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

In the matter of	)	
	)	Docket No. 9315
Evanston Northwestern Healthcare Corporation,	)	**Public Record**

RESPONDENT'S REPLIES TO COMPLAINT COUNSEL'S PROPOSED FINDINGS OF FACT

VOLUME VII of XI

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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).

Response to Finding No. 1499:

This proposed finding is misleading. Newton's role in the Merger and post-Merger MCO negotiations was extremely limited, thus providing no foundation for him to testify concerning these matters. (RFF-Reply ¶¶ 1387, 1462, 1465).

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).

Response to Finding No. 1500:

This proposed finding is misleading. (RFF-Reply ¶¶ 1387, 1462-1463, 1465). ENH did use the higher of the two hospital contracts as the starting point in its MCO negotiations. (Hillebrand, Tr. 1856).

REDACTED

(RFF ¶¶ 783, 789, 851-52, 891; RFF ¶¶ 750-752, 788, 841, 846-47, 871-872, 889-890, 892 *in camera*). For instance, PHCS felt that its major categories of service (medical/surgical, normal deliveries and C-Sections) should be on fixed rates and negotiated an escalator clause for the remaining discount-off-charges categories. (RFF ¶¶ 846-847). Moreover, United indicated that it was its preference to use the better of the two contracts as a benchmark in negotiations. (CX 111 at 1). In any event,

REDACTED

(CX 5174 at 11-12, *in camera*).

REDACTED

(Foucre, Tr. 1118-19, *in camera*; CX 5174 at 12, *in camera*). After the Merger, ENH

negotiated lower prices than HPH's previous discount-off-charges rates for inpatient services at PHCS, CCN, Health Network, Preferred Plan and First Health. (RX 871 at ENH JL 3239; *see also* RFF ¶ 735). ENH also negotiated lower prices than HPH's previous discount-off-charges rates for outpatient services at PHCS, CCN, Health Network, Preferred Plan, First Health, and the State of Illinois. (RX 871 at ENH JL 3239; RFF ¶ 736).

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).

Response to Finding No. 1501:

This proposed finding is misleading and false. This proposed finding is supported solely by the testimony of Newton, who was not a credible witness. Newton's role in the Merger and post-Merger MCO negotiations was limited, thus providing no foundation for him to testify concerning these matters. Moreover, Newton's testimony reflects improper lay opinion; he was not qualified as an expert witness. Newton had no foundation to testify about how much MCOs "really needed" ENH. Such testimony, therefore, should be given no weight. (RFF-Reply ¶¶ 1387, 1462-1463, 1465).

This proposed finding also ignores the testimony of Neaman that ENH's 2000 negotiation plan risked losing contracts with MCOs. (RFF-Reply ¶ 1433). Nevertheless, ENH had little reason for such concerns because one-time catch-ups on outdated and under-market contracts were the primary reasons for ENH's proposed rate increases. (RFF ¶¶ 322, 681, 687, 707, 719, 732, 754, 796, 864).

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).

Response to Finding No. 1502:

This proposed finding is misleading. This proposed finding is supported solely by the testimony of Newton, who was not a credible witness. Newton's testimony speaks only for Newton, not HPH management. Such testimony should be given no weight because it is pure speculation. (RFF-Reply ¶¶ 1387, 1462-1463, 1465).

This proposed finding is further misleading because discount-off-charges is a very common reimbursement methodology. Generally, discount-off-charges is the standard methodology for outpatient services. (RFF-Reply ¶ 799).

REDACTED

(RFF ¶ 82-85, *in camera*). Since 2000, Chicago area hospitals have pressed more aggressively for discount-off-charges provisions for inpatient services. (RFF ¶ 86).

REDACTED

(RFF ¶¶ 87-89, *in camera*).

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).

Response to Finding No. 1503:

This proposed finding is misleading. (RFF-Reply ¶ 1502).

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).

Response to Finding No. 1504:

This proposed finding is misleading. (RFF-Reply ¶ 1497). Moreover, Hillebrand testified his intent was to use the United negotiations as a benchmark for many, but not necessarily all, of the subsequent MCO negotiations. (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).

Response to Finding No. 1505:

This proposed finding is misleading. (RFF-Reply ¶¶ 1365, 1368).

1506.

REDACTED

(Chan, Tr. 844-46, *in camera*; CX 5906 at 2).

Response to Finding No. 1506:

This proposed finding is misleading. As an initial matter, Chan's estimate of $21 million is contradicted by other documents cited by Complaint Counsel. For example, CX 17, Neaman's final report on the Merger integration, attributed only $18 million to contract renegotiations, a figure that also included $3 million from the Blue Cross renegotiations. (CX 17 at 5-8; CCFF ¶ 1398; RFF-Reply ¶ 1398).

Whatever the correct figure may be, the cited document confirms that these increases were the result of ENH bringing its prices up to market. CX 5906 notes that the "impact of [contract renegotiations] on net revenue at ENH-Highland Park Hospital is much less significant" than on the net revenue for Evanston and Glenbrook Hospitals. (CX 5906 at 1).

Because Evanston Hospital was so far below market for an academic system, this is exactly the expected outcome – an outcome consistent with the learning about demand theory.

CX 5906 also reveals that ENH was hardly able to put a "premium" on the higher of the two merging hospitals contracts. In fact, it reveals that ENH often had trouble negotiating even pre-Merger HPH's superior rates for post-Merger ENH. For example, post-Merger ENH's inpatient rates with United, PHCS, CCN, Health Network, Preferred Plan and First Health all fell below the standard set by pre-Merger HPH. (CX 5906 at 3; RFF-Reply ¶ 1500).

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).

Response to Finding No. 1507:

This proposed finding is misleading. The only reason ENH was able to negotiate more favorable rates with these MCOs after the Merger was because these MCOs – especially Cigna, PHCS and United – had long reimbursed Evanston Hospital at below-market rates and ENH learned about the demand for its services at the time of the Merger. (RFF ¶¶ 778-784, 827-838, 877-884).

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).

Response to Finding No. 1508:

This proposed finding is misleading. (RFF-Reply ¶ 1494).

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)).

Response to Finding No. 1509:

This proposed finding is inaccurate, misleading and false. Respondent addresses below the documents at issue as they are used by Complaint Counsel in the following proposed findings of fact.

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).

Response to Finding No. 1510:

This proposed finding is incomplete and misleading because it fails to detail why Bain believed a potential Merger might enhance pre-Merger ENH's competitive and operating position. According to Bain the "merger present[ed] the opportunity to gain efficiencies in core central functions, to use purchasing leverage and to improve that [sic] cost and quality of onsite functions through the sharing of best practices." (CX 66 at 1-2). According to Neaman, he understood that Bain advised that the Merger presented the opportunity, but not the guarantee, to get better contracts when purchasing things like medical supplies or capital equipment; and also

the opportunity, not the guarantee, to improve costs and quality by sharing ENH and HPH's best practices with each other. (Neaman, Tr. 1368-69; (RX 2047 at 8-9, 14 (Ogden, Dep.)).

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).

Response to Finding No. 1511:

This proposed finding is misleading because it exaggerates the importance of the "core" sub-market, which, in reality, is not a relevant measure of ENH's market share. (RFF-Reply ¶¶ 49, 57).

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).

Response to Finding No. 1512:

This proposed finding is misleading. (RFF-Reply ¶ 1510).

1513. Bain proposed, among other projects, creating "a unified contracting strategy reflecting the combined entities" of Highland Park and ENH. (CX 66 at 2).

Response to Finding No. 1513:

This proposed finding is incomplete and misleading. As an initial matter, the March 1999 letter revealed that Evanston Hospital was not, at the time, interested in having Bain focus on this "unified contracting strategy." (CX 66 at 2). This further confirms that MCO contracting was never a particularly important part of Merger planning. Nevertheless, because Evanston and Glenbrook Hospitals had long used a "unified contracting strategy" and because unified contracting would later become an integral part of harmonizing quality of care and achieving efficiencies, it is little surprise that Bain would consider this strategy one of the many parts of its Merger analysis. (RFF-Reply ¶¶ 1381).

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).

Response to Finding No. 1514:

Respondent has no specific response.

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).

Response to Finding No. 1515:

Respondent has no specific response.

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).

Response to Finding No. 1516:

This proposed finding is incomplete and, therefore, misleading. The cited sentence reads in its entirety: "The merger provides the opportunity to reduce costs, refocus activities at the three hospitals, shift activity from the overcrowded Evanston Hospital and negotiate contracts with payors from a stronger position." (CX 2072 at 1). This sentence, when read as a whole, confirms that Evanston Hospital and HPH hoped that the merged entity would be able to negotiate from a stronger position as a result of improved quality (refocusing and shifting clinical activities) and as a result of being more cost-effective. (RFF-Reply ¶¶ 1361, 1407; (RX 2047 at 15 (Ogden, Dep.)). Even one of Complaint Counsel's lead witnesses, Newton, recognized that hospitals had to be cost-effective and had to present a high quality product to the market in order to negotiate better rates from MCOs. (Newton, Tr. 408).

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).

Response to Finding No. 1517:

This proposed finding is useful for highlighting that Bain's use of the word "leverage" was not a code word for market power as implied by Complaint Counsel. Instead, "leverage" also applied to "service line opportunities," an area in which market power could not possibly exist. (RFF ¶¶ 996-98, *in camera,* RFF ¶ 999).

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).

Response to Finding No. 1518:

This proposed finding is misleading for several reasons. First, Bain did not use "leverage" to mean market power. (RFF ¶¶ 996-99; RFF-Reply ¶ 1517). Second, Ogden, who was the Bain representative responsible for the ENH Merger project, testified that Bain eventually found that HPH was too small to make a difference to MCOs, *i.e.*, the importance to a MCO of Evanston Hospital did not differ from the importance of Evanston Hospital plus HPH. (RX 2047 at 38 (Ogden, Dep.)). Ogden further testified that while Bain thought the Merger provided several benefits to ENH, "[w]e weren't trying to renegotiate based on a changed position because of the merger. We said we need to renegotiate because we don't have a contract. You haven't negotiated with us in five years. Here is who Evanston is, and it really was overwhelmingly a focus on Evanston" and what Bain thought was "fair market value." (RX 2047 at 32 (Ogden, Dep.)). Ogden continued, explaining that HPH was a "tiny hospital" and the Merger did not change ENH's "position in the marketplace at all." (RX 2047 at 33 (Ogden, Dep.)). What made ENH's post-Merger contracting efforts successful was the application of

"better people and a better process." (RX 2047 at 33 (Ogden, Dep.)). Finally, when Ogden testified, she was not employed by Bain, ENH or any other involved party – thus making her testimony free of any potential bias. (RX 2047 at 3 (Ogden, Dep.)).

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).

Response to Finding No. 1519:

This proposed finding is misleading and irrelevant. (RFF-Reply ¶¶ 1517-1518). It is also false because the Merger did not create an entity with the largest admissions in the Chicago area. This statement by Bain did not consider other Chicago area hospital systems – such as the Resurrection Health Care System, the Advocate Health Care System, and the Rush Presbyterian System – when making the above-cited determination. (Neaman, Tr. 1165).

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(RX 1361 at ENHE DL 6610; RX 1331 at ENHE DL 11883, *in camera*). And Advocate's nine hospitals, Resurrection's eight hospitals, and Rush's five hospitals all likely have more admissions in the Chicago area than does ENH. (RX 1361 at ENHE DL 6610-11).

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).

Response to Finding No. 1520:

This proposed finding is misleading. To be clear, Hillebrand agreed that "leverage means gaining strength, and bargaining power is a measure of strength." (Hillebrand, Tr. 1802). But, again, "leverage" did not necessarily mean market power. (RFF-Reply ¶¶ 1517-1518). Even assuming, for the sake of argument, that the term "leverage" incorporates the concept of

"bargaining power," the Merger did not change ENH's measure of such power. (RFF-Reply ¶ 1518).

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.)).

Response to Finding No. 1521:

This proposed finding is misleading because Bain believed that pre-Merger Evanston Hospital's position in the marketplace was equally as good as was its post-Merger position. Specifically, Bain found that HPH was too small to make a difference to MCOs, *i.e.*, the importance to a MCO of Evanston Hospital did not differ from the importance of Evanston Hospital plus HPH. (RX 2047 at 38 (Ogden, Dep.)). Ogden further explained that HPH was a "tiny hospital" and the Merger did not change ENH's "position in the marketplace at all." (RX 2047 at 33 (Ogden, Dep.)).

1522. This "good position" was attributable to the post-merger ENH's "size and quality in the marketplace." (RX 2047 at 156 (Ogden, Dep.)).

Response to Finding No. 1522:

This proposed finding is misleading because Bain determined that the Merger did not change ENH's "position in the marketplace at all." (RX 2047 at 33 (Ogden, Dep.); RFF-Reply ¶¶ 1518, 1521). Nevertheless, Complaint Counsel here explicitly concedes, and Respondent agrees, that ENH's quality was an important reason for its "good position" in the marketplace for negotiating better rates with MCOs.

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).

Response to Finding No. 1523:

This proposed finding is misleading. (RFF-Reply ¶¶ 1492, 1521).

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).

Response to Finding No. 1524:

This proposed finding is misleading because the very reasons for which Bain advised that ENH had enough "leverage" to improve terms on the above-mentioned contracts were that they were large, poorly performing contracts. Ogden confirmed that the "leverage" that ENH had with MCOs after the Merger was a function of what Evanston Hospital had been paid before the Merger, and ENH's position as a major-sized hospital (even without HPH). (RX 2047 at 41 (Ogden, Dep.)). Once again, "leverage" is shown not to be related in any way to market power. (RFF-Reply ¶¶ 1517-1518).

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).

Response to Finding No. 1525:

This proposed finding is misleading because Bain's advice to "sell ENH's benefits to payor" was not related to the Merger. Ogden and Bain concluded that the Merger did not make ENH any more powerful and, therefore, whatever benefits ENH was "selling" existed before the Merger. (RFF-Reply ¶¶ 1518, 1521). Moreover, this proposed finding represents nothing more than a negotiation tactic, not an exercise of market power. As part of Bain's advice to ENH that it get more aggressive during MCO negotiations, Bain suggested that ENH ask for a price higher than what it might ultimately accept. (RX 2047 at 62 (Ogden, Dep.); RFF ¶¶ 710-725). This included "[t]argeting 10 percent above the best contract from either [Evanston Hospital or HPH]." (RX 2047 at 31 (Ogden, Dep.)).

This proposed finding is further misleading because, as it turned out, ENH was rarely able to negotiate prices better than those of pre-Merger HPH, let alone "premium prices." For

example, an ENH document prepared in May 2000 reveals that post-Merger ENH's inpatient rates with United, PHCS, CCN, Health Network, Preferred Plan, and First Health all fell below the standard set by pre-Merger HPH. (CX 5906 at 3; RFF-Reply ¶¶ 1500, 1506).

1526. Bain provided ENH with "action plans" for individual health care plan negotiations. (CX 1998 at 44, 49).

Response to Finding No. 1526:

This proposed finding is incomplete because it fails to mention that these action plans were part of Bain's overall effort to systematize ENH's negotiation process. Bain laid out a template for ENH to use in its contract negotiations "that highlighted that [ENH] should be doing an annual review, [] the data that they should put together before every negotiation, and then some thoughts on how to conduct the negotiation itself." (RX 2047 at 61 (Ogden, Dep.)).

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).

Response to Finding No. 1527:

This proposed finding is misleading. Bain further advised ENH on the cited page that the PHCS contract would soon expire in February 2000 and that HPH had a more attractive contract than did Evanston Hospital. (CX 1998 at 44). Accordingly, the "leverage" that ENH had with MCOs after the Merger was a function of what Evanston Hospital had been paid before the Merger, and ENH's position as a major-sized hospital (even without HPH). (RX 2047 at 41 (Ogden, Dep.)). Once again, "leverage" is shown not to be related in any way to market power. (RFF-Reply ¶¶ 1517-1518).

Bain further concluded that the addition of HPH did not change pre-Merger Evanston Hospital's negotiating position. Accordingly, Evanston Hospital still would have had the same

"North Shore presence," and PHCS still would have "need[ed]" Evanston Hospital in its network, even without the Merger. (RFF-Reply ¶¶ 1518, 1521).

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).

Response to Finding No. 1528:

Because the cite, CX 67 at 39, is nearly identical to CX 1998 at 44, this proposed finding is misleading for exactly the same reasons detailed in Respondent's reply to proposed finding 1527. (RFF-Reply 1527). This proposed finding is further misleading because Bain listed as yet another source of ENH's leverage with PHCS the fact that PHCS's "initial proposal is below existing contract." (CX 67 at 39 (emphasis in original)). Once again, "leverage" is shown to be, in part, a function of what Evanston Hospital had been paid before the Merger, and not some proxy for Merger-created market power. (RX 2047 at 41 (Ogden, Dep.); RFF-Reply ¶¶ 1517-18).

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).

