzinga, Tr. 2385-86).
1668. In defining a geographic market for general, inpatient acute care hospital services, the use of patient flow analysis in general, and the Elzinga-Hogarty test in particular, has two fundamental flaws. These two problems – the “payer problem” and the “silent majority fallacy” – make patient flow analysis and the Elzinga-Hogarty test misleading and inapplicable to defining the geographic market for general, inpatient acute care hospital services. Further, if used, patient flow analysis and the Elzinga-Hogarty test will yield a geographic market definition that is larger than the actual geographic market for general inpatient acute care hospital services. (Elzinga, Tr. 2356-57, 2384-87, 2395-97).

The Payer Problem

1669. A fundamental assumption underlying patient flow analysis and the Elzinga-Hogarty test in defining geographic markets for hospital services is that individual patients will base their choice of hospitals on the prices charged for the services. (Elzinga, Tr. 2395). This assumption is erroneous because of the "payer problem." The payer problem exists because of the dominant role of health care insurance. Because managed care plans and other health care insurers pay for most general inpatient acute care hospital services rendered in the United States, the individual patients (and their doctors) who choose the hospital at which to seek services do not bear the costs of those services. (Elzinga, Tr. 2395-96).
1670. In the United States, the patient (and his or her doctor) choose the hospital at which to obtain services, but the managed care plan (or other health insurance plan) pays for the hospital services. Thus, the person who chooses the hospital at which to obtain hospital services is not the same person who pays for those services. (Elzinga, Tr. 2395-96).
1671. Reactions to changes in Highland Park's prices for hospital services would primarily come from health plans. On the other hand, typically the individual patient did not even know whether there was a contract in place between Highland Park and the managed care plan in which that individual patient was enrolled. (Spaeth, Tr. 2165).
1672. The enrollee of a managed care plan and who selects (with his or her doctor) the hospital at which to obtain hospital services does not base his or her selection of a hospital on the different relative prices charged by hospitals because that patient will pay for few, if any, of the hospital services he or she receives. (Elzinga, Tr. 2389).
1673. The assumption underlying the use of patient flow analysis and the Elzinga-Hogarty test in defining the geographic market for hospital services is that the patient must take prices (and changes in the prices) for hospital services into account in selecting a hospital. However, due to the payer problem, the patient (and his or her doctor) do not take prices into account in choosing the hospital at which to obtain hospital services. Therefore, the assumption underlying the use of patient flow analysis and the Elzinga-Hogarty test in defining the geographic market for hospital services is erroneous. (Elzinga, Tr. 2400-01).

The Silent Majority Fallacy

1674. A fundamental assumption underlying patient flow analysis and the Elzinga-Hogarty test for defining the geographic market for hospital services is that if some patients currently travel to a distant facility for services, then an even larger number of people will travel from their home to that distant facility if local hospitals increase their prices, thereby disciplining any price increases by local hospitals. (Elzinga, Tr. 2385-86, 2409-10).

1675. The use of patient flow analysis and the Elzinga-Hogarty test to define geographic markets for general, inpatient acute care hospital services is flawed because of the “silent majority fallacy.” The “silent majority fallacy” is the erroneous assumption that the willingness of some residents of a local area to travel to more distant hospitals prevents local hospitals from raising prices to those local residents who choose not to travel. (Elzinga, Tr. 2386-87). The assumption is that if local hospitals do raise prices, even more local residents would travel to distant hospitals. (Elzinga, Tr. 2385-87).
1676. The problem with the assumption of increasing numbers of travelers is that, unlike with purchases of beer or coal, a decision to select a particular hospital is not driven primarily by relative prices between hospitals. (Elzinga, Tr. 2388-89).
1677. For example, some residents of a given area may be willing to travel significant distances to obtain hospital services because they prefer to obtain some particular service or amenity at a distant hospital or because they have family who lives some distance away. (Elzinga, Tr. 2387). Their decisions to travel significant distances for hospital services is highly personal, and is not indicative of the willingness of the other residents of that area to travel longer distances for hospital services. (Elzinga, Tr. 2387).
1678. People who obtain hospital services at a hospital close to their homes usually do so either because their doctors had staff privileges at that local hospital, their doctors choose the local hospital on behalf of the patient; or the patient chooses the local hospital for his or her own convenience or for the convenience of his or her family. (Elzinga, Tr. 2388, 2390).
1679. Due to the silent majority fallacy, patient flow analysis and the Elzinga-Hogarty test exaggerate the size of the geographic market for general, inpatient acute care hospital services. Further, the use of patient flow analysis and the Elzinga-Hogarty test will erroneously understate the market shares of the hospitals in that area. (Elzinga, Tr. 2393-94).

Implications of the Payer Problem and the Silent Majority Fallacy

1680. In light of the silent majority fallacy and the payer problem, the Elzinga-Hogarty test using patient flow data is inapplicable “to hospital merger analysis.” Applying the Elzinga-Hogarty test in such analysis would be a “misuse of the test.” (Elzinga, Tr. 2384-85).
1681. The use of patient flow analysis and the Elzinga-Hogarty test typically results in identifying an area that is broader than the actual geographic market for hospital services. (Elzinga, Tr. 2393).
1682. A geographic area that is larger than the actual geographic market in which two merging general acute care hospitals are located will include other, more distant hospitals that are

not properly included in the geographic market of the merging hospitals. Because these other, more distant hospitals do not have the ability to discipline the pricing discretion of the merging hospitals by offering to sell their services at a price lower than that charged by the merging hospitals, these other, more distant hospitals are not in the geographic market of the merging hospitals. As a result, the use of patient flow analysis and the Elzinga-Hogarty test will erroneously include too many hospitals in the geographic market of the merging hospitals and reduce the market shares of the merging hospitals. (Elzinga, Tr. 2393-94).

- 1683. The silent majority fallacy and the payer problem are intrinsic defects in the use of any patient flow analysis in defining geographic markets for general, inpatient acute care hospital. (Elzinga, Tr. 2417-18).
- 1684. Respondents disavowed the use of the Elzinga-Hogarty test in defining a geographic market for the sale of acute care inpatient hospital services to managed care plans. (Sibarium, Tr. 1970-72).

4. Evidence from Dr. Haas-Wilson Regarding the Triangle Geographic Market

- 1685. The relevant geographic market is “the area adjacent or contiguous to the three hospital campuses that make up ENH,” Evanston Hospital, Highland Park Hospital and Glenbrook Hospital. (Haas-Wilson, Tr. 2452, 2667). By “contiguous,” Dr. Haas-Wilson meant the area that lies inside the three points of the hospitals, and possibly some of the area around those hospitals. (Haas-Wilson, Tr. 2667).
- 1686. Dr. Haas-Wilson employed the principles of the Merger Guidelines, in particular the hypothetical monopolist test, to find that ENH successfully raised its prices in a significant way over the long term and that customers did not turn to alternative sellers located outside of the geographic area. (Haas-Wilson, Tr. 2667).
- 1687. For assessing a consummated merger’s competitive effects, an economist can look at direct evidence, such as post-merger price behavior in the marketplace, evidence of how the merging parties assessed the merger, and the assessment of the consequences of the merger by customers, rather than “inferential data.” (Elzinga, Tr. 2362).
- 1688. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2942, *in camera*).

1689. It was not necessary to use patient flow information and zip codes to define the geographic market because managed care insurers are the relevant customers at the first stage of competition where price is determined. (Haas-Wilson, Tr. 2668). { [REDACTED] } (Haas-Wilson, Tr. 2920-21, *in camera*).

5. Consistent Evidence from Current and Former ENH Executives

1690. In making their price proposals, ENH management did not consider the risk of health plans switching to other hospitals. (Neaman, Tr. 1211-12; Hillebrand, Tr. 1764-5)
1691. ENH did not see a decrease in the number of managed care admissions as a result of ENH's price increases in 2000. (Neaman, Tr. 1211-12; Hillebrand, Tr. 1764-5).
1692. In the 2000 contract renegotiations, ENH management did not believe that other hospitals would change their prices as a result of ENH's price setting. (Neaman, Tr. 1212). Mr. Hillebrand did not write and does not recall seeing any analysis of the possibility that ENH's 2000 price increases would lead to ENH losing health plans to other hospitals. (Hillebrand, Tr. 1757-58). Mr. Hillebrand does not recall anyone at ENH recommending against the 2000 ENH price increases on the grounds that they would lead to ENH losing health plans to other hospitals. (Hillebrand, Tr. 1758).
1693. With regard to pricing decisions in 2000, Jeff Hillebrand did not factor in the possibility of a competitive pricing response by any other hospital. (Hillebrand, Tr. 2036).
1694. The former administrator of Highland Park testified that hospital competition is very localized. He testified that hospital services are essentially provided in a local service area (Spaeth, Tr. 2156). Thus, a hospital's success is determined in the local marketplace. (Spaeth, Tr. 2155). Pre-merger, Highland Park really did not look to draw patients from a secondary service area, because most of the specific services that Highland Park offered would not have made much difference in the secondary market. (Spaeth, Tr. 2164-65).
1695. Before the merger, Highland Park viewed Evanston as a competitor, particularly in the area of geographic overlap south of Highland Park and north of Evanston. (Spaeth, Tr. 2088, 2107, 2157). Highland Park viewed this competition as competition in its "core area." (Spaeth, Tr. 2157). Highland Park competed to keep the patients it served to continue to receive services at Highland Park rather than at Evanston. (Spaeth, Tr. 2088).
1696. Highland Park Hospital was competing head to head for market share on the southern part of its primary service area with Evanston. (Spaeth, Tr. 2127). As early as 1997, Mr. Spaeth believed that the competition was intensifying from Evanston Hospital. (Spaeth, Tr. 2108).

1697. Mr. Spaeth's testimony is consistent with the fact that Evanston and Highland Park Hospitals were "equally distant" for a person living in between the two communities. (Holt-Darcy, Tr. 1426). Other than the competition from ENH to the south, Highland Park faced little head to head competition in its service area. Ronald Spaeth, the administrator of Highland Park, testified that one way to look at Highland Park's service area is to draw a line North of Highland Park across Lake county where the patient population north of the line goes north into Wisconsin while the population south of the line tends to go south. (Spaeth, Tr. 2161-62). Highland Park's core service area went up into Lake Forest but not much north of that. (Spaeth, Tr. 2161). Going west from Highland Park, the next hospital was "a good 45-minute, 40-minute drive," according to Mr. Spaeth, and there was not much in the way of hospitals competing with Highland Park going west. (Spaeth, Tr. 2164).
1698. Evanston's two hospitals and Highland Park "form a triangle . . . within this market of these really affluent communities. . . . These organizations together would have a significant market penetration in these very affluent, attractive communities." (Newton, Tr. 351-52).

1699. { [REDACTED] } (Chan, Tr. 839-40 (discussing CX 1607 at 5, *in camera*), *in camera*).

6. Consistent Evidence from Health Plans Regarding the Triangle Market

1700. { [REDACTED] } (CCFF 959-1312, *in camera*). { [REDACTED] } (See, e.g., Ballengee, Tr. 179-80; Mendonsa, Tr. 520, *in camera*; Foucre, Tr. 901-02).
1701. Health plans testified that the three ENH hospitals combined form a triangle of service or catchment area in which the service areas of the hospitals are contiguous. (Foucre, Tr. 901-902 ("there are no hospitals within that triangle, there are no other facilities"); Ballengee, Tr. 168 ("Highland Park sits to the north of these communities Evanston on the south. There's [sic] no hospitals in between and it tends to be a north-south migration of the populace"); Holt-Darcy, Tr. 1425-6). The area in this triangle is a very heavily populated with very affluent communities, where corporate decision-makers and prospective customers live. (Foucre, Tr. 901-903).
1702. ENH told payers after the merger that ENH held power in the contiguous area that its hospitals surrounded. For example, ENH indicated to PHCS that ENH was an entity

“controlling all of these communities.” (Ballengee, Tr. 176, 177 (“they indicated that they already had the market share for these communities” indicating a 60% market share.)) ENH executives told PHCS that eliminating St. Francis, Rush North Shore, and Condell would not justify a lower rate because they were not viewed by ENH as significant competitors. (Ballengee, Tr.181-82). { [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED] } (CX 129 at 1; *in camera*).

1703. { [REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1561, *in camera*). { [REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1602, *in camera*).

1704. [REDACTED]
[REDACTED]
[REDACTED]
(Mendonsa, Tr. 544, *in camera*).

1705. { [REDACTED]
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 542-43, *in camera*).

1706. Eliminating the ENH system from the health plan’s network would leave a large area that would be “uncovered” from the standpoint of the health plan. (Ballengee, Tr. 181). Other hospitals in PHCS’s network, such as Rush North Shore, Lake Forest or Lutheran General Hospitals, were not considered to be “viable alternatives” to ENH because “there would be a large area that would be not served by the community hospitals.” (Ballengee, Tr. 183-84).

1707. The access problem was heightened because companies located in or near the triangle area include Kraft Foods, Allstate, Sarah Lee, and Abbott Laboratories. There are no non-ENH hospitals in this triangle. United Healthcare does not believe it could have a viable network without ENH. (Foucre, Tr. 901-903). { [REDACTED]
[REDACTED]
[REDACTED] } (Mendonsa, Tr. 517, *in camera*).

7. ENH’s “Combined Core Service Area” As a Proxy for the Triangle Market

1708. Some of the Respondent’s documents concerning the hospital service area are based on patient-flow data, which tends to exaggerate the size of the area of competitive interest. (Elzinga, Tr. 2393-94, 2417-18). However, these documents still show a substantial

competitive overlap between Evanston and Highland Park before the merger. For example, before the merger, Highland Park had a 32% share of its own core market, and Evanston had a 33% share of that market. (Neaman, Tr. 1057-58; CX 359 at 15).

1709. The closest proxy for ENH's relevant geographic market, based on ENH documents, is a larger 19 zip code area that ENH documents describe as its "Combined Core Service Area". The CCSA included the towns of Deerfield, Highland Park, Ft. Sheridan, Highwood, Lake Forest, Glencoe, Northbrook, Glenview, Golf, Kenilworth, Techny, Wilmette, Winnetka, Evanston and Skokie. (CX 348 at 3; CX 360 at 11; CX 359 at 16; CX 84 at 21). The northern boundary of the CCSA is Lake Forest, the western boundary is Deerfield, Northbrook and Glenview, and the southern boundary is Skokie and Evanston. (CX 348 at 2; CX 360 at 11; CX 359 at 16; CX 84 at 21).
1710. A proxy for ENH's business is hospital admissions. (Hillebrand, Tr. 1815). ENH's core service area is "the geography where [it] get[s] approximately 80-85 percent of [its] patients." (Hillebrand, Tr. 1815). ENH's core market included approximately 20 zip codes. (Neaman, Tr. 1055-56).

D. Market Shares and Concentration

1. Dr. Haas-Wilson's Calculations of Market Share and Concentration in the Triangle Market

1711. Based on Dr. Haas-Wilson's economic research, and using the SSNIP test, the relevant geographic market is the area adjacent or contiguous to the three hospital campuses that make up ENH: Evanston Hospital, Highland Park Hospital and Glenbrook Hospital. (Haas-Wilson, Tr. 2452, 2667).

2. Calculations Based on ENH Documents and Testimony for the Combined Core Service Area

1712. ENH (44%) and Highland Park (11%) together accounted for a 55% share in the Combined Core Service Area of the two hospitals according to reports produced for the Evanston and Highland Park boards in 1999 as part of the merger process. (CX 84 at 21 (Evanston Northwestern Healthcare and Lakeland Services Proposed Merger, Presentation to the Board of Directors, June 25, 1999); CX 1876 at 18 (Lakeland Health Services, Inc. and Evanston Northwestern Healthcare: Proposed Merger, Presentation to the Board of Directors, Lakeland Health Services, Inc., June 28, 1999); CX 359 at 16 (Evanston Northwestern Healthcare and Lakeland Services Proposed Merger, Presentation to the Executive Committee, April 14, 1999); Hillebrand, Tr. 1792-94).
1713. ENH characterized Evanston and Highland Park as already having established "strong positions" in the CCSA before the merger. (CX 360 at 5).

1714. Information about the combined core service area shares of Evanston and Highland Park was useful to the ENH board of directors in assessing the proposed merger. (Neaman, Tr. 1060). At a board meeting, the proposed merger was described as a “platform to increase market share and growth on the North Shore.” (CX 514 at 8).
1715. On June 25, 1999, Evanston Northwestern made a presentation to its board of directors related to the proposed merger with Highland Park. The presentation showed that ENH (44%) and Highland Park (11%) comprised a 55% share in the combined core service area of the two hospitals. (CX 84 at 21). This presentation showed that ENH had the largest share in Highland Park’s core service area, with ENH at 33% and Highland Park at 32%. (CX 84 at 20).
1716. On June 28, 1999, Lakeland Health Services made a presentation to its board of directors related to the proposed merger with Evanston Northwestern. The presentation showed that ENH (44%) and Highland Park (11%) comprised a 55% share in the combined core service area of the two hospitals. (CX 1876 at 18). This presentation also showed that ENH had the largest share in Highland Park’s core service area, with ENH at 33% and Highland Park at 32%. (CX 1876 at 17).
1717. A December 7, 1999, Presentation to Standard and Poor’s, Strategic and Capital Structure Review, referred to Evanston and Highland Park together having a 55% share of the core service area. (RX 704 at ENH HJ 001631).
1718. Mr. Neaman testified to the accuracy of these core service area share figures, confirming that Evanston and Highland Park combined made up a 55% share, and, within Highland Park’s core service area, Highland Park had a 32% share and Evanston had a 33% share. (Neaman, Tr. 1057-58 (discussing CX 359 at 15-16)).
1719. After the merger, in ENH’s “Corporate Strategy for 2001-2003”, ENH’s “tactics” included to “protect the ‘core’ – increase from 55% to 60% in immediate zip codes.” That strategy was reported to the ENH board and was a goal of ENH. (CX 68 at 11; Neaman, Tr. at 1209).
1720. Bain, a consultant hired by ENH., also found that “[w]ith the Highland Park merger, ENH now commands a 55% market share.” (CX 1607 at 5). {
[REDACTED]
[REDACTED]
[REDACTED]}
(Chan, Tr. 839-40 (discussing CX 1607 at 5), *in camera*).

3. Dr. Noether’s Calculations for the Market As Defined by Her

1721. Dr. Noether’s minimum defined geographic market is a 32 zip code area that includes Rush North Shore, St. Francis, Advocate Lutheran General, Resurrection Lake Forest and Condell. (Noether, Tr. at 5928, 39) In the year prior to the merger, ENH accounted for

23% of total net patient revenue (including outpatient), and Highland Park accounted for 7%, for a total of 30%. (RX 1912 at 57, *in camera*). However, her market is significantly broader than the triangle market and ENH's CCSA.

E. Comparison of ENH HHIs to HHIs in the Merger Guidelines and Prior Case Law

1. HHIs for the Triangle Market

1722. Using the methodology established in the Merger Guidelines results in the following geographic boundaries for ENH – the geographic area including the three hospital campuses (Evanston, Glenbrook, and Highland Park) of ENH – but no other hospitals. (Haas-Wilson, Tr. 2452, 2667).
1723. Accordingly, the post-merger HHIs is 10,000, “which is 100 squared, if you had a single monopolist in the market.” (Noether, Tr. 5963). An HHI of 10,000 is the highest possible HHI. This is the most highly concentrated market possible under the Merger Guidelines. (Merger Guidelines, § 1.5 n.17).

2. HHIs from Noether

1724. { [REDACTED] } (RX 1912 at 57, *in camera*). Dr. Noether acknowledged that the post-merger HHIs are “over 1900, increasing by about 300 from pre-merger levels.” (Noether Tr, at 5963).

1725. { [REDACTED] } (Noether, Tr. at 5965; RX 1912 at 57, *in camera*),.

1726. Using either of Dr. Noether’s HHI calculations, the post-merger HHIs are above the 1800 threshold level that the Merger Guidelines signifies as a “highly concentrated market.” (Noether, Tr. at 5963; Merger Guidelines, § 1.51 (c)). In addition, the HHI increase is greater than the 100 point threshold that the Merger Guidelines utilizes to establish the presumption that the merger is “likely to create or enhance market power or facilitate its exercise.” (Merger Guidelines, § 1.51 (c)).

3. Comparison With Past Hospital Merger Cases in Seventh Circuit Where Enforcement Action Was Successful

1727. In the *HCA/Chattanooga* case, the Herfindahl-Hirschman Index increased from 1932 to 2416 measured by approved acute care beds. HCA increased its market share in the Chattanooga area from 13.6% to 26.7% measured by approved acute care beds. *Hospital*

Corporation of America, 106 F.T.C. 361 at 61 (Commission Opinion) (1985), *aff'd*, 807 F.2d 1381 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987).

1728. In the *Rockford* case, the pre-merger HHI as measured by beds was 2555, with a net increase of 2048. Each of the defendants had a pre-merger market share of beds of 32%. *United States v. Rockford Memorial Corp.*, 717 F. Supp. 1251, 1280 (N.D. Ill. 1989); *aff'd*, 898 F.2d 1278 (7th Cir. Ill. 1990), *cert. denied*, 498 U.S. 920 (1990).

XIII. ENH's PRICE INCREASES HAVE NOT BEEN CONSTRAINED BY ENTRY

1729. ENH's price increases have not been constrained by entry. ENH has not been forced to roll back the price increases due to entry. (CCFF 392-393, 643-692, 952-954).
1730. Since Evanston's merger in 2000 with Highland Park, there has been no new hospital entry in the North Shore area (D. Jones, Tr. 1664), even though Evanston has raised prices substantially. (See generally Haas-Wilson, Tr. 2562-63, 2565, 2573-74, 2579, 2583, 2586 ({ [REDACTED] }), *in camera*. See also Hillebrand, Tr. 1764-65 (In the process of setting its prices for the 2000 negotiations with health plans, and the 2002 increases to its chargemaster, ENH did not factor in whether patients or the health plans would switch to other hospitals in response to the increases.)).
1731. Illinois has a state Certificate of Need ("CON") Law that governs future hospital entry or expansion. (D. Jones, Tr. 1653-54, 1655; Spaeth, Tr. 2167).
1732. Certificate of need approval from the state's Planning Board is required if a health care facility is going to engage in a transaction that is clinical in nature and exceeds either the capital expenditure or the major medical equipment threshold. (D. Jones, Tr. 1655).
1733. The Planning Board, when reviewing a certificate of need application for additional beds, considers whether the proposed beds are actually needed at the facility. (D. Jones, Tr. 1656).
1734. Bed need is calculated with need formulas established by the board in its administrative rules. The Division of Health Statistics compiles the data and variables necessary to compute those bed needs for the Division of Health Systems Development. (D. Jones, Tr. 1664).
1735. Based on the Planning Board's current addendum to its inventory, there is no need for beds in the Evanston, Glenview, and Highland Park areas (*i.e.*, the areas in which Evanston, Glenbrook, and Highland Park Hospitals are located) for services such as med/surg, pediatrics, or intensive care units. (D. Jones, Tr. 1665).
1736. If someone were to submit a certificate of need application for the construction of a new hospital in Evanston today, the Department of Public Health's report would most likely issue a negative finding regarding the bed need for a new facility by referencing the existing providers in the Evanston area, referencing the current bed need calculation for that area, and determining that additional beds are not needed based on the Planning Board's inventory. (D. Jones, Tr. 1666-67).
1737. The state Certificate of Need Board has denied hospitals beds where there is no bed need. It has denied applications where the data suggested that there was "overbedding." The CON Board has also denied applications in areas even when the data suggests the number

of beds is already at the right number. Mr. Spaeth testified that, if an area is overbedded, he thought that the likelihood that the State of Illinois would approve additional beds is minimal. Furthermore, in such cases, other hospitals might intervene to oppose the CON application. (Spaeth, Tr. 2168-69).

1738. There have been no certificate of need applications for the construction of new hospitals in the area around Highland Park or Evanston or Glenbrook over the past five years. (D. Jones, Tr. 1664).
1739. In addition to a Certificate of Need, a person would need to get approval from other state agencies and local governments to build a new hospital. The Illinois Department of Health reviews facility plans, and a city council may need to provide zoning approval for the new hospital. (Spaeth, Tr. 2169).
1740. While the CON law contains a sunset provision, which would apply if the law was not renewed, the CON law has been renewed. (Spaeth, Tr. 2169).
1741. Even if there were no CON law, it would take about two and a half to three years to build a new hospital. (Spaeth, Tr. 2169).

XIV. DR. BAKER LACKS CREDIBILITY

A. Dr. Baker's Compensation

1742. { [REDACTED]
[REDACTED] } (Baker, Tr. 4708, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (Baker,
Tr. 4706, *in camera*; Baker, Tr. 4598-99). { [REDACTED]
[REDACTED] } (Baker, Tr. 4708, *in camera*).

1743. Charles River had approximately thirty people working on the ENH case. Charles River Associates bills out the time of those working on a case at a rate such that Charles River earns a profit on their billing. That was true in this case. (Noether, Tr. 6134).

B. Dr. Baker's First Report

1744. Dr. Baker submitted his original expert report on November 2, 2004. (Baker, Tr. 4599).

1745. { [REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4717-18, *in camera* (emphasis added)). { [REDACTED]
[REDACTED] } (Baker Tr. 4688-89, *in camera*).

1746. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4716-17 (discussing DX 7067 at 7, *in camera*), *in camera*).
{ [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4718-19 (discussing DX 7067 at 26,
in camera), *in camera*).

1747. { [REDACTED]
[REDACTED]
[REDACTED] }
(Baker, Tr. 4730-31, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED] (Baker, Tr. 4732, *in camera*).

1748. { [REDACTED]
[REDACTED] } (Baker, Tr. 4733-34, *in camera*): { [REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4734-35
(discussing DX 7067 at 45, *in camera*), *in camera*).

1749. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CCFF 1745-1749).

C. Dr. Ashenfelter's Rebuttal Report

1750. { [REDACTED] } (Baker, Tr. 4710, *in camera*). { [REDACTED]
[REDACTED] } (Baker, Tr. 4710-11, *in camera*). { [REDACTED]
[REDACTED] } (Baker, Tr. 4711, *in camera*).

1751. { [REDACTED] } (Baker, Tr. 4711-12), *in camera*). { [REDACTED]
[REDACTED] } (Baker, Tr. 4712-13, *in camera*). { [REDACTED]
[REDACTED] } (Baker, Tr. 4713, *in camera*). { [REDACTED]
[REDACTED] } (Baker, Tr. 4715, *in camera*).

1752. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] (Baker, Tr. 4741, in camera).

D. Dr. Baker's Second Report

1753. { [REDACTED] } (Baker, Tr. 4710, in camera). { [REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4736-38, in camera).

1754. { [REDACTED]
[REDACTED] } (Baker, Tr. 4737, in camera).

1755. { [REDACTED]
[REDACTED] } (Baker, Tr. 4739, 4787, in camera).

1756. { [REDACTED]
[REDACTED] } (Baker, Tr. 4786-87, in camera).

1757. { [REDACTED]
[REDACTED] } (Baker, Tr. 4739, in camera).

1758. { [REDACTED]
[REDACTED] } (CCFF 1754, 1757, in camera).

1759. { [REDACTED]
[REDACTED]

[REDACTED] } (Baker, Tr. 4689-90, *in camera*; compare RX 2038 at 4,⁴ *in camera*, and RX 2039 at 4,⁵ *in camera*).

1760. { [REDACTED]
[REDACTED]
[REDACTED] } (CCFF 1746-1747).

E. Dr. Baker's Testimony

1761. { [REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4685, 4732, *in camera*).

1762. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CCFF 1742-1761, *in camera*).

⁴ RX 2038 is cited to impeach Dr. Baker's testimony both here and when cited in subsequent findings.

⁵ RX 2039 is cited to impeach Dr. Baker's testimony both here and when cited in subsequent findings.

**UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION**

In the Matter of

EVANSTON NORTHWESTERN HEALTHCARE CORP.

Docket No. 9315

**COMPLAINT COUNSEL'S PROPOSED FINDINGS
OF FACT, CONCLUSIONS OF LAW, AND ORDER**

(Public Version)

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VOLUME III

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XV. THE LEARNING ABOUT DEMAND EXCUSE IS WITHOUT MERIT

A. Introduction to What the Alleged Defense Is

1763. According to Dr. Noether, the learning about demand explanation is that before the merger with Highland Park, Evanston had poor information about the true demand for its services, but that at the time of the merger, Evanston learned about the demand for its services and modified its pricing to reflect this greater understanding. (Noether, Tr. 5968-69).
1764. Dr. Noether's explanation for the price increases at ENH after the merger was that the pre-merger Evanston priced itself more like a community hospital rather than a major teaching hospital. (Noether, Tr. 5968).
1765. Dr. Noether claimed that Evanston obtained information about the demand for its own services from looking at Highland Park's managed care contracts during the due diligence work connected with the merger. (Noether, Tr. 5973-74).
1766. Dr. Haas-Wilson's understanding of the Respondents' experts' learning about demand excuse is that ENH gained information about the contracted rates in Highland Park Hospital's contracts with the health plans and that this knowledge somehow provided Evanston with information about its own demand with the health plans. (Haas-Wilson, Tr. 2643).

B. ENH Repeatedly and Vigorously Attempted to Re-Negotiate Contracts Throughout the 1990s

1767. Throughout the 1990s, ENH continually negotiated for better rates from health plans. Indeed, both Jack Sirabian and Jeff Hillebrand, who were in charge of health plan negotiations, were recognized for doing effective jobs. (Sirabian, Tr. 5728; Neaman, Tr. 1220).
1768. Jack Sirabian handled ENH's managed care contracting negotiations from approximately 1990 to 2000. (Sirabian, Tr. 5697-98).
1769. Throughout the period of his work on managed care contracting, Mr. Sirabian reported to Jeff Hillebrand with respect to managed care contracting. (Sirabian, Tr. 5728-29; Hillebrand, Tr. 1700).
1770. During the period in which Mr. Sirabian was responsible for contracting, he received positive evaluations from both Mr. Neaman and Mr. Hillebrand for his work at ENH. (Sirabian, Tr. 5728).

1771. When Bain provided contract negotiation advice in 1999 to ENH, neither Bain nor ENH management ever informed Mr. Sirabian that any of ENH's rates that were perceived to be unfavorable were the result of Mr. Sirabian's poor management in the 1990s. (Sirabian, Tr. 5762).
1772. Mr. Sirabian understood that terminating contracts was an option to be used during negotiations. In fact, he did terminate some health plans during his tenure. (Sirabian, Tr. 5750-53).
1773. Mr. Hillebrand had and still has general oversight and supervisory responsibility for health plan contracting. (Hillebrand, Tr. 1701; Neaman, Tr. 1220).
1774. Mr. Neaman believed Mr. Hillebrand to be an effective negotiator, with a good understanding of the marketplace and ENH's relationships with health plans. Mr. Neaman never criticized Mr. Hillebrand about ENH's pre-merger contracts with health plans. (Neaman, Tr. 1220).
1775. Mr. Hillebrand received a bonus after the merger in 2000. (Neaman, Tr. 1221).
1776. Mr. Hillebrand was never accused of being soft or of not bargaining hard with health plans. (Hillebrand, Tr. 1727).

C. There Is No Contemporaneous Evidence Showing That ENH Changed Its Pricing Strategy to Price at the Level of "Academic" Hospitals

1. Absence of Contemporaneous Business Records

1777. Despite the supposed importance of ENH's changes in negotiating strategy in late 1999, there are no contemporaneous business records mentioning ENH's alleged goal to price at the level of academic hospitals. (See Hillebrand, Tr. 2051-61 (acknowledging that Bain's contracting strategy recommendations did not describe pricing at academic hospital levels)).
1778. According to Mr. Hillebrand, ENH first learned that its contract prices were not as favorable as Highland Park's in late November 1999. (Hillebrand, Tr. 2051). Bain provided this information to ENH. (Hillebrand, Tr. 2049).
1779. Nowhere in Bain's contracting strategy documents did Bain mention that ENH should price at "academic" hospitals' levels. (See CX 74 (October 1999 Initial Review); CX 75 (November 1999 Project Review); CX 1998 (January 2000 Project Review); CX 67 (February 2000 Final Project Review)).