Response to Finding No. 1529:

This proposed finding is irrelevant because it does nothing to prove a connection between "leverage" and market power. Whether ENH had more or less opportunity to negotiate with Blue Cross before and after the Merger, does not reveal how the Merger changed ENH's "leverage" with other MCOs. As Bain's lead representative on the ENH project testified, the addition of HPH did nothing to improve Evanston Hospital's negotiating position. (RFF-Reply ¶¶ 1518). Moreover, ENH had "less opportunity" to negotiate with Blue Cross because Evanston Hospital's contract with Blue Cross turned out to be one of the few better than HPH's

– reflecting the time and effort Hillebrand and Sirabian put into maintaining pre-Merger Evanston Hospital's relationship with Blue Cross. Therefore, there was no need for a significant one-time catch-up on the Blue Cross contract. (RFF ¶¶ 757-760; RFF-Reply ¶ 1767; CX 1998 at 49).

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).

Response to Finding No. 1530:

This proposed finding is misleading because the then-existing Evanston Hospital contract with Blue Cross did not require a significant one-time catch-up to bring its rates up to competitive levels. (RFF ¶ 1529).

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).

Response to Finding No. 1531:

Respondent has no specific response.

1532.

REDACTED

(CX 1991 at 3, *in camera*).

Response to Finding No. 1532:

This proposed finding is incomplete and misleading.

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REDACTED (CX 1991 at 3, *in camera*). It is therefore not surprising that ENH,

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(CX 1991 at 3, *in camera*). Even so, in many other cases, ENH did not obtain rates as favorable as the rates of pre-Merger HPH. (RFF-Reply ¶ 1500).

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).

Response to Finding No. 1533:

Bain's February 2000 target is entirely reasonable given how much catch-up was needed to bring ENH up to market. (RX 684 at Bain 43; RFF-Reply ¶¶ 679, 732). This proposed finding is entirely consistent with the learning about demand theory. (RFF ¶¶ 656-1002).

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).

Response to Finding No. 1534:

This proposed finding is misleading. Neaman's later October 2000 final merger integration report, a report frequently and approvingly cited by Complaint Counsel, explains that the renegotiation of MCO contracts resulted in an annualized economic value of $18 million, not $21 million. (CX 17 at 5-8; CCFF ¶¶ 1330-31, 1398). That $18 million included a $3 million enhancement from the Blue Cross renegotiation, yet Complaint Counsel has not asserted that this $3 million enhancement was the result of ENH's market power. (RFF-Reply ¶ 1375). Moreover, that $18 million figure included $3 million from Cigna and $2 million from Humana. Complaint Counsel did not call any representatives from these MCOs. And to be clear, Bain's February 2000 figures underestimated the final Blue Cross number by $1.5 million and the final Humana number by $1 million. (CX 67 at 32). It is also not clear whether Bain's estimate

included any figure for Cigna. Given these discrepancies, it is difficult to compare such a rough and early estimate with the final numbers ENH itself calculated.

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).

Response to Finding No. 1535:

This proposed finding is inaccurate to the extent it claims that the NHN disbanded in the late 1990s. While the Network dissolution agreement was dated December 20, 1999, the agreement did not go into effect until January 2, 2000. (Neaman, Tr. 1016; CX 5 at 4).

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)).

Response to Finding No. 1536:

This proposed finding is misleading. To the extent it implies that the intent underlying the Network was an improper one, this proposed finding ignores that the Network received Hart-Scott-Rodino approval in 1993. (Neaman, Tr. 1360; RX 91 at 1).

Additionally, whatever Neaman, Spaeth and other representatives of Evanston Hospital and HPH intended to do with NHN, NH North or the eventual Merger is irrelevant to this case.

As discussed in Respondent's Post-Trial Brief at Section I.B., evidence of subjective intent of the merging parties is of minimal probative value in a Section 7 case and even less relevant in a post-consummated merger challenge where quantitative data is available.

Even assuming that this proposed finding has some relevance, it is further misleading. In particular, the Network was formed, in part, to handle the anticipated trend towards capitated contracts, pursuant to which a MCO paid a group of providers a fixed amount of dollars per member per month, thus placing all financial risk on that group of providers. (Neaman, Tr. 1360). This case does not involve capitated contracts.

Evanston Hospital itself joined the Network based on its belief that the then-existing Rush, Humana and Evangelical hospital systems in the Chicago area would be the operating model for the future. There was some fear that Evanston Hospital might be left behind if it did not become an integral part of a hospital network. (RX 357 at ENH JH 10385; RFF ¶ 205). HPH had its own reasons, and joined to enhance the hospital's quality of care as well as its perception in the marketplace. (Spaeth, Tr. 2194; RFF ¶ 206). Indeed, the Network's other primary goals included developing systems for assuring high quality patient care and strengthening the academic programs at the hospitals and Northwestern University. (CX 1780 at 5-6; CX 6306 at 2-4 (Mecklenburg, Dep.); RFF ¶ 201).

Finally, this proposed finding fails to explain why Network members did not want to give up individual autonomy in contracting. Not all members were convinced that the Network could get better terms from MCOs. (Neaman, Tr. 966; RFF ¶ 226). Northwestern Memorial's CEO, Gary Mecklenburg, recognized that there was no evidence that a larger market share, *e.g.*, 25 to 30%, of the entire Chicago area would lead to improved prices. (RX 177 at NHN 115; RFF ¶ 226).

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).

Response to Finding No. 1537:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶ 1536).

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).

Response to Finding No. 1538:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶ 1536).

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).

Response to Finding No. 1539:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536). Assuming it has some relevance, this proposed finding is still incomplete and misleading because it fails to mention that the Network's goal was to achieve "substantial market share" of the entire metropolitan Chicago area market. (CX 381 at 2; CX 1860 at 11; Neaman Tr. 994). Since the 30% market share cited above also refers to the entire Chicago area market, any effort to use the numbers outside of that context renders the percentages meaningless.

Moreover, this proposed finding does not define the term "indispensable." Because NHN would never achieve its "substantial market share" without presenting a high-quality and cost-efficient product to the market, "becoming indispensable" was shorthand for presenting a better product to MCOs. (RFF-Reply ¶ 1459).

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).

Response to Finding No. 1540:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536).

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).

Response to Finding No. 1541:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536).

1542. NHN's goals included "trying to achieve a global contract price and exclusivity with certain payors." (Newton, Tr. 308).

Response to Finding No. 1542:

This proposed finding is incomplete because it fails to detail NHN's other goals. (RFF-Reply ¶ 1536).

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).

Response to Finding No. 1543:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536).

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)

Response to Finding No. 1544:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536).

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).

Response to Finding No. 1545:

Respondent has no specific response.

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).

Response to Finding No. 1546:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536).

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).

Response to Finding No. 1547:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536).

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).

Response to Finding No. 1548:

Respondent has no specific response.

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%)).

Response to Finding No. 1549:

This proposed finding is irrelevant and is based on unreliable and inadmissible double hearsay in violation of JX 1 ¶ 5.

1550. Bain advised that NHN should gain "market influence" through "significant share (20-25%) of physician/hospital market." (CX 1860 at 48).

Response to Finding No. 1550:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536). This proposed finding is also incomplete and misleading because the Network's goal was to achieve "substantial market share – 20-25% of total covered lives in the [Chicago] metropolitan area (approximately 2.0 million people)," not some smaller subsection. (RX 357 at JH 010386; CX 1860 at 11; Neaman Tr. 994; RFF-Reply ¶ 1539). Any effort to use these numbers outside of that context renders the percentages meaningless.

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).

Response to Finding No. 1551:

This proposed finding is irrelevant because it is based on a third party's opinion of a subject that itself is irrelevant. (RFF-Reply ¶ 1536).

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).

Response to Finding No. 1552:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536). It also mischaracterizes Neaman's testimony because he stated that the "network would have *been able to do* a better job," not that it was certain to do a better job with a "strong, central contracting methodology." (Neaman, Tr. 989 (emphasis added)).

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.)).

Response to Finding No. 1553:

This proposed finding is incomplete because it fails to explain that the Network possessed all of the powers to be a strong, cohesive organization. (RFF ¶¶ 201-218). The Network opted not to exercise those powers. (Hillebrand, Tr. 1788-89; RFF ¶¶ 225, 227).

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).

Response to Finding No. 1554:

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 1553). It is further misleading because it fails to fully explain that the Network was formed, in part, to handle the anticipated trend towards capitated contracts, a contracting method that requires large volume because all the risk is placed on the hospital. (Neaman, Tr. 1360). While capitated contracts did come to Chicago in the mid-1990s, they never became the major factor many had predicted. (Neaman, Tr. 1361). Thus, one of the driving forces behind the formation of the Network never materialized in the Chicago area marketplace. (RX 584 at ENH JH 2951; CX 6306 at 13 (Mecklenburg, Dep.)).

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.)).

Response to Finding No. 1555:

This proposed finding is misleading. (RFF-Reply ¶ 1544). It also fails to explain that the market trends the Network was created to address did not materialize and also that certain member institutions never did believe size determined contracting success. (RFF-Reply ¶¶ 1536, 1554). Therefore, the Network did not dissolve because it did not do anything, but because its members did not think it had anything to do.

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.)).

Response to Finding No. 1556:

This proposed finding is misleading because NHN did have central authority. (RFF-Reply ¶ 1553). Many of its members, such as Northwestern Memorial, did not, however, see a reason for the Network to exercise that authority. (RFF-Reply ¶ 1536; RFF ¶ 226).

1557. NHN was ineffective on the managed care contracting front. (Neaman, Tr. 966).

Response to Finding No. 1557:

This proposed finding is misleading because it fails to mention that the Network was formed, in part, to handle capitated contracts, but these contracts never became the major factor many had predicted. (Neaman, Tr. 1360-61). It is therefore not surprising that the Network failed to be successful on the managed care contracting front. (RX 584 at ENH JH 2951; (CX 6306 at 13 (Mecklenburg, Dep.)).

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).

Response to Finding No. 1558:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536). This proposed finding is also misleading because it mischaracterizes Neaman's testimony. Neaman did not testify that collective action by members was certain to result in better prices and terms. (Neaman, Tr. 965-66). Rather, he viewed collective action as a "potential benefit," and he testified that the lack of collective action was just one of the factors for the Network's contracting failures. (Neaman, Tr. 965-66). Again, another significant factor was the failure of capitated contracting to materialize as expected in the Chicago area market. (RFF-Reply ¶ 1557).

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.)).

Response to Finding No. 1559:

This proposed finding is misleading because it fails to explain that "single signature contracting" did not necessarily require hospitals to jointly negotiate but, instead, required hospitals and physicians to jointly negotiate with MCOs. (CX 1802 at 5). This proposed finding is further misleading because it fails to explain that the Network possessed all the powers to be a strong, cohesive organization. It simply opted not to exercise all of those powers. (RFF-Reply ¶ 1553).

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.)).

Response to Finding No. 1560:

This proposed finding is misleading. NHN was not able to have a centralized capitation program because capitation never materialized in the Chicago area market. (RFF-Reply ¶ 1554).

1561. By 1998, NHN had evolved into more of a general grouping of hospitals, like a trade association, rather then a centralized organization. (Neaman, Tr. 1008).

Response to Finding No. 1561:

This proposed finding is misleading because the Network never relinquished the powers necessary to be a strong, cohesive organization. (RFF ¶ 1553; CX 381 at 4). This proposed finding also mischaracterizes Neaman's testimony because Neaman only agreed that the Network was "evolving" towards a "trade association," not that it had become one. (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).

Response to Finding No. 1562:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536). This proposed finding is also misleading because it fails to mention that a primary reason for "the lack of improved managed care contracts through NHN" was the failure of capitation to "materialize" in the Chicago area market. (CX 381 at 2-3). It further fails to mention that Evanston Hospital was also disappointed with the Network's inability to generate meaningful cost savings, its limited clinical synergies and the minimal sharing of clinical pathways. (CX 381 at 3; RFF ¶¶ 227, 229).

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.)).

Response to Finding No. 1563:

This proposed finding is misleading because NHN's dissolution agreement did not go into effect until January 2, 2000. (Neaman, Tr. 1016; CX 5 at 4). Moreover, the Articles of Dissolution were not "filed" until January 3, 2000. (CX 1833 at 1-2).

This proposed finding is further misleading because it fails to explain fully why members determined that the Network's future existence was not necessary. The Network was formed for a specific purpose and in anticipation of a specific marketplace. But the marketplace did not form as anticipated, and so the Network was not delivering value the way that its members had anticipated that it would. (CX 6306 at 13 (Mecklenburg, Dep.); RFF ¶ 228; RFF-Reply ¶ 2536).

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).

Response to Finding No. 1564:

This proposed finding is misleading because NHN's dissolution agreement did not go into effect until January 2, 2000. (Neaman, Tr. 1016; CX 5 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).

Response to Finding No. 1565:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536). It is also misleading. The NH North planning documents are clear: NH North was not designed to succeed where the Network was failing. For instance, a 1996 document stated: "must identify key linkages (and no duplication to NHN). Example, managed care contracting to be in conjunction with NHN. Everything else at local level." (CX 393 at 9).

And similar to the Evanston Hospital-HPH Merger documents, NH North planning documents stated that NH North's "purposes" included enhancing quality, access and health of the hospitals' communities, enhancing efficient organization and decreasing healthcare costs. (CX 395 at 2).

This proposed finding also mischaracterizes Hillebrand's testimony. Hillebrand did not testify that "NH-North's key goal" was "to get better contracts by negotiating as one entity." Rather, he merely "believed" that one of the "reasons" for NH North "was to get better rates by negotiating as one entity." (Hillebrand, Tr. 1726). NH North planning documents reveal that the strategy for getting better rates was to achieve "market influence" through "differentiation" and

"cost leadership." (CX 394 at 13). [D]ifferentiation" was to be achieved through "superior outcomes," "brand equity" and "best physicians." (CX 394 at 13; Hillebrand, Tr. 2020). "Cost leadership" was to be achieved through reducing "cost per unit of care," "develop[ing] pathways" and "hospital & physicians common incentives." (CX 394 at 13; Hillebrand, Tr. 2020-21).

Had NH North been created, its brand name was to play a particularly important role. Specifically, NH North was to "increase market share and obtain premium pricing through brand." (CX 393 at 14). The idea was to use name-brand to differentiate NH North in such a way that it would make NH North very distinctive and very desirable in the minds of customers. (Neaman, Tr. 1363-64; Hillebrand, Tr. 2020).

But as Complaint Counsel points out, NH North never came into existence. Discussions between HPH, Evanston Hospital and Northwest Community broke down in 1997 as the result of differences over NH North's organization (such as the composition of the board), personality conflicts and a lack of interest on the part of Northwest Community. (CX 6305 at 9 (Stearns, Dep.); Neaman, Tr. 1035; Hillebrand, Tr. 1791-92; RFF ¶ 239). Evanston Hospital and HPH were also not ready to go ahead with NH North in 1997. (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).

Response to Finding No. 1566:

Respondent has no specific response.

1567. This proposed "sub-regional" merger was called "NH-North." (CX 394 at 2).

Response to Finding No. 1567:

Respondent has no specific response.

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).

Response to Finding No. 1568:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536). This proposed finding is also misleading. For NH North to get better contracts and achieve "market influence" it had to achieve "differentiation" and "cost leadership," not market share or market power. (CX 394 at 13). (RFF-Reply ¶ 1565).

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).

Response to Finding No. 1569:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536). Even assuming it is relevant, this proposed finding is misleading. The very same documents cited by Complaint Counsel reveal that the means to capture "30-40% of key health plans" and to achieve a level of "indispensability" were "differentiation" and "cost leadership." (CX 394 at 13). [D]ifferentiation" was to be achieved through "superior outcomes," "brand equity" and "best physicians." (CX 394 at 13; Hillebrand, Tr. 2020). "Cost leadership" was to be achieved through reducing "cost per unit of care," "develop[ing] pathways" and "hospital & physicians common incentives." (CX 394 at 13; Hillebrand, Tr. 2020-21; CX 395 at 2 (stating one of NH North's "principles" was to be "an entity that differentiates its product, its brand and is indispensable to the marketplace."). Thus, far from being a code word for market power,

"indispensability" stood for the hope that the customer would view NH North as the system of choice for healthcare as a result of NH North having the best outcomes, the best service, the best physicians and highest brand. (Hillebrand, Tr. 2021).

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).

Response to Finding No. 1570:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536). Even assuming it were relevant, it is still misleading because NH North documents clearly state that the means for getting higher rates from MCOs were improving quality, generating cost savings, and promoting NH North's brand. (RFF-Reply ¶¶ 1565, 1569).

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).

Response to Finding No. 1571:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536). Assuming it has some relevance, it is misleading. In its entirety, the above cited sentence reads: "The goal of this regional name/brand strategy will be particularly focused to increase market share and obtain premium sustainable pricing through managed care contracting." (CX 395 at 1). Once again, NH North's brand, a symbol for high quality, would be the key to growth and "premium pricing." (RFF-Reply ¶¶ 1565, 1569).

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).

Response to Finding No. 1572:

Respondent has no specific response.