1780. In Bain's final contracting strategy written presentation in February 2000, Bain did not mention to which hospitals ENH should compare itself, or whether it should be academic hospitals, community hospitals, or some combination of the two. (See CX 67).
1781. Nowhere in Bain's contracting strategy documents did Bain make any pricing comparisons between ENH and any other hospital except Highland Park. See (CX 74 (October 1999 Initial Review); CX 75 (November 1999 Project Review); CX 1998 (January 2000 Project Review); CX 67 (February 2000 Final Project Review)).
1782. Mr. Hillebrand acknowledged that he did not write any e-mail, memoranda, letters or other written product describing the supposed fundamental change in ENH's negotiating tactics to price at the level of academic hospitals. (Hillebrand, Tr. 2051).
1783. Mr. Hillebrand acknowledged that in Bain's written recommendations to ENH for negotiating with Humana and United, Bain did not mention a goal of matching academic hospital pricing. (Hillebrand, Tr. 2052-58). In fact, in these written recommendations, Bain did not mention the phrase "academic hospitals." (Neaman, Tr. 1385-91; RX 705 (Humana negotiating recommendations); RX 679).
1784. Mr. Neaman testified that he was "shocked" to learn that ENH's rates for United were less than Highland Park's at the time of the merger. However, Mr. Neaman did not send any e-mails or memoranda memorializing this surprise. (Neaman, Tr. 1384-85).
1785. Mr. Neaman did not recall Bain making any recommendations that ENH's prices should be at the level of other types of hospitals besides Highland Park. Mr. Neaman did not recall any comparisons made by Bain in the context of its 1999-2000 contracting recommendations comparing ENH to other hospitals besides Highland Park. (Neaman, Tr. 1387).

2. Testimony of Health Plans Regarding Learning About Demand

1786. Health plan representatives testified at trial that ENH in negotiations did not indicate that it was attempting to match academic pricing. (See, e.g., Ballengee, Tr. 193-94; Neary, Tr. 621; Holt-Darcy, Tr. 1447). These representatives also explained that they did not consider ENH to be an academic or advanced teaching facility. (See, e.g., Ballengee, Tr. 189; Neary, Tr. 621; Foucre, Tr. 936).
1787. Ms. Ballengee of PHCS testified that ENH demanded higher prices in the 2000 negotiations because ENH "controlled the marketplace." (Ballengee, Tr. 194-95). Ms. Ballengee does not consider ENH to be an advanced teaching hospital. (Ballengee, Tr. 189).

1788. Patrick Neary of OneHealth testified that, in the 2000 negotiations, ENH never made any price comparisons between it and academic teaching hospitals. Mr. Neary does not believe that ENH was an academic hospital. (Neary, Tr. 621).
1789. Lenore Holt-Darcy of Unicare testified that, in the 2000 negotiations, ENH never compared its pricing to academic hospitals. (Holt-Darcy, Tr. 1447). Ms. Holt-Darcy does not consider Evanston, Highland Park or Glenbrook to be academic hospitals. (Holt-Darcy, Tr. 1444).
1790. Jillian Foucre of United did not believe that any of the ENH facilities were academic hospitals. (Foucre, Tr. 936).
1791. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 2381 at 4, *in camera*; Foucre, Tr. 1081-85, *in camera*).
1792. { [REDACTED]
[REDACTED] } (CX 6277 at 3, *in camera*; Foucre, Tr. 1092, *in camera*).
1793. In a September 2003 meeting between United and ENH upper level executives, Mr. Hillebrand provided a draft letter to United. (Foucre, Tr. 920-22). ENH drafted the letter, which was addressed to the FTC's Director of the Bureau of Competition, Susan Creighton, and requested that United send the letter as if it came from United. (Foucre, Tr. 921-23). United never sent the letter to the FTC. (Foucre, Tr. 924).
1794. The draft letter stated, "The combination of ENH and HPH has not had any adverse impact on competition for hospital services in the Chicagoland area, including the suburbs north of the city in Cook and Lake Counties." (CX 6284 at 1). Ms. Foucre of United disagreed with this statement because United's data indicated "that there had been an adverse impact to United Healthcare." (Foucre, Tr. 924-25).
1795. The draft letter stated, "If confronted with such a price increase, UHC would drop the ENH hospitals from its network and replace them with competing hospitals." (CX 6284 at 1). Ms. Foucre disagreed that dropping ENH was a viable option because of ENH's "hospitals, their geography, the people who live in that geography." (Foucre, Tr. 924-25).
1796. The letter also purported to provide a "learning about demand" explanation. The letter stated that the increase in ENH's post-merger prices was attributable to a "one time 'catch up' increase" to make up for a long period without price adjustments. According to the letter, the price increases "did not reflect the creation, possession or exercise of any

market power on behalf of the hospitals as a result of the merger.” (CX 6284 at 1). United did not send the letter despite ENH’s request. (Foucre, Tr. 924).

D. Evanston Could Not Have Learned Anything Significant About Demand from Highland Park

1. Evanston Could Have Learned Little About the Demand for Its Own Services by Learning About the Demand for Highland Park’s Services Because They Were Not Identical Hospitals

1797. Hospital services are an example of a differentiated product. (Noether, Tr. 5910, 6131). Among other factors hospitals are differentiated by geography. (Noether, Tr. 5911). No other hospital was a perfect substitute for Evanston before the merger. (Noether, Tr. 6132-33).

1798. Evanston and Highland Park were different in a number of dimensions. Pre-merger, Highland Park was a community hospital, and Evanston Hospital was a community and tertiary hospital, spanning both groups. (Ballengee, Tr. 159). Evanston had a teaching program, and Highland Park did not. (RX 1912 at 60 (showing residents per bed)). Evanston had more beds than Highland Park. (RX 1912 at 60 (showing number of staffed beds)). { [REDACTED] } (RX 1912 at 44 ({ [REDACTED] })), in camera).

1799. { [REDACTED] } (RX 1912 at 44, in camera).

1800. The price that a hospital charges a health plan is determined in bargaining between the health plan and the hospital. The bargaining position of the hospital and the health plan will greatly affect the outcome of the bargaining. The bargaining position of the hospital and the health plan depends on the alternatives each party to the bargaining has available to it. (Haas-Wilson, Tr. 2469-70). The hospital’s bargaining position with a health plan and the hospital’s price depend upon the incremental value that the hospital brings to the health plans network. The hospital’s incremental value is in turn a function of the plan’s turning to the next best alternative network that excludes the hospital. (Haas-Wilson, Tr. 2475-76 (reading from Towne and Vistnes)).

1801. For only about one third of the 35 or 40 contracts between health plans and Highland Park were the contract rates at Highland Park higher than the rates for Evanston. (Sirabian, Tr. 5717).

1802. Since Evanston and Highland Park had some different characteristics, they were in different bargaining positions relative to health plans pre-merger. Evanston would not, therefore, learn about the demand by health plans for its own services by looking at a hospital like Highland Park that: (1) had no teaching programs; (2) had a smaller bed size than Evanston; (3) offered a more narrow array of services than Evanston; or (4) required different alternative networks from Evanston to be replaced in a health plans network. (CCFF 1797-1801).

2. Pre-Merger, Highland Park Charged Lower Actual Prices Than Evanston

1803. { [REDACTED] } (Haas-Wilson, Tr. 2645, *in camera*).
{ [REDACTED] } (Haas-Wilson, Tr. 2645, *in camera*). { [REDACTED] }
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
{ [REDACTED] }
(Haas-Wilson, Tr. 2647-48, *in camera*).

1804. { [REDACTED] }
(See CX 1373 at 14, *in camera* { [REDACTED] }
[REDACTED] }).

1805. { [REDACTED] }
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4633, *in camera*). { [REDACTED] }
[REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4744-46
(discussing DX 7068 at 43, *in camera*), *in camera*; RX 2040 at 1,⁶ *in camera*).

⁶ RX 2040 is cited to impeach Dr. Baker's testimony both here and when cited in (continued...)

1806. { [REDACTED] } (Baker, Tr. 4744-47 (discussing DX 7068 at 43 (Dr. Baker's second Expert Report), *in camera*), *in camera*; RX 2040 at 1⁷, *in camera*).

1807. { [REDACTED] } (Baker, Tr. 4744-46, *in camera*; RX 2040 at 1, *in camera*).

1808. { [REDACTED] } (Haas-Wilson, Tr. 2646 (discussing DX 7047, *in camera*), *in camera*). { [REDACTED] } (Haas-Wilson, Tr. 2646-47 (discussing DX 7047 ({ [REDACTED] })), *in camera*), *in camera*).

1809. Pre-merger, Highland Park charged lower actual prices than Evanston. (CCFF 1803-1808).

3. Dr. Noether's Rate Comparisons Cannot Be Taken at Face Value

1810. { [REDACTED] } (RX 1912 at 34, *in camera*). { [REDACTED] } (RX 1912 at 34, *in camera*).

(...continued)
subsequent findings.

⁷ This document is cited only to impeach Drs. Noether and Baker's claim that ENH could have learned about its own demand by looking at Highland Park's contract rates.

1811. { [REDACTED] } (CCFF 1818). They are all teaching hospitals, which Highland Park was not. (RX 1912 at 60 (showing residents per bed)). { [REDACTED] } (RX 1912 at 25-26, *in camera*).

1812. { [REDACTED] } (Noether, Tr. 6090, *in camera*; RX 1912 at 34, *in camera*).

1813. Dr. Noether's Rate Comparisons Cannot Be Taken at Face Value. (CCFF 1810-1812).

E. Respondent's Experts' Comparisons to Dr. Noether's Control Groups Are Biased and Inappropriate

1814. Dr. Noether looked at price levels and relied on a comparison of the price levels at ENH with the price levels of several major teaching hospitals in the Chicago area. (Noether, Tr. 5991-92).

1815. { [REDACTED] } (See Noether, Tr. 6060, *in camera*).

1816. The comparisons performed by Dr. Noether depend upon the hospitals that Dr. Noether selected for her two groups of hospitals. { [REDACTED] } (Haas-Wilson, Tr. 2697, *in camera*).

1817. { [REDACTED] } (Baker, Tr. 4617-18, *in camera*). { [REDACTED] } (Baker, Tr. 4637, *in camera*). { [REDACTED] } (Dr. Baker, Tr. 4638, *in camera*). { [REDACTED] } (Dr. Baker, Tr. 4740, *in camera*).

1818. { [REDACTED] }

[REDACTED] } (RX 1912 at 147-52 ([REDACTED]
[REDACTED] } (RX 1912 at 147-49) [REDACTED]
[REDACTED] } (RX 1912 at 150-52)), *in camera*).

1819. If Northwestern Memorial Hospital, University of Chicago Hospital, Rush-Presbyterian-St. Luke's Medical Center, and Loyola University Medical Center are excluded from Dr. Noether's "academic" hospital group, the average price of Dr. Noether's academic hospital group will be lower, because, if the four highest prices are excluded, the average must be lower. (*See* CCFF 1818).
1820. If Northwestern Memorial Hospital, University of Chicago Hospital, Rush-Presbyterian-St. Luke's Medical Center, and Loyola University Medical Center should be excluded from Dr. Noether's "academic" hospital group, then the results using those four hospitals are biased. (*See* CCFF 1818). (If the four highest prices should be excluded, then any comparisons made with the average price are being made to an average price that is higher than it should be.)

1. Dr. Noether Began with an Arbitrary Group of 20 Hospitals

1821. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2550-51, *in camera*).
1822. Dr. Noether began by considering only 20 hospitals. Dr. Noether claims that she selected hospitals that competed in one way or another with one of the merging hospitals. (Noether, Tr. 5913-14). The list included 18 hospitals plus Evanston and Highland Park. (Noether, Tr. 6149).
1823. Dr. Noether's original selection of the 20 hospitals was arbitrary. There was no single document that listed the hospitals as competitors. Dr. Noether had to pick and choose which hospitals she included. (Noether, Tr. 6149).
1824. There was no specific criteria used by Dr. Noether to include hospitals on her list of hospitals. (Noether, Tr. 6149). There were no journal articles in the economic literature used by Dr. Noether as the basis for her selection of the hospitals on her list. (Noether, Tr. 6150).
1825. Moreover, the hospitals were not selected as hospitals that competed with ENH for patients or as hospitals that insurance companies could use to replace ENH. (Noether, Tr. 6174-75).

1826. Dr. Noether's group of 20 hospitals excludes hospitals that are closer to the three ENH hospitals than some of the hospitals that Dr. Noether includes in her group. Alexian Brothers, Vista Saint Therese, and Vista Victory Memorial are in the group of 20 from which Dr. Noether selects her academic and community comparison groups.} (RX 1912 at 60). {

[REDACTED]

} (RX 1912 at 21, *in camera*). Not one of these six is included in the group of 20. (RX 1912 at 60).

1827. Dr. Noether left out of her group hospitals that were mentioned in documents that she cited to identify her 20 hospitals. (Noether, Tr. 6150).

1828. Hinsdale Hospital, Christ Hospital, and MacNeal Hospital are mentioned in documents cited by Dr. Noether in her expert report as competitors of ENH, but are left off her list of 20 hospitals. (Noether, Tr. 6150-52).

1829. In her expert report, Dr. Noether identifies Hinsdale Hospital, Christ Hospital, and MacNeil Hospital as "best practice competitors" of ENH. (Noether, Tr. 6152). Each of these three hospitals is also identified as a "best practice competitor" or ENH in a 1999 competitive analysis done for ENH. (CX 595 at 4). In that same document, each of the three hospitals is identified as a teaching hospital. (CX 595 at 4).

1830. In her expert report, Dr. Noether identifies Christ Hospital as a core competitor of ENH. (Noether, Tr. 6152).

1831. Dr. Noether included hospitals in her list of 20 hospitals that were not mentioned in the documents she cited in her expert report as competitors of ENH. Loyola University Medical Center and Rush-Presbyterian-St. Luke's Medical Center are not listed in the documents that Dr. Noether cited in her report as the basis for identifying competitors of ENH. (Noether, Tr. 6154).

1832. Dr. Noether could cite no ENH documents as the basis for including Loyola University Medical Center and Rush-Presbyterian-St. Luke's Medical Center in her list as competitors of ENH. (Noether, Tr. 6153-54).

1833. Dr. Noether then used her list of 20 hospitals (18 plus Evanston and Highland Park) to develop what she called her academic and community control group hospitals. (Noether, Tr. 6154-55)

2. Dr. Noether's Division of Her Hospitals into an Academic Hospital Group and a Community Hospital Group Is Arbitrary

1834. There is no official government designation of what hospitals are community hospitals. (Noether, Tr. 6155). There is no official government designation of what hospitals are academic hospitals. (Noether, Tr. 6155).

1835. Dr. Noether used three criteria to select which of the 20 hospitals to include in her academic control group: teaching intensity (i.e. rate of residents to beds), number of staffed beds, and breadth of services (i.e. number of Diagnosis Related Groups ("DRGs")). (Noether, Tr. 5993-95).

1836. MedPAC is the Medicare Payment Advisory Commission, an advisory body to Congress on Medicare reimbursement criteria. MedPAC defines a major teaching hospital as a hospital with at least .25 residents per bed. (Noether, Tr. 5995).

1837. The MedPAC criteria for classification as a major teaching hospital have nothing to do with the number of DRGs that a hospital offers. (Noether, Tr. 6155).

1838. In determining the number of DRGs to use as a criterion to include hospitals in her academic control group, Dr. Noether counted a hospital as offering a DRG only if it was offered four times or more in a year. The use of four DRGs was arbitrary. (Noether, Tr. 5914-15).

1839. The number of DRGs that a hospital is found to offer is sensitive to Dr. Noether's requirement that a hospital offer a DRG four cases in a year to be considered to be offering that DRG. Using Dr. Noether's criterion of four cases, even a change from looking at a fiscal year as opposed to looking at a calendar year can cause the number of DRGs that Dr. Noether counts to change. { [REDACTED] } (RX 1912 at 44 ({ [REDACTED] })), *in camera*; RX 1912 at 60 (Calendar Year 1999)).

1840. Then, Dr. Noether simply listed the hospitals in order of the number of DRGs that they offered, and took the top third of the hospitals as having enough DRGs to be classified as academic hospitals. (Noether, Tr. 6164-65).

1841. There is no basis in the health care literature to require a hospital to be above a certain number of DRGs in order to be considered an academic hospital. (Noether, Tr. 6165-66).

1842. Only after considering evidence describing the different hospitals on her list (Noether, Tr. 6166), and after looking over the list of hospitals, did Dr. Noether decide to include the top quarter, top third, or top half of the hospitals as having enough DRGs to be included as an academic hospital. (Noether, Tr. 6167).

1843. The last hospital to be included as having enough DRGs to be considered an academic hospital was Rush-Presbyterian-St. Luke's Medical Center. (Noether, Tr. 6167-6168). Rush-Presbyterian-St. Luke's Medical Center is one of the four highest priced hospitals in Dr. Noether's list of 20 hospitals. (CCFF 1818).

1844. The Rush system included Rush-Presbyterian-St. Luke's Medical Center. (Ballengee, Tr. 163; Dorsey, Tr. 1445). Beginning in December 2000, United did not have a contract with the hospitals in the Rush system. (Foucre, Tr. 932-933). { [REDACTED] }
{ [REDACTED] }
(Foucre, Tr. 932-33; Noether, Tr. 6244-45, *in camera*).

1845. { [REDACTED] }
{ [REDACTED] } (RX 1912 at 147, 150
{ [REDACTED] }
{ [REDACTED] }}, *in camera*).

3. Dr. Noether Left Hospitals off of Her List of 20 Hospitals That Met the Criteria for Inclusion in Her Academic Control Group If She Had Included Them in Her Original List

1846. Christ Hospital is a large teaching hospital in the Chicago area. Christ Hospital is a member of the Council of Teaching Hospitals ("COTH"). (Noether, Tr. 6152-53). Christ Hospital is not included in Dr. Noether's list of 20 hospitals. (Noether, Tr. 6151).

1847. { [REDACTED] }
{ [REDACTED] } (Noether, Tr. 6245, *in camera*).

1848. MacNeal Hospital is a member of the Council of Teaching Hospitals ("COTH"). (Noether, Tr. 6159). MacNeal hospital is not included in Dr. Noether's list of 20 hospitals. (Noether, Tr. 6151).

1849. The University of Illinois Medical Center is a major academic hospital. (Noether, Tr. 6158).

- 1850. The University of Illinois Medical Center is a member of the Council of Teaching Hospitals ("COTH"). The University of Illinois Medical Center has over 400 beds. (Noether, Tr. 6158).
- 1851. The University of Illinois Medical Center is on the cutting edge of medical technology. (Dorsey, Tr. 1445). The University of Illinois performs liver transplants, bone marrow transplants and kidney transplants. (Dorsey, Tr. 1473).
- 1852. The University of Illinois Medical Center participates in health plans such as Aetna, Blue Cross, United, and Humana. According to Dr. Noether, the University of Illinois Medical Center competes with the hospitals that she included in her academic control group. (Noether, Tr. 6168-69).
- 1853. Yet the University of Illinois Medical Center is not included in Dr. Noether's list of 20 hospitals. (Noether, Tr. 6158).

4. Dr. Noether's Criteria Excluded from Her Group of "Academic" Hospitals Some Hospitals (on Her List of 20 Hospitals) That Are Considered Major Teaching Hospitals and That Had Lower Post-Merger Prices Than Northwestern Memorial Hospital, University of Chicago Hospital, Rush-Presbyterian-St. Luke's Medical Center, Loyola University Medical Center, and ENH Itself

a. Louis A. Weiss Hospital

- 1854. Louis A. Weiss Hospital had a teaching program with more than .25 residents per bed. (Noether, Tr. 6170; RX 1912 at 60).
- 1855. Louis A. Weiss Hospital met the MedPAC criteria for a major teaching hospital. (CCFF 1836, 1854).
- 1856. Yet Dr. Noether classified Louis A. Weiss Hospital as a community hospital and not an academic hospital. (Noether, Tr. 6170-71; Noether, Tr. 5999-600; RX 1912 at 60).
- 1857. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (RX 1912 at 148, 151, *in camera*).

b. St. Francis Hospital

- 1858. St. Francis hospital had more than .25 residents per bed. (RX 1912 at 60).

1859. St. Francis Hospital met the MedPAC criteria for a major teaching hospital. (CCFF 1836, 1858).

1860. In a 1999 competitive analysis done for ENH, St. Francis is identified as a teaching hospital. (CX 595 at 4).

1861. Yet Dr. Noether classified St. Francis as a community hospital and not an academic hospital. (Noether, Tr. 5999; RX 1912 at 60).

1862. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (RX 1912 at 149, 152, *in camera*).

5. Dr. Noether's Criteria Excluded from Her Group of "Academic" Hospitals Some Hospitals (on Her List of 20 Hospitals) That Treated, on Average, More Complex Cases Than ENH and That Had Lower Post-Merger Prices Than Northwestern Memorial Hospital, University of Chicago Hospital, Rush-Presbyterian-St. Luke's Medical Center, Loyola University Medical Center, and ENH Itself

1863. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2594, *in camera*; Amended Glossary of Terms at 4, April 22, 2005).

1864. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2594, *in camera*; Amended Glossary of Terms at 6, April 22, 2005).

1865. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2594, *in camera*; Amended Glossary of Terms at 6, April 22, 2005).

1866. The case mix index is one measure of a hospital's capability. The case mix index is calculated as the average DRG case weight across all of the hospital's inpatient admissions. The higher the case mix index for a particular hospital, the more complex are the cases that the hospital treats. (Noether Tr. 6162-63).

a. Alexian Brothers Medical Center

1867. Alexian Brothers Medical Center, one of the hospitals on Dr. Noether's list of twenty hospitals, had a higher case mix index than ENH for every year from 1997 through 2003. (Noether, Tr. 6168; RX 1912 at 25 (same document as DX 7130)).

1868. { [REDACTED] } (RX 1912 at 26, *in camera*).

1869. { [REDACTED] } (RX 1912 at 27, *in camera*).

1870. { [REDACTED] } (Noether, Tr. 6169; RX 1912 at 44, *in camera*).

1871. Yet Dr. Noether classified Alexian Brothers Medical Center as a community hospital and not an academic hospital. (Noether, Tr. 6170; Noether, Tr. 5999; RX 1912 at 60).

1872. { [REDACTED] } (RX 1912 at 148, 151, *in camera*).

b. Louis A. Weiss Hospital

1873. Louis A. Weiss Hospital, one of the hospitals on Dr. Noether's list of twenty hospitals, had a higher case mix index than ENH for every year from 1997 through 2003. (Noether, Tr. 6170; RX 1912 at 25 (same document as DX 7130)).

1874. { [REDACTED] } (RX 1912 at 26, *in camera*).

1875. { [REDACTED] } (RX 1912 at 27, *in camera*)

1876. { [REDACTED] } (RX 1912 at 44, *in camera*).

1877. Louis A. Weiss Hospital had a teaching program with over .25 residents per bed. (CCFF 1854).

1878. Yet Dr. Noether classified Louis A. Weiss Hospital as a community hospital and not an academic hospital. (CCFF 1856).

1879. { [REDACTED]
[REDACTED]
[REDACTED] } (CCFF 1857, *in camera*).

c. Northwest Community Hospital

1880. Northwest Community Hospital, one of the hospitals on Dr. Noether's list of twenty hospitals, had a higher case mix index than ENH for every year from 1997 through 2003. (RX 1912 at 25).

1881. { [REDACTED]
[REDACTED] (RX 1912
at 26, *in camera*) [REDACTED]
[REDACTED] } (RX 1912 at 26, *in camera*).

1882. { [REDACTED]
[REDACTED]
[REDACTED] } (RX 1912 at 27, *in camera*).

1883. { [REDACTED]
[REDACTED]
[REDACTED] } (RX 1912 at 44, *in camera*).

1884. Yet Dr. Noether classified Northwest Community Hospital as a community hospital and not an academic hospital. (Noether, Tr. 5999; RX 1912 at 60).

1885. { [REDACTED]
[REDACTED]
[REDACTED] } (RX 1912 at 148, 151, *in camera*).

d. Resurrection Medical Center

1886. Resurrection Medical Center, one of the hospitals on Dr. Noether's list of twenty hospitals, had a higher case mix index than ENH for every year from 1997 through 2003. (Noether, Tr. 6171; RX 1912 at 25 (same document as DX 7130)).

1887. { [REDACTED] } (RX 1912 at 26; *in camera*).

1888. { [REDACTED] } (RX 1912 at 27).

1889. { [REDACTED] } (RX 1912 at 44, *in camera*).

1890. Yet Dr. Noether classified Resurrection Medical Center as a community hospital and not an academic hospital. (Noether, Tr. 5999, 6171; RX 1912 at 60).

1891. { [REDACTED] } (RX 1912 at 148, 151, *in camera*).

e. Rush North Shore Medical Center

1892. Rush North Shore Medical Center, one of the hospitals on Dr. Noether's list of twenty hospitals, had a higher case mix index than ENH for every year from 1997 through 2003. (Noether, Tr. 6171-72; RX 1912 at 25 (the same document as DX 7130)).

1893. { [REDACTED] } (RX 1912 at 26, *in camera*).

1894. { [REDACTED] } (RX 1912 at 27, *in camera*).

1895. { [REDACTED] } (RX 1912 at 44, *in camera*).

1896. Yet Dr. Noether classified Rush North Shore Medical Center as a community hospital and not an academic hospital. (Noether, Tr. 5999-600, 6171-72; RX 1912 at 60).

1897. { [REDACTED] } (RX 1912 at 149, 152, *in camera*).
1898. { [REDACTED] } (DX 1912 at 147-52, *in camera* ({ [REDACTED] })). { [REDACTED] } (Foucre, Tr. 932-33; Noether, Tr. 6244-45, *in camera*). { [REDACTED] } (Noether, Tr. 6244-45, *in camera*; Foucre, Tr. 932-33).
1899. { [REDACTED] } (RX 1912 at 149, *in camera*).

f. St. Francis Hospital

1900. St. Francis Hospital, one of the hospitals on Dr. Noether's list of twenty hospitals, had a higher case mix index than ENH for every year from 1997 through 2003. (Noether, Tr. 6172; RX 1912 at 25 (the same document as DX 7130)).
1901. { [REDACTED] } (RX 1912 at 26, *in camera*).
1902. { [REDACTED] } (RX 1912 at 27, *in camera*)
1903. { [REDACTED] } (RX 1912 at 44, *in camera*).
1904. St. Francis Hospital had a teaching program with over .25 residents per bed. (CCFF 1858).
1905. Yet Dr. Noether classified St. Francis Hospital as a community hospital and not an academic hospital. (CCFF 1861).

1906. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (CCFF 1862, *in camera*).

6. Dr. Noether's Criteria Excluded from Her Group of "Academic" Hospitals Some Hospitals That Were Included in Her 20 Hospital List and That Treated, on Average, More Complex Cases Than Another Hospital Included in Dr. Noether's Academic Control Group

1907. Dr. Noether included Advocate North Side Medical Center in her academic control group. (Noether, Tr. 6173).

1908. Advocate North Side Medical Center had a lower case mix index than ENH for every year from 1997 to 2003. (Noether, Tr. 6173; RX 1912 at 25 (the same document as DX 7130)).

1909. { [REDACTED]
[REDACTED] } (RX 1912 at 26, *in camera*).

1910. Alexian Brothers Medical Center, Louis A. Weiss Hospital, Northwest Community Hospital, Resurrection Medical Center, Rush North Shore Medical Center, and St. Francis Hospital all had higher case mix indexes than Advocate North Side Medical Center for every year from 1997 through 2003. (Noether, Tr. 6173; RX 1912 at 25 (same document as DX 7130)).

1911. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (RX 1912 at 26, *in camera*). Yet, of these hospitals, only Advocate North Side Medical Center appeared in Dr. Noether's academic control group. (Noether, Tr. 6000).

7. Dr. Noether's Academic Control Group Is Not an Appropriate Control Group

1912. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2698, *in camera*).

a. Case Mix and Services Provided

1913. { [REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2698-99, *in camera*).

1914. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2701-02, *in camera*).

1915. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2702, *in camera*; CX 6282 at 1-2, *in camera*; Neaman, Tr. 1378).

1916. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }
(RX 1912 at 44, *in camera*).

1917. "Hospitals that have a broader range of services are, all else equal, likely to be in higher demand." (Noether, Tr. 5994).

1918. Dr. Noether's academic control group did not include hospitals that were similar to ENH in terms of the overall inpatient services they provided. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2703-2704, *in camera*).

1919. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2705-06, *in camera*; CX 6282 at 7, *in camera*).

1920. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson,
Tr. 2706, *in camera*; CX 6282 at 7).

1921. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2706-07, *in
camera*; CX 6282 at 7).

1922. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2707, *in camera*; CX 6282
at 7-8).

b. Teaching Intensity

1923. { [REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2708, *in
camera*).

1924. Some of the hospitals that Dr. Noether has in her academic control group have more residents per bed than ENH has. ENH has .3386 residents per bed, while Loyola University Medical Center has .6060 residents per bed, Northwestern Memorial Hospital has .5670 residents per bed, Rush-Presbyterian-St. Luke's Medical Center has .7606 residents per bed, and University of Chicago has .7938 residents per bed. (RX 1912 at 60).

1925. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }
(Haas-Wilson, Tr. 2708-09, *in camera*; RX 1912 at 60).

c. National Recognition

1926. { [REDACTED]
[REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2711-12, *in camera*).

8. Health Plans Do Not Consider ENH to Be Comparable to Northwestern Memorial Hospital, Rush-Presbyterian-St. Luke's, or the University of Chicago

a. PHCS

1927. PHCS categorizes hospitals as community, tertiary, and advanced teaching hospitals. Pre-merger, Highland Park fell into the community hospital group and Evanston Hospital was a community and tertiary hospital, spanning both groups. Post-merger, ENH was still a community and tertiary hospital. (Ballengee, Tr. 158-59).
1928. Advanced teaching hospitals offered the really high level procedures, such as transplants, burn units, and hyperbaric centers. (Ballengee, Tr. 159).
1929. The advanced teaching hospitals in the Chicago area are Northwestern Memorial Hospital, Rush-Presbyterian-St. Luke's Medical Center, University of Chicago Hospital, Loyola University Medical Center, and University of Illinois Medical Center. (Ballengee, Tr. 189).
1930. ENH is not an advanced teaching hospital. (Ballengee, Tr. 189).
1931. The advanced teaching hospitals typically are significantly more expensive than other hospitals. (Ballengee, Tr. 189).
1932. PHCS dropped the University of Chicago Hospital from its network in 1999, in a rate dispute. (Ballengee, Tr. 189-90). PHCS compared the rates that University of Chicago wanted with the rates at Northwestern Memorial, Rush-Presbyterian-St. Luke's, and Loyola University, in making the decision to drop the University of Chicago Hospital. PHCS did not compare the rates of the University of Chicago with the rates at ENH. (Ballengee, Tr. 190).

b. One Health

1933. In negotiating with hospitals to be in its network, One Health made judgments about the hospitals level of services. Academic teaching hospitals are institutions that are part of a medical school that offer higher levels of services than community hospitals, such as transplant services, burn units, higher levels of cardiac services, and cardiac transplants. (Neary, Tr. 622).
1934. Evanston Hospital is not an academic teaching hospital. (Neary, Tr. 621). Loyola University Medical Center, University of Chicago Hospital, Northwestern Memorial

Hospital, Rush-Presbyterian-St. Luke's Medical Center, and University of Illinois Medical Center are all academic teaching hospitals. (Neary, Tr. 622-23).

- 1935. Hospitals that offer services that are comparable to Evanston Hospital include Rush North Shore, Condell, Swedish Covenant, and St. Therese. (Neary, Tr. 624).
- 1936. Academic hospitals are teaching facilities that train physicians. Such hospitals are on the cutting edge of medical technology, performing services that other general acute care facilities and community hospitals do not perform. (Dorsey, Tr. 1443).
- 1937. Academic hospitals in the Chicago area include the University of Chicago Hospitals, Rush-Presbyterian-St. Luke's Medical Center, Northwestern Memorial Hospital, Loyola University Medical Center, and University of Illinois Medical Center. (Dorsey, Tr. 1443-44).
- 1938. None of the hospitals (Evanston Hospital, Glenbrook Hospital, and Highland Park Hospital) in ENH are academic hospitals. (Dorsey, Tr. 1444).

c. United

- 1939. An academic hospital is one that has a medical school as part of the hospital. (Foucre, Tr. 935).
- 1940. Loyola University Medical Center, University of Chicago Hospital, Northwestern Memorial Hospital, and Rush-Presbyterian-St. Luke's Medical Center are all academic hospitals. Evanston Hospital, Glenbrook Hospital, and Highland Park Hospital are not academic hospitals. (Foucre, Tr. 935-36).

9. ENH's Pricing History to Blue Cross Showed No Trend Toward the Prices Charged by the Academic Control Group

- 1941. The "full information" price is the price a hospital would obtain from a health plan if the hospital had full information about the health plans demand for its services. (Noether, Tr. 6146). Dr. Noether claims that the prices that Evanston was charging to Blue Cross pre-merger were closer to the "full information" prices that were the prices that ENH was charging to other health plans. (Noether, Tr. 6147-48).
- 1942. { [REDACTED]
[REDACTED]
[REDACTED] } (RX 1912 at 61-63, *in camera*; Noether, Tr. 6070-74). { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2728, *in camera*).

10. **Dr. Noether Treated Highland Park Hospital Inappropriately in Her Comparisons**

1943. { [REDACTED]
[REDACTED]
[REDACTED] } (Haas-Wilson, Tr. 2551-52, *in camera*).

1944. { [REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4638-39, *in camera*).

1945. { [REDACTED]
[REDACTED] } (Noether, Tr. 6192-93; Foucre, Tr. 890; Holt-Darcy, Tr. 1528, *in camera*).

1946. Other hospital systems in the Chicago area, such as Rush and Advocate, charged different prices for their tertiary hospitals than for their community hospitals. The Rush system has multiple hospitals, Rush-Presbyterian-St. Luke's Medical Center and several community hospitals. Rush charges higher prices at Rush-Presbyterian-St. Luke's Medical Center than at the other Rush hospitals. (Ballengee, Tr. 163-64; Dorsey, Tr. 1445-46), The Advocate system charged different prices for the different hospitals in its system. (Dorsey, Tr. 1446; Foucre, Tr. 890-91). United paid different prices for different hospitals in the Advocate System, the Resurrection system, and the Provena system. (Foucre, Tr. 890-91). { [REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1529, *in camera*).

1947. { [REDACTED]
[REDACTED]
[REDACTED] } (See, e.g., RX 1912 at 147-52, *in camera*).

1948. Highland Park Hospital did not meet any of the three criteria that Dr. Noether used to select hospitals that she placed in her academic control group. Highland Park Hospital had only 157 beds. (RX 1912 at 60), Highland Park Hospital had no residents (RX 1912 at 60), { [REDACTED] } (RX 1912 at 44, *in camera*).

1949. Respondent's experts' comparisons to Dr. Noether's control groups are biased and inappropriate. Dr. Noether's and Dr. Baker's analyses depend upon the appropriateness of the control groups selected by Dr. Noether. (CCFF 1816-1817). Dr. Noether made arbitrary decisions to arrive at her control group. (CCFF 1821-1845). These arbitrary decisions excluded Chicago area hospitals that met her criteria for inclusion in her academic control group. (CCFF 1846-1853).

1950. The arbitrary decisions by Dr. Noether excluded from her academic control group Chicago area hospitals that were major teaching hospitals (CCFF 1854). These arbitrary decisions excluded from her academic control group Chicago area hospitals that treated more complex and resource-intensive cases than ENH. (CCFF 1867-1871, 1873-1878, 1880-1884, 1886-1890, 1892-1896, 1900-1905). The hospitals that were arbitrarily excluded from the academic control group had lower prices than ENH. (CCFF 1857, 1862, 1872, 1885, 1891, 1897-1899).

1951. { [REDACTED] } (CCFF 1818, *in camera*). She did this while excluding hospitals that were more appropriate for comparison with ENH and which had lower prices. (CCFF 1854-1906).

F. ENH Flunked the Learning About Demand Test

1952. Dr. Baker's own analysis cuts against his learning about demand hypothesis. { [REDACTED] } (Baker, Tr. 4739, *in camera*). In his second report, Dr. Baker focuses his attention on the overall average, rather than individual health plan-by-health plans comparisons. { [REDACTED] } (Baker, Tr. 4820-21; (discussing RX 2040 at 4,⁸ *in camera*), *in camera*).

1953. { [REDACTED] } (Baker, Tr. 4710, *in camera*). The December 23 report was not a rebuttal report but rather a "supplemental report that corrected the mistake [involving the conversion of regression results into predicted prices]." (Baker, Tr. 4600).

⁸ RX 2040 is cited to impeach Dr. Baker's testimony both here and when cited in subsequent findings.

1954. { [REDACTED] } (See CCFF 1744-1762, *in camera*).
1955. Only in his first report did Dr. Baker address the consequences of ENH's prices for any *individual* health plan rising above the average prices that hospitals in the "academic" group charged to that same health plan. { [REDACTED] } (RX 2038 at 4,⁹ *in camera*).
1956. { [REDACTED] } (Baker, Tr. 4716 (discussing quoted portion of RX 2038 at 3, *in camera*), *in camera*).
1957. Dr. Baker's second report deleted this reference to individual health plan comparisons between ENH and the academic grouping, instead focusing on ENH's *overall average* for all health plans studied compared to the academic group's average. { [REDACTED] } (RX 2039 at 4¹⁰, *in camera*).
1958. { [REDACTED] } (Baker, Tr. 4739 (discussing RX 2040 at 4, *in camera*); *in camera*).
1959. { [REDACTED] } (Baker, Tr. 4743, *in camera*).
1. United
1960. { [REDACTED] } (Baker, Tr. 4739, (discussing RX 2040 at 4, *in camera*), *in camera*).

⁹ RX 2038 is cited to impeach Dr. Baker's testimony both here and when cited in subsequent findings.

¹⁰ RX 2039 is cited to impeach Dr. Baker's testimony both here and when cited in subsequent findings.

1961. { [REDACTED]
[REDACTED]
[REDACTED] } (RX 2040 at 4, *in camera*).

1962. { [REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4783-84 (discussing RX 2040 at 4, *in camera*), *in camera*).

1963. { [REDACTED]
[REDACTED] } (Baker, Tr. 4784-85 (discussing RX 2040 at 4, *in camera*); *in camera*).

2. Humana

1964. { [REDACTED]
[REDACTED] } (Baker, Tr. 4739 (discussing RX 2040 at 4, *in camera*), *in camera*).

1965. { [REDACTED]
[REDACTED] } (RX 2040 at 4, *in camera*).

3. Blue Cross

1966. { [REDACTED] } (Baker, Tr. 4695, *in camera*).

1967. { [REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4759, *in camera*).

1968. { [REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4759, *in camera*).

1969. { [REDACTED]
[REDACTED]
[REDACTED] } (Baker, Tr. 4820-21, *in camera*).

1970. { [REDACTED]
[REDACTED] } (Baker, Tr. 4821, *in camera*).

1971. { [REDACTED]
[REDACTED] } (Baker, Tr. 4821, *in camera*).

G. The Learning About Demand Excuse Is Implausible

1. There Is No Dispute That ENH Had Market Power After the Merger with Highland Park

1972. Market power is the ability to raise and maintain prices above a competitive level. (Noether, Tr. 5991-92).

1973. Dr. Noether acknowledged that Highland Park and Evanston Hospital both had some market power before the merger. (Noether, Tr. 6131 (Highland Park had market power pre-merger); Noether, Tr. 6132 (Evanston had market power pre-merger)).

1974. Dr. Noether acknowledged that after the merger between Evanston Hospital and Highland Park, there was no perfect substitute for ENH. (Noether, Tr. 6132-6133). Post-merger, ENH would have faced a downward sloping demand curve and would have had some market power. (Noether, Tr. 6133).

2. The Theory of Learning About Demand Is Just a Claim That ENH Did Not Know How Much Market Power It Had Prior to the Merger

1975. The theory of learning about demand is that prior to the merger, Evanston had poor information about the true demand for its services. (Noether, Tr. 5968).

1976. The theory of learning about demand implies that because Evanston was not well informed about the demand for its services, the market was not in equilibrium. (Noether, Tr. 5990).

1977. The theory of learning about demand implies that pre-merger Evanston misunderstood the level and the elasticity of the demand curve for its services. (Noether, Tr. 6136).

1978. The elasticity of demand is the percentage change in quantity demanded divided by the percentage change in price. (Noether, Tr. 6136). So, if prices increase, the elasticity tells you the ratio of the percentage decline in quantity demanded to the percentage increase in the price. (Noether, Tr. 6137).

1979. If ENH learned that its demand was more inelastic than it thought it was, that means that ENH could have raised its prices and lost less business than it had previously thought. (Noether, Tr. 6137).

1980. If a hospital's demand curve is more inelastic than it previously thought, then that hospital has more market power than it previously thought. (Noether, Tr. 6138-39).
1981. Learning about demand is really just a claim that ENH had more market power pre-merger than it thought it did. (CCFF 1977-1980).

3. ENH Had Substantial Market Power Post-Merger

1982. After the merger, ENH was able to charge substantially more per case than other nearby hospitals, that Dr. Noether claimed are in the same geographic market, that treated cases as complex or more complex as those treated by ENH, and that included some major teaching hospitals. (CCFF 1983-2015).

1983. { [REDACTED]
[REDACTED]
[REDACTED] } (Noether, Tr. 5928; Noether, Tr. 6238, *in camera*).

a. Rush North Shore Medical Center

1984. { [REDACTED]
[REDACTED] } (RX 1912 at 149, 152, *in camera*).

1985. { [REDACTED]
[REDACTED] } (Noether, Tr. 6241, *in camera*).

1986. Rush North Shore Medical Center had a higher case mix index than ENH for every year from 1997 through 2003. (Noether, Tr. 6171-72; RX 1912 at 25).

1987. { [REDACTED]
[REDACTED] } (RX 1912 at 26, *in camera*).

1988. { [REDACTED]
[REDACTED] } (RX 1912 at 27, *in camera*).

1989. { [REDACTED]
[REDACTED] } (RX 1912 at 44, *in camera*).

b. St. Francis Hospital

1990. { [REDACTED]
[REDACTED]
[REDACTED] } (RX 1912 at 149, 152, *in camera*).

1991. { [REDACTED]
[REDACTED] } (Noether, Tr. 6242, *in camera*).

1992. St. Francis hospital had more than .25 residents per bed. (RX 1912 at 60). St. Francis Hospital met the MedPAC criteria for a major teaching hospital. (CCFF 1836).

1993. St. Francis Hospital had a higher case mix index than ENH for every year from 1997 through 2003. (Noether, Tr. 6172; RX 1912 at 25).

1994. { [REDACTED]
[REDACTED] } (RX 1912 at 26, *in camera*).

1995. { [REDACTED]
[REDACTED] } (RX 1912 at 27, *in camera*).

1996. { [REDACTED]
[REDACTED] } (RX 1912 at 44, *in camera*).

c. Advocate Lutheran General Hospital

1997. { [REDACTED]
[REDACTED]
[REDACTED] } (RX 1912 at 149, 152, *in camera*).

1998. { [REDACTED]
[REDACTED] } (Noether, Tr. 6240-41, *in camera*).

1999. Advocate Lutheran General Hospital had more than .25 residents per bed. (RX 1912 at 60). Advocate Lutheran General Hospital met the MedPAC criteria for a major teaching hospital. (CCFF 1836). Dr. Noether claimed that Advocate Lutheran General Hospital was a member of her academic control group. (Noether, Tr. 6000; RX 1912 at 60).

2000. Advocate Lutheran General Hospital had a higher case mix index than ENH for every year from 1997 through 2003. (RX 1912 at 25 (the same document as DX 7130)).

2001. { [REDACTED] } (RX 1912 at 26, *in camera*).

2002. { [REDACTED] } (RX 1912 at 27, *in camera*).

2003. { [REDACTED] } (RX 1912 at 44, *in camera*).

d. Resurrection Medical Center

2004. { [REDACTED] } (RX 1912 at 149, 152, *in camera*).

2005. { [REDACTED] } (Noether, Tr. 6242, *in camera*).

2006. Resurrection Medical Center had a higher case mix index than ENH for every year from 1997 through 2003. (Noether, Tr. 6171; RX 1912 at 25).

2007. { [REDACTED] } (RX 1912 at 26, *in camera*).

2008. { [REDACTED] } (RX 1912 at 27, *in camera*).

2009. { [REDACTED] } (RX 1912 at 44, *in camera*).

e. Lake Forest Hospital

2010. { [REDACTED]
[REDACTED]
[REDACTED] } (RX 1912 at 148, 151, *in camera*).

2011. { [REDACTED]
[REDACTED] } (Noether, Tr. 6240-41, *in camera*).

2012. { [REDACTED]
[REDACTED] } (RX 1912 at 44, *in camera*).

f. Condell Medical Center

2013. { [REDACTED]
[REDACTED]
[REDACTED] } (RX 1912 at 148, 151, *in camera*).

2014. { [REDACTED]
[REDACTED] } (Noether, Tr. 6241-42, *in camera*).

2015. { [REDACTED]
[REDACTED] } (RX 1912 at 44, *in camera*).

g. ENH Was Able to Raise Prices Without Losing Managed Care Business

2016. Despite the higher prices at ENH, no health plans switched their business away from ENH following the merger with Highland Park. (Noether, Tr. 6201). That includes United, Aetna, Private Healthcare Systems, One Health, and UniCare, none of which switched their purchases of hospital services away from ENH to other hospital providers. (Noether, Tr. 6200-01).

2017. Following the merger with Highland Park, ENH was able to exercise substantial market power, charging thousands of dollars per case more than other hospitals that Dr. Noether claimed were in the same geographic market as ENH. (CCFF 1983-2015).

4. The Learning About Demand Theory Implies That ENH Could Have Charged the Post-Merger Prices Pre-Merger, Which It Could Not

2018. Dr. Noether claims that under the learning about demand theory, the merger did not create *any* market power at the merged entity (emphasis added). (Noether, Tr. 5900; Noether, Tr. 5902; Noether, Tr. 5967).
2019. If the learning about demand theory is true, then ENH could have charged the post merger prices before the merger with Highland Park. Under that theory, the merger did not create any market power and ENH simply didn't realize how much health plans were willing to pay for its hospital services pre-merger. (CCFF 1975-1977).
2020. { [REDACTED] } (Ballengee, Tr. 166-69, 171; Mendonsa, Tr. 530, *in camera*).
2021. During negotiations between United and ENH in September 2003, ENH asked United to send a letter to the FTC stating that the higher prices to United do not reflect the exercise of "market power" created by the merger, but rather reflect a "one time 'catch up' increase" to account for lapses in price adjustments since the late 1990s. (CX 6284 at 1). United refused to send the letter to the FTC. (Foucre, Tr. 924).
2022. Before the merger, ENH leadership believed that the government and health plans would increase pricing pressures on hospitals. (Neaman, Tr. 1042). For example, as early as the beginning of 1998, ENH experienced "significant reductions in reimbursement" from both Blue Cross and Humana. (CX 2037 at 2-3; Neaman, Tr. 1151-52).
2023. Before the merger, Highland Park executives did not believe HPH could raise its prices further. The price trend before the merger was down, and, in Mr. Spaeth's, view that has not changed. (Spaeth, Tr. 2201-02).
2024. Mr. Spaeth, the former president of Highland Park testified that at the time of the merger Highland Park would not have been successful in raising its rates. He did not see an opportunity to raise the rates before the merger. (Spaeth, Tr. 2172-73). The hospital could not sustain a strategy where it kept losing contracts, as such a strategy would have proved very difficult to stick to. (Spaeth, Tr. 2178-79).
2025. { [REDACTED] } (Chan, Tr. 820, *in camera*, CX 1099 at 1-67, *in camera*).
2026. ENH could not have charged the post-merger prices in the pre-merger period, contrary to what the learning about demand theory predicts. (CCFF 2020-2025).

5. It Is Implausible That ENH Could Have Remained in Disequilibrium Pre-Merger Because Health Plans Would Have Known Their Own Demand for Evanston's Services Pre-Merger

2027. Under the learning about demand theory, payers would have had better knowledge of their demand than Evanston, pre-merger. (Noether, Tr. 6138).
2028. Under the learning about demand theory, Evanston was not pricing on its "full information demand curve. In other words, at least some payers would have been willing to pay more for the services that Evanston was selling premerger. (Noether, Tr.6138-39).
2029. Under the learning about demand theory, if Evanston was not pricing on its "full information" demand curve, there may be some payers who would want more services than they were getting at the price that Evanston was charging. (Noether, Tr. 6141).
2030. There is no evidence that any health plan valued the services at ENH pre-merger more than the services at the surrounding hospitals and pre-merger moved any of its business to ENH to take advantage of any "bargain" prices. (Noether, Tr. 6141-42).
2031. The learning about demand theory is implausible given the facts of this case. Following the merger with Highland Park, ENH possessed and exercised substantial market power, charging thousands of dollars more per case than other hospitals. ENH could not have charged those prices pre-merger. Nor is there any evidence that before the merger, ENH's pricing was in disequilibrium, with managed care providers being charged below equilibrium prices. (CCFF 1983-2030).

XVI. The Quality of Care Changes Do Not Excuse the Merger

2032. In its Answer, Respondent alleges that the merger of HPH into ENH “facilitated significant improvements in the quality of patient care throughout the ENH system that outweigh any alleged anticompetitive effects.” (Respondents’ Second Amended Answer at 21). The evidence does not show that the merger of HPH into ENH facilitated significant improvements in the quality of patient care throughout the ENH system. (Romano, Tr. 3004-05, 3008; Romano, Tr. 3192, *in camera*).

A. Respondent Failed to Prove That Quality Improved

1. Respondent Did Not Even Attempt to Show That ENH’s Quality Improved Compared to Other Hospitals

a. No Analysis of Control Group or Other Hospitals Outside ENH

2033. Dr. Mark Chassin, Respondent’s expert in quality of care, did not compare quality at Highland Park Hospital or Evanston to quality at any ENH identified peer group or control group of hospitals. (Chassin, Tr. 5448-49).

2034. [REDACTED] (Baker, Tr. 4618, 4620, *in camera*; Haas-Wilson, Tr. 2637-8, *in camera*). But neither Dr. Chassin, nor any other ENH witness, attempted to compare the quality of care at those hospitals to the quality of care, pre and post merger, at any ENH hospital. (Noether, Tr. 6181-83; Chassin, Tr. 5448-49).

b. Claims of Quality Improvements Limited to Some Aspects of One of Three Hospitals in ENH System

2035. Respondent presented testimony from approximately five executives of ENH, nine clinical physician and nursing administrators working for or associated with ENH, and two members of the community. The quality-related testimony of all these witnesses focused entirely on Highland Park Hospital.¹¹

¹¹ The five ENH executives included Jeffrey Hillebrand, Mark Neaman, Mary O’Brien, Ronald Spaeth, and Harry Jones. The nine administrators included Drs. Michael Ankin, Leon Dragon, Bruce Harris, Stanley Kent, Todd Rosengart, Richard Silver, Thomas Victor, Arnold Wagner, and Heidi Krasner. The two members of the community are Michael Belsky and James Styer.

2036. Dr. Chassin's assignment was to evaluate the effect of the merger on the quality of care delivered at Highland Park Hospital. (Chassin, Tr. 5130, 5449). Dr. Chassin's opinions concerning improvements in quality of care were limited to Highland Park Hospital, one of the three ENH hospitals. Respondent presented no evidence showing whether or not the merger affected the quality of patient care at Evanston Hospital and Glenbrook Hospital. (Chassin, Tr. 5446-47).
2037. In his analysis, Dr. Chassin did not even consider all of the services provided by Highland Park Hospital. By his own admission he did not have "a listing of every single service they provided." (Chassin, Tr. 5450-5451). Dr. Chassin only focused on areas of improvement and quality problems rather than the overall effect of the merger. (Chassin, Tr. 5450-5452). For example, he did not consider the fertility clinic or the breast center. (Chassin, Tr. 5455).

c. Respondent Failed to Prove That Quality Changes Outweigh the Anticompetitive Effects of the Merger and Even Failed to Offer a Methodology for Making Such a Comparison

2038. Respondent cannot prove that any changes to Highland Park Hospital's quality outweighed the anticompetitive effects of the merger. (Noether, Tr. 6181-83).
2039. While Dr. Noether, Respondent's economic expert, opined that the quality of Highland Park Hospital's hospital services has improved after the merger, she is not an expert in the assessment of clinical quality, and she has never given an expert opinion on whether a hospital's quality has changed over time. (Noether, Tr. 6181-83).
2040. Dr. Noether never compared changes in quality at Highland Park Hospital with changes in quality at other hospitals. (Noether, Tr. 6183).
2041. Dr. Chassin did not provide any method by which one could determine the "value" of the improvements claimed at Highland Park Hospital, in order to weigh them against the price increases. (Chassin, Tr. 5447-49).
2042. Dr. Chassin could not comment on the pricing of hospital services at ENH or Highland Park Hospital after the merger. (Chassin, Tr. 5447).
2043. Mr. Neaman admitted that he never saw any documents correlating the higher prices with the quality changes at Highland Park. (Neaman, Tr. 1241-42).
2044. Respondent did not explain how quality changes at ENH could have offset the larger price increases at ENH relative to other Chicago hospitals. (CX 6279 at 18-20 (
- [REDACTED]
- [REDACTED]
- [REDACTED]

_____)}, *in camera*).

2. Complaint Counsel Presented the Only Quantitative Analysis of Quality, and the Results Prove That Quality Did Not Improve in All of the Areas Where Objective Data Was Available

a. Dr. Romano Is Complaint Counsel's Expert Witness for Quality of Care Issues

2045. The only comprehensive or objective analysis of Respondent's quality claims was provided by Complaint Counsel, through the testimony of a leading quality of care expert, Dr. Patrick Romano. Dr. Romano concluded that there was "no discernible improvement" in quality at Highland Park Hospital and the entire ENH system. (Romano, Tr. 3004-05 (discussing DX 7033 at 2)).
2046. Dr. Patrick Romano is Professor of Medicine and Pediatrics at the University of California Davis School of Medicine. Dr. Romano teaches, among other things, research design and methods, particularly involving health care quality. (Romano, Tr. 2966).
2047. Dr. Romano has been extensively involved in peer review, serving for five years as deputy editor of Medical Care, the official journal of the Medical Care Section of the American Public Health Association. He currently serves on the editorial advisory board of Health Services Research, the official journal of Academy Health. (Romano, Tr. 2967).
2048. Dr. Romano has served as an adviser to the U.S. Health Care Financing Administration ("HCFA"), now the Center for Medicare and Medicaid Services, regarding its analyses of hospital quality and risk-adjusted mortality. He also served as a member of an expert committee funded by HCFA to set performance standards for risk adjustment models that are used in evaluating hospital performance. (Romano, Tr. 2968-69).
2049. Dr. Romano has also served as a member of one of the expert panels convened by the Joint Commission for the Accreditation of Healthcare Organizations ("JCAHO") to help identify appropriate quality measures for use in the hospital accreditation process. He specifically served on a panel related to surgical procedures and complications. (Romano, Tr. 2969).
2050. Dr. Romano has also worked extensively with the U.S. Agency for Healthcare Research and Quality ("AHRQ"), the lead federal agency responsible for developing and promoting methods for quality of care research in the United States. AHRQ maintains a data clearinghouse called HCUP, which consists of data submitted by state health data organizations from around the country. Dr. Romano has served as an advisor for that project to help understand how these data can and should be used. (Romano, Tr. 2969).

2051. AHRQ also puts forth 46 measures of quality of care. (Romano, Tr. 6273). Dr. Romano led the literature review component of the project to assemble evidence regarding the validity of these measures. (Romano, Tr. 6278).
2052. Dr. Romano has also been involved in advising various groups on selecting appropriate quality measures for various purposes. A major thrust in the field is "value-based purchasing," which means linking payment to health care providers with the quality of care offered by the providers. Dr. Romano has assisted a coalition of purchasers with selecting appropriate measures for quality of care-focused purchasing. (Romano, Tr. 2970).

b. Dr. Romano's Analysis of Outcomes

2053. Dr. Romano selected the areas of study for his original report from Respondent's white papers. (Romano, Tr. 3009-10). Dr. Romano studied each of the clinical areas in which an improvement was claimed: 1) cardiac surgery, 2) interventional cardiology, 3) heart attacks, 4) cancer care, 5) emergency care, 6) intensivist coverage, 7) psychiatry and substance abuse care, 8) academic medicine, 9) critical pathways, 10) integration of medical staffs, and 11) so-called "rationalization" of clinical services. (Romano, Tr. 3009 (discussing DX 7033 at 6)).
2054. In Dr. Chassin's expert report, dated November 2, 2004, respondent augmented its claim of improvements by adding several areas ignored in the initial white papers. (Romano, Tr. 3010). According to Dr. Chassin, those white papers, contained "inconsistencies, incompleteness, and inaccuracies with respect to quality." (Chassin, Tr. 5461). Thus, for his rebuttal report, Dr. Romano studied these additional clinical areas, including 12) obstetrics and gynecology, 13) nursing, 14) quality assurance/improvement, 15) physical plant, 16) laboratory medicine and 17) pathology services, 18) pharmacy services, 19) radiology and radiation medicine services, and 20) Epic. (Romano, Tr. 3010 (discussing DX 7033 at 7)).
2055. In forming his opinions in this case, Dr. Romano reviewed a number of documents including those produced by ENH describing various aspects of clinical performance and healthcare quality. (Romano, Tr. 2976). He also reviewed data from the Illinois Department of Public Health ("IDPH"), JCAHO, Health Grades, National Registry of Myocardial Infarction ("NRMI"), the Society of Thoracic Surgeons ("STS"), and patient satisfaction surveys. (Romano, Tr. 2978-82). { [REDACTED] } (Romano, Tr. 3185, *in camera*).
2056. Dr. Romano focused his evaluation principally on Highland Park Hospital since Respondent's claims for quality improvement were specific to Highland Park Hospital, although he also evaluated Evanston Hospital and the ENH system as a whole. (Romano, Tr. 3005).

2057. In carrying out this analysis, however, Dr. Romano evaluated the change in performance at Highland Park Hospital and Evanston Hospitals, the ENH system as a whole, and compared them to the change in performance to a control group of ENH-identified peer hospitals. (Romano, Tr. 6289).

(1) **Dr. Romano Found No Discernible Improvement in Quality of Care at Highland Park After the Merger**

2058. There was "no discernible improvement" at Highland Park Hospital after the merger in many areas of health care quality. (Romano, Tr. 3004). In addition, quality of care possibly deteriorated in some areas of Evanston Hospital and within the ENH system as a whole after the merger. (Romano, Tr. 3005). { [REDACTED] } (Romano, Tr. 3081-84, 3093, 3212-13, *in camera*).

2059. The changes made at Highland Park Hospital after the merger have resulted in a "questionable impact" on outcomes. For the most part, there is no evidence that the structural changes at Highland Park Hospital have benefitted patients in terms of improved outcomes. (Romano, Tr. 3008). { [REDACTED] } (Romano, Tr. 3192, *in camera*).

(a) **There Was No Improvement in Heart Attack Care After the Merger**

2060. To test Respondent's claim that ENH improved cardiac services at Highland Park through the merger, Dr. Romano analyzed both outcome (*e.g.*, mortality) and process data. He concluded that no statistically significant improvement in mortality could be measured systemwide at ENH, or at Highland Park, and that the statistically significant deterioration in mortality at Evanston was correlated with a deterioration in process of care. (Romano, Tr. 3005-07).

2061. { [REDACTED] } (Romano, Tr. 3090-93, 3210-11 (discussing DX 7034A at 1, *in camera*), *in camera*).

2062. { [REDACTED] } (Romano, Tr. 3093, 3204, 3212-13, 6303-04 (discussing DX 7034A at 1, *in camera*), *in camera*).

2063. { [REDACTED]
[REDACTED] } (Romano, Tr. 3077, 3093, 3215, (discussing DX 7034A at 1, *in camera*), *in camera*). { [REDACTED]
[REDACTED] } (Romano, Tr. 3078-79 (discussing DX 7033 at 10, *in camera*), *in camera*).

2064. { [REDACTED]
[REDACTED] }
(Romano, Tr. 3204, 3214-15 (discussing DX 7034A at 1, *in camera*), *in camera*).

2065. { [REDACTED]
[REDACTED] } (Romano, Tr. 3211-12 (discussing DX 7034A at 1, *in camera*), *in camera*).

2066. { [REDACTED]
[REDACTED] }
(Romano, Tr. 6303-04 (discussing DX 440 at 28, *in camera*), *in camera*).

2067. The deterioration of heart attack care at Evanston Hospital after the merger may be explained by the fact that establishment of an interventional cardiology program at Highland Park Hospital might have taken human resources away from Evanston Hospital. (Romano, Tr. 3007-08).

2068. { [REDACTED]
[REDACTED] }
(Romano, Tr. 3081, *in camera*). { [REDACTED] } (Romano, Tr. 6323, *in camera*).

2069. { [REDACTED]
[REDACTED] } (Romano, Tr. 3067-69, *in camera*).

2070. { [REDACTED]
[REDACTED] } (Romano, Tr. 3069, 3080-81, 6319, *in camera*).

2071. Heart attack patients may be treated with aspirin or beta blockers:

1. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3080, *in camera*).

2. { [REDACTED]
[REDACTED] } (Romano, Tr. 3081, *in camera*).

3. { [REDACTED]
[REDACTED] } (Romano, Tr. 3069, *in camera*).

4. { [REDACTED]
[REDACTED] } (Romano, Tr. 3070-71, *in camera*).

2072. { [REDACTED]
[REDACTED] } (Romano, Tr. 3071-72, *in camera*).

2073. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3072 (discussing DX 441 at 82, *in camera*), *in camera*).

2074. Based upon NRMI data:

1. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3081-82 (discussing DX 441 at 83, *in camera*), *in camera*).

2. { [REDACTED]
[REDACTED] } (Romano, Tr. 3083 (discussing DX 441 at 84, *in camera*), *in camera*).

3. { [REDACTED]
[REDACTED]
[REDACTED] }

[REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3083-84 (discussing DX 441 at 85, *in camera*), *in camera*).

4. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3071-72, *in camera*).

i. { [REDACTED]
[REDACTED] } (Romano, Tr. 3083-84 (discussing DX 441 at 86, *in camera*), *in camera*).

ii. { [REDACTED]
[REDACTED] } (Romano, Tr. 3070-71, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3072 (discussing DX 441 at 82, *in camera*), *in camera*).

e. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3079, *in camera*).

2075. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 6324-25, *in camera*). { [REDACTED]
[REDACTED] } (Romano, Tr. 6324, *in camera*).

(b) **ENH's Opening of a Cardiac Surgery Program at Highland Park Hospital May Have Worsened the Quality of Cardiac Surgery at ENH**

2076. { [REDACTED] } (Romano, Tr. 3022-23; Romano, Tr. 3049-51, 3053-54, *in camera*).

2077. Coronary artery bypass graft surgery ("CABG") is a surgical procedure used to restore blood flow to the heart muscle using grafted veins or arteries that come from other body sites. (Romano, Tr. 3022-23).

2078. { [REDACTED] } (Romano, Tr. 3217-18, *in camera*).

2079. { [REDACTED] } (Romano, Tr. 3054-55 (discussing DX 440 at 16, *in camera*), *in camera*). { [REDACTED] } (Romano, Tr. 3046, 3050-01, 3054-55, *in camera*). { [REDACTED] } (Romano, Tr. 3050-51, *in camera*).

2080. { [REDACTED] } (Romano, Tr. 3053-54 (discussing DX 440 at 15, *in camera*), *in camera*).

2081. There are many studies showing that hospitals and surgeons that do more bypass surgery have better outcomes. There is, therefore, an increasing interest in keeping surgical volumes high. (Romano, Tr. 3023). Since the merger, Highland Park Hospital has had problems generating volumes associated with optimal outcomes for the CABG program. (Romano, Tr. 3022).

2082. Several groups have set minimum volume standards for cardiac surgery. For example, the Leapfrog Group set a minimum standard of 450 cases per year. (Romano, Tr. 3025). Also, the American College of Cardiology ("ACC") and the American Heart Association ("AHA") set a minimum standard of 100 cases per year. (Romano, Tr. 3025-26). { [REDACTED] } (Romano, Tr. 3064-65, *in camera*). It should also be noted that ENH's consultant, Bain, set a target volume for cardiac surgery at Highland Park Hospital at 200 cases per year. (CX 1998 at 52).

2083. The volume of bypass surgery performed at Highland Park Hospital in the years 2000, 2001, 2002, and 2003 was consistently and significantly below the ACC/AHA standard. (Romano, Tr. 3026 (discussing DX 7035)).

2084. { [REDACTED] } (Romano, Tr. 3063, *in camera*). { [REDACTED] } (Romano, Tr. 3064-65, *in camera*).

2085. With regard to volumes, New York and Illinois have different approaches to cardiac surgery. New York has a model of very few centers performing very high numbers of open heart procedures. In contrast, the pattern for the State of Illinois is to have heart surgery at virtually every hospital in Chicago, so there are more cardiac surgery programs in Chicago than in the entire State of New York. Dr. Rosengart, who is in charge of ENH's Division of Cardiothoracic Surgery, agreed that the merits of the Illinois approach are debatable. (Rosengart, Tr. 4459-60).

2086. There was even concern among Evanston Hospital cardiologists at the time of the merger that the establishment of a cardiac surgery program at Highland Park Hospital by ENH would spread resources too "thin". (CX 1998 at 21).

(c) There Was No Improvement in Interventional Cardiology at Highland Park Hospital or at ENH As a Whole After the Merger

2087. { [REDACTED] } (Romano, Tr. 3070-72, 3081-84, 3218, *in camera*).

2088. { [REDACTED] } (Romano, Tr. 3218, *in camera*).