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).

Response to Finding No. 1573:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536).

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).

Response to Finding No. 1574:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536). Moreover, to the extent that NH North was to obtain "premiums," it would be through its brand, not market power. (RFF-Reply ¶¶ 1565, 1569).

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).

Response to Finding No. 1575:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536). If Complaint Counsel meant to compare this advice to that later provided by Bain in 1999, this proposed finding is still not relevant. First, Northwest Community and its share of some vague geographic market were not involved in the 2000 Merger. Second, Evanston Hospital and HPH's shares of the other vaguely defined markets are equally irrelevant. Complaint Counsel has not provided any evidence of how these geographic markets are defined, *e.g.*, how many zip codes they contain, or of what relevance these markets were to the NH North parties, let alone a connection to the 2000 Merger.

1576. Bain advised that a "key need" for the merger was "marketshare 'clout' (30-50%)." (CX 393 at 1).

Response to Finding No. 1576:

This proposed finding is vague and irrelevant. (RFF-Reply ¶ 1536). This proposed finding is also misleading because it fails to explain that NH North was to grow market share through enhanced quality, enhanced cost savings, and brand recognition. (RFF-Reply ¶¶ 1565, 1569; CX 393 at 1 (listing the other two "key needs" as "cost improvement" and "differentiation brand/name benefit")). And it fails to mention the size of the market in which NH North was to achieve this "clout." As is clear from the NH North documents, the "market" being referenced is a "70 Zip Code Area" which includes over 40 townships – nearly every Northern and Northwest suburb in the Chicago metropolitan area. (CX 394 at 5). The market share numbers from the 2000 Merger that Compliant Counsel routinely cites were in reference to the "core" which contained less than one third of the area being used to analyze the NH North alliance. (CX 84 at 21; Neaman, Tr. 1055). Once again, any attempt to reference these market share numbers outside the context of a "70 Zip Code Area" makes the percentages useless.

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).

Response to Finding No. 1577:

This proposed finding is misleading. (RFF-Reply ¶ 1536). NH North planning documents, many of which were prepared by Bain, make it clear that NH North was to grow market share and secure better rates from MCOs through quality, cost savings and brand – not market power. (RFF-Reply ¶¶ 1565, 1569; CX 393 at 1). Complaint Counsel is correct to argue that the 2000 Evanston Hospital-HPH Merger was built on many of these same premises but, beyond that, any comparison is of little value. (RFF-Reply ¶¶ 1361, 1369-1370, 1407)

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).

Response to Finding No. 1578:

Respondent has no specific response. (RFF-Reply ¶ 1565).

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).

Response to Finding No. 1579:

This proposed finding should be afforded no weight because it relies on the subjective intent of the merging parties. (RFF-Reply ¶ 1536). It is further irrelevant and, therefore, misleading because it relies on Newton, who was not a credible witness. (RFF-Reply ¶¶ 1387, 1463). It is also misleading because quality and cost improvements, not MCO contracting strategies, were the focus of Merger planning. (RFF ¶¶ 259-297; RFF-Reply ¶¶ 1346-1350, 1352-56, 1358-1359). And to the extent the merging parties hoped to improve their position with MCOs, these quality and cost improvements would be the means to that end. (RFF-Reply ¶¶ 1361, 1369, 1407; Newton, Tr. 408).

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).

Response to Finding No. 1580:

This proposed finding is incomplete and misleading because Evanston Hospital and HPH were both thinking about a potential merger as early as December 12, 1996. (Spaeth, Tr. 2203). In fact, to ensure its long term survival and to enhance care for its community, HPH had long been interested in aligning with other institutions. (RFF ¶¶ 240-243).

1581. In the late 1990's health plans were decreasing rates for hospital services. (Neaman, Tr. 1037-38).

Response to Finding No. 1581:

This proposed finding is incomplete and, therefore, misleading. (RFF-Reply ¶ 1403).

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).

Response to Finding No. 1582:

This proposed finding is incomplete and misleading. It first fails to explain that Evanston Hospital did not anticipate the particular pricing pressures that materialized in 1997. (RFF-Reply ¶ 1409). More importantly, this proposed finding fails to explain that the most significant pricing pressure came from the Balanced Budget Act, the Act that severely reduced the hospital's reimbursements from its largest payor, Medicare. (RFF-Reply ¶¶ 1409-1410).

1583. ENH viewed these "pricing pressures" as a "significant threat." (CX 2037 at 3).

Response to Finding No. 1583:

This proposed finding is misleading because it does not explain that Evanston Hospital experienced the most severe pricing pressures from the Balanced Budget Act. (RFF ¶¶ 627-636). And when the Balanced Budget Act hit in full force in late 1998, it alone turned Evanston Hospital's operating income from positive to negative. (RFF ¶¶ 630-631, 633-634).

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).

Response to Finding No. 1584:

This proposed finding is misleading because quality and cost improvements, not MCO contracting strategies, were the focus of Merger planning. (RFF ¶¶ 259-297; RFF-Reply ¶¶ 1346-1350, 1352-1356, 1358-1359). And, to the extent the merging parties hoped to improve their position with MCOs, these quality and cost improvements would be the means to that end. (RFF-Reply ¶¶ 1361, 1369, 1407; Newton, Tr. 408).

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).

Response to Finding No. 1585:

This proposed finding is misleading because the quote in this proposed finding is not related to a desire to obtain and use market power. (RFF-Reply ¶¶ 1381, 1584).

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).

Response to Finding No. 1586:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536). It is also misleading because there is no relationship between being "indispensable" and market power. Becoming "indispensable" is a function of quality, brand and cost efficiency. (RFF-Reply ¶ 1569; RX 367 at ENH DR 4205; RFF ¶ 1001).

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).

Response to Finding No. 1587:

This proposed finding is inaccurate and misleading because the quote in this proposed finding relates to physician issues, not hospital services. (RFF-Reply ¶ 1360).

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).

Response to Finding No. 1588:

This proposed finding is in accurate and misleading. The text Complaint Counsel quotes above actually is a subheading of a point titled "Implement in coordinated fashion 'major medical office' expansion strategy throughout north/northwestern suburban combined service area. Particular emphasis on 'north' expansion." (CX 442 at 5). Because the "do not compete" reference falls under the "major medical office" title, and because the cited document was part of a December 1998 "ENH/HPH Medical Staff Meeting," where Neaman and a physician made a presentation titled "Major Medical Offices: Geography and Competition," it is clear that all references to ending competition between the two sides related only to medical office/physician issues. (CX 442 at 3; RFF-Reply ¶ 1357 (addressing CX 1)).

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).

Response to Finding No. 1589:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536). Moreover, it is pure speculation as to what would have happened to HPH had the Merger not occurred. However, in proffering this proposed finding, Complaint Counsel implicitly concedes that Evanston Hospital did not see HPH as a significant competitor and that only with outside help could HPH be improved.

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).

Response to Finding No. 1590:

This proposed finding is irrelevant because it is based on Newton's opinion, which is neither relevant nor credible. (RFF-Reply ¶¶ 1387, 1463). Newton's "concerns" apparently did not reflect reality because, as he testified at trial, pre-Merger HPH had contracts with virtually all MCOs. (Newton, Tr. 457; RFF-Reply ¶ 1467).

1591. Health plans continually informed Highland Park during negotiations that there were "other hospitals will fill that bill." (Newton, Tr. 303).

Response to Finding No. 1591:

This proposed finding is vague, unintelligible, misleading and unsupported by credible evidence. (RFF-Reply ¶ 1467).

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).

Response to Finding No. 1592:

This proposed finding is irrelevant. (RFF-Reply ¶¶ 1387, 1463). To the extent that Newton can comment on HPH's "fundamental business tenet," the proposed finding is still misleading. (RFF-Reply ¶ 1469).

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).

Response to Finding No. 1593:

This proposed finding is irrelevant and misleading because Newton cannot speak for HPH management. (RFF-Reply ¶¶ 1387, 1463, 1485). Specifically, the cited Strategic Planning Retreat draft, CX 1869, does not speak for HPH management but, rather, merely reflects the opinion of its author, Newton. (Newton, Tr. 345-46). Newton was tasked with assisting the development of merger strategy and options, but he was not primarily responsible for their development or implementation. (Spaeth, Tr. 2283). Spaeth and HPH Chairman Neele Stearns had that responsibility and both confirmed that building "negotiating strength" with MCOs was not a make-or-break reason for the Merger. (Spaeth, Tr. 2187, 2283; CX 6305 at 13-14 (Stearns, Dep.)).

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).

Response to Finding No. 1594:

This proposed finding is irrelevant and false because Newton cannot speak for HPH management. (RFF-Reply ¶¶ 1387, 1463, 1485).

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).

Response to Finding No. 1595:

This proposed finding is misleading because HPH management and Spaeth, in particular, had little confidence in joint ventures. (Spaeth, Tr. 2269; RFF ¶ 247). Neaman and Northwestern Memorial's CEO, Mecklenburg, were likewise doubtful joint ventures could succeed. (CX 1865 at 6; CX 1866 at 5; RFF ¶¶ 247, 249). During the late 1990s, HPH's

strategic consultant, Kaufman Hall, did not recommend joint ventures because they would not solve HPH's main problem of capital capacity. (Kaufman, Tr. 5823; RFF ¶ 2313).

Finally, Spaeth and HPH management had good reason to reject joint ventures. Before the Merger, HPH's various joint ventures, all run by Newton, were failures and, in 1999, lost more than $2 million. (RFF ¶¶ 310, 2335, 2371-75).

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).

Response to Finding No. 1596:

This proposed finding is misleading. (RFF-Reply ¶ 1595). It is also incorrect. Neaman explained to Spaeth that he had yet to even inform the ENH Board and Executive Committee about these proposals. (CX 1866 at 2). Neaman could only assure Spaeth that he "had no reason to believe that the Executive Committee would not be supportive of our leadership's recommendation to vigorously pursue the development of the heart surgery and oncology programs" with HPH. (CX 1866 at 2). But it was in this very same letter that Neaman warned, and Spaeth agreed, that "'joint ventures' are confusing, lead to mistrust, and are full employment acts for accountants, lawyers, and consultants." (CX 1865 at 6; Spaeth, Tr. 2269).

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).

Response to Finding No. 1597:

This proposed finding is misleading because, as previously mentioned, HPH, Evanston Hospital and Northwestern Memorial were all skeptical that joint ventures could succeed in the Chicago market. (RFF-Reply ¶ 1595).

1598. In September 1998, Highland Park contemplated mergers with Evanston, Northwest Community, Lake Forest and Condell. (Newton, Tr. 350; CX 1869 at 6).

Response to Finding No. 1598:

This proposed finding is inaccurate because Newton cannot speak for HPH management. (RFF-Reply ¶¶ 1387, 1463, 1485). Specifically, the cited Strategic Planning Retreat document, CX 1869, does not speak for HPH but, rather, reflects the opinion of its author, Newton. (Newton, Tr. 345-46). Newton was tasked with assisting the development of merger strategy and options, but he was not primarily responsible for their development or implementation. (Spaeth, Tr. 2283). Spaeth and HPH Chairman Neele Stearns had that responsibility. (Spaeth, Tr. 2283).

And according to both Spaeth and Stearns, HPH rejected, or was rejected by, all potential merger candidates, save Evanston Hospital. For example, discussions between Northwestern Memorial and HPH did not progress beyond initial stages because Northwestern Memorial was not responsive to HPH's inquiries and because HPH doubted Northwestern Memorial's ability to deliver what HPH thought its community needed. (Spaeth, Tr. 2270-71; RFF ¶¶ 244, 287). Spaeth spoke with Advocate senior executives about linking but, after initial discussions, HPH determined Advocate was not the best fit because Advocate's religious affiliation might have affected patient care in the Highland Park community. (Spaeth, Tr. 2271-72; RFF ¶ 245). HPH also approached Lake Forest Hospital from time to time, but Lake Forest was not interested or not available, in part, because of its affiliation with Rush-Presbyterian. (CX 6305 at 12 (Stearns, Dep.); RFF ¶ 285). In the late 1990s, Condell did not have the financial and clinical wherewithal to be an attractive merger partner to HPH. (CX 6305 at 12 (Stearns, Dep.); RFF ¶ 286). Aside from NH North discussions in 1996 and 1997, there is no evidence that HPH and Northwest Community approached one another a second time. HPH did briefly consider merging with a

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

HPH ultimately decided to merge with Evanston Hospital because there seemed to be a good "fit" between the two organizations. Both were part of the North Shore culture, and many of the hospitals' physicians knew each other and trained with each other in the same medical schools. (Spaeth, Tr. 2273; RX 288 at ENH RS 1031; RFF ¶ 283). But more importantly, Evanston Hospital desired to fulfill the needs of the Highland Park community through a capital infusion, an academic linkage and the initiation of specific clinical programs. (Spaeth, Tr. 2273).

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).

Response to Finding No. 1599:

This proposed finding is false and misleading. (RFF-Reply 1598). It does, however, show that Newton was well aware that expanding the breadth of clinical services and offering a higher quality product would improve HPH's chances of negotiating better rates from MCOs. (Newton, Tr. 408).

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).

Response to Finding No. 1600:

This proposed finding is inaccurate because it is based on Newton's testimony, which was not credible. (RFF-Reply ¶¶ 1387, 1463, 1465, 1485, 1536).

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).

Response to Finding No. 1601:

This proposed finding is inaccurate because it is based on Newton's testimony, which was not credible. (RFF-Reply ¶¶ 1387, 1463, 1485, 1536, 1579).

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).

Response to Finding No. 1602:

This proposed finding is inaccurate because it is based on Newton's testimony, which was not credible. (RFF-Reply ¶¶ 1387, 1463, 1485, 1536, 1579).

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).

Response to Finding No. 1603:

This proposed finding is inaccurate because it is based on Newton's testimony, which was not credible. (RFF-Reply ¶¶ 1387, 1463, 1485, 1536, 1579). Moreover, having failed to call any employers as trial witnesses, Complaint Counsel cannot now use Newton's suspect and misinformed speculation to speak for these employers or as quasi-expert testimony.

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).

Response to Finding No. 1604:

This proposed finding is inaccurate and misleading because the above-quote refers to physician issues, not hospital services. (RFF-Reply ¶ 1351).

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).

Response to Finding No. 1605:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536). Even assuming it is of some relevance, it is still misleading for numerous reasons. (RFF-Reply ¶¶ 1352, 1356).

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).

Response to Finding No. 1606:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536). Even assuming it is of marginal relevance, it is still misleading for numerous reasons. (RFF-Reply ¶ 1354).

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).

Response to Finding No. 1607:

This proposed finding is misleading for numerous reasons. (RFF-Reply ¶¶ 1359-1360). This proposed finding is also false because the cited document does not record Neaman as stating "[t]his would be an opportunity to join forces and grow together rather than compete with each other." (CX 2 at 7). Rather, the document does not attribute the comment to any particular person. A natural reading suggests that it was made by a physician. (CX 2 at 7). Given that all references to ending competition have been made in the context of medical offices and other physician issues, this is also the natural conclusion. (RFF-Reply ¶¶ 47, 48, 57, 58, 61, 1351, 1355, 1357, 1588).

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.)).

Response to Finding No. 1608:

This proposed finding is irrelevant. (RFF-Reply ¶ 1536). Even assuming it is of marginal relevance, it is still misleading. Stearns and Spaeth have never implied that the HPH Board ignored MCO issues. But they have always maintained, and the documents confirm, that building "negotiating strength" with MCOs was not a make-or-break or even "top five" reason for the Merger. (CX 6305 at 13-14 (Stearns, Dep.); Spaeth, Tr. 2187; RFF ¶¶ 259-297).

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).

Response to Finding No. 1609:

This proposed finding is irrelevant because the law requires proof of a relevant market. Nevertheless, this finding is misleading to the extent it suggests that sufficient evidence exists in this case to support a finding of direct evidence that the Merger is anticompetitive. To reach such a finding (again, from an economic, as opposed to legal, perspective), an economist must have evidence that the firm raised its market prices *and* reduced industry output. "The end game objective [of merger analysis] is to try and assess or infer whether combining these two firms will raise market prices and reduce industry output." (Elzinga, Tr. 2360). In order to support a finding of "direct evidence," Complaint Counsel must show that ENH's post-Merger prices increased in an anticompetitive manner (i.e. above competitive levels), or that output decreased. (Haas-Wilson, Tr. 2451 (defining market power as "the willingness and ability of a firm to raise its prices above competitive levels.")). Complaint Counsel, however, made no such showing.

Dr. Haas-Wilson's analysis of post-Merger prices only considered the price changes without any evaluation of price levels. But considering only price changes (and not price levels) does not support a finding of direct evidence. Dr. Haas-Wilson admitted that **REDACTED**

REDACTED

(Haas-Wilson, Tr. 2834-36, *in camera*; RFF ¶¶ 1053, 1059-1061; RFF ¶¶ 1054-1058, 1062-1064, *in camera*). Consequently, it is impossible to conclude that the post-Merger price changes were anticompetitive based on a simple examination of price changes, without a consideration of competitive price levels. Respondent's experts provided the only empirical analysis of price levels suggesting that ENH was not pricing at competitive levels before the Merger. That analysis demonstrated that the post-Merger price increases were not anticompetitive. (RFF ¶¶ 1110-1164).