(d) There Was No Improvement in the Quality of Obstetrics and Gynecology Care at Highland Park Hospital or at ENH As a Whole After the Merger

2089. { [REDACTED]
[REDACTED]
[REDACTED] }
(Romano, Tr. 3188-89, 3226-28, 3231-32, *in camera*).
2090. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3222-3, *in camera*).
2091. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3189, 3231-32, *in camera*).
2092. The National Perinatal Information Center ("NPIC") is a "non-profit organization which, among other activities, gathers perinatal data from member hospitals – based upon hospital administrative data – from which it provides quarterly comparative data reports." (Amended Glossary of Terms at 8, April 22, 2005).
2093. Dr. Chassin agreed that neonatal mortality rate is a very important measure. (Chassin, Tr. 5466). { [REDACTED]
[REDACTED] } (Romano, Tr. 3188-89, *in camera*). [REDACTED]
[REDACTED] } (Romano, Tr. 3224, *in camera*).
2094. { [REDACTED]
[REDACTED]
[REDACTED] }
(Romano, Tr. 3230-32, *in camera*).
2095. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3187-88 (discussing DX 7037 at 3, *in camera*), *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3187-88 (discussing DX 7037 at 3, *in camera*), *in camera*).
2096. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3226-28, *in camera*).

2097. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3228, *in camera*).

(e) **There Was No Significant Improvement in the Quality of Nursing Services at Highland Park Hospital or ENH After the Merger**

2098. { [REDACTED]
[REDACTED] } (Romano, Tr. 3232-34, *in camera*).

2099. { [REDACTED]
[REDACTED] } (Romano; Tr. 3232-35, *in camera*).

2100. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3233-34, *in camera*).

2101. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3232-33, *in camera*).

(f) **Highland Park Hospital Does Not Perform As Well As Academic Hospitals in Key Outcome Measures**

2102. Respondent has also included as a quality improvement Highland Park Hospital's academic affiliation through ENH with Northwestern University Medical School. (Chassin, Tr. 5376). { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3117, 3121-22, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3123, 3214, 3218-22, *in camera*).

2103. { [REDACTED] } (Romano, Tr. 3118; *in camera*).

(2) **The Validity of Dr. Romano's Analysis**

2104. The validity of Dr. Romano's methodology is supported in the field of hospital quality. (Romano, Tr. 6274-75, 6279-87). [REDACTED] } (Romano, Tr. 3204-09, 6311-12, 6326, *in camera*).

The Validity of the Measurements Used

2105. For his analysis, Dr. Romano used data from the Illinois Department of Public Health ("IDPH"). (Romano, Tr. 2978). Dr. Romano applied this data to his analysis through AHRQ measures that were proven to be valid indicators of quality due to a strong connection between processes of care and outcomes:

1. Heart attack mortality is a valid indicator of quality and is one of the AHRQ measures. (Romano, Tr. 6274-75). Heart attack mortality satisfies the concept of "construct validity" because studies have shown a strong connection between certain treatments or processes of care, and the reduction of mortality after heart attacks. (Romano, Tr. 6279-80). There is similar evidence supporting the validity of cardiac surgery mortality, congestive heart failure mortality, and pneumonia mortality as valid indicators of quality. (Romano, Tr. 6280-81).
2. While the evidence connecting processes of care with outcomes relating to stroke mortality was mixed, it was still strong enough to meet AHRQ's standards for validity and inclusion. (Romano, Tr. 6281-82).
3. Percutaneous Coronary Interventions (PCI) mortality was another AHRQ indicator Dr. Romano used. (Romano, Tr. 6282). AHRQ wanted it included as a measure based on literature showing high volume programs having better outcomes in mortality. (Romano, Tr. 6282).

2106. Other AHRQ measures used by Dr. Romano are considered valid due to the consensus among experts in the field accepting their validity. (Romano, Tr. 6283). In his own work, Dr. Chassin has used similar expert panels to establish by consensual validity the appropriateness of certain types of surgery. (Romano, Tr. 6284). The following measures used by Dr. Romano meet the standard for consensual validity: decubital ulcers, failure to rescue, postoperative hip fractures, selected infections, and birth trauma. (Romano, Tr. 6284-87).

2107. While Dr. Chassin claimed that only six of 46 AHRQ measures were valid, he did not identify the six nor explain why the others were invalid. (Romano, Tr. 6273-74). Dr.

Romano's testimony concerning the validity of the AHRQ measures he used stands undisputed.

2108. Dr. Romano also used two measures from JCAHO in his analysis of the IDPH data, vaginal birth after cesarean (VBAC) and neonatal mortality. (Romano Tr. 6287). An expert panel review led JCAHO to endorse neonatal mortality as a core measure of quality, and JCAHO has specific standards for establishing validity. (Romano, Tr. 6288). JCAHO has also endorsed VBAC as a core measure related to pregnancy and complications. (Romano, Tr. 6287-88).

2109. { [REDACTED] } (Romano, Tr. 6314-15, *in camera*).

2110. { [REDACTED] }

1. { [REDACTED] } (Romano, Tr. 6315-16 (discussing DX 7135 at 1, *in camera*), *in camera*).

2. { [REDACTED] } (Romano, Tr. 6317-18 (discussing DX 7135 at 2, *in camera*), *in camera*).

2111. { [REDACTED] } (Romano, Tr. 3206, *in camera*).

2112. While Respondent has criticized the use of administrative data it is possible to learn a lot more from using administrative data to evaluate risk-adjusted outcomes and quality of care than relying on structural data, a major source for Dr. Chassin's analysis. (Romano, Tr. 3409). In this case, relying on administrative data from the IDPH is more informative than relying strictly on interview data, another major source for Dr. Chassin's analysis. (Romano, Tr. 3411).

Difference in Differences and Risk Adjustment

2113. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3203-05, *in camera*).

2114. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3204, *in camera*).

2115. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3204-05, *in camera*).

2116. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3205-07, *in camera*).

2117. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3208-09, *in camera*).

2118. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3209, *in camera*).

2119. Dr. Chassin criticized Dr. Romano's analysis as offering only a "snapshot" in time and ignoring the trends in performance over a period of time. (Chassin, Tr. 5188-90). In fact, Dr. Romano also followed the trends in each of the quality indicators he used. He so noted in his initial report, and he provided graphs showing this trend analysis. (Romano, Tr. 6290).

2120. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }

[REDACTED] } (Romano, Tr. 6311-12, *in camera*). [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 6312, *in camera*).

2121. { [REDACTED]
[REDACTED] } (Romano, Tr. 6326, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 6328, *in camera*).

(3) Experts in the Field of Quality Measurement, As Well As ENH Itself, Rely Principally on Outcome and Process Measures

- 2122. Dr. Romano's focus on outcomes is consistent with both the consensus of experts in the field and ENH's own practices. Experts in the field of healthcare quality prefer to rely principally on process and outcome measures. Process and outcome measures are often correlated with each other because, when a better process is provided, better outcomes result. (Romano, Tr. 2988-89).
- 2123. Respondent did not show that there was a significant improvement in outcomes after the merger. (Romano, Tr. 3008, 2991-92, 2996).
- 2124. In the quality of care field, terms that are used include "outcome measures," "structural measures," and "process measures." (Romano, Tr. 2986).
- 2125. "Outcome measures reflect what actually happens to patients in the end as a result of the care" given to them. (Romano, Tr. 2987). Patient outcomes measure things like patient mortality, complication rates, and medication event reported rates, which are the results of medical procedures. (O'Brien, Tr. 3556). Process measures reflect what the health professionals do at the bedside in providing care. Structural measures reflect specific characteristics or features of the health care delivery organization. These include physical resources, the training and expertise of the professionals who provide care, and the volume of cases. (Romano, Tr. 2986-87).
- 2126. Structural measures are enabling factors that provide the conditions under which care is delivered. Structural measures are insufficient by themselves to measure quality because they tell us very little about the care that is actually provided to patients. (Romano, Tr. 2988).
- 2127. Dr. Chassin admits that structural changes are "very remote from the actual outcomes that we like to see delivered." (Chassin, Tr. 5152).

2128. { [REDACTED] } (Romano, Tr. 6333-34, *in camera*).
2129. In its Performance Improvement Plan for 2001, ENH defined quality as the "best possible clinical *outcomes* for our patients; satisfaction for all of our many customers; retention of talented staff; sound financial performance." (CX 2052 at 5 (emphasis added); O'Brien, Tr. 3554-55).
2130. Patients care most about what outcomes they get when they go into a hospital. (O'Brien, Tr. 3556). When in past years Mary O'Brien evaluated quality of care in her position as senior vice-president of Evanston Hospital, she looked at outcomes of patient care. (O'Brien, Tr. 3555-56). Dr. Chassin also agreed that outcomes are what we all care about and that we all want to have good outcomes. (Chassin, Tr. 5153, 5461).
2131. As senior vice-president in charge of quality, Ms. O'Brien typically measured outcomes in patient care and compared them to benchmarks, such as NRMI (National Registry of Myocardial Infarction). (O'Brien, Tr. 3556-57).
2132. Prior to the merger, ENH tracked C-section rates, VBAC rates, nosocomial infection rates, and Press Ganey scores in connection with its performance improvement plan. (CX 2436 at 26-28, 4, 30, 36, 37). Prior to the merger, ENH also tracked its neonatal mortality rate, which is a very important measure. (Chassin, Tr. 5465-66).

c. Dr. Romano's Analysis of Patient Satisfaction Data

(1) Dr. Romano's Findings Based on Data from Press-Ganey

2133. In addition to outcomes, another objective measure of quality of care is patient satisfaction data, which was measured numerically by the same vendor, Press-Ganey, at both Evanston and Highland Park, pre- and post-merger. Press-Ganey is a survey research firm focusing on patient satisfaction with health care. Many hospitals contract with Press-Ganey to obtain systematic feedback about processes of care, typically focusing on those that are perceptible to patients. (Amended Glossary of Terms, April 22, 2005 at 10).
2134. { [REDACTED] } (Romano, Tr. 3098, 3109-10, 3116-17, 3127, 3136-38, *in camera*).
2135. { [REDACTED] } (Romano, Tr. 3098, 3109-10, 3116-17, 3127, 3136-38, *in camera*).

2136. Before the merger, Highland Park Hospital had always obtained the highest or second highest patient satisfaction scores in the Northwestern Healthcare Network. (CX 541 at 3). It achieved a score of 90.1% for outpatient services and 84.5% for emergency care in 1997. (CX 541 at 3). In 1998, those scores increased to 100% and 99%, respectively. (CX 542 at 2).

2137. According to a patient satisfaction survey in 1999 by another survey firm, Rhea Kaiser, the percentage of Highland Park Hospital patients who believed that the merger would benefit Highland Park Hospital was 74%, and 4% of those patients felt that the merger would hurt Highland Park Hospital. In a follow up survey in 2002, after the merger, only 50% of Highland Park Hospital patients felt that the merger benefitted Highland Park Hospital, and 19% felt that the merger actually hurt Highland Park Hospital. (Romano, Tr. 3423).

(a) Patient Satisfaction with Nursing Services Declined at Highland Park and Evanston Hospitals After the Merger

2138. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3136-37
(discussing DX 441 at 70, *in camera*), *in camera*). [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3137 (discussing DX 441 at
71, *in camera*), *in camera*).

1. After the merger, patient satisfaction with prompt nursing response declined at Highland Park Hospital, while patient satisfaction with nursing skill declined at Evanston Hospital. (RX 1130).
2. After the merger, by August 2001, ENH considered Highland Park Hospital to be under-performing on its Press-Ganey patient satisfaction survey results for nursing. (RX 1131 at ENH PL 001251). Highland Park Hospital could not score above 50% of their "peer group" in its Press-Ganey survey results at the time, and "well below" the target. (RX 1131 at ENH PL 001251).
3. { [REDACTED]
[REDACTED]
[REDACTED] } (RX 1326 at ENHE JG 015731, *in camera*).

2139. Dr. Chassin agreed that patient satisfaction with nursing care is a useful measure of nursing quality. It is an important outcome measure that we all want to see at the highest possible levels. (Chassin, Tr. 5467).

(b) There Was No Improvement in Patient Satisfaction with Cancer Care Services at Highland Park Hospital After the Merger

2140. { [REDACTED] } (Romano, Tr. at 3098, *in camera*).

2141. Respondent claims to have improved cancer care, not by adding new services, but simply by offering the same services in an allegedly more coordinated fashion. { [REDACTED] } (Romano, Tr. at 3098, *in camera*).

1. { [REDACTED] } (Romano, Tr. 3098, 3101-02 (discussing DX 441 at 98, *in camera*), *in camera*).

2. { [REDACTED] } (Romano, Tr. 3102-03 (discussing DX 441 at 104, *in camera*), *in camera*).

3. { [REDACTED] } (Romano, Tr. 3103 (discussing DX 441 at 105, *in camera*), *in camera*).

4. { [REDACTED] } (Romano, Tr. 3104, *in camera*).

2142. { [REDACTED] } (Romano, Tr. 3104-05, *in camera*; CX 6300).

(c) There Was No Improvement in Patient Satisfaction with Obstetrics and Gynecology at Highland Park Hospital After the Merger

2143. { [REDACTED] } (Romano, Tr. 3127 (discussing DX 7033 at 19, *in camera*), *in camera*). { [REDACTED] } (Romano, Tr. 3127 (describing DX 441 at 1-50 ({ [REDACTED] })), *in camera*), *in camera*).

(d) There Was No Improvement In Patient Satisfaction at Highland Park Hospital in Other Areas After the Merger

2144. { [REDACTED] } (Romano, Tr. 3109-10 (discussing DX 441 at 94, *in camera*), *in camera*).

2145. { [REDACTED] } (Romano, Tr. 3116-17 (discussing DX 441 at 107, *in camera*), *in camera*).

(2) ENH Uses Press-Ganey Data to Measure Patient Satisfaction

2146. ENH also considered patient satisfaction survey results to be outcomes worth analyzing. (RX 1130). { [REDACTED] } (Chassin, Tr. 5433-35; Neaman, Tr. 1136-37, *in camera*).

2147. { [REDACTED] } (Neaman, Tr. 1136, *in camera*; CX 1566 at 4). Press Ganey patient satisfaction scores, JCAHO scores, and academic ratings are important barometers for monitoring quality at ENH. (Neaman, Tr. 1127-28; CX 1566 at 4).

2148. Before and after the merger, ENH typically tracked patient satisfaction using Press Ganey data for key performance indicators. (RX 889 at ENHL PK 016482-83; RX 1445 at ENHL PK 051620-21; CX 2436 at 30, 36, 37; Chassin, Tr. 5433-34, 5435). { [REDACTED] } (Romano, Tr. 3099, *in camera*).

B. Quality Changes Are Exaggerated

1. Dr. Chassin's Qualitative Analysis Was Inadequate

2149. Dr. Chassin's evaluation of quality in this case was principally qualitative rather than quantitative. (Romano, Tr. 3012). For most of his findings, he principally relies on 34 formal interviews with the leadership at ENH, as well as informal conversations with physicians, nurses, and managers during his site visits to Highland Park. (Chassin, Tr. 5161-66). Dr. Chassin used the interviewees' observations of the quality of care at Highland Park before and after the merger for his assessment of the clinical areas he analyzed, such as cardiac surgery, obstetrics and gynecology, and quality assurance. (Chassin, Tr. 5165-68).
2150. Quantitative research in medicine is research that involves numbers and analysis of data describing multiple patients' experience. Qualitative data are data that cannot be easily summarized in numerical form. (Romano, Tr. 3011-12).
2151. In most areas, Dr. Chassin did not follow accepted standards of qualitative research. Dr. Chassin concedes that there are no empirical guides to compare quality of care at Highland Park Hospital before and after the merger. (Chassin, Tr. 5471). For example, Dr. Chassin's sampling strategy was not clearly described or justified and was not comprehensive. (Romano, Tr. 3013).
2152. Sampling strategy is the method used to select participants, who are the individuals from whom information is obtained. It is important for a sampling strategy to be comprehensive so that individuals who are chosen represent the breadth of experience within the organization. (Romano, Tr. 3014).
2153. Dr. Chassin's method was not comprehensive in that the sampling strategy focused largely on administrative, physician, and nursing leadership at ENH. There was very little effort to formally interview people actually in the front lines of providing care. (Romano, Tr. 3015). Also, some interviewees were not with Highland Park before the merger. (Chassin, Tr. 5165).
2154. Dr. Chassin's sampling strategy was inadequate because there was no effort to seek out alternative views or individuals having contradictory opinions who might have a fundamentally different perspective from that of ENH leadership. (Romano, Tr. 3015).

2155. Dr. Chassin did 34 formal interviews during his visits to Highland Park Hospital. Typically one or two attorneys from Winston & Strawn were present during the interviews. Mr. Hillebrand, ENH's Chief Operating Officer, was also present for some of the early interviews. (Chassin, Tr. 5163).
2156. Dr. Chassin's technique of interviewing an employee with a supervisor or an attorney for the employer present is highly problematic. A cardinal principle for any type of interview research is that the interviewee should be interviewed alone without the presence of supervisors or legal counsel. (Romano, Tr. 3015-16).
2157. The Joint Commission for the Accreditation of Healthcare Organizations uses a "tracer methodology" in its site visits of hospitals during the accreditation process. Dr. Chassin did not use this technique, which requires following the patient's course of treatment by the organization. (Romano, Tr. 3016-17).
2158. It is also preferable in qualitative research to have more than one researcher reviewing the same material because the process is so subjective. Dr. Chassin failed to do this. (Romano, Tr. 3017-18).
2159. The evidence also indicates that Dr. Chassin did not seek out observations that might have contradicted or modified his analysis, or if he did, such evidence was not transferred from his written notes to his report. (Romano, Tr. 3018).
2160. Another way that Dr. Chassin's technique was inconsistent with qualitative research methods is that he did not include very much original evidence such as direct quotes from the individuals he interviewed. (Romano, Tr. 3019).
2161. Dr. Chassin's ability to evaluate the quality of care at Highland Park Hospital before the merger was limited by the methodology he selected which involved visiting the hospital and interviewing people in 2004 to try to understand what was happening with quality in 1998 or 1999; many of the people who provided care before the merger have moved to other positions or even other organizations. (Romano, Tr. 3021). For example, Mark Newton, the former Senior Vice President of Highland Park Hospital, was not interviewed. (Chassin, Tr. 5472).
2162. The views of current ENH employees that Dr. Chassin would have talked to during his site visits may have had biased views. (Romano, Tr. 2980).
2163. No peer review technique used in health services research allows a researcher to go into an organization on one date and evaluate the organization's quality of care through site visits as of some date several years earlier. (Romano, Tr. 3021).

2. There Was No Significant Quality Improvement at Highland Park Hospital Due to the Merger¹²

2164. There was no significant quality improvement at Highland Park Hospital due to the merger. (Romano, Tr. 3109-10, 3124, 3174-76, 3233-34; CX 405 at 2). { [REDACTED] } (Chassin, Tr. 5479-80; Silver, Tr. 3831; Romano, Tr. 3142, 3151, 3159, *in camera*).

a. There Was No Significant Quality Improvement in Nursing Services at Highland Park Hospital Due to the Merger

2165. { [REDACTED] } (Romano, Tr. 3136, *in camera*; CX 405 at 8; RX 924 at ENHLMN001411; RX 938 at ENHE F35 000317; RX 1347 at ENHL PK051851, *in camera*).

Pre-Merger

2166. Highland Park Hospital made improvements to its nursing culture before the merger as well as after the merger. (Chassin, Tr. 5479-80).

2167. In April 1998, Highland Park Hospital invited the American College of Obstetricians and Gynecologists ("ACOG") to visit the hospital and review the Family Birthing Center. (Newton, Tr. 390-91; Krasner, Tr. 3752). Highland Park Hospital requested the site visit in response to a 1997 malpractice verdict involving a 1993 incident in the birthing center. (Krasner, Tr. 3733-34). The ACOG review team made many observations relating to nursing care. The ACOG review team was impressed with Highland Park Hospital's "cohesive and comprehensive plan" to improve the quality of care in nursing. (RX 324 at ENHL PK 029765). The review team also found that despite working without a steady nursing leader of the Family Birthing Center before the hiring of Heidi Krasner, nurses at Highland Park Hospital functioned "fairly well." (RX 324 at ENHL PK 029765)

2168. ACOG commended Highland Park Hospital's hiring of nursing leaders such as Heidi Krasner and Janet Stenske. (RX 324 at ENHL PK 029764-029765). The ACOG reviewer team also complimented the Highland Park Hospital Family Birthing Center's cross-training program for its nurses. (RX 324 at ENHL PK 029769).

2169. The ACOG site visit to Highland Park Hospital resulted in a series of recommendations that the hospital began to address with follow-up actions. (Newton, Tr. 391; Spaeth, Tr.

¹² For a discussion on the merger's effect on heart attack care, cardiac surgery and interventional cardiology on Highland Park Hospital and the ENH system, see CCFF 2060-2088, *in camera*.

2116; Krasner, Tr. 3753; CX,98 at 2). Heidi Krasner was involved in implementing some of the recommendations. Three of the ACOG recommendations that Heidi Krasner worked on included a review and revision of policies and procedures, increased fetal monitoring nurse education, and revision of documentation forms to improve nursing documentation. (Krasner, Tr. 3753-54).

2170. { [REDACTED] } (Romano, Tr. 3155-56, *in camera*). { [REDACTED] } (Newton, Tr. 498, *in camera*).

2171. { [REDACTED] } (Newton, Tr. 499, *in camera*). { [REDACTED] } (Newton, Tr. 499, *in camera*).

2172. { [REDACTED] } (CX 6265 at, e.g., 7, 9, 10,16, *in camera*; Newton, Tr. 498-512, *in camera*).

2173. { [REDACTED] } (See CCFF 2174-2176, 2199, *in camera*).

2174. { [REDACTED] } (Romano, Tr. 3157, *in camera*; Newton, Tr. 509; CX 6265 at 18, *in camera*). { [REDACTED] } (CX 6265 at 25, *in camera*).

2175. In connection with its site visit, CHRPP reported on several areas of strength at Highland Park Hospital relating to nursing including:

1. { [REDACTED] } (CX 6265 at 19, *in camera*).

2. { [REDACTED] } (CX 6265 at 21, *in camera*;

Romano; Tr. 3158, *in camera*). [REDACTED]
[REDACTED]
[REDACTED] } (CX 6265 at 21, *in camera*).

2176. [REDACTED]
[REDACTED]
[REDACTED] } (CX 6265 at 19, *in camera*, Krasner, Tr. 3877, *in camera*). [REDACTED]
[REDACTED]
[REDACTED] } (Newton, Tr. 509, 513, *in camera*; O'Brien, Tr. 3672, *in camera*).

2177. Highland Park Hospital had a "high quality nursing staff" in the 1990s. (Newton, Tr. 383. *See also* Dragon, Tr. 4403). As of February 1, 1999, the registered nurse vacancy rate at Highland Park Hospital was only 6.17%. (CX 6264 at 1). [REDACTED]
[REDACTED] } (Romano, Tr. 3136-37, *in camera*).

2178. The ongoing quality improvement efforts in Highland Park Hospital's overall and obstetrical nursing areas before the merger are exemplified by the hiring of Jane Stenske and Heidi Krasner both of whom were good leaders who implemented a number of improvements at Highland Park Hospital. (Krasner, Tr. 3721, 3746-3749) Both the problems and improvements in Highland Park Hospital's nursing services continued post-merger. (Chassin, Tr. 5480-81).

Post-Merger

2179. [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3233-34, *in camera*). [REDACTED]
[REDACTED] } (Romano, Tr. 3136, *in camera*).

2180. [REDACTED]
[REDACTED] } (CX 405 at 8; RX 924 at ENH MLN 001411; RX 900 at ENH GW 000528; RX 938 at ENHE F35 000317; RX 1347 at ENHL PK051851, *in camera*).

2181. Even six months after the merger in January 2000, Highland Park Hospital still had a high nursing vacancy rate of 11.4%. (RX 900 at ENH GW 000528).

2182. Even after the merger, a Highland Park Hospital nurse, Linda Morris, noted in an August 2000 letter to Mark Neaman that the "environment is very negative and the nursing staff [is] very frustrated with staffing issues of professional and support staff." (RX 924 at ENHLMN001411). She noted that she was not able to attend nursing orientation until almost a month after she started at Highland Park Hospital in June 2000, and there was no

nursing orientation at Highland Park Hospital when she started there. (RX 924 at ENHLMN001411).

2183. There were problems with nursing turnover and high nursing vacancy rates at ENH after the merger; physicians were concerned about morale issues and how the nursing turnover would effect nursing staffing and quality of care provided to patients. (RX 938 at ENHE F35 000317).

2184. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (RX 1347 at ENHL PK051851, *in camera*).

2185. Highland Park Hospital physicians complained in 2002, two years after the merger, that nursing staff was "understaffed and underachieving." (CX 405 at 8).

b. There Was No Significant Quality Improvement in Obstetrics and Gynecology at Highland Park Hospital Due to the Merger

2186. { [REDACTED]
[REDACTED] } (Krasner, Tr. 3748; Silver, Tr. 3929-31, *in camera*; O'Brien, Tr. 3672).

2187. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3188-89, 3224, 3226-28, 3230-32, *in camera*). [REDACTED]
[REDACTED] } (Romano, Tr. 3127 (discussing DX 7033 at 19, *in camera*), *in camera*).

Pre-Merger

2188. Prior to the merger, there were ongoing efforts at Highland Park Hospital to improve the quality of care in obstetrics. (Silver, Tr. 383; Chassin, Tr. 5498).

2189. In the late 1990s, Highland Park Hospital had a good obstetrics program. The hospital had a "unique," renovated OB department and a comprehensive obstetrics program. Highland Park also had relationships with a perinatal network and advanced pediatric coverage. (Newton, Tr. 389). According to Dr. Silver, Chairman of ENH's OB/GYN Department, there were, prior to the merger, a number of good physicians in the Highland Park Hospital OB department. (Silver, Tr. 3831).

2190. An outside consultant to ENH, Bain, described Highland Park Hospital's obstetric and neonatology facilities as "excellent" in a reported dated January 6, 2000, just days after the merger was consummated. (CX 1998 at 11).
2191. { [REDACTED] } (Newton, Tr. 511, *in camera*). { [REDACTED] } (Newton, Tr. 511, *in camera*).
2192. { [REDACTED] } (Romano, Tr. 3132, *in camera*).
2193. Before the merger, Dr. Silver did attend meetings at Highland Park Hospital to review high-risk cases related to the Illinois perinatal network, and he was not aware of any individual cases at Highland Park Hospital prior to the merger where there were deficiencies in the quality of care in the OB department. (Silver, Tr. 3832). He has never discovered any deficiencies, based on any data used by Highland Park Hospital prior to the merger to measure quality, at Highland Park Hospital's OB department prior to the merger. (Silver, Tr. 3832).
2194. Evanston Hospital has "high-risk" obstetrics patients as well as a "high-risk" nursery. (Silver, Tr. 3771). Before the merger, Highland Park Hospital referred its high-risk obstetrics cases to Evanston Hospital. (Neaman, Tr. 1306-07, Silver, Tr. 3829). After the merger, the high-risk cases are still handled by Evanston Hospital rather than Highland Park Hospital. Highland Park Hospital does not have a specialty care nursery post-merger – the nursery continues to be located at Evanston Hospital. (Silver, Tr. 3829).
2195. The ACOG report commended Highland Park Hospital's changes in nursing leadership before the merger, stating that such changes made it more likely for Highland Park Hospital to establish a center of excellence for women's and children's services. (RX 324 at ENHL PK 029763).
2196. { [REDACTED] } (RX 365 at ENHRS003456, *in camera*).
2197. Highland Park Hospital made many improvements in its obstetrics and gynecological department in a period of less than a year and a half, between May 1998 (the time of the ACOG visit) and September 1999 (the time of the CHRPP visit). { [REDACTED] }

[REDACTED]
[REDACTED]
[REDACTED] } (CX 6265 at 20, *in camera*).

2198. { [REDACTED]
[REDACTED] } (Newton, Tr. 508-09, *in camera*).

2199. { [REDACTED]
[REDACTED] } (CX 6265 at 25, *in camera*).

2200. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3133, *in camera*).

2201. There is no literature yet on the link between ENH's preoperative review program and patient outcomes. It is also not possible to compare ENH's preoperative review program to any national benchmarks. (Silver, Tr. 3852).

Post-Merger

2202. { [REDACTED]
[REDACTED] } (Krasner, Tr. 3748; Silver, Tr. 3842, 3857-58; Silver, Tr. 3929, *in camera*; O'Brien, Tr. 3672).

2203. After the merger, there continued to be nursing vacancies at Highland Park Hospital while Heidi Krasner was in the family birthing center. (Krasner, Tr. 3748). Highland Park Hospital still uses agency nurses after the merger. (O'Brien, Tr. 3672).

2204. ENH claims that the institution of in-house physician coverage was a major improvement of the merger, but in fact, ENH operated the obstetrics and gynecology department at Highland Park Hospital from the time of the merger, January 1, 2000, until the summer of 2001 without in-house physician coverage. (Silver, Tr. 3841-42).

¹³ See CCFF 2174-2176, *in camera*.

2205. { [REDACTED]
[REDACTED]
[REDACTED] } (Silver, Tr. 3929-39, *in camera*; RX 2034, *in camera*).

2206. Although Respondent claimed that it improved quality at HPH by eliminating the practice of performing D&C procedures (dilation and curettage, or the surgical evacuation of miscarriages) in the emergency room, ENH allowed physicians to perform D&Cs in the emergency room at Highland Park Hospital from the time of the merger until after the Spring of 2001. (Silver, Tr. 3781, 3857-58). In addition, ENH allowed certain second trimester abortions to be performed in labor and delivery at Highland Park Hospital until at least the Spring of 2001. (Silver, Tr. 3857-58).

2207. ENH's improvements to Highland Park Hospital's obstetrics and gynecology department did not take place until long after the merger. The critical pathways or protocols for OB were not even "published to the physicians," much less fully implemented, until between September of 2001 to May 2004. (Silver, Tr. 3845). A full-time chairperson was not installed at Highland Park Hospital until spring 2001. (Silver, Tr. 3841). In-house obstetrician coverage was not implemented until the summer of 2001. (Silver, Tr. 3842).

2208. { [REDACTED]
[REDACTED]
[REDACTED] } (Neaman, Tr. 1401-02, *in camera*; CX 1033 at 1-2, *in camera*).

c. There Was No Significant Improvement in Highland Park Hospital's Quality Assurance Activities Due to the Merger

2209. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] }
(Romano, Tr. 3159, *in camera*).

2210. Prior to the merger, Highland Park Hospital had a system in place to keep track of the quality of care at the hospital. (Spaeth, Tr. 2090). The medical staff at Highland Park Hospital prior to the merger was fairly interested in improving the quality of care at the hospital. (Spaeth, Tr. 2095). [REDACTED]
[REDACTED] } (Romano, Tr. 3142, *in camera*; CX 6296 at 10-22, *in camera*). Highland Park Hospital would also discipline problematic physicians before the merger. (Newton, Tr. 381-383). [REDACTED]
[REDACTED] } (See, e.g., CX 464 at 2-3, *in camera*).

Pre-Merger

2211. { [REDACTED] } (Romano, Tr. 3145, *in camera*).

2212. { [REDACTED] } (Romano, Tr. 3142, *in camera*). { [REDACTED] } (Romano, Tr. 3146, *in camera*; CX 6296 at 3-6, *in camera*). { [REDACTED] } (Romano, Tr. 3151, *in camera*; CX 6296 at 3-6, *in camera*).

2213. { [REDACTED] } (*See, e.g.*, RX 346 at ENHL PK 024709, *in camera*). { [REDACTED] } (RX 414 at ENHL PK 039155, 039164, *in camera*).

2214. Before the merger, Highland Park Hospital undertook an internal program to examine and improve quality. (RX 417 at ENHL PK 017693). Through this program, Highland Park Hospital self-identified problems in the quality of care it provided to patients and process to improve quality. (RX 417 at ENHL PK 017694-017697).

2215. Highland Park Hospital, analyzed the quality of care it provided and actively sought to improve the quality of its services. (RX 178 at ENHL PK 015618-015621). { [REDACTED] } (RX 204 at ENHL PK 031140, *in camera*).

2216. The 1999-2002 Strategic Plan for Highland Park Hospital included attention to providing documented and measurable outcomes of quality that exceeded those of the competition. This would be accomplished by creation of additional clinical pathways and changing the way care was provided. (Newton, Tr. 331-32; CX 1868 at 12).