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

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(Haas-Wilson, Tr. 2823-24, *in camera*). Consequently, Dr. Haas-Wilson's failure to rule out all benign explanations for the price increases she measured is fatal to a finding of direct evidence of anticompetitive effects. (RFF-Reply ¶¶ 739-741).

In addition, Complaint Counsel admits that "ENH did not see a decrease in the number of managed care admissions as a result of ENH's price increases in 2000." (CCFF ¶ 1653). Consequently, there is no support for a finding of direct evidence of anticompetitive effects.

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)

Response to Finding No. 1610:

This proposed finding is misleading to the extent it suggests that Dr. Haas-Wilson's empirical analysis of post-Merger prices provides "years of data on the actual competitive effects of this merger." To conclude that there is direct evidence of anticompetitive effects, one would need to find either an anticompetitive price increase or an anticompetitive decrease in output. (RFF-Reply ¶ 1609). Neither of these conditions is present in this case. (RFF-Reply ¶ 1610).

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).

Response to Finding No. 1611:

This proposed finding is misleading to the extent that it suggests that "the best available method for determining whether the merger created or enhanced market power" excludes an evaluation of price levels. (RFF-Reply ¶ 1605). This proposed finding is also misleading to the extent it suggests that Dr. Haas-Wilson was able to "rule" out all possible explanations for the price increase. She did not effectively rule out all possible explanations. (RFF-Reply ¶¶ 739-741). In fact, the only price level analysis conducted in this case, by Respondent's experts, supports one of these possible explanations – learning about demand. (RFF ¶¶ 1110-1164).

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).

Response to Finding No. 1612:

This proposed finding is misleading to the extent it suggests that market analysis is not necessary in this case – either legally or factually. As discussed in RFF-Reply ¶ 1609, there is no support for a finding of direct evidence of anticompetitive effects.

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(Noether, Tr. 5904; Baker, Tr. 4702, *in camera*).

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).

Response to Finding No. 1613:

This proposed finding is inaccurate. Under the Horizontal Merger Guidelines, for product market, the relevant inquiry begins with the products "produced or sold" by the merging firms. (1992 Horizontal Merger Guidelines, §1.11; Noether, Tr. 5905).

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).

Response to Finding No. 1614:

This proposed finding is inaccurate. Under the Horizontal Merger Guidelines, for geographic market, the relevant inquiry begins with an identification of the "next best substitutes" for the merging firms. (1992 Horizontal Merger Guidelines, § 1.21; Noether, Tr. 5928).

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).

Response to Finding No. 1615:

This proposed finding is misleading because it ignores the substantial evidence demonstrating that the post-Merger price increases were not anticompetitive. (RFF ¶¶ 515-1164). Faced with non-anticompetitive price increases, customers would not be expected to turn to alternative sellers. In addition,

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

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).

Response to Finding No. 1616:

This proposed finding is inaccurate. Because MCOs purchase all of the services of a particular hospital in one contract when they negotiate prices with hospital, the relevant product market includes all hospital-based acute care services sold to MCOs – i.e. inpatient and outpatient services. (Noether, Tr. 5901, 5904, 5906-08, 5927).

REDACTED

(Neary, Tr. 590-91; Holt-Darcy, Tr. 1586, *in camera*; RFF ¶ 371, *in camera*).

REDACTED

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

REDACTED

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

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).

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(CCFF 959-1304, *in camera*).

Response to Finding No. 1617:

This proposed finding is inaccurate and misleading. (RFF-Reply ¶¶ 959-1304, 1613).

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).

Response to Finding No. 1618:

Respondent has no specific response except that the referenced glossary, by its terms, was submitted to the Court as a reference only and not as an admission by either party.

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").

Response to Finding No. 1619:

This proposed finding is misleading to the extent that it implies patients of hospitals generally require an overnight stay at a hospital. Rather, over the last couple of decades, the proportion of hospital services that are delivered on an outpatient basis (*i.e.*, services that do not require an overnight stay) has increased substantially. (CX 6321 at 82; Neaman, Tr. 1153; RFF ¶ 73). As of February 2005, ENH's percentage of outpatient services was approximately 45%. (Neaman, Tr. 1295-96; RFF ¶ 74).

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).

Response to Finding No. 1620:

This proposed finding is irrelevant. (Noether, Tr. 5908; RFF ¶ 378; RFF-Reply ¶¶ 1616, 1625).

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)

Response to Finding No. 1621:

Respondent agrees that Evanston Hospital and HPH provided different services before the Merger. (CCFF ¶¶ 1798-1799). Nevertheless, this proposed finding is misleading because it does not fully detail the vast differences between the services provided by pre-Merger Evanston Hospital and HPH. (RFF ¶¶ 32-34, 41, 47-48). This proposed finding also ignores relevant trial testimony from MCO representatives, specifically Ballengee, that Evanston Hospital provided more than just "some tertiary services" but, instead, was a "teaching hospital" affiliated with the Northwestern Medical School. (RFF ¶¶ 9, 30).

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).

Response to Finding No. 1622:

This proposed finding is false. Emergency room, radiology and diagnostics, psychiatry, pediatrics and plastic surgery are not purely inpatient related services. For example, a visit to the emergency room, an x-ray, or a routine visit to a pediatrician often does not require an overnight stay. (RFF ¶ 2273 (explaining that roughly 80% of patients who use HPH's emergency room are treated on an outpatient basis)). In fact, CX 573, cited above, confirms that these services, like many others, are not provided solely on an inpatient basis. Specifically, in planning to generate efficiencies by consolidating services, ENH planned to rationalize "[i]npatient [psychiatry] and most outpatient [psychiatry] to Highland Park Hospital" and to rationalize "[i]npatient [pediatrics] to Evanston Hospital [and] expand selected outpatient [pediatrics] services at Highland Park Hospital." (CX 373 at 11). Because ENH's outpatient services constitute 45% of the hospital's business, it is hardly surprising that most, if not all, of the services listed above by

Complaint Counsel have a major outpatient component that needed to be rationalized in tandem with the inpatient component. (Neaman, Tr. 1295-96).

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).

Response to Finding No. 1623:

This proposed finding is inaccurate in its reference to these service lines as "inpatient service lines." Many, if not all, of the above listed services have significant outpatient components. (RFF-Reply ¶ 1622). Moreover, the evidence demonstrated that HPH's Kellogg Cancer Care Center – which, along with radiation medicine, nuclear medicine and the breast imaging center – are now housed in the new Ambulatory Care Center, i.e., a facility for outpatient services. (RFF ¶¶ 1560, 1753-1754, 1989, 2275).

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).

Response to Finding No. 1624:

Respondent has no specific response.

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).

Response to Finding No. 1625:

This proposed finding is misleading because, under the Horizontal Merger Guidelines, the relevant product market inquiry begins not with a consideration of demand- or supply-side substitution, but with an identification of the product purchased or sold. (RFF-Reply ¶ 1609). The uncontroverted evidence demonstrated that

REDACTED

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

REDACTED

RFF ¶ 374, *in camera*

REDACTED

. This is consistent with MCO testimony suggesting that a MCO could not contract with a hospital for only its outpatient or inpatient services but, instead, is required to contract for "all of the services that [the hospital] offered." (Neary, Tr. 592). This testimony is inconsistent, under the Merger Guidelines, with the exclusion of outpatient from the product market.

1626.

REDACTED

(Haas-Wilson, Tr. 2615, *in camera*).

Response to Finding No. 1626:

This proposed finding is not relevant to the definition of product market.

REDACTED

and outpatient rates.} (Neary, Tr. 590-91; Holt-Darcy, Tr. 1587, *in camera*; Mendonsa, Tr.

557, *in camera*). The relevant inquiry, in defining the product market, begins with the products "produced or sold." (RFF-Reply ¶ 1613).

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).

Response to Finding No. 1627:

This proposed finding is misleading because it ignores that the relevant inquiry, under the Horizontal Merger Guidelines, is not whether an outpatient-only plan could substitute for an inpatient-only plan. Instead, the relevant inquiry focuses on the product purchased or sold. (RFF-Reply ¶ 1613). In this case, the uncontroverted evidence demonstrated that MCOs purchase the hospital-based inpatient and outpatient services together in the same contract. (RFF-Reply ¶ 1625). If the relevant inquiry focused solely on substitution, Dr. Haas-Wilson's inpatient-only market would be no more defensible than Dr. Noether's inpatient and outpatient market, as individual inpatient services are not substitutes for each other. (Noether, Tr. 5909). Despite this fact, Dr. Haas-Wilson lumps all inpatient services into her market because they are purchased together.

In addition, this finding is misleading to the extent it suggests that Dr. Noether included outpatient-only service providers as market participants in her relevant market. Dr. Noether expressly excluded non-hospital providers of outpatient services from her market. (Noether, Tr. 5923).

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).

Response to Finding No. 1628:

This proposed finding is inaccurate. Testimony "concerning health plans accepting higher prices for inpatient services in return for lower prices for outpatient services" is consistent with other MCO testimony suggesting that they purchase the entire bundle of hospital-based services at once. (RFF-Reply ¶ 1625). This evidence is inconsistent with the exclusion of outpatient services from the product market. (RFF-Reply ¶ 1625).

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).

Response to Finding No. 1629:

This proposed finding is misleading to the extent it suggests that there is a clear definition of quaternary services.

REDACTED

(Noether, Tr. 6001; Haas-Wilson, Tr. 2876, *in camera*). This definition, however, conflicts with the Complaint,

REDACTED

(Haas-Wilson, Tr. 2876, *in camera*; Compl. ¶ 16).

REDACTED

(Haas-Wilson, Tr. 2882, *in camera*).

REDACTED

(Haas-Wilson, Tr. 2879-90, *in camera*).

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).

Response to Finding No. 1630:

This proposed finding is misleading because "quaternary services" are not clearly defined. (RFF-Reply ¶ 1629).

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).

Response to Finding No. 1631:

This proposed finding is misleading because "quaternary services" are not clearly defined. (RFF-Reply ¶ 1629).

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).s

Response to Finding No. 1632:

This proposed finding is misleading. (RFF-Reply ¶¶ 1629-1631). This proposed finding also ignores Ballengee's testimony and PHCS authored-documents that identified Evanston Hospital as an "advanced teaching hospital" that provided a higher level of services than a community hospital. (Ballengee, Tr. 159, 212; RX 107 at GWL 859). Finally, this proposed finding is misleading because Evanston Hospital did, and continues to, offer "advanced services." (RFF-Reply ¶ 33; RFF ¶¶ 1, 9,12, 24, 27, 30).

1633.

REDACTED

REDACTED

(Dorsey, Tr. 1443-44, *in camera*).

Response to Finding No. 1633:

This proposed finding is misleading. The evidence demonstrated that Evanston Hospital/ENH has long been an academic teaching hospital that not only trains physicians, but is at the "cutting edge of new medical technology." (Noether, Tr. 5922; RX 1912 at 60; RFF ¶¶ 10, 101, 559; RFF-Reply ¶¶ 33, 1632). Even a One Health representative conceded that Northwestern Memorial, one of One Health's "academic teaching hospitals" listed above, was an alternative to ENH. (Neary, Tr. 631; RFF ¶¶ 458, 564). One Health representatives further testified that Advocate Lutheran General, a hospital Complaint Counsel agrees is a "major teaching hospital," was one of the main alternatives to ENH. (Neary, Tr. 630-31; Dorsey, Tr. 1480-81; CCFF ¶ 1999).

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).

Response to Finding No. 1634:

This proposed finding is misleading. (RFF-Reply ¶¶ 1632-1633).

REDACTED

(Foucre, Tr. 1112, *in camera*).

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 prieed hospitals. (Haas-Wilson, Tr. 2663).

Response to Finding No 1635:

The first sentence of this proposed finding is inaccurate. The remainder of this proposed finding is misleading and irrelevant. (RFF-Reply ¶ 1627).

1636. None of the outpatient centers in the Evanston area have 24 hour nursing or lodging of patients. (Spaeth, Tr. 2076).

Response to Finding No. 1636:

This proposed finding is irrelevant. Respondent does not contend that these outpatient centers are included in the relevant product market. (Noether, Tr. 5923; RFF ¶ 379; RFF-Reply ¶ 1625). Moreover, the presence or absence of outpatient service centers in the relevant product market does not undermine the fact that outpatient services are an integral part of the overall services provided by acute care hospitals. These hospitals, including ENH, could not render proper care without outpatient services. (RFF-Reply ¶¶ 1616, 1622-1623). More importantly, without outpatient services, MCOs could not offer a useful product to their customers and, for this reason, MCOs contract "for the entire set of services at a hospital." (Ballengee, Tr. 200; RFF ¶¶ 369-371).

1637. Outpatient centers would require Certificate of Need approval from the state to have beds for patients. (Spaeth, Tr. 2077).

Response to Finding No. 1637:

This proposed finding is irrelevant. (RFF-Reply ¶¶ 1636). Moreover, the Illinois CON requirements, which are not a particularly high barrier to entry, are set to expire in July 2006. (RFF ¶¶ 2280-2297; RFF-Reply ¶¶ 1731-1732).

1638. The physician determines whether a patient should be admitted to the hospital. (Hillebrand, Tr. 1756; Spaeth, Tr. 2076; Newton, Tr. 302).

Response to Finding No. 1638:

Respondent has no specific response.

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).

Response to Finding No. 1639:

This proposed finding is irrelevant. (RFF-Reply ¶¶ 1625-1627, 1637).

1640. Changes in inpatient pricing have no impact on patients switching from inpatient services to outpatient prices. (Neaman Tr. 1210; Hillebrand, Tr. 1755-56).

Response to Finding No. 1640:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶¶ 1625-1627).

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).

Response to Finding No. 1641:

This proposed finding is misleading and irrelevant. (RFF-Reply ¶¶ 1625-1627).

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 form inpatient to outpatient services as a result of changes in inpatient prices. (Hillebrand, Tr. 1756).

Response to Finding No. 1642:

This proposed finding is misleading and irrelevant. (RFF-Reply ¶¶ 1625-1627).

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).

Response to Finding No. 1643:

This proposed finding is inaccurate. Testimony "concerning health plans accepting higher prices for inpatient services in return for lower prices for outpatient services" is consistent with other MCO testimony suggesting that they purchase the entire bundle of hospital based services at once. (RFF-Reply ¶ 1625). All such testimony is inconsistent with the exclusion of outpatient services from the product market. (RFF-Reply ¶ 1625).

1644. **REDACTED**

(Haas-Wilson, Tr. 2615, *in camera*).

Response to Finding No. 1644:

This proposed finding is not relevant to the definition of product market.

REDACTED

(Neary, Tr. 590-91; Holt-Darcy, Tr. 1587, *in camera*; Mendonsa, Tr. 557, *in camera*). The relevant inquiry, in defining the product market, begins with the products "produced or sold." (RFF-Reply ¶ 1613).

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).

Response to Finding No. 1645:

This proposed finding is inaccurate. The appropriate geographic market in this case includes, at least, the merging hospitals, Rush North Shore, St. Francis, Advocate Lutheran

General, Resurrection, Lake Forest Hospital and Condell. (Noether, Tr. 5928, 5960; RFF-Reply ¶ 54).

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).

Response to Finding No. 1646

This proposed finding is inaccurate for several reasons. First, Dr. Haas-Wilson did not properly employ the principles of the Merger Guidelines. The relevant geographic market inquiry under the Merger Guidelines begins with an identification of the "next best substitutes" for the merging firms. (RFF-Reply ¶ 1614). Under the Guidelines, Dr. Haas-Wilson's market would only make sense if Evanston Hospital and HPH were next best substitutes in geographic terms. (Noether, Tr. 5932). Evanston Hospital and HPH were not next best geographic substitutes. (Noether, Tr. 5932; RFF ¶¶ 387-484).

REDACTED

(Baker, Tr. 4703-04, *in camera*).

REDACTED

Second, this finding also is misleading to the extent it suggests that an examination of patient preferences is irrelevant in this case. The analysis in this case focuses on the MCO as the

relevant customer. (CCFF ¶ 1646). These same MCOs testified that they consider patient preferences – driven, in part, by travel patterns – when building their network. (Foucre, Tr. 885; Holt-Darcy, Tr. 1420). MCOs consider these patient preferences because they recognize that they need to put together provider networks that are going to be attractive to employers. And employers, in turn, are concerned about where their employees want to seek hospital care. Consequently, to the extent that patients value convenience, there is a derived demand by the MCOs for hospitals that are convenient to their enrollees. (Noether, Tr. 5936-37, 5948).

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)).

Response to Finding No. 1647:

This proposed finding is inaccurate. (RFF-Reply ¶ 54).

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)).

Response to Finding No. 1648:

This proposed finding is inaccurate and misleading. (RFF-Reply ¶ 55).

1649.

REDACTED

(Haas-Wilson, Tr. 2734-36, *in camera*, citing for example Ballengee, Tr. 179-80, Neary, Tr. 617, and Mendonsa, Tr. 520, *in camera*).

Response to Finding No. 1649:

This proposed finding is inaccurate and misleading. (RFF-Reply ¶ 742).

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).

Response to Finding No. 1650:

This proposed finding is inaccurate. (RFF-Reply ¶ 1709).

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).

Response to Finding No. 1651:

This proposed finding is misleading. (RFF-Reply ¶ 1692).

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).

Response to Finding No. 1652:

This proposed finding is misleading. (RFF-Reply ¶ 1692).

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).

Response to Finding No. 1653:

Respondent has no specific response.

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).

Response to Finding No. 1654:

This proposed finding is inaccurate. Under the Horizontal Merger Guidelines, for geographic market, the relevant inquiry begins with an identification of the "next best substitutes" for the merging firms. (1992 Horizontal Merger Guidelines, § 1.21; Noether, Tr. 5928). In addition, this proposed finding ignores the substantial evidence demonstrating that the post-Merger price increases were not anticompetitive. Customers would not be expected to turn to alternative sellers when they are faced with price increases that are not anticompetitive.

REDACTED

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

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).

Response to Finding No. 1655:

This proposed finding ignores the substantial evidence demonstrating that the post-Merger price increases were not anticompetitive. Customers would not be expected to turn to alternative sellers when they are faced with price increases that are not anticompetitive.

REDACTED

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

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).

Response to Finding No. 1656:

This proposed finding is inaccurate. (RFF-Reply ¶¶ 743, 1688).

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).

Response to Finding No. 1657:

This proposed finding is misleading. (RFF-Reply ¶ 1692).

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).

Response to Finding No. 1658:

This proposed finding is misleading. (RFF-Reply ¶ 1692).

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).

Response to Finding No. 1659:

Respondent has no specific response.

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.)).

Response to Finding No. 1660:

This proposed finding is vague and misleading. (RFF-Reply ¶ 1693).

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).

Response to Finding No. 1661:

Respondent has no specific response.

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).

Response to Finding No. 1662:

This proposed finding is irrelevant because no expert in this case used the Elzinga-Hogarty test. (RFF-Reply ¶ 1665).

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).

Response to Finding No. 1663:

This proposed finding is irrelevant because no expert in this case used the Elzinga-Hogarty test. (RFF-Reply ¶ 1665).

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).

Response to Finding No. 1664:

Respondent has no specific response.

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).

Response to Finding No. 1665:

This proposed finding is irrelevant because no expert in this case used the Elzinga-Hogarty test. Dr. Noether applied the principles underlying the Merger Guidelines in defining her minimum geographic market by taking each of the merging hospitals and identifying its closest competitors to build up the markets, an iterative kind of approach. (Noether, Tr. 5958). To the extent Complaint Counsel implies that Dr. Noether conducted an Elzinga-Hogarty analysis "in disguise," that is not the case. (Noether, Tr. 5947-48). For a detailed description of how Dr. Noether defined the relevant geographic market see RFF ¶¶ 393-498.

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).

Response to Finding No. 1666:

This proposed finding is irrelevant because no expert in this case used the Elzinga-Hogarty test. (RFF-Reply ¶ 1665).

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).

Response to Finding No. 1667:

This proposed finding is irrelevant because no expert in this case used the Elzinga-Hogarty test. (RFF-Reply ¶ 1665). Further, the analyses utilized in past hospital cases is best understood by a review of those cases, and are not findings of fact relevant to this case. Finally, many of the recent hospital merger cases explicitly used patient flow analysis only as a starting point before proceeding with an analysis of where patients would turn in the event of an anticompetitive price increase. (*California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057, 1068-1073 (N.D. Cal. 2000)).

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).

Response to Finding No. 1668:

This proposed finding is irrelevant because no expert in this case used the Elzinga-Hogarty test, and Complaint Counsel never introduced any evidence of a "silent majority" problem in this case. (RFF-Reply ¶¶ 1665, 1675). This proposed finding is also incorrect to the

extent it suggests that patient preferences do not matter to MCOs in building their networks. (RFF-Reply ¶ 1669).

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).

Response to Finding No. 1669:

This proposed finding is incorrect to the extent it suggests that patient preferences, as reflected in patient travel patterns, do not matter to MCOs in building their networks. In fact, Complaint Counsel's experts fully acknowledge that MCOs take into account patient preferences.

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(Elzinga, Tr. 2407; Haas-Wilson, Tr. 2803, *in camera*). The employers, in turn, are driven to provide a plan that is attractive to their employees, subject to the constraints of cost, because employees may consider health care benefits in deciding where to accept employment. (Elzinga, Tr. 2407). Therefore, MCOs must take patient preferences into consideration in constructing their hospital networks. (Elzinga, Tr. 2407-08; RFF ¶ 386). This view is supported by the testimony of Foucre (United), Mendonsa (Aetna) and Holt-Darcy (Unicare), all of whom testified that MCOs consider patient preferences. (Noether, Tr. 5937; Foucre, Tr. 885; Mendonsa, Tr. 485; Holt-Darcy, Tr. 1420). Similarly, Ballengee (PHCS) testified that geography and price play roles in what patients demand from their health care

network; in general, patients want to know that they are receiving cost-effective healthcare as well as access to quality health care. (Ballengee, Tr. 152-53; RFF ¶ 385).

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).

Response to Finding No. 1670:

This proposed finding is incorrect to the extent it suggests that patient preferences do not matter to MCOs in building their networks. (RFF-Reply ¶ 1669).

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).

Response to Finding No. 1671:

This proposed finding is incorrect to the extent it suggests that patient preferences do not matter to MCOs in building their networks. (RFF-Reply ¶ 1669).

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).

Response to Finding No. 1672:

This proposed finding is incorrect to the extent it suggests that patient preferences do not matter to MCOs in building their networks. (RFF-Reply ¶ 1669).

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).

Response to Finding No. 1673:

This proposed finding is irrelevant because no expert in this case used the Elzinga-Hogarty test. (RFF-Reply ¶ 1665). This proposed finding is also incorrect to the extent it suggests that patient preferences do not matter to MCOs in building their networks. (RFF-Reply ¶ 1669).

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).

Response to Finding No. 1674:

This proposed finding is irrelevant because no expert in this case used the Elzinga-Hogarty test. (RFF-Reply ¶ 1665).

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).

Response to Finding No. 1675:

This proposed finding is irrelevant because Complaint Counsel never introduced any evidence that the patient data in this case represents a minority of the patients affected and that a "majority" of the patients would not turn to alternatives if faced with an anticompetitive price increase.

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).

Response to Finding No. 1676:

This proposed finding is irrelevant because Complaint Counsel never introduced any evidence of a "silent majority" problem in this case. (RFF-Reply ¶ 1675).

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).

Response to Finding No. 1677:

This proposed finding is irrelevant because Complaint Counsel never introduced any evidence of a "silent majority" problem in this case. (RFF-Reply ¶ 1675).

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).

Response to Finding No. 1678:

This proposed finding is irrelevant because Complaint Counsel never introduced any evidence of a "silent majority" problem in this case. (RFF-Reply ¶ 1675).

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).

Response to Finding No. 1679:

This proposed finding is irrelevant because Complaint Counsel never introduced any evidence of a "silent majority" problem in this case. (RFF-Reply ¶ 1675).

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).

Response to Finding No. 1680:

This proposed finding is irrelevant because no expert in this case used the Elzinga-Hogarty test, and Complaint Counsel never introduced any evidence of a "silent majority" problem in this case. (RFF-Reply ¶¶ 1665, 1675). This proposed finding is also incorrect to the extent it suggests that patient preferences do not matter to MCOs in building their networks. (RFF-Reply ¶ 1669).

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).

Response to Finding No. 1681:

This proposed finding is irrelevant because no expert in this case used the Elzinga-Hogarty test. (RFF-Reply ¶ 1665). This proposed finding is also incorrect to the extent it implies that the use of patient travel patterns by Dr. Noether was inappropriate. Dr. Noether analyzed what the hospitals themselves analyze – *i.e.*, they look at what kinds of patient travel patterns are evident – and she used this information as one piece of evidence, among other pieces, to determine the likely dimensions of geographic competition. (Noether, Tr. 5948). Patient travel patterns are important in this context – even when the customer is the MCO, and not the individual patient – because the MCO must consider whether its network will be attractive to enrollees, who are the ultimate consumers. Dr. Noether thus examined patient travel patterns to examine patient preferences in this context. (Noether, Tr. 5948).

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).

Response to Finding No. 1682:

This proposed finding is irrelevant because no expert in this case used the Elzinga-Hogarty test. (RFF-Reply ¶ 1665).

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).

Response to Finding No. 1683:

This proposed finding is incorrect to the extent it implies that the use of patient travel patterns by Dr. Noether was inappropriate. (RFF-Reply ¶ 1681). Further, Complaint Counsel never introduced any evidence of a "silent majority" problem in this case. (RFF-Reply ¶ 1675).

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).

Response to Finding No. 1684:

Respondent has no specific response.

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).

Response to Finding No. 1685:

This proposed finding is inaccurate. (RFF-Reply ¶ 54).

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).

Response to Finding No. 1686:

This proposed finding is inaccurate and misleading. (RFF-Reply ¶ 55).

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).

Response to Finding No. 1687:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶ 1609).

1688.

REDACTED

(Haas-Wilson, Tr. 2942, *in camera*).

Response to Finding No. 1688:

This proposed finding is inaccurate. (RFF-Reply ¶¶ 1656, 1688).

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*).

Response to Finding No. 1689:

This proposed finding is inaccurate and misleading. (RFF-Reply ¶¶ 1646).

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)

Response to Finding No. 1690:

This proposed finding is inaccurate. The evidence demonstrates that Neaman was concerned that in renegotiating its contracts, using Bain's more aggressive negotiation strategy, ENH risked losing contracts with MCOs. In response to these concerns, Bain prepared a plan to deal with the possible loss of MCO contracts. (Neaman, Tr. 1349; RFF ¶ 725; RFF-Reply ¶ 1433). Given that ENH was facing increased financial pressure, the possibility of securing necessary extra revenue was worth the risk of losing managed care contracts. (Neaman, Tr. 1343-44, 1346-47).

REDACTED

(RFF ¶¶ 322, 681, 687, 707, 719, 732, 754, 796, 864).

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).

Response to Finding No. 1691:

Respondent has no specific response.

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).

Response to Finding No. 1692:

This proposed finding is vague and misleading. (RFF-Reply ¶ 1690). There is no evidence to suggest that any other hospitals were aware of ENH's 2000 contract negotiations

because negotiated rates are confidential. Other hospitals do not know ENH's rates, and ENH does not know other hospitals' rates. (Newton, Tr. 373-74; Neaman, Tr. 1344; Ballengee, Tr. 193-94). Accordingly, this proposed finding makes no sense. (RFF-Reply ¶ 1431).

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).

Response to Finding No. 1693:

This proposed finding is vague and misleading. (RFF-Reply ¶¶ 1431, 1692).

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).

Response to Finding No. 1694:

This proposed finding is vague and misleading because it fails to define "localized," "local service area," or "local marketplace."

Nevertheless, Spaeth testified that hospital administrators typically look to their service area, i.e., the area from which their hospitals draw roughly 80% of their patient business. (Spaeth, Tr. 2156). Hospitals, including pre-Merger HPH and Evanston Hospital, would not be able to survive alone on areas any more "local" than the service area, such as the "core." (RFF-Reply ¶¶ 49, 57).

Finally, that pre-Merger HPH did not look to draw patients from its secondary service area, i.e., the area outside its service area, merely confirms that HPH was a community hospital lacking the tertiary services necessary to draw patients from more distant communities. And because HPH lacked these tertiary services, Highland Park residents were referred to advanced

teaching hospitals, such as Evanston Hospital, that could offer such services. (RFF-Reply ¶¶ 41, 48).

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).

Response to Finding No. 1695:

This proposed finding is misleading. This proposed finding mischaracterizes Spaeth's testimony. Spaeth specifically said that HPH competed with Evanston Hospital *only* in the southern portion of HPH's service area. (Spaeth, Tr. 2088, 2107, 2157). The competition between Evanston Hospital and HPH was minimal because Evanston Hospital was much larger and offered a much greater breadth and sophistication of services than HPH. (CCFF ¶¶ 1798-1799). In short, Evanston Hospital and HPH were not good substitutes for healthcare services. (RFF ¶¶ 480-481, 538-559).

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).

Response to Finding No. 1696:

This proposed finding is misleading. (RFF-Reply ¶ 1695). To the extent that competition was intensifying from Evanston Hospital, it was a result of Evanston Hospital continually upgrading its capabilities while HPH struggled to keep up in the Chicago market. (RFF ¶¶ 30-49).

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).

Response to Finding No. 1697:

This proposed finding is misleading. (RFF-Reply ¶ 1695). Also, there are numerous hospitals closer to Evanston Hospital than HPH. This long list includes: St. Francis, Rush North Shore, Advocate Lutheran General, Resurrection Medical Center, Northwestern Memorial, Swedish Covenant, Louis A. Weiss, Advocate North Side and Holy Family. (RFF ¶ 389). There are also several hospitals closer to HPH than Evanston Hospital, including: Lake Forest Hospital, Condell and Rush North Shore hospitals, further demonstrating that HPH and Evanston Hospital were not close geographic substitutes for one another. (RFF ¶¶ 390, 560).

This proposed finding is also misleading because it ignores the realities of patient travel. Given the road conditions in the Chicago area, a patient can easily travel between Rush North Shore to HPH and to Lake Forest on Interstate 94 and Highway 41. (Neaman, Tr. 1304; Spaeth, Tr. 2241). Consequently, it is not surprising that the evidence demonstrated that Lake Forest Hospital and Condell were regarded by pre-Merger HPH and MCOs as far more important competitors of HPH than Evanston Hospital. (RFF ¶¶ 577-587).

Moreover, whether HPH's "core service area went up into Lake Forest Hospital but not much north of that" is of little importance because pre-Merger HPH would not be able to survive alone on areas any more "local" than the service area, such as the "core." (RFF-Reply ¶¶ 49, 57).

Finally, this proposed finding mischaracterizes Spaeth's testimony. Spaeth testified that the next hospital going "*straight* west" was 40-45 minute drive. (Spaeth, Tr. 2164 (emphasis added)). Moreover, Spaeth did not testify that HPH's service area was defined by "a line North of Highland Park that gets drawn across Lake County." (Spaeth, Tr. 2161-62). He did agree that such an imaginary line exists, but it served to define Lake County's demographics, not HPH's service area. (Spaeth, Tr. 2162).

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).

Response to Finding No. 1698:

This proposed finding is false and misleading. This proposed finding is supported solely by the testimony of Newton, who was not a credible witness. Newton's testimony, especially the testimony concerning the purported relevance of the "triangle," is supported by no contemporaneous documents, and no witness testified that this term was ever used before the Complaint in this action was filed. To be sure, the concept of this "triangle" was made up by Complaint Counsel for purposes of this litigation, and Newton clearly was prepared by Complaint Counsel to use this particular term at trial. Such testimony, therefore, should be given little or no weight. (RFF-Reply ¶¶ 1387, 1462-1463, 1465).

1699. **REDACTED** (Chan, Tr. 839-40 (discussing CX 1607 at 5, *in camera*), *in camera*).

Response to Finding No. 1699:

This proposed finding is misleading. **REDACTED**

(Chan, Tr. 839, *in camera*). Bain likely calculated ENH's rough-share of its "core," a sub-market that is too small to sustain ENH's business and, therefore, is of little relevance to the hospital. (RFF-Reply ¶¶ 49, 57).

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).

Response to Finding No. 1700:

This proposed finding is false. The only reason these MCOs agreed to accept ENH's price increases was because Evanston Hospital/ENH finally realized through the Merger integration process that these MCOs had long under-compensated Evanston Hospital for its academic hospital services. (RFF ¶¶ 322, 681, 687, 707, 719, 732, 754, 796, 864, 1111-1112; RFF-Reply ¶¶ 853-854, 959-1312, 1365, 1367, 1372, 1374-1376, 1378, 1395-1397).

Moreover, the purported "thrust of the health plans' testimony" is based only on speculation because Complaint Counsel failed to provide any testimony or evidence that the cited MCO representatives or their MCOs even attempted to form networks without ENH.

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).

Response to Finding No. 1701:

This proposed finding is false. The term "triangle" was invented by Complaint Counsel, was used only by witnesses Complaint Counsel prepared to testify and, above all, does not appear in any of the relevant, contemporaneous documents. In short, the only party that has "termed" this area a "triangle" is Complaint Counsel itself. (RFF-Reply ¶¶ 5, 54).

This proposed finding is also false because the North Shore is not a "heavily" populated area. Foucre, the cited source for this assertion, does not live in the North Shore and, by her own admission, she lacks a "sense of [this] geography." (Foucre, Tr. 941; RFF-Reply ¶ 50).