2217. Highland Park Hospital reviewed outliers before the merger, which are cases that lie outside the norm for a particular illness. Highland Park Hospital also looked at partial negative outcomes which is where expectation of the patient's recovery was not 100%. In these instances, the hospital looked at "pieces of the care that was rendered" in order to determine if the physician provided the proper care. (Spaeth, Tr. 2092).
2218. Before the merger, Highland Park Hospital kept track of quality of care through case reviews by physicians. These reviews identified problem cases that might end up with the hospital mentoring the physician. The hospital also looked at cases over time as to trends with regard to possible outcomes. (Spaeth, Tr. 2090-91).
2219. At Highland Park Hospital prior to the merger, the board of directors would credential and re-credential physicians based upon the recommendation of the medical executive committee and the department chairmen. Prior to the merger, there was also a committee in place that had Board members and members of the medical staff leadership that would look at quality issues and peer review issues. (Newton, Tr. 381).
2220. At Highland Park Hospital prior to the merger, there was also a Vice President of the medical staff administration who would work with department chairmen "to make sure they effectively conducted their professional responsibilities." (Newton, Tr. 381). At Highland Park Hospital during the 1990s, there were disciplinary actions taken against physicians practicing at Highland Park. Such actions included reduction of privileges, suspension of privileges, or removal from staff. (Newton, Tr. 382-83).
2221. In the late 1990s, Highland Park Hospital had a specific quality assurance program for its obstetrics department that included a set of processes by the medical staff (peer review, chart review, re-credentialing), reviews through the neonatal network, reviews through CHRPP's standard elements program, and an internal program that looked at any "sentinel events." (Newton, Tr. 392). There were ongoing efforts at Highland Park Hospital before the merger to improve the quality of care in the OB/Gyn department. (Silver, Tr. 3831).
2222. Information obtained through Highland Park Hospital's quality assurance efforts in the obstetrics department would be distributed to the joint conference committee of the medical staff and to the hospital's board of directors. This information would not be ignored but would be addressed. (Newton, Tr. 392-93).
2223. { [REDACTED] } (Romano, Tr. 3154, *in camera*). { [REDACTED] } (Romano, Tr. 3155, *in camera*).

2224. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3155, *in camera*). { [REDACTED]
[REDACTED] } (Romano, Tr. 3155-56, *in camera*).

2225. Up until the time of the merger in 2000, the various clinical departments of medicine at Highland Park Hospital selected their chairmen from among private practitioners on the medical staff. Highland Park Hospital's practice of choosing its clinical department chairmen from among the private practitioners on the medical staff did not present a problem for assuring quality of care. (Newton, Tr. 379-80).

2226. It does not make any difference to quality of care if a hospital chooses its department chairmen from among private practitioners who are on the medical staff, or directly employs the chairmen, because physicians are professionals who go through a peer review process. (Newton, Tr. 380). Most community hospitals have elected officers, and JCAHO has not taken a position that elected medical staff officers are adverse to quality. (Spaeth, Tr. 2315).

Post-Merger

2227. { [REDACTED]
[REDACTED] } (Romano, Tr. 3142, 3151, 3159, *in camera*).

2228. Even after the merger, physicians at Highland Park Hospital complained of lack of communication regarding policy, ineffective leadership, and no representation in ENH. (CX 405 at 2) They also complained about the Quality Control committee being moved out of Highland Park Hospital after the merger. (CX 405 at 6).

2229. { [REDACTED]
[REDACTED] } (CX 464 at 2, *in camera*).
{ [REDACTED]
[REDACTED] } (CX 464 at 3, *in camera*)

2230. As of February 2004, Mark Neaman, ENH's CEO, was still addressing organizational and leadership problems in its Cardiology Department resulting in a "toxic" and dysfunctional environment in the department that had existed for years without ever being fixed. These problems had become an issue in ENH's attempts to keep Dr. Vatopka at ENH. (CX 773 at 1). Dr. Vatopka was a cardiac surgeon at ENH who subsequently left ENH to start a new program of his own. (Rosengart, Tr. 4441).

2231. Prior to the merger, cardiologists practicing at ENH agreed that operations at Evanston Hospital needed improvement. (Neaman, Tr. 1177 (discussing CX 1998 at 22)). Also, the performance of the cath lab at ENH was poor versus ENH's key competitors and needed improvement. (Neaman, Tr. 1177-78 (discussing CX 1998 at 24)).

d. There Was No Significant Improvement in Highland Park Hospital's Quality Improvement Activities Due to the Merger

2232. { [REDACTED] } (Romano, Tr. 3168-70, *in camera*; Krasner, Tr. 3746-48; O'Brien, Tr. 3561-62; RX 284 at ENHL PK 026595-96).

Pre-Merger

2233. There were ongoing quality improvement efforts at Highland Park Hospital prior to the merger. (Krasner, Tr. 3746-48; RX 284 at ENHL PK 026595-026596). Before the merger, Highland Park Hospital's quality improvement activities included a drive toward clinical best practices through the use of guidelines on care or care maps. (O'Brien, Tr. 3562).

2234. { [REDACTED] } (RX 253 at ENHL PK 031272-031273, 031283, *in camera*).

2235. { [REDACTED] } (RX 442 at ENH RS 004658, *in camera*).

2236. Before the merger, Highland Park Hospital looked at quality indicators such as the length of time in the operating room and the time spent by a patient in the cath lab. Highland Park Hospital also tracked Press Ganey scores prior to the merger. (Spaeth, Tr. 2092-94).

2237. There were ongoing quality improvement efforts prior to the merger especially in Highland Park Hospital's obstetrics and nursing areas:

1. In 1997, Highland Park Hospital hired Jane Stenske as vice president of nursing, who was a good hire for Highland Park Hospital, supportive of nursing at Highland Park Hospital, and a good leader at the hospital prior to the merger. (Krasner, Tr. 3746-47). Ms. Stenske instituted a 24 hour/day seven days per week nursing on-call program before the merger. (Krasner, Tr. 3746).
2. In 1997, Highland Park Hospital also hired Heidi Krasner as the clinical nurse manager in the Family Birthing Center to improve nursing in the birthing center.

(Krasner, Tr. 3691, 3747). Ms. Krasner did a good job and accomplished quite a bit prior to the merger while working at Highland Park Hospital. (Krasner, Tr. 3747).

3. Before the merger, Ms. Krasner successfully filled most of the nursing vacancies in the Family Birthing Center. (Krasner, Tr. 3721, 3748). Ms. Krasner also began to cross-train nurses, trained nurses to scrub in the operating room, and provided training programs to build the nursing staff's clinical competence. (Krasner, 3721, 3748-49).

2238. One aspect of ENH's claims of quality improvement are its "critical pathways."
{ [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3166, *in camera*). A critical care pathway is a "map" of a suggested course of action for a specific disease or a specific problem. Its use is not mandated, but is developed as a best practices technique. (Ankin, Tr. 5054-55). Critical pathways are always being revised. (O'Brien, Tr. 3561-62).

2239. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3168, *in camera*).

2240. There is no evidence that ENH's critical pathways are better than the care maps used by Highland Park Hospital before the merger. (O'Brien, Tr. 3560-62).

2241. Even before the merger, Highland Park improved upon its care maps and was creating new ones. (CX 95 at 3).

2242. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3168, *in camera*).

2243. { [REDACTED]
[REDACTED] } (Romano, Tr. 3169, *in camera*).

2244. { [REDACTED]
[REDACTED] } (Romano, Tr. 3169, *in camera*).

Post-Merger

2245. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3170, *in camera*).

- 2246. In practice, the reviews are mixed on what critical pathways can accomplish in obstetrics and gynecology. For example, a typical delivery pathway may not be helpful with a heterogeneous patient mix. Complicating factors in patients may delay the various steps of a pathway from being implemented. (Silver, Tr. 3839).
- 2247. Implementation of a majority of ENH critical pathways was not complete until August 2002, more than two years after the merger, with 14 of those 33 pathways not implemented until between October 2001 and August 2002. (RX 1357 at ENHE F42 021021).
- 2248. While HPH requested a site visit from ACOG before the merger to aid its quality improvement efforts in obstetrics and gynecology, ENH has not requested an ACOG site visit for HPH after the merger. (Krasner, Tr. 3752).

e. There Was No Significant Quality Improvement in Laboratory Medicine and Pathology Services Due to the Merger

- 2249. There is no evidence that the quality of laboratory and pathology services at Highland Park Hospital improved because of the merger. (Victor, Tr. 3642-44).
- 2250. Prior to the merger, Highland Park Hospital and Lake Forest Hospital operated a lab called Consolidated Medical Laboratories ("CML") as a joint venture. (Victor, Tr. 3638-39). CML had a main lab located at Lake Bluff and an immediate response lab at each hospital. (Victor, Tr. 3639). After the merger, ENH converted the laboratory at Highland Park Hospital to a full-service lab. (Victor, Tr. 3640-41).
- 2251. An immediate response lab just does "stat" testing, which is testing that must be performed immediately. (Victor, Tr. 3639-40). For situations that are not urgent, a lab specimen can safely be sent off-site for testing. (Victor, Tr. 3640).
- 2252. Before the merger, there were two separate hospitals that each had an interest in the performance of Consolidated Medical Laboratories. (Victor, Tr. 3640).
- 2253. Prior to the time that ENH took over the management of the lab at Highland Park Hospital, Dr. Victor, the Chairman of the Clinical Pathology Department at ENH, had not been to Highland Park Hospital's lab to assess its quality. (Victor, Tr. 3642).
- 2254. Dr. Victor had no statistics to back up any claim that turnaround time at the lab at Highland Park Hospital was longer before June 1, 2000, that it was after that date. He

also had no statistics to show to what extent there were mislabeled specimens at the Highland Park Hospital lab prior to June 1, 2000. Dr. Victor's overall view of quality improvement at Highland Park Hospital's lab after June 1, 2000, was not based upon any statistics or studies. (Victor, Tr. 3643-44).

f. There Was No Significant Quality Improvement in Oncology at Highland Park Hospital Due to the Merger

2255. { [REDACTED]
[REDACTED] } (Dragon, Tr. 4406; O'Brien, Tr. 3565, 3568-69; Romano, Tr. 3097-98, *in camera*). { [REDACTED]
[REDACTED] } (Romano, Tr. 3097, *in camera*; Dragon, Tr. 4390-91).

2256. The Kellogg Cancer Care Center at Highland Park Hospital is an outpatient facility. (Dragon, Tr. 4405). { [REDACTED]
[REDACTED] } (Romano, Tr. 3097-98, *in camera*). { [REDACTED]
[REDACTED] } (Romano, Tr. 3097-98, *in camera*). { [REDACTED]
[REDACTED] } (Romano, Tr. 3097, *in camera*).

2257. { [REDACTED]
[REDACTED] }
(Romano, Tr. 3098, *in camera*).

2258. { [REDACTED]
[REDACTED] } (Romano, Tr. 3097, *in camera*).

2259. Dr. Dragon is the medical director of the Kellogg Cancer Care Center at Highland Park Hospital, a position he has held since December 2002. (Dragon, Tr. 4306). Dr. Dragon was in private practice when he first became credentialed to practice at Highland Park Hospital in 1999. (Dragon, Tr. 4304).

2260. After Dr. Dragon became director of the Kellogg Cancer Care Center in December 2002, the Center moved into the office space that Dr. Dragon had been using for his private practice, which was located in the medical office building across the street from Highland Park Hospital. (Dragon, Tr. 4389). It was not until February 2005 that the Kellogg Cancer Care Center moved to its present location. (Dragon, Tr. 4390).

- 2261. Dr. Dragon's patients, before the merger, could obtain complementary services such as counseling, dietary services, pharmacy services, and psycho-social services in the Highland Park area. These services are those that are predominantly used in conjunction with the provision of Dr. Dragon's services after the merger. (Dragon, Tr. 4390-91).
- 2262. Patient outcome measures for oncology include survival rates, symptom management, and quality of life. ENH as an institution does not look at these measures on a regular basis. (Dragon, Tr. 4397-98). Dr. Dragon had no measurements beyond his own personal observations to compare quality of life before 2002 with quality of life after 2002. (Dragon, Tr. 4406).
- 2263. Mary O'Brien, President of Highland Park Hospital, did not know how bringing the Kellogg Cancer Care Center to Highland Park Hospital impacted patient outcomes for cancer care. (O'Brien, Tr. 3565). She was also unaware of what the patient outcomes for cancer care were at Highland Park Hospital before the merger. (O'Brien, Tr. 3568).

g. There Was No Significant Quality Improvement in Emergency Care at Highland Park Hospital Due to the Merger

- 2264. { [REDACTED] } (Harris, Tr. 4283-84; Romano, Tr. 3109-10, *in camera*).
- 2265. { [REDACTED] } (Romano, Tr. 3109-10, *in camera*). Highland Park Hospital already had a good emergency department before the merger. (Harris, Tr. 4264-67, 4271).
- 2266. Before the merger, quality in the Highland Park Hospital emergency department was monitored to make sure it was at a level the department felt was acceptable for its internal standards and any area-wide standards. (Harris, Tr. 4209).
- 2267. Prior to the merger, Highland Park Hospital had a formal QA/QI program which measured the quality of care offered at Highland Park Hospital's emergency room. The emergency room had a variety of indicators to monitor performance. (Harris, Tr. 4264-65).
- 2268. One indicator of Highland Park Hospital's emergency room pre-merger QI program was turn-around time, which is the time from when the patient comes into the door until the time the patient leaves, is transferred, or admitted. (Harris, Tr. 4266).
- 2269. Highland Park Hospital made improvements to the emergency room pre-merger. For example, around 1995 or 1996, the Highland Park Hospital emergency department instituted changes to expedite the treatment of patients with minor injuries and illness. This was the fast-track program. The fast-track program reduced the turn-around time for

patients. (Harris, Tr. 4266). Implementing the fast-track program pre-merger and adding physician assistants to the emergency department in 1997 were significant improvements to the department. (Harris, Tr. 4267).

2270. Highland Park Hospital implemented fast-track procedures prior to the merger partially as a result of survey responses received from Press Ganey. The Press Ganey survey was "one more piece of information" used to make decisions. (Harris, Tr. 4270). Prior to the merger, Highland Park Hospital also streamlined the X-ray procedure in the emergency department, also partially as a result of survey responses received from Press Ganey. (Harris, Tr. 4270-71.)

2271. Even before the merger, there were times when Highland Park Hospital would have more than one physician present in the emergency room. (Harris, Tr. 4277).

2272. Dr. Harris did not see or was not aware of any:

1. Studies that compared clinical outcomes of patients who used the Highland Park Hospital emergency room prior to the renovations with the clinical outcomes after the renovation. (Harris, Tr. 4283).
2. Data that compared Highland Park Hospital's emergency room pre-merger and post-merger turn-around times, the turn-around times of fast-track patients, or the amount of time it took a patient to get an EKG. (Harris, Tr. 4283-84).
3. Instance in which a patient transferred from Highland Park Hospital prior to the merger had a worse clinical outcome because of the transfer. (Harris, Tr. 4287-88).

h. There Was No Significant Quality Improvement in Intensive Care at Highland Park Hospital Due to the Merger

2273. There is little evidence showing that the ENH's merger with Highland Park Hospital has improved the quality of intensive care at Highland Park Hospital. (Ankin, Tr. 5091-92).

2274. Dr. Ankin is the President of Pulmonary Physicians of the North Shore. (Ankin, Tr. 5033). Pulmonary Physicians of the North Shore is the physician group that contracted with ENH to provide intensivist coverage at Highland Park Hospital after the merger. (Ankin, Tr. 5103-04). Dr. Ankin considers himself to be an intensivist although he is not certified as one. (Ankin, Tr. 5038).

2275. An intensivist is a physician who focuses his practice on the care of critically ill or injured individuals. (Ankin, Tr. 5035).

2276. Prior to the merger, Highland Park Hospital had a physician at the hospital during nighttime and weekend hours who would evaluate patients in the ICU and talk to the attending physician. (Ankin, Tr. 5058).
2277. Dr. Ankin did not try to determine how much, if at all, mortality rates have improved for Highland Park Hospital since the intensivist program was implemented in 2001. (Ankin, Tr. 5091). In addition, Peggy King, a Senior Vice President at ENH and quality coordinator, did not approach Dr. Ankin about ascertaining how outcomes at Highland Park Hospital changed since the merger. (Ankin, Tr. 5091-92).
2278. ENH operated the Highland Park Hospital intensive care unit without intensivists from January 2000 until the spring of 2001. (Ankin, Tr. 5078-79). It also did not start an intensivist program at Glenbrook Hospital until the same time it implemented the program at Highland Park Hospital. (Ankin, Tr. 5085). ENH implemented the intensivist program only after it was recommended, in 2001, by a national organization. (RX 1097 at ENHL PK 016335). (See CCFF 2393).

i. There Was No Significant Quality Improvement in Pharmacy Services at Highland Park Hospital Due to the Merger

2279. { [REDACTED] } (Kent, Tr. 4936; RX 1326 at ENHE JG 015738, *in camera*; CX 1034 at 10; Romano, Tr. 3181, *in camera*).
2280. Medication error rates are one of the things that ENH's pharmacy department looks at to evaluate its pharmacy services. (Kent, Tr. 4878-79).
2281. { [REDACTED] } (Romano, Tr. 3181, *in camera*; CX 1034 at 10).
2282. { [REDACTED] } (Kent, Tr. 4936, *in camera*; RX 1326 at ENHE JG 015738, *in camera*).

j. There Was No Significant Quality Improvement in Psychiatric Care at Highland Park Hospital Due to the Merger

2283. { [REDACTED] } (Romano, Tr. 3115-16, *in camera*).
2284. { [REDACTED] }

[REDACTED]
[REDACTED] } (Romano, Tr. 3115, *in camera*).

2285. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3116-17, *in camera*).

k. The Merger Did Not Significantly Improve the Quality of Care at Highland Park Hospital Because of the So-Called Clinical "Rationalization"

2286. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3174-76, *in camera*),

2287. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3174, *in camera*).

2288. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3174-75, *in camera*).

2289. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3176, *in camera*).

l. There Was No Significant Quality Improvement at Highland Park Hospital by Virtue of Academic Affiliation

2290. { [REDACTED]
[REDACTED] } (Romano, Tr. 3124-25, *in camera*).

2291. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3118, *in camera*).

2292. { [REDACTED] } (Romano, Tr. 3124, *in camera*).

2293. { [REDACTED] } (Romano, Tr. 3118, *in camera*). { [REDACTED] } (Romano, Tr. 3124, *in camera*).

C. The Quality Changes Are Not Merger Specific Because Highland Park, on Its Own Or with Others, Could Have Achieved the Same Quality Changes

2294. The quality changes are not merger specific because Highland Park Hospital could have achieved the same quality changes on its own or through another affiliation. (CX 92 at 3, 12, 20; CX 541 at 1; CX 545 at 3; CX 98 at 1-2).

1. Highland Park Hospital Was Already a Good Hospital Before the Merger

2295. Highland Park Hospital was already a good hospital before the merger that, pre-merger, added new clinical services and made improvements. (Newton, Tr. 292, 293, 376, 377, 388; CX 2415 at 2-9; CX 1052 at 4-5; CX 98 at 2; CX 96 at 1; Spaeth, Tr. 2102-05, 2110-11, 2113-17, 2120-22; Ballengee, Tr. 185). Prior to the merger, both Highland Park Hospital and Evanston Hospital were pretty good hospitals. (Ballengee, Tr. 160).

2296. Mr. Newton stated that even before the merger Highland Park Hospital wanted to be recognized by the consuming public as maintaining a high level of quality due to the pressure to be included in health plan networks. (Newton, Tr. 303-05). If a hospital had a "poor image of quality" among enrollees, that perception would be transmitted back to the health plans. (Newton, Tr. 304-05).

2297. JCAHO is the Joint Commission for the Accreditation of Healthcare Organizations, which is the entity responsible for accrediting hospitals and certain other types of healthcare organizations in the U.S. (Romano, Tr. 2969).

2298. Quality at Highland Park Hospital from 1977 to 1985 (Ms. Ballengee's time at the hospital) was good. (Ballengee, Tr. 185-86). Highland Park Hospital did very well with its JCAHO evaluations from 1977 to 1985. During this time period, the hospital never failed to pass JCAHO standards. (Ballengee, Tr. 151-52).

2299. The quality of care at Highland Park Hospital up until the year 2000 was "very good, if not excellent." (Newton, Tr. 376). The hospital was well-respected in the community and considered by many to be one of the "finest community hospitals in the country." (Newton, Tr. 301. *See also* Spaeth, Tr. 2095). There was never a time between 1988 and 2000 (Mr. Newton's time at the hospital) when Highland Park Hospital did not have JCAHO accreditation. (Newton, Tr. 386).
2300. In its accreditation process, JCAHO looks at about 1200 very specific aspects of hospital activities that are called elements of performance. (Chassin, Tr. 5156-57). Roughly 75% of JCAHO's elements of performance are structural in nature, and the remaining 25% are process measures. (Chassin, Tr. 5157).
2301. In 1999, Highland Park Hospital received a preliminary JCAHO accreditation score of 95, an exceptional outcome. (Neaman, Tr. 1198; Newton, Tr. 388; Spaeth, Tr. 2122; CX 96 at 1; CX 2304 at 3). Neele Stearns, the Chairman of the Board of Highland Park Hospital, also characterized the 95 score as exceptional in his report to the Highland Park Hospital Board. (CX 96 at 1; Spaeth, Tr. 2149).
2302. { [REDACTED] } (RX 412 at ENHL PK 017794, *in camera*)
2303. ENH received a preliminary score of 94 on the JCAHO preliminary report for its 1999 survey. (Neaman, Tr. 1231; CX 871 at 4). ENH's final JCAHO score as of February 2000 was 95. (Neaman, Tr. 1198; CX 6 at 5). ENH's CEO, Mark Neaman, considers a JCAHO score of 95 to be exceptional. (Neaman, Tr. 1198).
2304. ENH considers the four most significant entities that measure quality of care at hospitals to be JCAHO, Medicare, Press Ganey, and Leapfrog. (Neaman, Tr. 1226). Among these four, ENH places most significance on the JCAHO analysis. (Neaman, Tr. 1227).
2305. Most hospitals in the country use JCAHO scores to look at quality of care. (Spaeth, Tr. 2154).
2306. In 1996, before the merger, Highland Park Hospital scored a 93 out of 100 on a JCAHO survey. (RX 178 at ENHL PK 015620)
2307. The community of Highland Park and the other communities surrounding Highland Park Hospital respected the hospital and saw value in the hospital. (Neaman, Tr. 1228-29; CX 874 at 5 (February 23, 1999, Evanston board meeting minutes reflecting that "Highland Park is a strong community hospital"))).
2308. Highland Park Hospital was recognized by patients before the merger as rendering more sophisticated medical care than the average community hospital. (Spaeth, Tr. 2095).

Many people before the merger viewed Highland Park Hospital as a high quality institution rendering high quality care. (Spaeth, Tr. 2098).

2309. Ronald Spaeth is employed by ENH as the President of the Evanston Northwestern Healthcare Foundation. He formerly served as the Chief Executive Officer of Highland Park Hospital from 1983 up to and including the time of the merger. (Spaeth, Tr. 2235-36). Mr. Spaeth agrees that Highland Park Hospital "was a good community hospital" before the merger (Spaeth, Tr. 2095).
2310. Other clinical administrators employed by or affiliated with ENH also agree that Highland Park Hospital was a good hospital before the merger. For example, Dr. Dragon, Medical Director of the Kellogg Cancer Care Center at Highland Park Hospital, agrees that Highland Park Hospital was a "good quality community institution" before the merger. (Dragon, Tr. 4402-03). Similarly, Dr. Ankin, who provides the intensivist coverage at Highland Park Hospital through his group, Pulmonary Physicians of the North Shore, agrees that before the merger, Highland Park Hospital was a good hospital. (Ankin, Tr. 5087-88).
2311. Prior to the merger, Highland Park Hospital sought to recruit the best physicians, to render the most effective experience for a patient, to have the best outcomes for its patients, and to have the highest quality at the hospital. (Spaeth, Tr. 2089).
2312. Both Mark Neaman and Ronald Spaeth agree that prior to the merger, Highland Park Hospital had good doctors on staff. (Neaman, Tr. 1228; Spaeth, Tr. 2239). One of the things that attracted ENH to Highland Park before the merger was that the doctors had very strong and positive relationships with the community. (Neaman, Tr. 1228-29).
2313. The medical staff at Highland Park Hospital before the merger was an excellent medical staff, consisting of a very good group of primary care physicians and a very excellent group of specialists, including medical oncologists. (Dragon, Tr. 4315).
2314. Approximately 85% to 90% of the physicians on staff at Highland Park Hospital prior to the merger were board certified in their area of medical specialty. (Newton, Tr. 377). The hospital had a quality medical staff with significant coverage over a range of about 45 specialties. (Newton, Tr. 320).
2315. Before the merger, the Highland Park Hospital medical staff would elect a chairman of each department, and the staff as a whole would elect a medical staff leader on an annual basis, although some terms were for two years. (Spaeth, Tr. 2250-51).
2316. The physicians elected to leadership roles at Highland Park Hospital before the merger were not employed by the hospital, but were voluntary physicians on the medical staff. (Spaeth, Tr. 2251). Prior to the merger, Highland Park Hospital paid a stipend to its clinical department chairmen. (Spaeth, Tr. 2080). The role of the department chairmen

was revised, and they became salaried by Highland Park Hospital effective in 1999. (CX 95 at 3; CX 98 at 5; CX 99 at 3).

2317. Highland Park Hospital had a high quality nursing staff in the 1990s. It was not dysfunctional. (Newton, Tr. 383). The hospital also had an outstanding group of nurses who were oncology nursing certified to provide chemotherapy. (Dragon, Tr. 4403).
2318. In 1997, Highland Park Hospital received the Lincoln Award, which is given for quality improvement. The award required a site visit to the hospital. (Spaeth, Tr. 2103-04; CX 2415 at 4). Highland Park Hospital was one of only five hospitals in Illinois to receive the Lincoln Award and the hospital planned to seek even higher levels of recognition within the program. (CX 2415 at 4; CX 2056 at 3; Spaeth, Tr. 2103).
2319. Although Highland Park Hospital received a deficiency letter from the Department of Health and Human Services in 1999, the deficiencies referred to the hospital's physical facilities, not to the quality of the medical staff or to the hospital's patient outcomes. (Hillebrand, Tr. 1775). Highland Park Hospital began correcting the facility deficiencies noted by the Department of Health and Human Services before the merger. (Spaeth, Tr. 2229; CX 1720 at 306). The total cost of repairing the deficiencies was approximately \$922,000. (RX 1379 at ENH JG 011545. *See also* CX 1720 at 12 (\$750,000 and \$1,000,000)).
2320. Health plans considered Highland Park Hospital to have good quality before the merger. { [REDACTED] } (Mendonso, Tr. 529, *in camera*). PHCS considered Highland Park to be a good hospital before the merger. (Ballengee, Tr. 166). Highland Park Hospital also met the quality requirements of One Health prior to the merger. (Neary, Tr. 625).
2321. In 1996, before the merger Highland Park Hospital received a positive review from the Chicago Hospital Risk Pooling Program (CHRPP) in CHRPP's risk management program. (RX 147 at ENHL PK 015803) At that time, Highland Park Hospital also experienced positive outcomes in hip injury patients. (RX 147 at ENHL PK 015804). In 1996, Highland Park Hospital also reached the "99th percentile" in measurements of inpatient satisfaction. (RX 147 at ENHL PK 015805).
2322. { [REDACTED] } (RX 413 at ENHL PK 017847, *in camera*).
2323. At the time of the merger, Mr. Stearns believed that HPH was an attractive candidate for other hospitals for acquisition or purchase or merger. (CX 6305 at 12 (Stearns Dep.)).

a. **Highland Park Hospital Offered Leading Edge and Innovative Clinical Programs Before the Merger**

2324. Highland Park Hospital offered leading edge and innovative clinical programs before the merger. (Newton, Tr. 291-92, 339, 415; Dragon, Tr. 4403, 4399; CX 1863 at 10; CX 2415 at 2-4; CX 1052 at 4-5; CX 98 at 2. See CX 413 at 7 (“HPH has over the last several years brought leading edge and innovative clinical services to residents of Lake County.”)).
2325. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3172, *in camera*).
2326. From the early 1990s up until the time of the merger, Highland Park Hospital created “Centers of Excellence” by which it would focus on certain clinical functions for which Highland Park Hospital would be particularly distinguished. (Newton, Tr. 291-92). Highland Park Hospital created Centers of Excellence in oncology, reproductive endocrinology, breast cancer, and women’s health. (Newton, Tr. 292).
2327. Before the merger, Highland Park Hospital offered particularly strong services in reproductive endocrinology and the Breast Center, which was a multi-disciplinary program in breast cancer. (Newton, Tr. 377). Before the merger, patients at risk for breast disease were followed by a cancer specialist at Highland Park Hospital’s Breast Center, which still exists today at Highland Park Hospital. (O’Brien, Tr. 3568; CX 98 at 2).
2328. Prior to the merger in 1998, Highland Park Hospital offered women considered at risk for breast cancer the opportunity to participate in a national clinical cancer trial called STAR (Study of Tamoxifen and Raloxifene). (Spaeth, Tr. 2086; CX 699 at 5-6).
2329. The women’s health program included of education, creation of new facilities, recruitment of physicians, and the expansion of clinical services. The program also involved creation of one of the first concepts approved by the State of Illinois for single-room maternity care. (Newton, Tr. 292-93). The concept called for labor, delivery, recovery, and post-partum (“LDRP”) activities to take place within one room. (Newton, Tr. 293; Spaeth 2115-16). The LDRP unit was one of Highland Park Hospital’s pre-merger innovations in the women’s health program. (Newton, Tr. 293).
2330. Before the merger, Highland Park Hospital had recruited one of the only 400 physicians in the country with special qualifications in reproductive endocrinology. As a result, Highland Park Hospital’s fertility center was one of the top ten fertility programs in the country, as measured by clinical pregnancy rates. (Newton, Tr. 376-77; CX 2415 at 3 (“one of the premiere IVF programs in the Midwest”)).

2331. In the late 1990s, Highland Park Hospital had a "very good" obstetrics program. The hospital had a unique, renovated OB department and a comprehensive obstetrics program. Highland Park also had relationships with a perinatal network and advanced pediatric coverage. (Newton, Tr. 389). Dr. Silver, Chairman of ENH's OB/GYN Department, agrees that prior to the merger, there were a number of good physicians in the Highland Park Hospital OB department. (Silver, Tr. 3831).
2332. Before the merger, Highland Park Hospital had a relationship with Children's Memorial Hospital in which Children's provided 24-hour advanced pediatric care through its neonatologists on-site at Highland Park. (Newton, Tr. 339, 415; Spaeth, Tr. 2123; CX 699 at 6).
2333. The Intensive Care Unit at Highland Park Hospital in the late 1990s was a modern unit that was managed by independent physicians, with no problems with nurse staffing. (Newton, Tr. 393). Prior to the merger, Highland Park Hospital had physicians providing 24-hour critical care who had board certification in critical care, internal medicine, and pulmonology. (Newton, Tr. 394; Spaeth, Tr. 2117). Highland Park Hospital had intensivists who were available in both their offices and through hospital rounds for an hour or two a day at the hospital. (Spaeth, Tr. 2278).
2334. The Emergency Department at Highland Park Hospital in the late 1990s was "very good" with staffing provided by an independent physician group. Prior to the merger, the Emergency Department served as a resource hospital that trained paramedics in Lake County and northern Cook County. (Newton, Tr. 394-95).
2335. In the late 1990s, the Emergency Department at Highland Park Hospital was a Level II trauma institution and was equal to or better than Highland Park's peer hospitals. (Newton, Tr. 394-95; Spaeth, Tr. 2082, 2116-17).
2336. Before the merger, Highland Park Hospital's Department of Radiation Medicine had a linear accelerator and was staffed by a physician group from Northwestern Memorial Hospital and Northwestern Medical School. (Newton, Tr. 399. *See also* CX 699 at 24; O'Brien, Tr. 3491, 3493 (When Ms. O'Brien assessed Highland Park Hospital's radiology department in 2000, HPH had two CT scanners, while Glenbrook Hospital had one. (O'Brien, Tr. 3493).
2337. Before the merger, the Highland Park Hospital radiology department had a full array of diagnostic and therapeutic capabilities, including CT, MRI, and ultrasound. In addition, there were radiologists who had special qualifications in mammography. The quality of the equipment was exceptional. (Newton, Tr. 399).
2338. Before the merger, Dr. Leon Dragon, who is now the Director of the Kellogg Cancer Care Center at Highland Park Hospital, served on the medical staff of Highland Park Hospital. (Spaeth, Tr. 2084). Highland Park Hospital had a "tumor board" before the merger

relating to cancer care activities whose members discussed cases in a collaborative manner. There also was a cancer committee at the hospital. (Spaeth, Tr. 2120-21; Dragon, Tr. 4403).