This proposed finding is also misleading to the extent it asserts that the North Shore contains some of the "most affluent communities in the Chicago area." While the North Shore, like many other parts of the Chicago area, contains affluent citizens, trial witnesses testified that cities such as Evanston and Highland Park also have a significant number of elderly and minority patients who cannot pay for their care at the ENH hospitals. (Styer, Tr. 4981; RFF ¶¶ 15, 2420; RFF-Reply ¶ 50).

As to Complaint Counsel's final assertion regarding "senior executives and decision makers," there is no evidence that the North Shore has more of these people than any other affluent community in the Chicago area. (RFF-Reply ¶ 50). This aspect of the proposed finding is based on pure speculation; none of the purported "senior executives and decision makers" testified, or were even identified, at trial.

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

(CX 129 at 1, *in camera*).

Response to Finding No. 1702:

As an initial matter, Ballengee's "recollection" of conversations from five years ago should be afforded no weight. As discussed in Reply-RFF ¶ 1080, this Court should view with suspicion all testimony by MCO representatives that is not reflected in contemporaneous documents since they have a plain interest in this litigation. (Reply-RFF ¶ 1080). Moreover, Hillebrand testified that he never told Ballengee that ENH had a 60% market share, the claim on which Complaint Counsel partially bases the allegation that ENH was an "entity controlling all of these communities." (Hillebrand, Tr. 1894). Ballengee's characterizations of ENH comments (to the extent they have any independent relevance – which they do not) are clearly self-serving, uncorroborated and subject to dispute. Therefore, such testimony should be disregarded.

REDACTED

(Mendonsa, Tr. 559, *in camera*; Holt-Darcy, Tr. 1588, *in camera*).

This proposed finding is also false because ENH executives never told Ballengee, or any other PHCS representative, that St. Francis, Rush North Shore, or Condell were not viewed by ENH as significant competitors. To the contrary, Hillebrand told Ballengee that excluding Rush North Shore from PHCS's network would have been worth something to ENH because Rush North Shore was an "important competitor," a view Ballengee and numerous other MCO representatives shared. (Hillebrand, Tr. 1746; RFF ¶ 570-76; RX 1331 at ENHE DL 11881 (*describing* "RNS" as a "key competitor")). Evanston Hospital has long viewed St. Francis as an important competitor as well. (RFF ¶ 477). Again, numerous MCO representatives, including

Ballengee, saw St. Francis as a perfectly viable alternative to Evanston Hospital. (RFF ¶¶ 570-576). St. Francis itself saw Evanston Hospital as its strongest competitor to the north. (RFF ¶ 463). And finally, there is no doubt ENH considers Condell to be an important, or "key," strong competitor of its HPH campus. (RFF ¶ 477; Hillebrand, Tr. 2005; RX 1331 at ENHE DL 11881). Once again, this view is shared by all the MCO representatives who testified at trial, including Ballengee. (RFF ¶ 577).

Hillebrand ultimately did not agree to PHCS's offer to exclude from its network St. Francis, Rush North Shore and Condell because the product offered by PHCS, a PPO, cannot by definition accommodate any exclusions. (Hillebrand, Tr. 1746, 1894). And even if Hillebrand could have accepted the offer, it would have been futile because Ballengee's superiors did not support the exclusion approach. (Hillebrand, Tr. 1894).

Finally, this proposed finding is misleading because

REDACTED

(Holt-Darcy, Tr. 1579, *in camera*; CX 129 at 1, *in camera*).

REDACTED

(RFF ¶¶ 869-875, *in camera*).

1703. **REDACTED**

(Holt-Darcy, Tr. 1561, *in camera*). **REDACTED**

(Holt-Darcy, Tr. 1602, *in camera).*

Response to Finding No. 1703:

This proposed finding is misleading **REDACTED**

REDACTED

(Holt-Darcy, Tr. 1579, *in camera*; CX 129 at 1, *in camera*).

REDACTED

(RFF ¶¶ 869-875, *in camera*).

REDACTED

(RX 1331 at ENHE DL 11884; RFF-Reply ¶¶ 49, 57).

1704.

REDACTED

(Mendonsa, Tr. 544, *in camera*).

Response to Finding No. 1704:

This proposed finding is misleading because it is based on nothing more than Mendonsa's speculation. Dr. Noether concluded that the concentration resulting from the Merger was entirely acceptable. Accordingly, Mendonsa's improper lay opinion testimony regarding concentration should be given no weight. (RFF ¶¶ 508-514).

1705.

REDACTED

(Mendonsa, Tr. 542-43, *in camera*).

Response to Finding No. 1705:

This proposed finding is misleading based on nothing more than Mendonsa's speculation and lay opinion. (RFF-Reply ¶ 1704). Moreover, there is no evidence anyone at Aetna consulted any consumers to form this conclusion. Nor is there any evidence that Aetna even tried to form a network without ENH.

REDACTED

(RX 1331 at ENHE DL 11884, *in camera*; RFF-Reply ¶¶ 49, 57).

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).

Response to Finding No. 1706:

This proposed finding is misleading because the

REDACTED

(RFF ¶¶ 454-460; RFF-Reply ¶ 1298).

REDACTED

REDACTED (CCFF ¶¶ 1297-1298; RFF ¶¶ 577-587). This claim is unpersuasive.

PHCS's own documents recognize that adding St. Francis to the hospitals listed in this proposed finding would constitute a "viable alternative" to ENH. When PHCS notified its customers about the Merger, PHCS specifically recognized alternatives to ENH in the "same geographical area," including: "St. Francis Hospital (Evanston, IL), Lake Forest Hospital (Lake Forest, IL), Advocate Lutheran General Hospital (Park Ridge, IL), Rush North Shore Medical Center (Skokie, IL), and Holy Family Medical Center (Des Plaines, IL)." (RX 712 at PHCS 891; Ballengee, Tr. 213-14; RFF ¶ 457).

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

(Mendonsa, Tr. 517, *in camera*).

Response to Finding No. 1707:

This proposed finding is misleading and based on facts not in evidence. (RFF-Reply ¶¶ 5, 54, 999). Indeed, Foucre admitted that ENH has a number of competitors that could serve as alternatives to the ENH hospitals. (RFF-Reply ¶ 978). As a result, Foucre's speculation regarding whether United could have a "viable network" without ENH is entitled to no weight.

As to Complaint Counsel's final assertion regarding "senior executives and decision makers," there is no evidence that the North Shore has more of these people than any other affluent community in the Chicago area. Instead, Complaint Counsel relies on the testimony of a witness who has little knowledge of the North Shore. **REDACTED**

REDACTED

(Mendonsa, Tr. 475; Mendonsa, Tr. 556, *in camera*). Not a single one of the referenced "executives" testified at trial or, for that matter, was even mentioned by name. Nor is there any evidence – other than Mendonsa's pure conjecture – that these anonymous executives would have acted on a self-interested basis, perhaps contrary to the desires of employees, in choosing a health plan that serviced their own communities. In short, Mendonsa's testimony on this issue should be afforded no weight.

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).

Response to Finding No. 1708:

This proposed finding is misleading. As initial matter,

REDACTED

(RFF ¶¶ 499-504, 506; RX 1331 at ENHE DL 11884, *in camera*). As of early 2005, ENH received only half of its patients from the "core" market. (Neaman, Tr. 1307-8; RFF ¶ 502). With only half of its business coming from the "core," ENH could not survive alone on that subset of its overall service area. For this reason, ENH focuses on its 50+ Zip code service area. (RFF-Reply ¶¶ 49, 57). Therefore the term "core" is not at all relevant.

This proposed finding is also misleading because it describes a "competitive overlap" that simply never existed. Evanston Hospital and HPH were not comparable hospitals or close

substitutes and, therefore, did not compete for the same patients and services. (RFF ¶¶ 480-481, 538-587; RFF-Reply ¶¶ 47, 48, 57, 58, 61, 1417, 1473-1474, 1695, 1697). Consequently, Evanston Hospital's solid market share in HPH's "core" communities was the result of HPH physicians referring their patients to Evanston Hospital for the advanced care HPH simply could not provide. (Spaeth, Tr. 2302-03).

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).

Response to Finding No. 1709:

This proposed finding is inaccurate.

REDACTED

(RX 1331 at ENHE DL 11883, *in camera*; RX 1361 at ENHE DL 6610; RX 1429 at ENHE F16 4561; RX 2021 at ENH DL 3443, *in camera*; Hillebrand, Tr. 1996-98; Spaeth, Tr. 2156; Neaman, Tr. 1055, 1307, 1311; RFF ¶ 502; RFF ¶ 506, *in camera*). ENH's "core" represents but one subset of the service area, and constitutes an area too small to sustain ENH's operations. (RFF-Reply ¶¶ 49, 57).

REDACTED

(RX 1331 at ENHE DL 11883, *in camera*; RX 1361 at ENHE DL 6610; RX 2021 at ENH DL 3443, *in camera*; Neaman, Tr. 1311).

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).

Response to Finding No. 1710:

This proposed finding is inaccurate and is based on a gross mischaracterization of Hillebrand's testimony. Hillebrand testified that ENH's *service area*, not its core, is "the geography where [ENH] get[s] approximately 80-85 percent of [its] patients." (Hillebrand, Tr. 1815). ENH's service area covers at least 50 zip codes, not 20, and ENH gets perhaps half of its business from the "core," not 80 to 85%. (RFF-Reply ¶¶ 49, 57; CCFF ¶ 60 (showing that Complaint Counsel previously agreed ENH's service area spanned 50 zip codes)).

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).

Response to Finding No. 1711:

This proposed finding is misleading. (RFF-Reply ¶ 1645).

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).

Response to Finding No. 1712:

This proposed finding is inaccurate. (RFF-Reply ¶¶ 55, 1709).

1713. ENH characterized Evanston and Highland Park as already having established "strong positions" in the CCSA before the merger. (CX 360 at 5).

Response to Finding No. 1713:

This proposed finding is misleading because the Combined Core Service Area does not represent the service area that the hospitals typically considered in evaluating competition and measuring market share. Hospital administrators typically looked at their primary service area (i.e. where approximately 80% of their patients come from) in evaluating market shares. (Spaeth, Tr. 2156). ENH documents confirm that its primary service area is "defined as 51 zip codes representing the communities where approximately 85% of [ENH's] patients reside. Fifteen hospitals are located in this 51 zip code service area and provide services to this population." (RX 1429 at ENHE F16 4561).

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).

Response to Finding No. 1714:

This proposed finding is misleading. (RFF-Reply ¶ 1713).

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).

Response to Finding No. 1715:

This proposed finding is misleading and irrelevant. (RFF-Reply ¶ 57).

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).

Response to Finding No. 1716:

This proposed finding is misleading and irrelevant. (RFF-Reply ¶¶ 57, 1650, 1709).

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).

Response to Finding No. 1717:

This proposed finding is misleading. (RFF-Reply ¶ 1713).

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)).

Response to Finding No. 1718:

This proposed finding is misleading. (RFF-Reply ¶ 1708).

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).

Response Finding No. 1719:

This proposed finding is misleading, vague and irrelevant. (RFF-Reply ¶ 1449).

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

(Chan, Tr. 839-40 (discussing CX 1607 at 5), *in camera*).

Response to Finding No. 1720:

This proposed finding is misleading. (Reply-RFF ¶ 1713). ENH's documents show that, in 2004, ENH had a 22% inpatient market share in the service area typically considered by hospital administrators. (RX 1429 at ENHE F16 4561).

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.

Response to Finding No. 1721:

This proposed finding is misleading to the extent it suggests that the triangle market or the CCSA market are the appropriate markets within which to analyze competition. (RFF-Reply ¶¶ 1645-1646, 1713).

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).

Response to Finding No. 1722:

This proposed finding is inaccurate. (RFF-Reply ¶¶ 54, 1645-1646).

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).

Response to Finding No. 1723:

This proposed finding is misleading because the HHI calculations are based on an inappropriate, and unprecedented, geographic market comprised of only the merging hospitals. This market is not supported by logic or the Guidelines methodology. (RFF-Reply ¶¶ 1645-1646). Consequently, this HHI calculation is meaningless.

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).

Response to Finding No. 1724:

This proposed finding is inaccurate.

REDACTED

(RX 1912 at 57, *in camera*). In addition, this proposed finding is misleading because it ignores that Dr. Noether's estimate of concentration levels using her minimum market was necessarily conservative. For example, there are some hospitals outside of this minimum market that place substantial competitive constraint on hospitals in the market. (Noether, Tr. 5929, 5930-31).

1725. **REDACTED**

(Noether, Tr. at 5965; RX 1912 at 57, *in camera*),.

Response to Finding No. 1725:

This proposed finding is misleading. (Reply-RFF ¶ 1725).

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)).

Response to Finding No. 1726:

This proposed finding is misleading because it ignores testimony that, while the calculated HHIs were above the Merger Guidelines thresholds, the HHIs were based on a very conservative market definition. (RFF-Reply ¶ 1724). In addition, this finding ignores testimony

that even this very conservative market is not concentrated relative to the types of transactions that are "typically challenged as likely to cause anticompetitive effects." (Noether, Tr. 5963).

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).

Response to Finding No. 1727:

This proposed finding is misleading. The *HCA/Chattanooga* case was based on a theory of coordinated effects rather than unilateral effects theory, the theory at issue in this case. (*Hosp. Corp. of Am.*, 807 F.2d 1381 (7th Cir. 1986); RFF ¶ 517). In addition, this proposed finding is misleading because it ignores that the pre-Merger HHI in *HCA/Chattanooga* was greater than the conservatively calculated HHIs in this case. (CCFF ¶¶ 1724-1726; RFF-Reply ¶¶ 1724-1726).

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).

Response to Finding No. 1728:

This proposed finding is misleading. It ignores that the pre-Merger HHI in *Rockford* was materially higher than the conservatively calculated post-Merger HHIs in this case. (CCFF ¶¶ 1724-1726; RFF-Reply ¶¶ 1724-1726). This finding also is misleading because it ignores that the change in HHI in *Rockford* was nearly 10 times greater than the conservatively measured changes in HHI in this case. (CCFF ¶¶ 1724-1726; RFF-Reply ¶¶ 1724-1726).

REDACTED

REDACTED (RX 1912 at 57, *in camera*).

Finally, this proposed finding is misleading to the extent it ignores that *Rockford* was based on a coordinated effects theory rather than a unilateral effects theory, the theory at issue in this case.

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).

Response to Finding No. 1729

This proposed finding is false and misleading. The concept of entry includes "an existing hospital upgrading its capacity, expanding its capacity, adding new services, updating its physical plant, doing things that essentially make it a more attractive facility to managed care organizations and their enrollees and thereby making it more competitive in the marketplace." (Noether, Tr. 6023; RFF ¶¶ 330-332). ENH's prices have been, and continue to be, constrained by area competitors that are constantly repositioning themselves through the construction of new hospitals, expansion of facilities and addition of services. (RFF ¶¶ 2289-2297; RFF ¶¶ 411-453). Additionally, since ENH's price increases merely resulted in bringing under-market rates up to competitive levels, there is no competitive need to roll back the price increases. (RFF ¶¶ 1110-1155).

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.)).

Response to Finding No. 1730

This proposed finding is incomplete, irrelevant and misleading. While there has been no entry by new providers, existing providers have expanded by constructing new hospitals. (RFF ¶¶ 2290-2291). For example, in 2003, Northwestern Memorial Hospital was granted a permit to build a new women's hospital by the Illinois Health Facilities Planning Board. (D. Jones, Tr. 1681; RFF ¶ 2290). Construction of the new dedicated hospital is anticipated to make

Northwestern Memorial an even larger presence in drawing obstetrics patients from all over the Chicago area. (RFF ¶ 2291).

Further, the alleged substantial price increases are irrelevant because ENH's prices are competitive in the marketplace. (RFF ¶¶ 1110-1155). Even Dr. Haas-Wilson, Complaint Counsel's economic expert, admitted that price increases, alone, do not demonstrate the existence of market power. (Haas-Wilson, Tr. 2482; RFF ¶ 315).

Finally, this proposed finding improperly suggests that ENH's 2002 chargemaster increases were done without regard to competitive concerns. As Respondent demonstrated at trial, ENH's chargemaster was under-market and was raised based on the strategic pricing advice provided by Deloitte Consulting. (RFF ¶¶ 932-964). This evidence was not rebutted by Complaint Counsel.

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).

Response to Finding No. 1731

This proposed finding is incomplete. The Illinois CON law is scheduled to be repealed on July 1, 2006. (D. Jones, Tr. 1685; RFF ¶¶ 2281-2282). Unless the Illinois CON law is extended or new laws are enacted, the CON process will cease to exist in July 2006. (D. Jones, Tr. 1685). If the CON statute expires and there is no replacement and/or similar statute enacted, all of the regulatory barriers would be removed. (D. Jones, Tr. 1685-86). This legal change will likely make entry and expansion much easier. (Noether, Tr. 6025).

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).

Response to Finding No. 1732

This proposed finding is incomplete. In 2000, Illinois increased the minimum capital expenditure threshold for a permit to be required from the Illinois Health Facilities Planning Board from $2 million to $6 million. (D. Jones, Tr. 1673; RFF ¶¶ 2287-2288). The threshold amount required for a permit prior to the acquisition of major medical equipment was also increased from $1 million to $6 million. (D. Jones, Tr. 1673-74). As a result of the increases, some projects that previously required a CON approval no longer require such approval. (D. Jones, Tr. 1674).

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).

Response to Finding No. 1733

Respondent has no specific response.

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).

Response to Finding No. 1734

Respondent has no specific response.

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).

Response to Finding No. 1735

This proposed finding is misleading. The trial record demonstrated that Don Jones's testimony regarding "bed need" was limited only to "those services [Complaint Counsel] mentioned" – intensive care, med/surg, pediatrics and obstetrics. (D. Jones, Tr. 1665). Jones

further testified that there could be a need for more beds in other service areas, but he did not have sufficient information to answer with respect to all services. (D. Jones, Tr. 1665-66). Further, Complaint Counsel's unilateral definition of "area" is not supported by the record. Jones testified that the Planning Board "developed planning areas for certain categories of service, and those are essentially geographic boundaries that the board developed." (D. Jones, Tr. 1665). Complaint Counsel did not further inquire as to the "geographic boundaries" or areas that the Planning Board developed for Evanston Hospital, Glenbrook Hospital and HPH.

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).

Response to Finding No. 1736

This proposed finding is misleading and incomplete. Jones testified that a "negative finding" by the Department of Public Health does not equate to a denial of a CON application. (D. Jones, Tr. 1667-68). The Department of Health does not make a recommendation on whether a project should be approved. (D. Jones, Tr. 1668).

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).

Response to Finding No. 1737

This proposed finding is false and misleading. Despite calling a witness from the Illinois Department of Public Health (Don Jones), who apparently did not provide Complaint Counsel with sufficient testimony to meet its burden on the entry issue, Complaint Counsel attempts to

attribute several pieces of information regarding the CON process to Spaeth. Spaeth, however, never worked for the Certificate of Need Board, and he has never been affiliated with the state regulatory agencies. (Spaeth, Tr. 2074-75, 2233-39). As a result, Complaint Counsel failed to show that Speath has any special knowledge of the CON laws sufficient to make him qualified to testify about past and future actions by the Certificate of Need Board. Complaint Counsel's proposed finding is based entirely on two pages of cross-examination where Complaint Counsel asked leading questions to which Spaeth responded "I believe so" and "perhaps." (Spaeth, Tr. 2168-69). Such testimony amounts to pure conjecture, is unreliable and, therefore, should be disregarded.

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).

Response to Finding No. 1738

Respondent has no specific response.

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).

Response to Finding No. 1739

This proposed finding is false and misleading. (RFF-Reply ¶ 1737).

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).

Response to Finding No. 1740

This proposed finding is false. Rather than cite to the testimony of its own witness from the Illinois Department of Health who testified that the CON law contains a sunset provision and has not yet been renewed (D. Jones, Tr. 1685-86), Complaint Counsel cites to its own leading

question and a response of "I believe so" from a witness who has never been affiliated with the state agency and does not have any special knowledge of the CON process. (Spaeth, Tr. 2169; RFF-Reply ¶ 1737). Spaeth's testimony on this point should be disregarded because it is pure speculation.

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).

Response to Finding No. 1741

This proposed finding is misleading. (RFF-Reply ¶ 1737).

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

In the matter of	)	
	)	Docket No. 9315
Evanston Northwestern Healthcare Corporation,	)	**Public Record**

RESPONDENT'S REPLIES TO COMPLAINT COUNSEL'S PROPOSED FINDINGS OF FACT

VOLUME VIII of XI

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XIV. DR. BAKER LACKS CREDIBILITY

A. Dr. Baker's Compensation

1742. **REDACTED** (Baker, Tr. 4708, *in camera*). **REDACTED** (Baker, Tr. 4706, *in camera*; Baker, Tr. 4598-99). **REDACTED** (Baker, Tr. 4708, *in camera*).

Response to Finding No. 1742:

This proposed finding is incomplete and misleading to the extent it suggests that Professor Baker's only recent working relationship has been with Charles River Associates. Professor Baker – the former Director of the Bureau of Economics for the FTC – is a Professor of Law at the Washington College of Law at American University. (Baker, Tr. 4588; RX 2036). Further, Professor Baker was an unpaid consultant to the FTC on merger policy, at the invitation of former FTC Chairman Timothy Muris, starting in 2002 and lasting for a couple of years. (Baker, Tr. 4595).

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).

Response to Finding No. 1743:

This proposed finding is inaccurate regarding Charles River Associates' billing for this case. Dr. Noether testified that Charles River Associates tries to make a profit on the time billed by the people working on the ENH case. In addition, she did not testify that Charles River Associates actually earned such a profit. (Noether, Tr. 6134).

B. Dr. Baker's First Report

1744. Dr. Baker submitted his original expert report on November 2, 2004. (Baker, Tr. 4599).

Response to Finding No. 1744:

Respondent has no specific response.

1745. **REDACTED**

(Baker, Tr. 4717-18, *in camera* (emphasis added)) **REDACTED**
(Baker Tr. 4688-89, *in camera*)).

Response to Finding No. 1745:

This proposed finding is incorrect.

REDACTED

(Baker, Tr. 4691-93, *in camera*).

REDACTED

(Baker, Tr. 4688, *in camera*).

REDACTED

(Baker, Tr. 4688-89, *in camera*).

REDACTED (RFF-Reply ¶ 1955, *in camera*).

1746.

REDACTED

(Baker, Tr. 4716-17 (discussing DX 7067 at 7, *in camera*), *in camera*).

REDACTED

(Baker, Tr. 4718-19 (discussing DX 7067 at 26, *in camera*), *in camera*).

Response to Finding No. 1746:

Respondent objects to this proposed finding to the extent that it is offered for the truth.

REDACTED

REDACTED

(Baker, Tr. 4717, 4719, *in camera*). The Court ruled that these passages can only come into the record for impeachment purposes. (Order Denying Complaint Counsel's Motion for the Admission of Portions of Dr. Baker's Expert Reports Into Evidence at 2 (May 10, 2005)). As such, reading the same passages onto the record, and asking Professor Baker whether he wrote those passages, also should only come into the record for impeachment purposes. Nevertheless, Complaint Counsel did not include the footnote required by paragraph 10 of the Court's Order dated April 6, 2005, indicating that this testimony was elicited for a purpose other than for the truth of the matter asserted.

REDACTED

(Baker, Tr. 4717, *in camera*; RFF-Reply ¶ 1955).

REDACTED

(Baker, Tr. 4691-93, *in camera*).

REDACTED

(Baker, Tr. 4688, *in camera*).

REDACTED

(Baker, Tr. 4688-89, *in camera*).

REDACTED (RFF-Reply ¶ 1955, *in camera*).

1747. **REDACTED**

(Baker, Tr. 4730-31, *in camera*). **REDACTED**

REDACTED

(Baker, Tr. 4732, *in camera*).

Response to Finding No. 1747:

Respondent objects to this proposed finding to the extent that it is offered for the truth. (RFF-Reply ¶ 1746).

REDACTED

(Baker, Tr. 4686-87, *in camera*).

REDACTED

(RFF-Reply ¶¶ 728-729, *in camera*).

REDACTED

(Baker, Tr. 4692-93, *in camera*).

1748.

REDACTED

(Baker, Tr. 4733-34, *in camera*).

REDACTED

(Baker, Tr. 4734-35 (discussing DX 7067 at 45, *in camera*), *in camera*).

Response to Finding No. 1748:

REDACTED

(CCFF ¶ 1751, *in camera*; Order Denying Complaint Counsel's Motion for the Admission of Portions of Dr.

Baker's Expert Reports Into Evidence at 1 (May 10, 2005) ("[B]y the time trial began, Baker had identified an error in his initial report and issued a supplemental report correcting the error")).

REDACTED

(RFF-Reply ¶¶ 728-729, 1747, *in camera*).

1749.

REDACTED

(CCFF 1745-1749).

Response to Finding No. 1749:

REDACTED

(RFF-Reply ¶ 1748).

REDACTED

(RFF-Reply ¶¶ 728-729, 1747-1748).

C. Dr. Ashenfelter's Rebuttal Report

1750. **REDACTED**

(Baker, Tr. 4710, *in camera*).

REDACTED

(Baker, Tr. 4710-11, *in camera*).

REDACTED

(Baker, Tr. 4711, *in camera*).

Response to Finding No. 1750:

This proposed finding is imprecise and incomplete. After reading Dr. Ashenfelter's rebuttal report, Professor Baker realized that he had made a mistake in the method he used to convert the output of a certain regression model into predicted prices. (Baker, Tr. 4599-600). Professor Baker wanted to correct the error right away, and so he worked to figure out how to do the output conversion correctly. He then submitted, with Complaint Counsel's consent, a supplemented report that corrected the mistake, and he revised the discussion to comport with what he found after correcting the method. (Baker, Tr. 4599-600). Professor Ashenfelter did not testify in this case.

1751. **REDACTED** (Baker, Tr. 4711-12), *in camera*). **REDACTED** (Baker, Tr. 4712-13, *in camera*). **REDACTED** (Baker, Tr. 4713, *in camera*). **REDACTED** (Baker, Tr. 4715, *in camera*).

Response to Finding No. 1751:

This proposed finding is misleading to the extent it suggests that Professor Baker's overall regression analysis changed from his first report to this supplemented report. The overall regression analysis was the same in the first report and supplemented reports. (Baker, Tr. 4599-600).

1752. **REDACTED** (Baker, Tr. 4741, *in camera*).

Response to Finding No. 1752:

This proposed finding is misleading and imprecise.

REDACTED

(Baker, Tr. 4687, *in camera*).

REDACTED

(Baker, Tr. 4741, *in camera*). **REDACTED**

(RFF-Reply ¶ 1747, *in camera*).

D. Dr. Baker's Second Report

1753. **REDACTED** (Baker, Tr. 4710, *in camera*).

REDACTED

(Baker, Tr. 4736-38, *in camera*).

Response to Finding No. 1753:

Respondent has no specific response.

1754. **REDACTED**

(Baker, Tr. 4737, *in camera*).

Response to Finding No. 1754:

Respondent has no specific response.

1755.

REDACTED

(Baker, Tr. 4739, 4787, *in camera*).

Response to Finding No. 1755:

This proposed finding is misleading, imprecise and irrelevant to Professor Baker's conclusion that ENH learned about its demand coincident with the Merger. As discussed above,

REDACTED (RFF-Reply ¶¶ 728-729, 1747, *in camera*).

REDACTED

(RFF-Reply ¶¶ 691, 734).

REDACTED

(Baker, Tr. 4787, *in camera* (emphasis added)).

REDACTED

(Baker, Tr. 4674, *in camera*).

1756.

REDACTED

(Baker, Tr. 4786-87, *in camera*).

Response to Finding No. 1756:

This proposed finding is incorrect. **REDACTED**

(Baker, Tr. 4674, *in camera*).

REDACTED

(Baker, Tr. 4674, *in camera*).

1757.

REDACTED

(Baker, Tr. 4739, *in camera*).

Response to Finding No. 1757:

This proposed finding is misleading, imprecise and irrelevant to Professor Baker's conclusion that ENH learned about its demand coincident with the Merger. As discussed above,

REDACTED (RFF-Reply ¶¶ 728-729, 1747, *in camera*).

REDACTED

(RFF-Reply ¶¶ 691, 734, *in camera*).

REDACTED

(Baker, Tr. 4787, *in camera*).

REDACTED

(Baker, Tr. 4674, *in camera*).

1758.

REDACTED

(CCFF 1754, 1757, *in camera*).

Response to Finding No. 1758:

This proposed finding is incorrect. **REDACTED**

(Baker, Tr. 4674, *in camera*).

REDACTED

(Baker, Tr. 4674, *in camera*).

1759.

REDACTED

REDACTED (Baker, Tr. 4689-90, *in camera*; *compare* RX 2038 at 4, *in camera*, *and* RX 2039 at 4, *in camera*).

Response to Finding No. 1759:

This proposed finding is misleading and inaccurate REDACTED

(RFF-Reply ¶ 1747, *in camera*).

REDACTED

(Baker, Tr. 4717, *in camera*; RFF-Reply ¶ 1955, *in camera*).

1760. REDACTED

(CCFF 1746-1747).

Response to Finding No. 1760:

Respondent objects to this proposed finding to the extent that it is offered for the truth. (RFF-Reply ¶ 1746).

REDACTED

(RFF-Reply ¶¶ 729-730, 1747, *in camera*).

E. Dr. Baker's Testimony

1761. REDACTED

(Baker, Tr. 4685, 4732, *in camera*).

Response to Finding No. 1761:

Respondent objects to this proposed finding to the extent that it is offered for the truth. (RFF-Reply ¶ 1746). **REDACTED**

(Baker, Tr. 4717, *in camera*; RFF-Reply ¶ 1955, *in camera*).

REDACTED

(RFF-Reply ¶¶ 728-729, 1747, *in camera*).

REDACTED

(RFF-Reply ¶¶ 729, 1952, *in camera*)

1762.

REDACTED

(CCFF 1742-1761, *in camera*).

Response to Finding No. 1762:

This proposed finding is incorrect, badly mischaracterizes Professor Baker's testimony and is not supported by any record evidence. **REDACTED**

(Baker, Tr. 4599-600).

REDACTED

(Haas-Wilson, Tr. 2591-92, *in camera*).

REDACTED

(Baker, Tr. 4653-54, 4671, 4811, *in camera*).

REDACTED

(Baker, Tr. 4815, *in camera*).

REDACTED

(Baker; Tr. 4669-71, *in camera*).

REDACTED

(RFF-Reply ¶¶ 1742-1761, *in camera*).

REDACTED

REDACTED

(RFF-Reply ¶¶ 729, 1952, *in camera*).

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).

Response to Finding No. 1763:

Respondent has no specific response.

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).

Response to Finding No. 1764:

Respondent has no specific response.

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).

Response to Finding No. 1765:

This proposed finding is misleading because it

REDACTED

(RFF ¶¶ 656-657, 663-665, 667-669; RFF ¶¶ 658-662, 666, *in camera* (learning through internal pricing analysis), 670-680, 682-683, 685; RFF ¶¶ 681, 684, 686-690, *in camera*).

REDACTED

(RFF ¶¶ 694-696; RFF ¶¶ 697-700). Bain

also advised ENH that its pricing was "behind" relative to other academic hospitals. (RFF ¶¶ 701-703). Finally, Bain provided Evanston Hospital/ENH with effective negotiating techniques and strategies. (RFF ¶¶ 704-733).

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).

Response to Finding No. 1766:

This proposed finding is misleading because "Dr. Haas-Wilson's understanding of the Respondents' experts' learning about demand" theory is inaccurate. As described in this proposed finding, "Dr. Haas-Wilson's understanding" of the learning about demand theory ignores the significant record evidence demonstrating a variety of sources and types of learning beyond "contracted rates in Highland Park Hospital's contracts." (RFF-Reply ¶ 1765; RFF ¶¶ 656-700). In addition, this proposed finding is misleading in its characterization of learning about demand as an "excuse." Even Dr. Haas-Wilson admitted that, as a matter of economic theory, "learning about demand" is a potential viable economic explanation for a price increase. (Haas-Wilson, Tr. 2488).

REDACTED

(Haas-Wilson, Tr. 2835-36, *in camera*).

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).

Response to Finding No. 1767:

This proposed finding is incomplete and misleading. As an initial matter, no one at Evanston Hospital knew that its MCO contract rates were under-market until late 1999. Because negotiated rates are confidential, Evanston Hospital did not know other hospitals' rates and there was no means of comparison. (Newton, Tr. 373-74; Neaman, Tr. 1344; Ballengee, Tr. 193-94; RFF ¶ 79). In fact, management believed the hospital was getting "good rates" during this period. (RX 2047 at 61 (Ogden, Dep.); RFF ¶ 677).

Just as importantly, Sirabian and Hillebrand did a good job of implementing and following Evanston Hospital's contracting philosophy as it existed in the 1990s. Specifically, until the very late 1990s, Evanston Hospital's financial needs were satisfied by its investment income and reimbursements from Medicare and other government programs. (RFF ¶¶ 641-643). Hospital management and the Board felt that the managed care pricing levels were sufficient as long as the hospital was able to get a 2% return from operations over the Medical Consumer Price Index ("CPI"). (Hillebrand, Tr. 1836; RFF ¶ 642). Consequently, MCO negotiations were not a priority, and Evanston Hospital's negotiation style reflected this mentality. Indeed, during the entire 10-year period in which Sirabian was responsible for managed care contracting, he did not have any support staff and he also had responsibilities other than contracting, including managing the hospital and professional business offices. (RFF ¶ 602). And when he did sit down to negotiate, Sirabian was passive, rarely threatening termination, and he allowed many contracts to expire without renegotiation. (RFF ¶¶ 605-623). Sirabian's modest goal in managed care negotiations was to ensure that Evanston Hospital be included in all the different MCO networks and to build relationships with the MCOs. (Sirabian, Tr. 5700, 5702, 5721; RFF ¶ 605). In fact, Chan, who worked with Sirabian (her Evanston Hospital counterpart) just before

and after the Merger, did not believe that Sirabian was a tough negotiator. (Chan, Tr. 740-41).