2339. Before the merger, Highland Park had received a certificate of approval from the commission on cancer of the American College of Surgeons. (CX 699 at 6, 24).
2340. Prior to the merger, Highland Park Hospital had an institutional review board ("IRB") and clinical oncology trials were done through the hospital IRB protocols, including trials relating to the Eastern Cooperative Oncology Group ("ECOG") and the National Surgical Adjuvant Breast Program. (Dragon, Tr. 4399-400; Newton, Tr. 419-20).
2341. Prior to the merger, Highland Park Hospital had a relationship with the Robert H. Lurie Comprehensive Cancer Center of Northwestern University that connected Highland Park with the National Cancer Network, an alliance of sixteen of the nation's leading cancer centers. (Spaeth, Tr. 2086; CX 699 at 5).
2342. Prior to the merger, the hospital also had radiation oncology, another component of an oncology program, in place. (Newton, Tr. 420).
2343. The physical facilities at Highland Park Hospital, including surgical suites and dialysis program, were exceptional prior to the merger. (Newton, Tr. 383-84). There were no major deficiencies in Highland Park's medical equipment in the late 1990s. (Newton, Tr. 384). Before the merger, Highland Park Hospital always had the latest piece of medical equipment that it needed, and the hospital felt that it had the ability to make investments and purchase new technology. (Newton, Tr. 384).
2344. Highland Park before the merger, started a cardiovascular program that provided "state of the art diagnostic screening that can detect symptoms of heart disease at an early age." (CX 699 at 6. See Spaeth, Tr. 2311).

b. Highland Park Hospital Continually Added New Clinical Services and Made Improvements Before the Merger

2345. Highland Park Hospital added new clinical services and made improvement before the merger. (Spaeth, Tr. 2101-05, 2110, 2113-14, 2122; Krasner, Tr. 3749-50; CX 2415 at 1-2; CX 1052 at 4; CX 98 at 2-3; CX 94).
2346. Accomplishments for Highland Park Hospital in 1997 included the opening of a new GI Center and approval from the State of Illinois for additional dialysis stations (Spaeth, Tr. 2102; CX 2415 at 3); broadening and enhancement of a number of clinical care maps for patient care at the hospital (Spaeth, Tr. 2105; CX 2415 at 7); creation of an in-patient Pediatric Adolescent Unit with 24-hour physician coverage (Spaeth, Tr. 2110; CX 1052

- at 4); and implementation of a Fast Track Triage System in the Emergency Department (Spaeth, Tr. 2110; CX 1052 at 4).
2347. The Highland Park Hospital in-patient pediatric unit created before the merger resulted from a relationship that Highland Park Hospital established with Children's Memorial Hospital. (Spaeth, Tr. 2121; CX 99 at 2). As of the end of 1998, Highland Park Hospital was also looking to develop an additional relationship with Children's Memorial Hospital to have pediatric sub-specialties at Highland Park Hospital. (Spaeth, Tr. 2122; CX 99 at 12).
2348. Accomplishments for Highland Park Hospital in 1998 included installation of a fast CT scanner in the hospital (Spaeth, Tr. 2113-14; CX 98 at 2) and the re-designation of its emergency room from a Level I training center to a Level II trauma center. (Spaeth, Tr. 2117; CX 98 at 5). A Level II Trauma Center designation by the State of Illinois requires 24-hour, seven-day a week physician coverage in the emergency room. (Spaeth, Tr. 2117).
2349. In 1998, Highland Park Hospital also expanded the family birthing center by adding nine beds to the unit. (Krasner, Tr. 3749; CX 98 at 2; CX 94 at 3). Prior to the merger, Highland Park Hospital also opened a fetal diagnostic center staffed by perinatologists from Evanston Hospital. (Krasner, Tr. 3750).
2350. The fast track program that Highland Park Hospital implemented in its emergency room in 1998, reduced turn-around time to 70 minutes or less that same year. (CX 566 at 1). Press-Ganey patient scores in 1998 for emergency care exceeded the target for that year. (CX 566 at 1).
2351. Even before the merger, Highland Park Hospital continued to improve its Care Maps and create new ones. (CX 95 at 3; CX 100 at 4; CX 2415 at 7; Spaeth Tr. 2105).
2352. In the 1999-2003 Presentation of the Financial Plan, HPH management identified new strategies to invest in the development of expanded clinical services. (CX 545 at 4).

2. Highland Park Hospital Already Had Plans to Implement Some of the Changes Before the Merger

2353. Up until the time of the merger in the year 2000, there was a growing breadth of clinical services provided by Highland Park Hospital. (Newton, Tr. 376). In addition, Lakeland Health Services' (Highland Park's parent entity) 1999-2002 Strategic Plan called for continued development of additional and deeper clinical services. (Newton, Tr. 330; CX 1868 at 10). Highland Park Hospital wanted to enhance its clinical services in cardiology, oncology, orthopedics, surgical services, and behavioral services. (CX 1868 at 17; CX 1908 at 18). It wanted to also pursue cardiac surgery, a joint oncology program

with its physicians, and advanced maternal/fetal health clinical capabilities. (CX 1868 at 17; CX 1908 at 18; CX 545 at 3).

2354. In March 1999, Lakeland Health Services' Joint Finance and Planning Committee developed a plan to enhance and expand the services at Highland Park Hospital without a merger with another hospital. (CX 92 at 3; Spaeth, Tr. 2224-31). For example, they planned for Highland Park Hospital to develop a cardiovascular surgery program through an agreement with Evanston Hospital, not a merger, and to implement a comprehensive oncology program through a partner in the Northwestern Healthcare Network or an affiliated medical group practice. (CX 92 at 12). They also planned for using technology to expand access to information to physician offices. (CX 92 at 20).

2355. Before the merger, Highland Park Hospital was seeking to develop a joint venture for a heart program with Evanston Hospital and a joint venture for an oncology program with Northwestern Memorial Hospital, both without merging. (CX 541 at 1; CX 1908 at 12; CX 1867 at 1-3).

2356. In the case of many of the improvements ENH claimed it made to HPH after the merger, such as the use of information technology, cardiac surgery and a comprehensive oncology program, HPH actively planned to make such changes before the merger regardless of whether it merged with another hospital. (CX 1908 at 3, 9, 12, 18, 20; CX 545 at 3).

a. Highland Park Hospital Had Decided to Develop a Cardiac Surgery Program Before the Merger

2357. Highland Park and ENH actually signed an agreement to develop a joint cardiac surgery program at Highland Park in April 1999, before they agreed to merge. (Rosengart, Tr. 4527-30, 4557; CX 2094).

2358. Shortly after signing their April 1999 agreement, Highland Park and ENH commenced the application process for a Certificate of Need ("CON") for open heart surgery at Highland Park Hospital. (Newton, Tr. 423). The CON application to the Illinois Health Facilities Planning Board, was signed by Mark Neaman, Mark Newton, and Ronald Spaeth. In the submission, the parties assert that Highland Park Hospital has brought "leading edge and innovative clinical services" to the community and has "consistently been the first provider in Lake County to develop and offer advanced clinical services." (CX 413 at 7).

2359. In their 1999 CON application for open heart surgery, ENH and Highland Park Hospital estimated that the cost of the open heart program would be approximately \$2.9 million, all of which was to come from HPH. (CX 413 at 12). (Highland Park Hospital had previously estimated that an open heart surgery program would cost about \$1 million and would not require tapping into any Highland Park Foundation money. (Newton, Tr. 422)).

2360. The parties' actual agreement to implement this program without a merger followed a planning process which had determined that the program would be feasible without a merger. (CX 92 at 12; CX 1868 at 13). As far back as 1997, Highland Park Hospital planned on developing a cardiovascular surgery program. (CX 1867 at 1; CX 91 at 2; CX 1869 at 4). Highland Park Hospital's 1999-2002 Strategic Plan called for implementing open heart surgery at Highland Park Hospital as part of a joint program with ENH. (Newton, Tr. 335).
2361. In the late 1990s, Highland Park Hospital and ENH had considered establishing open heart surgery at Highland Park as a joint program. (Neaman, Tr. 1243; Hillebrand, Tr. 2044; Spaeth, Tr. 2118; CX 99 at 1). The original pre-merger discussions between Highland Park Hospital and ENH to implement an open heart surgery program at Highland Park did not concern a merger between the two hospitals. (Hillebrand, Tr. 2045). Highland Park Hospital's proposals for a joint open heart surgery program with ENH or Northwestern Memorial Hospital prior to the merger were viable, despite the fact that they did not involve common ownership of the hospitals. (Newton, Tr. 422).
2362. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3060, *in camera*). See also (Newton, Tr. 423-24; Rosengart, Tr. 4527-28; CX 2078) (joint cardiac surgery program between Highland Park Hospital and ENH similar to other joint cardiac surgery programs not involving merger).
2363. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3075, *in camera*).
2364. At the same time in 1999 that ENH and Highland Park Hospital were working on a joint open heart surgery program, ENH was pursuing a joint open heart surgery program with Swedish Covenant Hospital. At that time, Swedish Covenant Hospital's open heart surgery program with ENH was structured the same way as Highland Park Hospital's open heart surgery program with ENH. (Newton, Tr. 423-24).
2365. Swedish Covenant Hospital and ENH are separate hospitals. (Newton, Tr. 424). Their joint open heart surgery program did not require a merger of the hospitals, but was accomplished through a contractual arrangement. (Hillebrand, Tr. 2046; Rosengart, Tr. 4443, 4557; CX 2078).
2366. The original cardiac surgery affiliation agreement between ENH and Highland Park Hospital is almost identical to the agreement between ENH and Swedish Covenant. (*Compare CX 2073 and CX 2094; Rosengart, Tr. 4527-28 (agreements are "relatively similar")*). In addition, the CON process for Highland Park Hospital to perform cardiac

surgery was essentially identical to the one for Swedish Covenant Hospital. (Rosengart, Tr. 4471-72).

2367. In addition to doing cardiac surgery at Swedish Covenant Hospital, ENH does cardiac surgery at Weiss Hospital through an affiliation agreement. (Rosengart, Tr. 4443). Both Swedish Covenant and Weiss are essentially community hospitals. (Rosengart, Tr. 4442). Each hospital runs its own cardiac surgery program, and Dr. Rosengart makes sure there are appropriate quality assurances in place. (Rosengart, Tr. 4444).
2368. Swedish Covenant Hospital and Weiss Hospital are located about seven to ten miles south of Evanston Hospital. (Rosengart, Tr. 4445).
2369. The medical director of cardiac surgery at Weiss Hospital is Dr. Rosengart. He also was the original medical director of cardiac surgery at Swedish Covenant Hospital, but he then eventually delegated that job to Dr. Curran, who is the ENH doctor performing cardiac surgery at Swedish Covenant. (Rosengart, Tr. 4442).
2370. In the case of Weiss Hospital, ENH insisted that Dr. Rosengart be the medical director of the cardiac surgery program in order to provide quality assurance as part of the agreement for ENH to perform cardiac surgery at that location. (Rosengart, Tr. 4443).
2371. ENH's affiliation agreements with Swedish Covenant Hospital and Weiss Hospital require ENH to provide perfusionists, which play a critical role. (Rosengart, Tr. 4461). Swedish Covenant Hospital and Weiss Hospital each have their own separate quality assurance programs, but ENH monitors the results. (Rosengart, Tr. 4468).
2372. The mortality rates for Swedish Covenant Hospital's open heart surgery program are within acceptable limits. ENH is also comfortable with its results for open heart surgery at Weiss Hospital. (Rosengart, Tr. 4502-03). Both of the joint heart surgery programs get passing grades in terms of performance. (Rosengart, Tr. 4504). Mark Newton, the President of Swedish Covenant Hospital, also agrees that the arrangement between Swedish Covenant Hospital and ENH is exceeding its quality parameters. (Newton, Tr. 424).
2373. If an open heart program with ENH was not possible, Highland Park Hospital was thinking about developing a relationship with Northwestern Memorial Hospital or Lutheran General Hospital involving an open heart program. (Newton, Tr. 338).

b. Highland Park Hospital Was Actively Pursuing a Joint Cancer Care Program with Other Hospitals, Including Evanston, Before the Merger

2374. Before the merger, Highland Park Hospital was pursuing joint programs in oncology with other hospitals, such as ENH and Northwestern Memorial Hospital, that did not involve a

merger. (Neaman, Tr. 1243; Hillebrand, Tr. 2044; Newton, Tr. 420; CX 1867 at 1-3; Spaeth, Tr. 2223-28; CX 1866 at 1, 5. *See also* CX 1862; CX 99 at 2 (referring to comprehensive oncology program)). As far back as 1998, Highland Park Hospital wanted to develop a "center of excellence" for cancer care services. (CX 91 at 2; CX 1869 at 4).

{ [REDACTED] }
(Romano, Tr. 3108, *in camera*).

2375. In the late 1990s, Highland Park Hospital and ENH had considered implementing a cancer care program at Highland Park as a joint program. (Neaman, Tr. 1243; Hillebrand, Tr. 2044; Spaeth, Tr. 2223-28). As a matter of fact, Highland Park was considering implementing a joint comprehensive oncology program with its local physicians, particularly a local medical group practice, Physician Reliance Network. (CX 1868 at 13; CX 99 at 2). Highland Park Hospital had also considered an oncology program with Northwestern Memorial Hospital prior to the merger. (Newton, Tr. 420; CX 1866 at 1, 5).

2376. The relationships that Highland Park Hospital pursued with Northwestern Memorial Hospital and ENH prior to the merger with regard to cancer care would have even been less formal than a structured joint venture with common ownership. (Newton, Tr. 420).

2377. { [REDACTED] } (Romano, Tr. 3107-08, *in camera*). { [REDACTED] }
(Romano, Tr. 3107-08, *in camera*).

2378. { [REDACTED] } (Romano, Tr. 3108, *in camera*).

2379. { [REDACTED] } (Romano, Tr. 3108, *in camera*).

2380. Highland Park Hospital did not have a CT/PET machine before the merger because such a combined machine did not exist before the merger. (Newton, Tr. 470).

c. Highland Park Hospital Was Already Planning to Renovate and Expand Its Emergency Department Before the Merger

2381. Highland Park Hospital was already planning to renovate and expand its Emergency Department before the merger. (Newton, Tr. 394; Harris, Tr. 4289-91; CX 98 at 2

("overall plans for a major reconstruction"). (These plans were in addition to the enhanced triage function and fast track plans that were actually executed pre merger. (CX 94 at 4)).

2382. In the late 1990s, Highland Park Hospital was making plans to expand the Emergency Department. (Newton, Tr. 394). Highland Park Hospital brought in an architect in the fall of 1998 to discuss expansion of the emergency room at the hospital. (Harris, Tr. 4290).

2383. { [REDACTED] } (Romano, Tr. 3111, *in camera*). { [REDACTED] }
{ [REDACTED] } (Romano, Tr. 3112, *in camera*).

3. Some of the Changes Were Part of a General Nationwide Trend of Improvement

2384. There was a nationwide focus on quality during the time period of ENH's alleged improvements to Highland Park Hospital. (Romano, Tr. 2998). As noted above, ENH has offered no comparison of the quality at Highland Park Hospital to other "peer" hospitals, and it is likely that Highland Park Hospital would have been part of the quality improvement trend even without the merger. (Romano, Tr. 2998).

2385. From 1997 to 2004, many studies were done relating to quality of care, including by the Center for Medicare and Medicaid Services and JCAHO. The National Quality Forum also was created for building consensus around quality measures and pushing forward the quality improvement agenda nationally. (Romano, Tr. 2999).

2386. In 1999, the Institute of Medicine published a well known report on patient safety. (Romano, Tr. 2998; Ankin, Tr. 5079-80). This report focused a huge amount of attention on the problem of healthcare quality, patient safety, and medical errors. In the years following the 1999 Institute of Medicine report, a tremendous amount of attention and resources have been put into measuring and improving healthcare quality. (Romano, Tr. 2999). This report was followed by recommendations from the Leapfrog Group in 2000. (Ankin, Tr. 5079-80).

2387. There have been studies showing that people were not only studying the quality problem, but also that hospitals were actually improving their quality during the time from 1997 through 2004. (Romano, Tr. 2999).

2388. Dr. Jencks, who is with the Center for Medicare and Medicaid Services, found significant improvements across the country in quality. He found that performance of the average performing hospitals improved on 20 out of 22 indicators. The average per state

improvement was 12% for inpatient indicators. (Romano, Tr. 3000-01). In Dr. Jencks' study on quality improvement, the trend in the State of Illinois was consistent with the 12% improvement on the national level. (Romano, Tr. 3001).

2389. Other studies have also found an actual improvement nationwide in quality of care from 1997 through 2004, including studies done by the National Committee for Quality Assurance using data from health plans as well as from the Department of Veterans Affairs. (Romano, Tr: 3001).
2390. In the absence of the merger, from 1997 to 2004, based upon what has happened nationwide, Highland Park Hospital would have been expected to move towards a more proactive stance in quality improvement, monitoring indicators prospectively and implementing some evidence-based systems to improve care. (Romano, Tr. 3003-04).
2391. Respondent's economics expert, Dr. Monica Noether, agrees that there has been some improvement and an increased focus on quality nationwide. (Noether, Tr. 6011, 6014). There has been greater public awareness, on the part of the consumer public, for greater hospital quality. (Noether, Tr. 6012, 6016).
2392. Dr. Noether also notes that other hospitals in the Chicago area, such as Lake Forest and Condell, have also expanded and upgraded their facilities in the past five years. (Noether, Tr. 6024-6025).
2393. The Leapfrog Group recommended intensivist coverage and computerized physician order entry after the merger. Those programs were implemented at Highland Park Hospital in 2001 (intensivist coverage) and 2003 (computerized physician order entry). (RX 1097 at ENHL PK 016335).

a. **Subsequent to the Merger, There Has Been an Increase in the Use of Intensivists by Hospitals**

2394. { [REDACTED] } (Romano, Tr. 3113-14, *in camera*).
2395. { [REDACTED] } (Romano, Tr. 3113, *in camera*). There has been increasing pressure from employers and purchasers for hospitals to provide intensivist coverage, and many hospitals have established such coverage. (Romano, Tr. 3003).
2396. Mark Newton, President of Swedish Covenant Hospital, agrees that critical care medicine has advanced in the last four or five years where hospitals now must have critical care

physicians on-site who either manage or co-manage critical care patients. (Newton, Tr. 393).

2397. The physicians who today are staffing Highland Park Hospital's Intensive Care Unit ("ICU") are the same physicians who staffed and treated patients in that ICU before the merger. (Newton, Tr. 466).

2398. { [REDACTED] } (Ankin, Tr. 5103-04; CX 2176, *in camera*). Dr. Ankin is the President of Pulmonary Physicians of the North Shore. (Ankin, Tr. 5033).

2399. Dr. Ankin, the director of Highland Park Hospital's intensivist program, agrees that the Leapfrog Group's recommendations for intensivist coverage influenced ENH's decision to implement an intensivist program at Highland Park Hospital. (Ankin, Tr. 5050-51). The Leapfrog Group's recommendations came out in the year 2000. (Ankin, Tr. 5080).

2400. { [REDACTED] } (Ankin, Tr. 5063; CX 2176, *in camera*). Pulmonary Physicians of the North Shore would be free to enter into a contract with a new owner of Highland Park Hospital. (Ankin, Tr. 5104). If there was a new owner of Highland Park Hospital and it agreed to a contract similar to the current contract, Pulmonary Physicians of the North Shore would entertain servicing the intensivist contract for the new owner. (Ankin, Tr. 5105).

2401. Lake Forest Hospital is another hospital that did not have an intensivist program before the merger, but it later implemented an intensivist program through Pulmonary Physicians of the North Shore. (Ankin, Tr. 5072-74, 5089).

2402. Dr. Ankin could not fault HPH for not having an intensivist program prior to the merger because few hospitals had such a program at that time and because he was unaware of any published materials advocating such a program prior to the merger. (Ankin, Tr. 5087).

b. There Has Been An Increase in the Use of Information Technology by Hospitals to Improve the Quality of Care

2403. The use of electronic medical records by hospitals has increased recently among community hospitals. (Wagner, Tr. 4067-69). Many other hospitals have purchased the EPIC electronic medical record system, and systems similar to it. (Wagner, Tr. 4066-68).
{ [REDACTED] } (CX 94 at 2, Romano, Tr. 3165, *in camera*).

2404. { [REDACTED] } (Romano, Tr. 3161,

- in camera*). { [REDACTED] } (Romano, Tr. 3162, *in camera*).
2405. { [REDACTED] } (Romano, Tr. 3163, *in camera*). { [REDACTED] } (Romano, Tr. 3162-63, *in camera*).
2406. { [REDACTED] } (Romano, Tr. 3163-65, *in camera*). { [REDACTED] } (Romano, Tr. 3164-65, *in camera*). { [REDACTED] } (Romano, Tr. 3165, *in camera*).
2407. The decision at ENH to purchase the EPIC system was influenced by the public recommendations of the Institute of Medicine and Leapfrog Group. (Wagner Tr. 4066; RX 1117 at ENH GW 003511).
2408. Other hospitals have purchased the EPIC electronic medical record system. (Wagner, Tr. 4066-67) Other hospitals in the Chicago area have purchased an integrated medical record system similar to EPIC's. (Wagner, Tr. 4067), Northwestern Memorial Hospital purchased the same EPIC system as ENH. (Wagner, Tr. 4068).
2409. Other community hospitals have purchased an electronic medical record system. (Wagner, Tr. 4067), Northwest Community Hospital, a stand-alone community hospital in the Chicago area, is considering purchasing an electronic medical record system from McKesson. (Wagner, Tr. 4068-4069).
2410. { [REDACTED] } (Romano, Tr. 3160, 3165, *in camera*).
2411. { [REDACTED] } (CX 94 at 2; Romano, Tr. 3160, 3165, *in camera*). In 1997, Highland Park Hospital also revised its "Information Technology Strategic Plan" and began to implement key parts of that plan including looking for a new IT vendor. (CX 94 at 2).

2412. Prior to the merger, Highland Park Hospital was planning to utilize technology to support patient care by exploring the use of internet technology and expanding access to information to physician offices. (CX 1908 at 20).
2413. EPIC is an electronic clinical information system that includes an electronic medical record, a computer order entry system, and a clinical decision support system. (Amended Glossary of Terms at 6, April 22, 2005). There is no evidence that the merger has improved outcomes at Highland Park Hospital through the deployment of EPIC. (Wagner, Tr. 4065).
2414. EPIC was not deployed at Highland Park Hospital until January 2004. (Wagner, Tr. 4070).
2415. Only three independent physician practices have EPIC installed in their office. (Wagner, Tr. 3978).

4. Highland Park Could Have Continued to Improve and Expand Other Clinical Services Without the Merger

2416. { [REDACTED] } (Silver, Tr. 3791, 3834, 3841; Romano, Tr. 3159, 3177-80, *in camera*). As explained above, Complaint Counsel believes that many of the changes do not qualify as "improvements" because they reflect merely an ongoing process that took place both before and after the merger. But for a similar reason, even if they are seen as "improvements" it is clear that they could have been accomplished without the merger.

a. Highland Park Hospital Could Have Implemented the Changes in Its Obstetrics and Gynecology Department Without the Merger

2417. The changes instituted in Highland Park Hospital's obstetrics and gynecology department after the merger could have been implemented without investment in construction or equipment. (Silver, Tr. 3848-49, 3834).
2418. ENH instituted a pre-operative review program in the obstetrics and gynecology department that was separate from any specific concerns of physicians at the time Dr. Silver became chairman of the department. (Silver, Tr. 3780). [REDACTED] } (Silver, Tr. 3892, *in camera*).
2419. Any deficiencies found through the pre-operative review program that might have related to Highland Park Hospital were not the reason for creating the program in the first place. (Silver, Tr. 3833-34). If the merger had not occurred, ENH still could have implemented

the pre-operative review program at Evanston Hospital and Glenbrook Hospital. (Silver, Tr. 3834).

2420. There has been a trend toward in-house physician coverage in hospital obstetrics departments in the region around ENH. (Silver, Tr. 3841). After Highland Park Hospital implemented in-house physician coverage in its obstetrics department, other Lake County hospitals such as Lake Forest Hospital, Condell Medical Center, and Victory Memorial Hospital also implemented in-house physician coverage in their obstetrics departments. (Silver, Tr. 3791).
2421. One of the reasons the Induction of Labor protocol was developed by the ENH OB Practice Committee was that it was an important subject area on a national level. (Silver, Tr. 3807).
2422. It was not necessary for ENH to construct buildings or invest in equipment in order to make changes in Highland Park Hospital's obstetrics and gynecology department such as implementation of in-house physician coverage, the pre-operative review program, changes in surgical procedures, and publishing of clinical protocols. (Silver, Tr. 3848).
2423. The changes made by ENH to Highland Park Hospital's obstetrics and gynecology department involved only changes in staffing levels, changes in procedures, and training of personnel, along with a budget of \$600,000 to pay stipends for ENH's obstetrics and gynecology department leaders. (Silver, Tr. 3848).
2424. The decision to stop doing D & Cs in the emergency room at Highland Park Hospital involved changing the location of the procedures. (Silver, Tr. 3857-58).
2425. If Highland Park Hospital were a stand-alone entity, it could simply pay \$150,000 per year to maintain the in-house OB physician coverage program. (Silver, Tr. 3864). If Highland Park Hospital were a stand-alone entity, it could also continue the policy of prohibiting D & Cs in the emergency room and second trimester abortions in labor and delivery. (Silver, Tr. 3864).

b. Highland Park Hospital Could Have Implemented the Changes in Its Quality Assurance and Quality Improvement Activities Without the Merger

2426. { [REDACTED] } (Romano, Tr. 3159, 3170-71, *in camera*).

2427. { [REDACTED] }

[REDACTED]
[REDACTED] }
(Romano, Tr. 3159, *in camera*).

2428. { [REDACTED]
[REDACTED] } (Romano, Tr. 3158-59, *in camera*). { [REDACTED]
[REDACTED] } (Romano, Tr.
3159, *in camera*).

2429. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano,
Tr. 3170-71, *in camera*). In developing the critical pathways ENH implemented at
Highland Park Hospital, Highland Park Hospital's pre-merger care maps were taken into
account. (CX 6286 at 4; O'Brien, Tr. 3560-61).

c. Highland Park Hospital Could Have Improved Its Physical Plant Without the Merger

2430. { [REDACTED]
[REDACTED] } (Romano, Tr. 3177, *in camera*).

2431. { [REDACTED]
[REDACTED] } (Romano, Tr. 3177, *in camera*).

2432. Highland Park Hospital's financial wherewithal to make the investments necessary to
improve the physical plant is discussed below. (See CCFF 2440-2443).

d. Highland Park Hospital Could Have Implemented the Changes in Its Laboratory Without the Merger

2433. { [REDACTED]
[REDACTED] } (Romano, Tr. 3178, *in camera*).

2434. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3179, *in camera*).

2435. Before the merger, Highland Park Hospital had a joint venture with Lake Forest Hospital in laboratory services through Consolidated Medical Laboratories, which was dissolved after the merger. (CX 10 at 2).

e. Highland Park Hospital Could Have Implemented the Changes in Its Pharmacy Services Without the Merger

2436. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3180, *in camera*).

2437. In the late 1990s, the pharmacy at Highland Park Hospital was centralized, but had plans to move to a more decentralized operation. Equipment for a Pyxis system of drug distribution is not expensive for a hospital, around \$20,000 per machine. (Newton, Tr. 397, 399).

f. Highland Park Hospital Could Have Implemented the Changes in Its Radiology Department Without the Merger

2438. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3184, *in camera*).

2439. The PACS technology ENH implemented at Highland Park Hospital was beginning to be available in the late 1990s. Highland Park Hospital had considered purchasing the technology, but had not made a decision by the time of the merger. Capital was available if the hospital wanted to move toward a PACS system. (Newton, Tr. 401; Spaeth, Tr. 2137-38. *See generally* CX 545 at 3).

5. Highland Park Hospital Possessed the Financial Assets to Implement Quality Changes on Its Own

2440. Highland Park's financial wherewithal is discussed in detail at (CCFF 302-372). Highland Park Hospital was financially able to implement the quality changes on its own. (CX 97 at 1; CX 545 at 3; CX 627 at 6; CX 1877 at 1; CX 1065 at 2-3; Newton, Tr. 383-84, 430-31; Spaeth, Tr. 2138, 2147).

2441. In the absence of the merger, Highland Park Hospital would have gone forward with the Strategic Plan and the Financial Plan, both of which were adopted by Lakeland Health Service's and the hospital's finance committees as well as Highland Park's board. (Spaeth, Tr. 2146, 2155; CX 1055 at 3; CX 96 at 4). In March 1999, the finance

committee concluded that the hospital would remain "financially strong over the foreseeable future." (Spaeth, Tr. 2147; CX 1055 at 3).

2442. Prior to the merger, Highland Park Hospital routinely made capital investments to upgrade and improve the facilities. (Newton, Tr. 383-84).
2443. Highland Park continued to plan to make capital investments and improvements just prior to the merger. Highland Park Hospital's 1999 long-range capital budget had two major components. One was for \$43 million for ambulatory, assisted-living, and facility expansion programs. The second component was another \$65 million for routine hospital construction. (Newton, Tr. 430-31; Spaeth, Tr. 2137-38; CX 545 at 3; CX 1055 at 2). The \$108 million specified in Highland Park Hospital's pre-merger long-range capital budget would have come out of operating earnings and cash and investments. (Newton, Tr. 431).

D. Virtually All of the Alleged Quality Improvements Occurred After Health Care Contracts Were Re-Negotiated

2444. Virtually all of the quality improvements claimed by ENH occurred after it had renegotiated its healthcare contracts at significantly higher rates. (See CCF 756, 759, 762, 765, 767, 831-832, 853, 855, 887, 970, 1094, 1221, 1289, 1306, 1308, 1311-1312).
2445. Highland Park Hospital's new ambulatory care center did not open until February 2005. (O'Brien, Tr. 3498).
2446. ENH opened a new open heart surgery suite at Highland Park Hospital in April 2000. The open heart surgery program started at Highland Park Hospital in June 2000. (O'Brien, Tr. 3504-05; Rosengart, Tr. 4482).
2447. ENH started a construction project at Highland Park Hospital in December 2003 to remodel patient units. (O'Brien, Tr. 3510).
2448. The equipment in the cardiac cath lab began to be upgraded in April 2000 in order to be able to start doing interventional cardiac cath. (O'Brien, Tr. 3488-89). Changes in HPH's cardiac cath lab were not completed until March 2002. (O'Brien, Tr. 3490).
2449. ENH did not extend RADNET, its radiology information system, to Highland Park Hospital until February 2001. (O'Brien, Tr. 3494). In February or March 2001, ENH also extended PACS, its filmless radiology system, to Highland Park Hospital. (O'Brien, Tr. 3494-95).
2450. ENH added equipment to the HPH radiology department after the merger, but ENH did not add the majority of the equipment until 2002 and later (equipment costing \$2.3

- million was added in 2000 and 2001 and equipment costing \$4.1 million was added in 2002, 2003, and 2004). (O'Brien, Tr. 3496-97).
2451. In the spring of 2001, ENH made changes to the psychiatry services to provide adolescent services at Highland Park Hospital and adult services at Evanston Hospital. (O'Brien, Tr. 3516-17). Before then, both hospitals had provided psychiatric services to adolescents and adults. An upgraded adolescent psychiatric unit did not open at Highland Park Hospital until December 2003. (O'Brien, Tr. 3518).
2452. EPIC began to be operational at ENH in 2003 and became fully implemented at all sites by April 2004. (Neaman, Tr. 1251).
2453. ENH did not implement the EPIC computer system at Highland Park Hospital until December 2003. (O'Brien, Tr. 3495-96). The physician order entry system component of EPIC was not implemented at HPH until five months later (April 2004). (O'Brien, Tr. 3521-22).
2454. ENH did not implement an intensivist program at Highland Park Hospital until May 2001. (O'Brien, Tr. 3529; Ankin, Tr. 5041).
2455. Veronica Zaman joined Highland Park Hospital as its vice president of nursing in August 2002. (O'Brien, Tr. 3538, 3575). Significant changes in the nursing culture at Highland Park Hospital did not occur until the period 2002 to 2004. (O'Brien, Tr. 3536-37).
2456. ENH took over the management of the Highland Park Hospital lab on June 1, 2000. (Victor, Tr. 3600). Dr. Rosencrans, a clinical laboratory scientist, was placed in the HPH lab in the fall of 2000. (Victor, Tr. 3618). ENH constructed new histology and cytology labs at Highland Park Hospital over the summer and fall and winter of 2000. (Victor, Tr. 3619).
2457. A replacement computer system was installed in the lab at Highland Park Hospital on June 1, 2000. (Victor, Tr. 3627-28). The earliest that lab results from Highland Park Hospital would have been available through the EPIC computer system at ENH was December 2003. (Victor, Tr. 3649).
2458. Dr. Silver became chairman of ENH's OB/GYN department in spring 2001. (Silver, Tr. 3841).
2459. ENH's OB/GYN department did not initiate the preoperative surgical review program until the fall of 2001. (Silver, Tr. 3889-90). { [REDACTED] } (Silver, Tr. 3892-93, *in camera*).
2460. ENH did not implement the in-house physician coverage program in the obstetrics department at Highland Park Hospital until the summer of 2001. (Silver, Tr. 3842).

2461. The dates that the various OB Practice Committee Protocols were implemented range from October 17, 2001, to May 31, 2004. (RX 1416 at ENHL PK 054590).
2462. The D&C surgical procedures performed in HPH's ER and the second trimester abortions performed in labor/delivery at HPH were not stopped at those particular locations until after the spring of 2001 (after Dr. Silver became chairman of the OB/GYN department at ENH). (Silver, Tr. 3857-58).
2463. Phase I of the HPH emergency department renovation involved the major clinical areas of the emergency room. (Harris, Tr. 4219). The Phase I renovation was not completed until September 2001. (Harris, Tr. 4219; RX 1148 at ENH GW 000271).
2464. Phase II of the HPH emergency department renovation involved mostly the non-clinical areas of the emergency room, such as the registration area, the triage room, and the waiting room. (Harris, Tr. 4226; RX 1148 at ENH GW 000271). The Phase II renovation was not complete until approximately December 2001. (Harris, Tr. 4226).
2465. Double physician coverage in the emergency room at HPH did not begin until July 2001. (Harris, Tr. 4230-31; RX 1148 at ENH GW 000271).
2466. The new equipment used to provide oncology services did not become available until the new Kellogg Cancer Care Center opened in February 2005. (Dragon, Tr. 4390).
2467. The PET scan technology has been commercially available for the last two to three years. Neither Evanston Hospital nor Glenbrook Hospital has a PET scanner. (Dragon, Tr. 4393-94).
2468. ENH did not add a third shift pharmacist at Highland Park Hospital until the summer of 2003. (Kent, Tr. 4849). ENH did not install Pyxis machines at Highland Park Hospital until near the end of 2000. (Kent, Tr. 4854-55).
2469. The pharmacists at Highland Park Hospital did not become decentralized until near the end of the 2000. (Kent, Tr. 4865). The ICU pharmacist did not begin practicing at Highland Park Hospital until the end of the year 2000 as the first decentralized pharmacist. (Kent, Tr. 4866-67). HPH pharmacists began participating in clinical rounds at the end of 2000 at HPH. (Kent, Tr. 4866).

E. ENH Did Not Negotiate Managed Care Contract Price Increases with Health Plans on the Basis of Quality Improvements

2470. During the internal contract negotiation strategy discussions at ENH during the winter of 2000, there was no discussion about the cost of making quality changes. (Newton, Tr. 366, 368).

2471. In the late 1990s, health plans would generally require Highland Park Hospital to have JCAHO accreditation as a term in their contracts. (Newton, Tr. 384-85).
2472. PHCS assesses the quality of care of hospitals in its network by looking at JCAHO accreditation or accreditation by the Osteopathic Society. PHCS also looks at Medicare certification. (Ballengee, Tr. 186).
2473. For PHCS, the negotiations with ENH after the merger in 2000 did not involve any quality issues. In addition, ENH never claimed that costs were going to rise because of quality changes at Highland Park Hospital. PHCS did not feel that, in agreeing to price increases with ENH, PHCS was paying for more quality at Highland Park Hospital. (Ballengee, Tr. 187-88).
2474. As of April 1, 2000, the date that the new contract between PHCS and ENH became effective, PHCS had no knowledge of any improvements in quality at Highland Park Hospital. (Ballengee, Tr. 188).
2475. PHCS considers the quality of care at Highland Park Hospital to be the same today as it was before the merger. (Ballengee, Tr. 187).
2476. ENH has not told PHCS about any quality changes in Highland Park Hospital. (Ballengee, Tr. 188). PHCS was unaware of any changes at Highland Park Hospital involving heart surgery, invasive cardiology, cancer care, emergency services, intensive care, radiology, and information systems. (Ballengee, Tr. 201-03).
2477. As of September 2003, Jillian Foucre of United did not know whether the merger of ENH and Highland Park Hospital had created an improved healthcare system that enhanced the quality of care at each hospital. (Foucre, Tr. 926-27). ENH has never provided United with information necessary to evaluate the quality of care at ENH. (Foucre, Tr. 927).
2478. { [REDACTED] } (Mendonsa, Tr. 538, *in camera*).
2479. { [REDACTED] } (Mendonsa, Tr. 538, *in camera*).
2480. { [REDACTED] } (Mendonsa, Tr. 537-38, *in camera*).

2481. With regard to quality, One Health looked to make sure that hospitals were accredited and licensed by Medicare and the state. (Neary, Tr. 625). During negotiations between ENH and One Health after the merger in connection with managed care pricing, no one from ENH talked about quality of care. (Dorsey, Tr. 1447).
2482. During negotiations between ENH and One Health after the merger in connection with managed care pricing, no one from ENH talked about quality increases or plans to improve quality in the future. (Neary, Tr. 624; Dorsey, Tr. 1447-48). In a telephone conversation with One Health personnel during contract negotiations after the merger, ENH's Chief Operating Officer, Jeffrey Hillebrand, did not say anything about higher quality services. (Dorsey, Tr. 1450).
2483. In negotiating with One Health after the merger, ENH did not promise to improve quality in return for higher prices. (Neary, Tr. 627). The language in the managed care contracts between One Health and ENH relating to quality remained the same before and after the merger. (Neary, Tr. 625).
2484. As of September 2004, Patrick Neary of One Health did not know that Highland Park Hospital had made any changes relating to cardiac surgery, invasive cardiology, emergency department, intensive care, radiology, or cancer care. (Neary, Tr. 639-40).
2485. { [REDACTED]
[REDACTED]
[REDACTED] } (Holt-Darcy, Tr. 1546, *in camera*).
2486. ENH's Chief Executive Officer, Mark Neaman, did not recall seeing any documents linking the new contract prices negotiated with health plans in 2000 with the costs of quality improvements that ENH intended to implement at Highland Park Hospital. (Neaman, Tr. 1241-42).
2487. ENH's Chief Operating Officer, Jeffrey Hillebrand, whose responsibilities at ENH include managed care contracting, did not believe that quality of care is a factor for health plans when they negotiate managed care contracts. (Hillebrand, Tr. 1783).
2488. ENH does not advertise to managed care companies. (Hillebrand, Tr. 1999).
2489. During contract negotiations with health plans after the 2000 merger, Mr. Hillebrand never told anyone from health plans that the higher prices that ENH was seeking were justified by quality improvements that would be implemented in the future. (Hillebrand, Tr. 1784).
2490. Lois Huminiak, ENH's Director of Performance Improvement, has not been involved in negotiating contracts with payers, nor has anyone within her area of responsibility been involved in negotiating such payer contracts. (CX 6285 at 2 (Huminak, Dep.)).

2491. { [REDACTED]
[REDACTED]
[REDACTED] } (CX 6285 at 3 (Huminiak, Dep.), *in camera*).
2492. Peggy King, ENH's Senior Vice President, is responsible for quality initiatives. She has been the quality coordinator at ENH since 1994. (CX 6286 at 3 (King, Dep.)). Ms. King is not involved at all in negotiating contracts with third-party payers. No one who is involved in contract negotiations with third-party payers has ever asked her for quality related information. (CX 6286 at 5 (King, Dep.)).
2493. Mary O'Brien has been president of Highland Park Hospital since October 2002. From October 2000 to October 2002, she served as executive vice president at Highland Park Hospital, and prior to that she served as senior vice president at Evanston Hospital since 1998. In these positions (except executive vice president of Highland Park), Ms. O'Brien has had responsibilities for quality and quality initiatives. (CX 6287 at 2 (O'Brien, Dep.)).
2494. Ms. O'Brien has never been involved in negotiating contracts with third-party payers. She has never worked with employees who work on contract negotiations with third-party payers, and no one within any of the groups she has been part of at ENH has ever been involved in third-party payer negotiations. (CX 6287 (O'Brien, Dep. at 19)). She knows of no one in the quality improvement group at ENH who has been involved in negotiations with third-party payers. (O'Brien, Tr. 3575).
2495. Around September 2003, ENH asked United to send a letter to the FTC stating that the merger of ENH and HPH created an "improved and expanded integrated healthcare delivery system that has enhanced the quality of care delivered at each of their hospitals." (Foucre, Tr. 921, 926; CX 6284 at 2). United refused to send the letter to the FTC. (Foucre, Tr. 924, 927).
2496. To determine whether ENH had improved quality after the merger, United would have needed information that included re-admission rates, complication rates, average length of stay, and other measures of that nature. (Foucre, Tr. 927).

XVII. ENH'S NON-PROFIT STATUS DID NOT RESTRAIN ITS EXERCISE OF MARKET POWER

A. ENH's Not-For-Profit Status Did Not Affect Its Approach to Post-Merger Price Increases

2000 Contract Changes

2497. As part of the merger with Highland Park, ENH decided to renegotiate contracts with the health plans in 2000. (Neaman, Tr. 1031).
2498. When ENH set prices for the 2000 contract re-negotiations with health plans, the fact that it was a non-profit entity did not weigh in as a reason not to take actions toward higher prices. (Neaman, Tr. 1032-33).
2499. "ENH's board did not try to ensure that price was set at basically the competitive level." (Simpson, Tr. 1622).
2500. ENH identified which among Highland Park and Evanston contracts had the better terms, and rates for the particular health plan. ENH gave no consideration to going with the lower priced health plan contract. (Neaman, Tr. 1031-32).
2501. ENH decided to take whichever was the more profitable of the two hospital contracts for the particular health plan and to apply those rates across the board for the post-merger entity. (See CCFE 884-895).
2502. ENH did not stop at electing the more favorable of the two hospital contract rates. In addition to choosing the higher of the two rates, ENH senior management decided to add a premium. (See CCFE 848-852).
2503. ENH does not see any limit on what is a reasonable enhancement of revenues for a hospital "in the context of what the community needs." (Spaeth, Tr. 2217-18).

2000 and Later Chargemaster Increases

2504. As part of the merger integration process, ENH consolidated the Highland Park and Evanston chargemasters in 2000. ENH examined the chargemasters at the two hospitals and adopted the higher of the Highland Park or Evanston chargemaster rates across the board for each line item. (See CCFE 884-895). ENH repeatedly increased the chargemaster rates after the merger. (See CCFE 918-924).

B. The Hospital Boards Did Not Get Involved in Pricing Issues

2505. The Highland Park Hospital board was not involved in pricing issues. (Spaeth, Tr. 2218).
2506. "ENH's board did not try to ensure that price was set at basically the competitive level." (Simpson, Tr. 1622).
2507. The ENH board did not actively monitor the pricing decisions of hospital management. (Simpson, Tr. 1629).
2508. Mr. Spaeth attended the board meetings of the Highland Park board before the merger and of the ENH board after the merger, (Spaeth, Tr. 2215). Over the years, including after the merger, Mr. Spaeth has never heard a board member make any comment regarding the rate at which the hospital was contracting with a particular payor. (Spaeth, Tr. 2218-19).
2509. Since the merger, Mr. Spaeth has not heard any board member or Mr. Neaman say that ENH should lower its rates to health plans. (Spaeth, Tr. 2219).
2510. Mr. Spaeth has never heard a hospital board member say that hospital prices should not go up. (Spaeth, Tr. 2215).
2511. Spaeth has never heard a hospital board member look behind a price increase to see whether it was warranted for that health plan or not. (Spaeth, Tr. 2215-16).
2512. ENH's board is not involved in negotiations with health plans. (CX 6304 at 17 (Livingston, Dep.)).
2513. The ENH board does not review contracts, nor is the board informed in advance of negotiating strategies. (CX 6304 at 18 (Livingston, Dep.)).
2514. Mr. Livingston, the chairman of the board, does not have knowledge of contract structures, nor does he recall discussions about forms of contracts (e.g., per diems or discount off charges) at board meetings. (CX 6304 at 19 (Livingston, Dep.)).

C. The Interests of Evanston, Highland Park, and ENH Management Did Not Align with the Interests of Consumers in Terms of Pricing and in Terms of Passing on Increased Revenues Resulting from the Merger

2515. ENH's compensation contracts did not align management's interests with consumers on the issue of price. (Simpson, Tr. 1629).
2516. ENH's managers were given bonuses for meeting revenue targets from operations. This gives managers the incentive to set supra-competitive prices. (Simpson, Tr. 1629).

2517. Dr. Simpson noted that there were two instances in which ENH's board offered managers bonuses for growing ENH's overall market share. This would have had little effect in prompting ENH's managers to lower price in order to gain market share. (Simpson, Tr. 1630).
2518. Evanston's managers thought they could meet the overall market share target simply through acquisition of Highland Park. (Simpson, Tr. 1630).
2519. On June 29, 1999, shortly before the Letter of Intent to Merge was signed, Highland Park senior executives entered into enhanced compensation agreements that replaced their previous agreements. The new agreements "offered additional retention bonuses as well as enhanced severance agreements" at a cost of \$8 million. (CX 534 at 3).
2520. ENH management had a plan for using some of the money derived from raising hospital prices post-merger. The president of ENH proposed adding an additional \$3 million into the 2000 bonus pool attributable to the merger integration activities. The board reduced this amount to \$1 million, which ultimately was the amount distributed to the top 50 people. (Neaman, Tr. 1263-64; CX 31 at 1).
2521. In his bonus proposal, Mr. Neaman proposed distributing bonuses to a number of personnel, including Mr. Hillebrand, Mr. Sirabian, Mr. Spaeth, and himself. (Neaman, Tr. 1264-65; CX 31 at 1).
2522. Several of ENH's senior executives received merit increases in their salaries in the range of 5-6% in 1998 to 1999 and a 10% increase from fall of 2000 to fall of 2001. This spike in compensation increases coincided with the completion of the merger integration efforts. The executives included Messrs. Hillebrand, Neaman, and Grady. (Neaman, Tr. 1265-67; CX 2099 at 2-3).
2523. A similar trend is apparent with annual incentive compensation awards. Various ENH executives received substantially higher awards at the end of 2000 compared to the awards in 1998 and 1999. (Neaman, Tr. 1267-69; CX 2099 at 8-9).

D. Economic Studies Support the View That Non-Profit Hospitals Exercise Market Power

2524. John Simpson has been a staff economist in the FTC's Bureau of Economics for the past 15 years. He has a doctorate in economics from UCLA. He has also published four articles relating to healthcare antitrust issues, one of which examined whether non-profit hospitals exploit market power. (Simpson, Tr. 1616-1617).
2525. "[E]conomic studies suggest that non-profit hospitals exercise market power." (Simpson, Tr. 1621). Market power is defined as the ability for the possessor of such power to set price above a competitive level. (Simpson, Tr. 1621).

2526. A non-profit hospital will exploit market power due to the influence of various interest groups within a hospital: the medical staff, hospital managers, and the employees of the hospital. (Simpson, Tr. 1623).
2527. The managers of a non-profit hospital may want the prestige that comes from operating a hospital that is very large and very sophisticated. (Simpson, Tr. 1623).
2528. An interest group within a non-profit hospital can cause the hospital to set high prices so the group can build up a surplus to fund a hospital that is larger and more sophisticated than the community needs. (Simpson, Tr. 1623).
2529. The customers in that situation have to pay for a hospital that is larger and more sophisticated than the community needs. (Simpson, Tr. 1623-1624).
2530. A non-profit hospital could set supra-competitive prices and use some of the surplus revenue for charity care, but some of the surplus could also be used on wasteful expenditures. (Simpson, Tr. 1648).
2531. The surplus resulting from supra-competitive prices can also be used for higher executive salaries. In other words, it can be used to benefit the hospital executives rather than consumers. (Simpson, Tr. 1649).
2532. There are six peer-reviewed studies, which look at whether hospitals in more concentrated markets tend to set higher prices than hospitals in less concentrated markets. Four of these studies found that hospitals tend to exploit market power and that non-profit hospitals in concentrated markets set higher prices than in less concentrated markets. (Simpson, Tr. 1624-25).
2533. The two remaining studies, which found that non-profit hospitals did not exercise market power, were both performed by Dr. William Lynk. These two studies used different data sets from the four studies finding that hospitals tend to exploit market power. (Simpson, Tr. 1625-27).
2534. The four studies refuting Dr. Lynk's studies by concluding that non-profit hospitals tend to exploit market power were done by four different sets of researchers. An additional case study involving a single merger of non-profit hospitals that was done by a different set of researchers, using a different methodology, also found that non-profit hospitals exercised market power. (Simpson, Tr. 1627-1628).

XVIII. ENH'S MEMBERSHIP IN THE NORTHWESTERN HEALTHCARE NETWORK DOES NOT ELIMINATE ENH'S LIABILITY UNDER SECTION 7 OF THE CLAYTON ACT

A. The Northwestern Healthcare Network Did Not Exercise Central Control

2535. The Northwestern Healthcare Network lacked central control over the individual member hospitals. (CX 6304 at 3 (Livingston, Dep.); CX 6306 at 17-18 (Mecklenburg, Dep.)).
2536. The Northwestern Healthcare Network was not effective because the individual member hospitals were unwilling to give up any of their autonomy. (CX 1777 at 49, 52; CX 6305 at 6 (Stearns, Dep.)).
2537. Even after the formation of the Northwestern Healthcare Network, the individual hospital members "operated as independent entities." (Newton, Tr. 307).
2538. The hospitals that were members of the Northwestern Healthcare Network continued to compete with each other, unilaterally negotiating contracts with managed care companies, "'slicing' each other up in the market," and "undercutting each other." (CX 1768 at 3).

B. Evanston and Highland Park Were Two Separate Entities Prior to the Merger

1. Separate Administrations

2539. Under the Network Affiliation Agreement of the Northwestern Hospital Network, the governing boards of each of the hospitals retained "local autonomy and control." (CX 1777 at 50, 52, 68).
2540. The Northwestern Healthcare Network could not exercise its discretion to terminate the employment of the administrators of the individual member hospitals. (CX 1831 at 13).
2541. Under the Network Affiliation Agreement, a member of the Northwestern Healthcare Network could withdraw from the network if the network attempted to implement network-wide managed care agreements that substantially favored one member hospital to the detriment of the withdrawing hospital. (CX 1831 at 9-11).
2542. Under the Network Affiliation Agreement, a member of the Northwestern Healthcare Network could withdraw from the network if the network failed to exercise reasonable efforts to support the academic affiliation of that hospital. (CX 1831 at 10).

2. Separate Staffs

2543. Each hospital in the Northwestern Hospital Network maintained its own medical staff. (Hillebrand, Tr. 1786).
2544. Under the Network Affiliation Agreement of the Northwestern Hospital Network, each member of the Northwestern Hospital Network retained the exclusive authority over granting medical staff privileges at its hospital. (CX 1777 at 72).
2545. Under the Network Affiliation Agreement, a member of the Northwestern Healthcare Network could withdraw from the network if the network attempted to require members of that hospital's medical staff to become members or employees of a network-wide organization. (CX 1831 at 10).
2546. Under the Network Affiliation Agreement of the Northwestern Hospital Network, the medical staff of each hospital remained autonomous. (CX 1777 at 49-50, 52).

3. Separate Services

2547. Under the Network Affiliation Agreement of the Northwestern Hospital Network, each institution retained autonomy and control over the local-based decisions related to the delivery of health care services. (CX 1777 at 52).
2548. The president and chief executive officer of Northwestern Memorial Healthcare does not recall the Northwestern Healthcare Network ever consolidating any services among the hospitals. (CX 6306 at 7 (Mecklenburg, Dep.)).
2549. Under the Network Affiliation Agreement, a member of Northwestern Healthcare Network could withdraw from the network if the network attempted to implement program expansions or consolidations that substantially favored one member hospital to the detriment of the withdrawing hospital. (CX 1831 at 9-10).

4. Financial Independence

2550. Under the Network Affiliation Agreement of the Northwestern Hospital Network, the network hospitals were autonomous in their financial operations. (CX 1777 at 50; see CX 6307 at 12-13 (Schelling, Dep.)).
2551. The president and chief executive officer of Northwestern Memorial Healthcare does not recall Northwestern Memorial Healthcare ever being placed at financial risk for a debt of another hospital in the Northwestern Hospital Network. (CX 6306 at 5 (Mecklenburg, Dep.)).
2552. ENH was not responsible for any debts incurred by other members of the Northwestern Hospital Network. (CX 6304 at 4 (Livingston, Dep.)).

- 2553. Members of the Northwestern Hospital Network only shared the cost of running the network. There was no combined profit and loss or profit-sharing. Members' balance sheets were separate. (Newton, Tr. 311).
- 2554. The Network Affiliation Agreement restricted the authority of the network to transfer assets of any individual member hospital. (CX 1777 at 62).
- 2555. Under the Network Affiliation Agreement, a member of the Northwestern Healthcare Network could withdraw from the network if the network attempted to impose certain obligations to transfer assets to another member of the network. (CX 1831 at 9).

C. The Northwestern Healthcare Network Disbanded Before the Evanston-Highland Park Merger Occurred

- 2556. In an August 3, 1999, board meeting, the ENH board voted to authorize the termination of the Northwestern Healthcare Network effective October 31, 1999. (CX 872 at 7).
- 2557. The Lakeland Health Services board of directors voted on August 23, 1999, to approve the dissolution of the Northwestern Healthcare Network. (RX 592A at ENH RS 000880).
- 2558. The Northwestern Healthcare Network members authorized the dissolution of the network on October 26, 1999. (CX 1833 at 2).
- 2559. The articles of dissolution were adopted by the Northwestern Healthcare Network on December 22, 1999. (CX 1833 at 2).

XIX. REMEDY

A. The Proposed Remedy Is Practicable and Will Restore Competition

2560. Complaint Counsel's proposed order calls for divestiture of HPH. (See Complaint Counsel's proposed order). Under that order, improvements, if any, to HPH would remain with HPH.
2561. There was some post-merger consolidation of Evanston and Highland Park, which is dealt with in the proposed order. After the merger, ENH consolidated HPH staff, consolidated clinical procedures, and moved some clinical and corporate services to locations other than Highland Park Hospital:
1. The physicians at Highland Park Hospital were merged into ENH's professional staff. (Neaman, Tr. 1354. See also CX 501 at 36). The responsibilities of the clinical chairmen at ENH were also extended to oversee Highland Park Hospital. (Neaman, Tr. 1354; Hillebrand, Tr. 1841; O'Brien, Tr. 3525);
 2. ENH eliminated all of the corporate functions at Highland Park Hospital including human resources, purchasing, managed care contracting, the business office, and the information systems department. (Hillebrand, Tr. 1839. See also Neaman, Tr. 1345). ENH also eliminated Highland Park Hospital's separate registration process and consolidated the chargemaster to have a single billing system. (Hillebrand, Tr. 1990); and
 3. In other clinical areas, ENH aligned the care maps at Highland Park Hospital with the clinical pathways at Evanston Hospital. The two sets of clinical procedures were brought together. (O'Brien, Tr. 3528, 3560). ENH also eliminated adult inpatient psychiatric services at Highland Park Hospital. (O'Brien, Tr. 3516-17).
2562. Because ENH consolidated HPH staff and combined some services at locations other than Highland Park Hospital, the proposed order requires reasonable ancillary provisions to assist an acquirer to re-establish clinical and corporate functions at HPH in connection with divestiture.
2563. Highland Park, which has been in existence since 1918, was a good hospital before the merger. (See CCFF 2295-2352).
2564. HPH could have continued as a stand-alone competitor without the merger. (See CCFF 302-367).
2565. Highland Park was and remains an attractive candidate for other mergers and acquisitions, due to its location and various other factors. (See CCFF 368-372).

2566. The proposed remedy will restore the competition lost due to the Evanston-HPH merger. (See CCFF 284-301, 2560-2565).

B. Divestiture Would Not Have a Significant Impact on Quality at Highland Park Hospital

2567. { [REDACTED] } (Romano, Tr. 3193, *in camera*).

2568. Prior to the merger, Highland Park Hospital had been pursuing plans to establish a cardiac surgery program. (See CCFF 2357-2361). ENH operates a joint cardiac surgery program with Swedish Covenant Hospital and Weiss Memorial Hospital, each pursuant to an affiliation agreement. (See CCFF 2363-2367).

2569. If Highland Park Hospital is divested, the new operating room suite, the equipment used in cardiac surgery, and the clinical protocols would all remain in place at that hospital. (Rosengart, Tr. 4558-60).

2570. { [REDACTED] } (Romano, Tr. 3194, *in camera*).

2571. { [REDACTED] } (Romano, Tr. 3073, *in camera*). { [REDACTED] } (Romano, Tr. 3073-74, *in camera*).

2572. { [REDACTED] } (Romano, Tr. 3073-74, *in camera*).

2573. { [REDACTED] } (Romano, Tr. 3075, *in camera*).

2574. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3075, *in camera*).

2575. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3194-95, *in camera*).

2576. { [REDACTED]
[REDACTED] } (Romano, Tr. 3195, *in camera*).

2577. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3195-96, *in camera*).

2578. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3195-96, *in camera*). Indeed, the psychiatric services HPH lost due to the merger (CCFF 2283-2285) could be restored. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3196, *in camera*).

2579. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3196-97 (discussing the clinical areas in DX 7033 at 7, *in camera*), *in camera*).

2580. { [REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr. 3197, *in camera*).

XX. PROPOSED CONCLUSIONS OF LAW

Jurisdiction

1. On or about January 1, 2000, Evanston Northwestern Healthcare Corporation (“ENH”), a non-profit Illinois corporation, and Lakeland Healthcare Services, a non-profit Illinois corporation, merged (the “Merger”).
2. Before and after the Merger, ENH was engaged in commerce or an activity affecting commerce, as defined by Section 1 of the Clayton Act, 15 U.S.C. § 12.
3. Before and after the Merger, Lakeland Healthcare Services, and its wholly-owned subsidiary, Highland Park Hospital, a non-profit Illinois corporation (collectively, “Highland Park”), were engaged in commerce or an activity affecting commerce, as defined by Section 1 of the Clayton Act, 15 U.S.C. § 12.
4. The Merger is a transaction subject to Section 7 of the Clayton Act, 15 U.S.C. § 18.
5. The Federal Trade Commission (“FTC”) has jurisdiction over the Merger, pursuant to Sections 7 and 11 of the Clayton Act, 15 U.S.C. § § 18, 21(b).

Burden of Proof

6. Pursuant to § 3.43 of the Federal Trade Commission’s Rules of Practice, Complaint Counsel bear the burden of proof of establishing, by a preponderance of the evidence, each element of the violations alleged in the Complaint.
7. Pursuant to § 3.43 of the Federal Trade Commission’s Rules of Practice, Respondent bears the burden of proof of establishing, by a preponderance of the evidence, each element of its affirmative defenses to the violations alleged in the Complaint.

Statutory Standard

8. Section 7 of the Clayton Act prohibits any acquisition of stock or assets “where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition or to tend to create a monopoly.” 15 U.S.C. § 18.

Count I: The Merger of ENH and Highland Park Had Anticompetitive Effects Within a Defined Product and Geographic Market

9. The appropriate line of commerce (*i.e.*, the product market) within which to evaluate the effects of the Merger, are primary, secondary, and tertiary acute care inpatient hospital services sold to health plans.

10. The appropriate section of the country, *i.e.*, the geographic market, within which to evaluate the effects of the Merger is an area north of Chicago, Illinois, consisting of and contiguous to the triangle formed by ENH's three hospitals.
11. Through the Merger, ENH controlled a significant share of the relevant market.
12. The Merger took place in a market that was already highly concentrated and, thus, the Merger increased market concentration in the relevant market to levels that are anticompetitive.
13. There are significant barriers to entry into the relevant market, including the significant capital costs of building a new acute care hospital, the statutory prohibition of building a new hospital without the prior approval of the State of Illinois, and the significant administrative delays in obtaining the approval under the laws of the State of Illinois. It is highly unlikely, if not impossible, that there could be a new acute care hospital constructed in the Evanston, Illinois, area within a period of two years. No new hospital has been constructed in the relevant market in the five years since the Merger.
14. The Merger enabled ENH to raise prices unilaterally in the relevant market because it eliminated the discretion of health care plans to contract with Highland Park (in combination with other hospitals) as an alternative to contracting with Evanston Hospital (in combination with other hospitals). In addition, the Merger eliminated the discretion of health care plans to contract with ENH (in combination with other hospitals) as an alternative to contracting with Highland Park Hospital (in combination with other hospitals).
15. The Merger violates Section 7 of the Clayton Act "because the effect of the acquisition may be substantially to lessen competition and to tend to create a monopoly." 15 U.S.C. § 18.

Count II: The Merger of ENH and Highland Park Had Actual Anticompetitive Effects

16. The Merger gave ENH market power in the market for general inpatient acute care hospital services sold to health plans in the Evanston, Illinois, area.
17. The Merger resulted in higher prices for general inpatient acute care hospitals services sold to health plans and, ultimately, higher prices to employers and consumers.
18. Since 2000, the Merger enabled ENH to charge health plans supracompetitive prices, in the following ways:

- a. The Merger enabled ENH to raise unilaterally its post-merger price for specific services rendered at either hospital to the pre-merger price of either ENH or Highland Park, whichever was greater.
 - b. The Merger enabled ENH to raise prices by renegotiating contracts with health plans at rates that were higher than those specified in the contracts with those same health plans at the time of the Merger.
 - c. The Merger enabled ENH unilaterally to require health plans, as a condition of renegotiating contracts with ENH after the Merger, to pay ENH based on ENH's charges for the goods or services, rather than a fixed price formula.
 - d. The Merger enabled ENH to increase its charges for goods and services to health plans by unilaterally changing its list price, as set forth in its chargemaster, for those goods or services.
19. The Merger had anticompetitive effects in the relevant market.
 20. The Merger violates section 7 of the Clayton Act "because the effect of the acquisition may be substantially to lessen competition and to tend to create a monopoly." 15 U.S.C. § 18.

Respondent Has Not Presented Sufficient Evidence to Support Its Affirmative Defenses of the Merger

21. The Merger did not have any cognizable or demonstrable efficiencies that could have been achieved only through the Merger.
22. The Merger did not significantly improve the quality of care furnished at either ENH or Highland Park in ways that could have been achieved only through the Merger.
23. After the formation of the Northwestern Healthcare Network, the individual member hospitals remained separate economic and legal entities, with separate economic interests and pursuing divergent goals. Evanston Northwestern Healthcare Corporation and Lakeland Health Services, Inc. were separate entities at the time of the Merger on January 1, 2000.
24. If Evanston Northwestern Healthcare Corporation and Lakeland Health Services, Inc., created a single entity through the formation of the Northwestern Healthcare Network, the formation of the Network constitutes a merger of ENH and Highland Park that is subject to Section 7 of the Clayton Act, 15 U.S.C. § 18.
25. Highland Park was well able to meet its financial obligations at the time of the Merger, with sufficient resources to remain a viable competitor.

26. At the time of the Merger, Highland Park failed to examine whether there were alternative companies with which it could merge that would keep its tangible and intangible assets in the relevant market and pose a less severe danger to competition than its merger with ENH.

Equitable Relief Is Warranted

27. Divestiture of Highland Park by ENH is a proper remedy that will restore competition in the relevant market.
28. Complete divestiture, consistent with the proposed order submitted by Complaint Counsel, is required to restore competition, and will restore competition in the relevant market as it existed prior to the Merger.

XXI. PROPOSED ORDER

**UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION**

In the matter of)
)
)
Evanston Northwestern Healthcare)
Corporation,)
a corporation, and)
)
ENH Medical Group, Inc.,)
a corporation.)
)
)
)

Docket No. 9315

ORDER

I.

IT IS HEREBY ORDERED that, as used in this Order, the following definitions shall apply:

- A. "Acquirer" means any Person approved by the Commission to acquire the Highland Park Hospital Assets pursuant to this Order.
- B. "Acquirer Hospital Business" means all activities relating to general acute care inpatient hospital services and other related health care services to be conducted by the Acquirer in connection with the Highland Park Hospital Assets.
- C. "Acute Care Hospital" means a health care facility licensed as a hospital, other than a federally-owned facility, having a duly organized governing body with overall administrative and professional responsibility, and an organized professional staff, that provides 24-hour inpatient care, that may also provide outpatient services, and having as a primary function the provision of General Acute Care Inpatient Hospital Services.
- D. "Commission" means the Federal Trade Commission.
- E. "Direct Cost" means the cost of direct material and direct labor used to provide the relevant assistance or service.
- F. "Divestiture Agreement" means any agreement between Respondent (or between a Divestiture Trustee appointed pursuant to Paragraph VI. of this Order) and an Acquirer approved by the Commission, and all amendments, exhibits, attachments, agreements,

and schedules thereto that have been approved by the Commission, to accomplish the purpose and requirements of this Order.

- G. "Divestiture Trustee" means the Person appointed pursuant to Paragraph VI. of this Order.
- H. "ENH" means Evanston Northwestern Healthcare Corporation, its directors, officers, employees, agents, attorneys, representatives, successors, and assigns; its subsidiaries, divisions, joint ventures, groups, and affiliates controlled by ENH (including, but not limited to, ENH Faculty Practice Associates and ENH Medical Group, Inc.), and the respective directors, officers, employees, agents, representatives, successors, and assigns of each. ENH Faculty Practice Associates is an Illinois non-profit corporation that, *inter alia*, employs physicians who primarily serve the patients of ENH, and is the sole shareholder of ENH Medical Group, Inc., an Illinois for-profit corporation.
- I. "ENH Contractor" means any Person that provides physician or other health care services pursuant to a contract with ENH (including, but not limited to, the provision of emergency room, anesthesiology, pathology, or radiology services) in connection with the operation of the Post-Merger Hospital Business at Highland Park Hospital.
- J. "ENH Employee" means any Person employed by ENH in the operation of the Post-Merger Hospital Business, including, but not limited to, any physician employed by ENH Faculty Practice Associates.
- K. "ENH License" means: (i) a worldwide, royalty-free, paid-up, perpetual, irrevocable, transferable, sublicensable, non-exclusive license to all Intellectual Property owned by or licensed to ENH relating to operation of the Post-Merger Hospital Business other than the HPH Name and Marks, which shall be divested, assigned and conveyed to the Acquirer on a permanent and exclusive basis, and (ii) such tangible embodiments of the licensed rights (including but not limited to physical and electronic copies) as may be necessary or appropriate to enable the Acquirer to utilize the rights.
- L. "ENH Medical Staff Member" means any physician or other health care professional who: (1) is not an ENH Employee and (2) is a member of the ENH medical staff, including, but not limited to, any ENH Contractor.
- M. "General Acute Care Inpatient Hospital Services" means a broad cluster of basic medical and surgical diagnostic and treatment services for the medical diagnosis, treatment, and care of physically injured or sick persons with short term or episodic health problems or infirmities, that include an overnight stay in the hospital by the patient. General Acute Care Inpatient Hospital Services include what are commonly classified in the industry as primary, secondary and tertiary services, but exclude: (i) services at hospitals that serve solely military and veterans; (ii) services at outpatient facilities that provide same-day

service only; (iii) those specialized services known in the industry as quaternary services; and (iv) psychiatric, substance abuse, and rehabilitation services.

N. "Highland Park Hospital" means the Acute Care Hospital located at 718 Glenview Avenue, Highland Park, Illinois 60035.

O. "Highland Park Hospital Assets" means all of ENH's right, title, and interest in and to Highland Park Hospital and all related healthcare and other assets, tangible or intangible, business, and properties, including any improvements or additions thereto made subsequent to the Merger, relating to the operation of the Post-Merger Hospital Business in Highland Park, Illinois, including, but not limited to:

1. All real property interests (including fee simple interests and real property leasehold interests), whether or not located on the Highland Park Hospital campus;
2. All personal property, including equipment and machinery;
3. All inventories, stores, and supplies;
4. All rights under any contracts and agreements (e.g., leases, service agreements such as dietary and housekeeping services, supply agreements, procurement contracts), including, but not limited to, all rights to contributions, funds and other provisions for the benefit of Highland Park Hospital pursuant to the Foundation Agreement dated December 16, 1999, between ENH and Highland Park Hospital Foundation ("Foundation Agreement");
5. All rights and title in and to use of the HPH Name and Marks on a permanent and exclusive basis (even as to ENH), and an ENH License to all other Intellectual Property ("Licensed Intellectual Property"); *provided, however*, that ENH may retain a worldwide, royalty-free, paid-up, perpetual, irrevocable, transferable, sublicensable, non-exclusive license to the Licensed Intellectual Property; *provided further, however*, that ENH shall retain no rights to use the HPH Name and Marks;
6. All governmental approvals, consents, licenses, permits, waivers, or other authorizations;
7. All rights under warranties and guarantees, express or implied;
8. All items of prepaid expense; and
9. All books, records, and files (electronic and hard copy).

Provided, however, that the Highland Park Hospital Assets shall not include assets not located exclusively in Highland Park, Illinois, whose use is shared with or among other ENH Acute Care Hospitals.

- P. "Hospital Provider Contract" means a contract between a Payor and any hospital to provide General Acute Care Inpatient Hospital Services and related healthcare services to enrollees of health plans.
- Q. "HPH Name and Marks" means the name "Highland Park Hospital" and "HPH," and any variation of these names, in connection with the Highland Park Hospital Assets, and all other associated trade names, business names, proprietary names, registered and unregistered trademarks, service marks and applications, domain names, trade dress, copyrights, copyright registrations and applications, in both published works and unpublished works, relating to the Highland Park Hospital Assets.
- R. "Intellectual Property" means, without limitation: (i) the HPH Name and Marks; (ii) all copyrights, copyright registrations and applications, in both published works and unpublished works, other than those associated with the HPH Name and Marks; (iii) all patents, patent applications, and inventions and discoveries that may be patentable; (iv) all know-how, trade secrets, software, technical information, data, registrations, applications for governmental approvals, inventions, processes, best practices (including clinical pathways), formulae, protocols, standards, methods, techniques, designs, quality control practices and information, research and test procedures and information, and safety, environmental and health practices and information; (v) all confidential or proprietary information, commercial information, management systems, business processes and practices, customer lists, customer information, customer records and files, customer communications, procurement practices and information, supplier qualification and approval practices and information, training materials, sales and marketing materials, customer support materials, advertising and promotional materials; and (vi) all rights in any jurisdiction to limit the use or disclosure of any of the foregoing, and rights to sue and recover damages or obtain injunctive relief for infringement, dilution, misappropriation, violation or breach of any of the foregoing.
- S. "Merger" means the merger of Highland Park Hospital into ENH pursuant to the Agreement and Plan of Merger among Evanston Northwestern Healthcare Corporation, Lakeland Health Services, Inc., and Highland Park Hospital dated as of October 29, 1999, which was consummated on or about January 1, 2000.
- T. "Monitor" means the Person appointed pursuant to Paragraph V. of this Order.
- U. "Payor" means any Person that pays, or arranges for payment, for all or part of any General Acute Care Inpatient Hospital Services for itself or for any other Person. Payor

includes any Person that develops, leases, or sells access to networks of Acute Care Hospitals.

- V. "Person" means any individual, partnership, firm, corporation, association, trust, unincorporated organization or other entity or governmental body.
- W. "Post-Merger Hospital Business" means all activities relating to the provision of General Acute Care Inpatient Hospital Services and other related health care services conducted by ENH after the Merger, including, but not limited to, all health care services, including outpatient services, offered at Highland Park Hospital.
- X. "Pre-Merger Highland Park Hospital Business" means all activities relating to the provision of General Acute Care Inpatient Hospital Services and other related health care services that Highland Park Hospital was offering or was planning to offer prior to the Merger.
- Y. "Respondent" means ENH.
- Z. "Transitional Administrative Services" means administrative assistance and expert advice with respect to the operation of an Acute Care Hospital and related health care services, including but not limited to assistance and expert advice relating to billing, accounting, governmental regulation, human resources management, information systems, managed care contracting, and purchasing.
- AA. "Transitional Clinical Services" means clinical assistance, support services, and expert advice with respect to operation of an Acute Care Hospital and related health care services, including but not limited to cardiac surgery, oncology services, and laboratory and pathology services.
- BB. "Transitional Services" means Transitional Administrative Services and Transitional Clinical Services.

II.

IT IS FURTHER ORDERED that:

- A. No later than one hundred eighty (180) days from the date the divestiture requirements of this Order become final, Respondent shall divest and convey the Highland Park Hospital Assets at no minimum price, absolutely and in good faith, to an Acquirer that receives the prior approval of the Commission and in a manner (including an executed divestiture agreement) that receives the prior approval of the Commission. To the extent that:

1. The Highland Park Hospital Assets as of the date the divestiture requirements of this Order become final do not include (i) assets that Respondent acquired on the date of the Merger; (ii) assets that replaced those acquired on the date of the Merger; or (iii) any other assets that Respondent acquired and has used in or that are related to the Post-Merger Hospital Business in Highland Park, Illinois, *then* Respondent shall add to the Highland Park Hospital Assets additional assets (of a quality that meets generally acceptable standards of performance) to replace the assets that no longer exist, are no longer controlled by Respondent or are no longer located in Highland Park, Illinois;
2. After the Merger and prior to the date the divestiture requirements of this Order become final, Respondent terminated any clinical service, clinical program, support function, or management function (i) performed by the Pre-Merger Highland Park Hospital Business, or (ii) introduced or performed by the Post-Merger Hospital Business in Highland Park, Illinois, *then* Respondent shall restore such service, program, or function (of a quality that meets generally acceptable standards of care or performance), no later than the date the Highland Park Hospital Assets are divested, or any other date that receives the prior approval of the Commission.

Provided, however, that Respondent shall not be required to replace any asset or to restore any service, program or function contemplated by Paragraphs II.A.1. or II.A.2. of this Order only if in each instance Respondent can demonstrate to the Commission that such asset, service, program or function is not necessary to achieve the purpose of this Order, and that the Acquirer does not need such asset, service, program or function to effectively operate the Acquirer Hospital Business in a manner consistent with the purpose of this Order, and the Commission approves the divestiture without the replacement or restoration of such asset, service, program or function.

- B. Respondent shall comply with all terms of the Divestiture Agreement approved by the Commission pursuant to this Order, and any breach by Respondent of any term of the Divestiture Agreement shall constitute a violation of this Order.
- C. Respondent shall cooperate with the Acquirer to ensure that the Highland Park Hospital Assets are transferred to the Acquirer as a financially and competitively viable Acute Care Hospital operating as an ongoing business, including but not limited to providing assistance necessary to transfer to the Acquirer all governmental approvals needed to operate the Highland Park Hospital Assets as an Acute Care Hospital.
- D. No later than the date the Highland Park Hospital Assets are divested, ENH shall grant to the Acquirer an ENH License to all Licensed Intellectual Property for any use in the Acquirer Hospital Business, and shall take all actions necessary to facilitate the unrestricted use of the Licensed Intellectual Property by the Acquirer.

- E. Respondent shall take all actions necessary to assist the Acquirer in ensuring the provision or continuation of a cardiac surgery program at Highland Park Hospital that is capable of providing an equivalent standard of care and performance and functioning in substantially the same manner as the cardiac surgery program established and provided at Highland Park Hospital after the Merger. *Provided, however,* that Respondent shall not be required to assist the Acquirer in ensuring the provision or continuation of a cardiac surgery program as contemplated by this Paragraph II.E. only if the Respondent can demonstrate to the Commission that the Acquirer does not need assistance from Respondent in providing or continuing a cardiac surgery program, or that a cardiac surgery program is not necessary to achieve the purpose of this Order, and the Commission approves the divestiture without the provision or continuation of a cardiac surgery program.
- F. Respondent shall take all actions necessary and shall effect all arrangements in connection with the divestiture of the Highland Park Hospital Assets as will ensure that the Acquirer can conduct the Acquirer Hospital Business in substantially the same manner as Respondent has conducted the Post-Merger Hospital Business at Highland Park Hospital, with an independent full-service medical staff capable of providing General Acute Care Inpatient Hospital Services, and an independent full-service hospital staff and management, including, but not limited to, providing Transitional Services, the opportunity to recruit and employ ENH Employees, and the opportunity to recruit, contract with, and extend medical staff privileges to any ENH Medical Staff Member, including as provided in Paragraphs II.G., II.H., and II.I. of this Order.
- G. At the request of the Acquirer, for a period not to exceed twelve (12) months from the date Respondent divests the Highland Park Hospital Assets, except as otherwise approved by the Commission, and in a manner (including pursuant to an agreement) that receives the prior approval of the Commission:
1. Respondent shall provide Transitional Services to the Acquirer sufficient to enable the Acquirer to conduct the Acquirer Hospital Business in substantially the same manner that Respondent has conducted the Post-Merger Hospital Business at Highland Park Hospital; and
 2. Respondent shall provide the Transitional Services required by this Paragraph II.G. at substantially the same level and quality as such services are provided by Respondent in connection with its operation of the Post-Merger Hospital Business.

Provided, however, that Respondent shall not (i) require the Acquirer to pay compensation for Transitional Services that exceeds the Direct Cost of providing such goods and services, (ii) terminate its obligation to provide Transitional Services because

of a material breach by the Acquirer of any agreement to provide such assistance, in the absence of a final order of a court of competent jurisdiction, or (iii) include a term in any agreement to provide Transitional Services that limits the type of damages (such as indirect, special, and consequential damages) that the Acquirer would be entitled to seek in the event of Respondent's breach of such agreement.

H. Respondent shall allow the Acquirer an opportunity to recruit and employ any ENH Employee in connection with the divestiture of the Highland Park Hospital Assets so as to enable the Acquirer to establish an independent, full-service medical staff, hospital staff and management, including as follows:

1. No later than six (6) weeks before execution of a divestiture agreement, Respondent shall (i) identify each ENH Employee, (ii) allow the Acquirer an opportunity to interview any ENH Employee, and (iii) allow the Acquirer to inspect the personnel files and other documentation relating to any ENH Employee, to the extent permissible under applicable laws.
2. Respondent shall (i) not offer any incentive to any ENH Employee to decline employment with the Acquirer, (ii) remove any contractual impediments with Respondent that may deter any ENH Employee from accepting employment with the Acquirer, including, but not limited to, any non-compete or confidentiality provisions of employment or other contracts with Respondent that would affect the ability of the ENH Employee to be employed by the Acquirer, and (iii) not otherwise interfere with the recruitment of any ENH Employee by the Acquirer, including, but not limited to, by refusing or threatening to refuse to extend medical staff privileges at any Respondent Acute Care Hospital.
3. Respondent shall (i) vest all current and accrued pension benefits as of the date of transition of employment with the Acquirer for any ENH Employee who accepts an offer of employment from the Acquirer no later than thirty (30) days from the date Respondent divests the Highland Park Hospital Assets and (ii) provide any ENH Employee to whom the Acquirer has made a written offer of employment with reasonable financial incentives to accept a position with the Acquirer at the time of divestiture of the Highland Park Hospital Assets, including, but not limited to (and subject to Commission approval), payment of an incentive equal to up to six (6) months of such employee's base salary to be paid upon the employee's completion of one (1) year of employment with the Acquirer.
4. For a period of two (2) years from the date the divestiture of the Highland Park Hospital Assets is completed, Respondent shall not, directly or indirectly, hire or enter into any arrangement for the services of any ENH Employee employed by the Acquirer, unless such ENH Employee's employment has been terminated by the Acquirer; *provided, however*, this Paragraph II.H.4. shall not prohibit

Respondent from: (i) advertising for employees in newspapers, trade publications, or other media not targeted specifically at the employees, or (ii) hiring employees who apply for employment with Respondent, as long as such employees were not solicited by Respondent in violation of this Paragraph II.H.4.

- I. Respondent shall allow the Acquirer an unimpeded opportunity to recruit, contract with, and otherwise extend medical staff privileges to any ENH Medical Staff Member in connection with the divestiture of the Highland Park Hospital Assets so as to enable the Acquirer to establish an independent, complete, full-service medical staff, including as follows:
1. No later than the date of execution of a divestiture agreement, Respondent shall (i) identify each ENH Medical Staff Member, (ii) allow the Acquirer an opportunity to interview any ENH Medical Staff Member, and (iii) allow the Acquirer to inspect the files and other documentation relating to any ENH Medical Staff Member, to the extent permissible under applicable laws.
 2. Respondent shall (i) not offer any incentive to any ENH Medical Staff Member to decline to join the Acquirer's medical staff; (ii) remove any contractual impediments with Respondent that may deter any ENH Medical Staff Member from joining the Acquirer's medical staff, including, but not limited to, any non-compete or confidentiality provisions of employment or other contracts with Respondent that would affect the ability of the ENH Medical Staff Members to be recruited by the Acquirer; and (iii) not otherwise interfere with the recruitment of any ENH Medical Staff Member by the Acquirer, including, but not limited to, by refusing or threatening to refuse to extend medical staff privileges at any Respondent Acute Care Hospital.
- J. Except in the course of performing its obligations under this Order, Respondent shall:
1. not provide, disclose, or otherwise make available any trade secrets or any sensitive or proprietary commercial or financial information relating to the Acquirer or the Acquirer Hospital Business to any Person other than the Acquirer, and shall not use such information for any reason or purpose;
 2. disclose trade secrets or any sensitive or proprietary commercial or financial information relating to the Acquirer or the Acquirer Hospital Business to any Person other than the Acquirer (i) only in the manner and to the extent necessary to satisfy its obligations under this Order and (ii) only to Persons who agree in writing to maintain the confidentiality of such information;
 3. enforce the terms of this Paragraph II.J. as to any Person and take such action as is necessary, including training, to cause each such Person to comply with the terms

of this Paragraph II.J., including any actions that Respondent would take to protect its own trade secrets or sensitive or proprietary commercial or financial information.

- K. No later than ninety (90) days from the date the Highland Park Hospital Assets are divested, Respondent shall terminate any Hospital Provider Contract negotiated or amended after the Merger that is in effect as of the date the divestiture provisions of this Order become final; *provided, however*, that nothing in this Paragraph II.K. shall preclude Respondent (i) from completing any post-termination obligations relating to any Hospital Provider Contract or (ii) from entering into a new Hospital Provider Contract with any Payor after the current contract has been terminated.
- L. The purpose of the divestiture of the Highland Park Hospital Assets and of the related obligations in this Order is to remedy the lessening of competition alleged in the Commission's complaint in Docket No. 9315, restore the competition in the provision of General Acute Care Inpatient Hospital Services by Acute Care Hospitals sold to Payors that was lost as a result of the Merger, and ensure the continued operation of the Highland Park Hospital Assets as an independent competitively viable Acute Care Hospital fully capable of providing General Acute Care Inpatient Hospital Services. In determining whether to approve a proposed Acquirer or manner of divestiture, the Commission will consider, among other things, the likely capability of the proposed Acquirer to achieve the Order's remedial purpose and whether the proposed Acquirer or manner of divestiture raises any competitive concerns in any markets or in any respects, including in markets or respects other than those alleged in the Commission's complaint in Docket No. 9315.

III.

IT IS FURTHER ORDERED that:

- A. From the date this Order becomes final (without regard to the finality of the divestiture requirements herein) until the date the Highland Park Hospital Assets are divested pursuant to this Order, Respondent shall take such actions as are necessary to maintain the viability, marketability, and competitiveness of the Highland Park Hospital Assets and the Post-Merger Hospital Business relating to the Highland Park Hospital Assets. Among other things that may be necessary, Respondent shall:
1. Maintain the operations of the Post-Merger Hospital Business relating to the Highland Park Hospital Assets in the ordinary course of business and in accordance with past practice (including regular repair and maintenance of the Highland Park Hospital Assets).
 2. Use best efforts to maintain and increase sales of the Post-Merger Hospital Business relating to the Highland Park Hospital Assets, and to maintain at

budgeted levels for the year 2005 or the current year, whichever are higher, all administrative, technical, and marketing support for the Post-Merger Hospital Business relating to the Highland Park Hospital Assets.

3. Use best efforts to maintain the current workforce and to retain the services of employees and agents in connection with the Post-Merger Hospital Business relating to the Highland Park Hospital Assets, including payment of bonuses as necessary, and maintain the relations and good will with customers, suppliers, vendors, employees, landlords, creditors, agents, and others having business relationships with the Post-Merger Hospital Business relating to the Highland Park Hospital Assets.
 4. Assure that Respondent's employees with primary responsibility for managing and operating the Post-Merger Hospital Business relating to the Highland Park Hospital Assets are not transferred or reassigned to other areas within Respondent's organization except for transfer bids initiated by employees pursuant to Respondent's regular, established job posting policy.
 5. Provide sufficient working capital to maintain the Post-Merger Hospital Business relating to the Highland Park Hospital Assets as an economically viable and competitive ongoing business and shall not, except as part of a divestiture approved by the Commission pursuant to this Order, remove, sell, lease, assign, transfer, license, pledge for collateral or otherwise dispose of the Highland Park Hospital Assets.
- B. No later than forty five (45) days from the date this Order becomes final, Respondent shall file a verified written report to the Commission that identifies (i) all assets included in the Highland Park Hospital Assets, (ii) all assets originally acquired or that replace assets originally acquired by Respondent as a result of the Merger, (iii) all assets relating to the Post-Merger Hospital Business in Highland Park, Illinois, that are not included in the Highland Park Hospital Assets, and (iv) all clinical services, support functions, and management functions that ENH discontinued at Highland Park Hospital after the Merger (hereinafter "Accounting").

IV.

IT IS FURTHER ORDERED that no later than ten (10) days from the date this Order becomes final (without regard to the finality of the divestiture requirements herein), Respondent shall provide a copy of this Order and Complaint to each of Respondent's officers, employees, or agents having managerial responsibility for any of Respondent's obligations under Paragraphs II and III of this Order.

V.

IT IS FURTHER ORDERED that:

- A. At any time after this Order becomes final (without regard to the finality of the divestiture requirements herein), the Commission may appoint a Person ("Monitor") to monitor Respondent's compliance with its obligations under this Order, consult with Commission staff and report to the Commission regarding Respondent's compliance with its obligations under this Order.
- B. If a Monitor is appointed pursuant to Paragraph V.A. of this Order, Respondent shall consent to the following terms and conditions regarding the powers, duties, authorities, and responsibilities of the Monitor:
1. The Monitor shall have the power and authority to monitor Respondent's compliance with the terms of this Order, and shall exercise such power and authority and carry out the duties and responsibilities of the Monitor pursuant to the terms of this Order and in a manner consistent with the purposes of this Order and in consultation with the Commission or its staff.
 2. Within ten (10) days after appointment of the Monitor, Respondent shall execute an agreement that, subject to the approval of the Commission, confers on the Monitor all the rights and powers necessary to permit the Monitor to monitor Respondent's compliance with the terms of this Order in a manner consistent with the purposes of this Order. If requested by Respondent, the Monitor shall sign a confidentiality agreement prohibiting the use, or disclosure to anyone other than the Commission (or any Person retained by the Monitor pursuant to Paragraph V.B.5. of this Order), of any competitively sensitive or proprietary information gained as a result of his or her role as Monitor, for any purpose other than performance of the Monitor's duties under this Order.
 3. The Monitor's power and duties under this Paragraph V shall terminate three business days after the Monitor has completed his or her final report pursuant to Paragraph V.B.8.(ii), or at such other time as directed by the Commission.
 4. Respondent shall cooperate with any Monitor appointed by the Commission in the performance of his or her duties, and shall provide the Monitor with full and complete access to Respondent's books, records, documents, personnel, facilities and technical information relating to compliance with this Order, or to any other relevant information, as the Monitor may reasonably request. Respondent shall cooperate with any reasonable request of the Monitor. Respondent shall take no action to interfere with or impede the Monitor's ability to monitor Respondent's compliance with this Order.

5. The Monitor shall serve, without bond or other security, at the expense of Respondent, on such reasonable and customary terms and conditions as the Commission may set. The Monitor shall have authority to employ, at the expense of Respondent, such consultants, accountants, attorneys and other representatives and assistants as are reasonably necessary to carry out the Monitor's duties and responsibilities. The Monitor shall account for all expenses incurred, including fees for his or her services, subject to the approval of the Commission.
 6. Respondent shall indemnify the Monitor and hold the Monitor harmless against any losses, claims, damages, liabilities, or expenses arising out of, or in connection with, the performance of the Monitor's duties, including all reasonable fees of counsel and other expenses incurred in connection with the preparation for, or defense of, any claim, whether or not resulting in any liability, except to the extent that such losses, claims, damages, liabilities, or expenses result from the Monitor's gross negligence or wilful misconduct. For purposes of this Paragraph V.B.6., the term "Monitor" shall include all Persons retained by the Monitor pursuant to Paragraph V.B.5. of this Order.
 7. If at any time the Commission determines that the Monitor has ceased to act or failed to act diligently, or is unwilling or unable to continue to serve, the Commission may appoint a substitute to serve as Monitor in the same manner as provided by this Order.
 8. The Monitor shall report in writing to the Commission (i) every sixty (60) days from the date this Order becomes final, (ii) no later than thirty (30) days from the date Respondent completes its obligations under this Order, and (iii) at any other time as requested by the staff of the Commission, concerning Respondent's compliance with this Order.
- C. Respondent shall submit the following reports to the Monitor: (i) no later than twenty (20) days after the date the Monitor is appointed by the Commission pursuant to Paragraph V.A., a copy of the Accounting required by Paragraph III.B. of this Order; and (ii) copies of all compliance reports filed with the Commission.
- D. The Commission may on its own initiative or at the request of the Monitor issue such additional orders or directions as may be necessary or appropriate to assure compliance with the requirements of this Order.

VI.

IT IS FURTHER ORDERED that:

- A. If Respondent has not divested, absolutely and in good faith the Highland Park Hospital Assets within the time and manner required by Paragraph II.A. of this Order, the Commission may at any time appoint one or more Persons as Divestiture Trustee to divest the Highland Park Hospital Assets, at no minimum price, in a manner that satisfies the requirements of this Order.
- B. In the event that the Commission or the Attorney General brings an action pursuant to § 5(l) of the Federal Trade Commission Act, 15 U.S.C. § 45(l), or any other statute enforced by the Commission, Respondent shall consent to the appointment of an Divestiture Trustee in such action. Neither the appointment of a Divestiture Trustee nor a decision not to appoint a Divestiture Trustee under this Paragraph VI shall preclude the Commission or the Attorney General from seeking civil penalties or any other relief available to it, including appointment of a court-appointed Divestiture Trustee, pursuant to § 5(l) of the Federal Trade Commission Act, or any other statute enforced by the Commission, for any failure by the Respondent to comply with this Order.
- C. If a Divestiture Trustee is appointed by the Commission or a court pursuant to this Paragraph VI, Respondent shall consent to the following terms and conditions regarding the Divestiture Trustee's powers, duties, authority, and responsibilities:
1. Subject to the prior approval of the Commission, the Divestiture Trustee shall have the exclusive power and authority to effect the divestiture for which he or she has been appointed pursuant to the terms of this Order and in a manner consistent with the purposes of this Order.
 2. Within ten (10) days after appointment of the Divestiture Trustee, Respondent shall execute an agreement that, subject to the prior approval of the Commission and, in the case of a court-appointed Divestiture Trustee, of the court, transfers to the Divestiture Trustee all rights and powers necessary to permit the Divestiture Trustee to effect the divestiture for which he or she has been appointed.
 3. The Divestiture Trustee shall have twelve (12) months from the date the Commission approves the agreement described in Paragraph VI.C.2. of this Order to accomplish the divestiture, which shall be subject to the prior approval of the Commission. If, however, at the end of the twelve-month period the Divestiture Trustee has submitted a plan of divestiture or believes that divestiture can be achieved within a reasonable time, the divestiture period may be extended by the Commission, or, in the case of a court appointed Divestiture Trustee, by the court.

4. Respondent shall provide the Divestiture Trustee with full and complete access to the personnel, books, records and facilities related to the assets to be divested, or to any other relevant information, as the Divestiture Trustee may request. Respondent shall develop such financial or other information as such Divestiture Trustee may reasonably request and shall cooperate with the Divestiture Trustee. Respondent shall take no action to interfere with or impede the Divestiture Trustee's accomplishment of the divestiture. Any delays in divestiture caused by Respondent shall extend the time for divestiture under this Paragraph in an amount equal to the delay, as determined by the Commission or, for a court-appointed Divestiture Trustee, by the court.
5. The Divestiture Trustee shall use his or her best efforts to negotiate the most favorable price and terms available in each contract that is submitted to the Commission, but shall divest expeditiously at no minimum price. The divestiture shall be made only to an Acquirer that receives the prior approval of the Commission, and the divestiture shall be accomplished only in a manner that receives the prior approval of the Commission; *provided, however*, if the Divestiture Trustee receives bona fide offers from more than one acquiring entity, and if the Commission determines to approve more than one such acquiring entity, the Divestiture Trustee shall divest to the acquiring entity or entities selected by Respondent from among those approved by the Commission; *provided, further*, that Respondent shall select such entity within five (5) business days of receiving written notification of the Commission's approval.
6. The Divestiture Trustee shall serve, without bond or other security, at the cost and expense of Respondent, on such reasonable and customary terms and conditions as the Commission or a court may set. The Divestiture Trustee shall have the authority to employ, at the cost and expense of Respondent such consultants, accountants, attorneys, investment bankers, business brokers, appraisers, and other representatives and assistants as are necessary to carry out the Divestiture Trustee's duties and responsibilities. The Divestiture Trustee shall account for all monies derived from the divestiture and all expenses incurred. After approval by the Commission and, in the case of a court-appointed Divestiture Trustee, by the court, of the account of the Divestiture Trustee, including fees for his or her services, all remaining monies shall be paid at the direction of the Respondent, and the Divestiture Trustee's power shall be terminated. The Divestiture Trustee's compensation shall be based at least in significant part on a commission arrangement contingent on the Divestiture Trustee's divesting the assets.
7. Respondent shall indemnify the Divestiture Trustee and hold the Divestiture Trustee harmless against any losses, claims, damages, liabilities, or expenses arising out of, or in connection with, the performance of the Divestiture Trustee's duties, including all reasonable fees of counsel and other expenses incurred in

connection with the preparation for, or defense of any claim, whether or not resulting in any liability, except to the extent that such liabilities, losses, damages, claims, or expenses result from gross negligence or willful misconduct by the Divestiture Trustee. For purposes of this Paragraph VI.C.7., the term "Divestiture Trustee" shall include all Persons retained by the Divestiture Trustee pursuant to Paragraph VI.C.6. of this Order.

8. If the Divestiture Trustee ceases to act or fails to act diligently, the Commission may appoint a substitute Divestiture Trustee in the same manner as provided in this Paragraph VI for appointment of the initial Divestiture Trustee.
 9. The Divestiture Trustee shall have no obligation or authority to operate or maintain the assets to be divested.
 10. The Divestiture Trustee shall report in writing to the Commission every sixty (60) days concerning the Divestiture Trustee's efforts to accomplish the divestiture.
- D. The Commission or, in the case of a court-appointed Divestiture Trustee, the court, may on its own initiative or at the request of the Divestiture Trustee issue such additional orders or directions as may be necessary or appropriate to accomplish the divestiture required by this Order.

VII.

IT IS FURTHER ORDERED that:

- A. Respondent shall file a verified written report with the Commission setting forth in detail the manner and form in which it intends to comply, is complying, and has complied with this Order (i) no later than thirty (30) days from the date this Order becomes final (without regard to the finality of the divestiture requirements herein), and every thirty (30) days thereafter (measured from the date the first report is filed) until the divestiture of the Highland Park Hospital Assets is accomplished, and (ii) thereafter, every sixty (60) days (measured from the date of divestiture) until the date Respondent completes its obligations under this Order; *provided, however*, that Respondent shall also file the report required by this Paragraph VII at any other time as the Commission may require.
- B. Respondent shall include in its compliance reports, among other things required by the Commission, a full description of the efforts being made to comply with the relevant Paragraphs of this Order, a description (when applicable) of all substantive contacts or negotiations relating to the divestiture required by Paragraph II of this Order, the identity of all parties contacted, copies of all written communications to and from such parties, internal documents and communications, and all reports and recommendations

concerning the divestiture, the date of divestiture, and a statement that the divestiture has been accomplished in the manner approved by the Commission.

VIII.

IT IS FURTHER ORDERED that Respondent shall notify the Commission at least thirty (30) days prior to (1) any proposed dissolution of Respondent, (2) any proposed acquisition, merger or consolidation of Respondent, or (3) any other change in Respondent that may affect compliance obligations arising out of this Order, including but not limited to assignment, the creation or dissolution of subsidiaries, or any other change in Respondent.

IX.

IT IS FURTHER ORDERED that, for the purpose of determining or securing compliance with this Order, and subject to any legally recognized privilege, and upon written request with reasonable notice, Respondent shall permit any duly authorized representative of the Commission:

- A. Access, during office hours and in the presence of counsel, to all facilities and access to inspect and copy all non-privileged books, ledgers, accounts, correspondence, memoranda and other records and documents in the possession or under the control of Respondent relating to any matter contained in this Order; and
- B. Upon five days' notice to Respondent and without restraint or interference from them, to interview their officers, directors, or employees, who may have counsel present, regarding any such matters.

SO ORDERED:

Stephen J. McGuire
Chief Administrative Law Judge

Date:

Respectfully submitted,

Chul Pak
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May 27, 2005

By: Renée S. Henning