REDACTED

(Haas-Wilson, Tr. 2820, *in camera*; RX 2030 at 2, *in camera*).

Bain labeled Sirabian a "pushover." (RX 2047 at 51 (Ogden, Dep.); RFF ¶ 717).

Nevertheless, Sirabian and Hillebrand paid particular attention to their Humana and Blue Cross contracts and relationships. (Sirabian, Tr. 5707; RFF ¶ 757). Sirabian made sure that the Humana and Blue Cross contracts were always current and up-to-date because the these two contracts represented a substantial portion of Evanston Hospital's managed care business. (Sirabian, Tr. 5707). Hillebrand would likewise negotiate face-to-face with these larger MCOs. (Hillebrand, Tr. 1700; RFF ¶ 604). Complaint Counsel did not call representatives from either Humana or Blue Cross to testify at trial.

1768. Jack Sirabian handled ENH's managed care contracting negotiations from approximately 1990 to 2000. (Sirabian, Tr. 5697-98).

Response to Finding No. 1768:

Respondent has no specific response.

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).

Response to Finding No. 1769:

This proposed finding is incomplete and misleading because while Sirabian did report to Hillebrand in connection with managed care negotiations, he did not normally report to him about specific contracts. (Sirabian, Tr. 5701).

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).

Response to Finding No. 1770:

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 1767).

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).

Response to Finding No. 1771:

This proposed finding is irrelevant and misleading. Because Bain realized that United considered Sirabian a "pushover," it recommended to Evanston Hospital that it use an "internal bad guy" during United negotiations, the benchmark for all subsequent negotiations, to "show them [United] that we're serious and that we're not just going to take whatever you give us." (RX 2047 at 51 (Ogden, Dep.); RFF ¶ 717).

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).

Response to Finding No. 1772:

This proposed finding is misleading. Sirabian was not an aggressive negotiator. (RFF-Reply ¶¶ 1767, 1771). This proposed finding also mischaracterizes Sirabian's testimony. Sirabian agreed that, during the 10 years he handled negotiations, terminations did occur, but they were "rare" and were not his "practice." (Sirabian, Tr. 5751). For example, the three most difficult MCOs with which to negotiate were Cigna, Aetna and United because they were not willing to bring negotiations to a conclusion. (Sirabian, Tr. 5710, 5715-16). Nevertheless, Sirabian never threatened to terminate any of these contracts. (Sirabian, Tr. 5763-64; RFF ¶ 612).

1773. Mr. Hillebrand had and still has general oversight and supervisory responsibility for health plan contracting. (Hillebrand, Tr. 1701; Neaman, Tr. 1220).

Response to Finding No. 1773:

This proposed finding is incomplete and misleading. During the 1990s, Sirabian did not normally report to Hillebrand about specific contracts. (Sirabian, Tr. 5701). During this period, Hillebrand's contracting focus instead was on maintaining relationships with some of the very large insurers, such as Blue Cross and Humana. (Hillebrand, Tr. 2012).

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).

Response to Finding No. 1774:

This proposed finding is misleading because no one at Evanston Hospital, including Neaman, had reason to believe that the hospital's contract rates were under-market before the Merger. (RFF-Reply ¶ 1767). In fact, management believed the hospital was getting "good rates" during this period. (RX 2047 at 61 (Ogden, Dep.); RFF ¶ 677).

1775. Mr. Hillebrand received a bonus after the merger in 2000. (Neaman, Tr. 1221).

Response to Finding No. 1775:

This proposed finding is misleading because Hillebrand's bonus was a reward for all of his hard work in 2000, such as making the Merger integration process a success and, in the process, achieving cost improvements and renegotiating competitive MCO contracts for ENH. (CX 2098 at 13). This bonus was approved by ENH's Board and the Board's independent compensation committee, which includes two independent consultants, one who provides data and one who is legal counsel employed specifically for compensation matters. (Neaman, Tr. 1372-73).

1776. Mr. Hillebrand was never accused of being soft or of not bargaining hard with health plans. (Hillebrand, Tr. 1727).

Response to Finding No. 1776:

This proposed finding is misleading. (RFF-Reply ¶¶ 1767, 1774).

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)).

Response to Finding No. 1777:

This proposed finding is inaccurate and misleading because Evanston Hospital/ENH and Bain did not have access to any other hospitals' pricing information, except for HPH's. (RFF-Reply ¶ 1767). Based on Bain's analysis and its own internal analyses, Evanston Hospital/ENH reached the simple conclusion that if Evanston Hospital (an academic hospital system) was being paid less than HPH (a community hospital), Evanston Hospital must have been being paid much less than other academic hospital systems. (Hillebrand, Tr. 1853-54; Neaman, Tr. 1344-45; RFF ¶ 528, 656-703, 734-893, 1110-1136, 1148-1155).

REDACTED

(Hillebrand, Tr. 1856; RX 2047 at 31 (Ogden, Dep.); RX 718 at 7, *in camera*; RFF ¶ 715, *in camera*).

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).

Response to Finding No. 1778:

This proposed finding is incomplete because Hillebrand and other Evanston Hospital personnel learned in mid-November 1999 that the hospital's United contract was "under-

market." (RX 679 at ENHL RG 4133-35). It was not until late November 1999 that Bain presented a much more comprehensive comparison of the two hospitals' various contracts. (RX 684 at BAIN 43; Hillebrand, Tr. 1852-53; RX 679 at ENHL RG 4140 (stating that "All Physician and Hospital Contracts need to be compared by November 19, 1999")).

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)).

Response to Finding No. 1779:

This proposed finding is misleading because Bain only had access to Evanston Hospital's and HPH's rates and, therefore, could not provide any specific information about other hospitals' rates. (Hillebrand, Tr. 1737-38; RFF-Reply ¶ 1767). Nevertheless, after comparing the two merging hospitals' contracts in late 1999, Bain reached the simple conclusion that, generally speaking, other academic hospitals similar to Evanston Hospital were getting much higher prices than Evanston Hospital. (RX 2047 at 31, 34 (Ogden, Dep.); RFF ¶ 701; Neaman, Tr. 1344-45; RFF ¶ 702; Hillebrand, Tr. 1853-54; RFF ¶ 703; RFF ¶ 677-693).

While Bain did not use the specific word "academic," it did advise ENH to talk to MCOs about its value – i.e. what it could "bring to the table," something Evanston Hospital had not been doing. (RX 2047 at 31 (Ogden, Dep.)). Bain also helped ENH come up with a clear articulation of who ENH "was and had been for five years and just wasn't getting credit for." (RX 2047 at 31 (Ogden, Dep.); RFF ¶ 718). To this end, Bain's November 1999 "Project Review" stressed certain "negotiation strategy lessons learned to date," in particular that negotiators should "emphasize the value ENH brings to a payor's network." (RX 684 at BAIN 53). These values included Evanston Hospital/ENH's "brand," "patient access," "cost management," and "quality." (RX 684 at BAIN 53). Because Evanston Hospital changed its

name to Evanston *Northwestern* Healthcare in 1997, emphasizing the ENH "brand" was just another means of explaining to MCOs that the hospital deserved the rates its university "brand" name commanded in the market. (Hillebrand, Tr. 1782; Spaeth, Tr. 2133; RFF ¶ 34). Bain again emphasized these very same "negotiating strategy lessons" in its February 2000 "Final Project Review." (RX 785 at ENH DS 211). In short, Bain did not have to use the specific word "academic" to advise Evanston Hospital/ENH that it deserved rates on par with other academic hospitals. (RX 679 at ENHL RG 004139 (listing "level of services" as part of Bain's recommended "negotiation strategies")).

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).

Response to Finding No. 1780:

This proposed finding is misleading. (RFF-Reply ¶ 1779).

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)).

Response to Finding No. 1781:

This proposed finding is misleading. (RFF-Reply ¶ 1779).

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).

Response to Finding No. 1782:

This proposed finding is incomplete and misleading because Hillebrand testified that he had conversations with people about the change in ENH's negotiation tactics. (Hillebrand, Tr. 2051). This testimony is corroborated by the fact that Neaman authorized Hillebrand to get more aggressive with MCOs after learning that Evanston Hospital's rates were significantly lower than

HPH's. (Neaman, Tr. 1343-44). Hillebrand's testimony is further corroborated by the Bain documents and the testimony from Bain's representative on the project, Kim Ogden, which in general revealed that Bain advised ENH to get more aggressive with the MCOs and to "emphasize the value ENH brings to a payor's network," in particular its Evanston *Northwestern* Healthcare "brand" name. (RFF ¶¶ 710-725; RFF-Reply ¶ 1779).

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).

Response to Finding No. 1783:

This proposed finding is misleading. (RFF-Reply ¶ 1779).

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).

Response to Finding No. 1784:

This proposed finding is misleading because, rather than writing an e-mail or a memo, after learning of HPH's superior rates, Neaman authorized Hillebrand to implement, with Bain's help, Bain's recommended aggressive negotiating tactics. (Neaman, Tr. 1343-44).

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).

Response to Finding No. 1785:

This proposed finding is misleading. (RFF-Reply ¶ 1779).

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).

Response to Finding No. 1786:

This proposed finding is misleading and inaccurate. (RFF-Reply ¶¶ 1632-1634). This proposed finding is misleading because Evanston Hospital/ENH did not know the prices of academic hospitals or, for that matter, any other hospital (save pre-Merger HPH). (Newton, Tr. 373-74; Neaman, Tr. 1344; Ballengee, Tr. 193-94).

REDACTED

(Neary, Tr. 595, 608, 633; RFF ¶¶ 719, 754, 864, 884, *in camera*). Several MCO representatives confirmed this fact at trial. (RFF ¶¶ 754, 796, 864).

REDACTED

(RFF ¶¶ 1111-1112, *in camera*).

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).

Response to Finding No. 1787:

This proposed finding is misleading. (RFF-Reply ¶ 1632). And Ballengee's "recollection" of conversations from five years ago should be afforded no weight. As discussed in Reply-RFF ¶ 1080, this Court should view with suspicion all testimony from MCO representatives that is not reflected in contemporaneous documents since they have a plain interest in this litigation. (Reply-RFF ¶ 1080). In fact, Hillebrand testified that he never told Ballengee that ENH had a 60% market share, the claim on which Complaint Counsel partially bases the allegation that ENH "controlled the marketplace." (Hillebrand, Tr. 1894). Ballengee's

characterizations of ENH comments (to the extent they have any independent relevance – which they do not) are clearly self-serving, uncorroborated and subject to dispute. Therefore, such testimony should be disregarded.

REDACTED

(Mendonsa, Tr. 559, *in camera*; Holt-Darcy, Tr. 1588, *in camera*).

1788. Patrick Neary of One Health 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).

Response to Finding No. 1788:

This proposed finding is misleading. (RFF-Reply ¶ 1633).

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).

Response to Finding No. 1789:

This proposed finding is misleading. (RFF-Reply ¶ 1786). Moreover, Holt-Darcy testified that

REDACTED

(Holt-Darcy, Tr. 1596-97, *in camera*; RFF ¶ 459).

REDACTED

(Holt-Darcy, Tr. 1596, *in camera;* RFF ¶ 567).

1790. Jillian Foucre of United did not believe that any of the ENH facilities were academic hospitals. (Foucre, Tr. 936).

Response to Finding No. 1790:

This proposed finding is misleading. (RFF-Reply ¶ 1634).

1791. **REDACTED**

(CX 2381 at 4, *in camera*; Foucre, Tr. 1081-85, *in camera*).

Response to Finding No. 1791:

This proposed finding is misleading because **REDACTED**

(RFF-Reply ¶ 987).

1792. **REDACTED**

(CX 6277 at 3, *in camera*; Foucre, Tr. 1092, *in camera*).

Response to Finding No. 1792:

This proposed finding is inaccurate and misleading. (RFF-Reply ¶¶ 958, 992, 995).

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).

Response to Finding No. 1793:

This proposed finding is misleading. Both sides agreed that Moeller, United's CEO, requested the draft letter and, pursuant to that request, Hillebrand provided it to United. (Foucre, Tr. 923; Hillebrand, Tr. 1887). Accordingly, this proposed finding should be accorded no weight. (Foucre, Tr. 928 (ruling that the Court will be mindful of CX 6284's due weight); RFF-Reply ¶ 1019).

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).

Response to Finding No. 1794:

This proposed finding is misleading. (RFF-Reply ¶ 1022). United "wanted to help with the hospitals' position in regards to the investigation." (Hillebrand, Tr. 1887). ENH's position, throughout this investigation and litigation, is that the Merger had no adverse impact on competition.

REDACTED

(RFF-Reply ¶¶ 967, 969, 978, 981-982, 987, 990-992). At the time, ENH asserted that this data was unreliable and inaccurate. United ceased relying upon such data after ENH pointed out their unreliability. (RFF ¶¶ 903-906).

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).

Response to Finding No. 1795:

This proposed finding is misleading. (RFF-Reply ¶¶ 1022, 1794). This proposed finding is further misleading because there is no evidence that United even tried to market a network without ENH. Given Foucre's lack of familiarity with the geographic landscape, any assertion on her part that dropping ENH was not a viable option due to "[ENH's] geography [and] the people who live in that geography" should be accorded no weight. (Foucre, Tr. 941; RFF-Reply ¶¶ 50, 1001).

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).

Response to Finding No. 1796:

This proposed finding is misleading. (RFF-Reply ¶¶ 1019, 1022, 1793-1794).

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).

Response to Finding No. 1797:

This proposed finding is misleading because it ignores that, in a differentiated product market, firms that are closer substitutes to each other are more likely to constrain each other's competitive behavior. (Noether, Tr. 5911).

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*).

Response to Finding No. 1798:

Respondent has no specific response.

1799. **REDACTED** (RX 1912 at 44, *in camera*).

Response to Finding No. 1799:

Respondent has no specific response.

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)).

Response to Finding No. 1800:

This proposed finding is misleading to the extent it ignores factors, other than the size of the MCO, that might influence the outcome of the bargain between hospitals and MCOs. (Reply-RFF ¶ 198).

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).

Response to Finding No. 1801:

This proposed finding is misleading to the extent it suggests that this ratio is meaningful without additional information. It is misleading to consider only the raw number of contracts in which HPH's contract rates exceeded Evanston Hospital's contract rates.

REDACTED (RX 684 at BAIN 43; Hillebrand, Tr. 1892-93; RX 762 at ENHL TC 9936, 9942 , *in camera*).

REDACTED (RX 1912 at 29, 31, *in camera*). This proposed finding is also misleading because the "one third" referred to in this finding also excludes instances were HPH's rates were equivalent to Evanston

Hospital's rates, a situation that would also inform Evanston that it was not pricing at appropriate levels.

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).

Response to Finding No. 1802:

This proposed finding is misleading. (Reply-RFF ¶¶ 1797-1801). In addition, this proposed finding is illogical, because it is the very differences between Evanston Hospital and HPH that made learning about demand possible. HPH and Evanston Hospital executives expected that Evanston Hospital, as an academic institution, would have higher rates than HPH, a community institution. (Sirabian, Tr. 5718; Spaeth, Tr. 2297; Neaman, Tr. 1344-45; Hillebrand, Tr. 1871). Evanston Hospital executives were thus "shocked" and "surprised." When Evanston Hospital discovered that it had lower rates and reimbursements than HPH for many key MCOs. (Neaman, Tr. 1344-45; Hillebrand, Tr. 1871). It is illogical to suggest that Evanston Hospital could not have learned about the demand for its services from this information.

2. Pre-Merger, Highland Park Charged Lower Actual Prices Than Evanston

1803. **REDACTED** (Haas-Wilson, Tr. 2645, *in camera*).

(Haas-Wilson, Tr. 2645, *in camera*).

REDACTED

REDACTED

(Haas-Wilson, Tr. 2647-48, *in camera*).

Response to Finding No. 1803:

This proposed finding is misleading. (RFF-Reply ¶¶ 696-698).

1804. **REDACTED**

(*See* CX 1373 at 14, *in camera* **REDACTED**

Response to Finding No. 1804:

This proposed finding is misleading. (RFF-Reply ¶ 814).

1805.

REDACTED

(Baker, Tr. 4633, *in camera*).

REDACTED

(Baker, Tr. 4744-46 (discussing DX 7068 at 43, *in camera*), *in camera*; RX 2040 at 1,[9] *in camera*).

Response to Finding No. 1805:

This proposed finding is incorrect. **REDACTED**

(Baker, Tr. 4759-60, *in camera*).

REDACTED

(Baker, Tr. 4633, *in camera*). **REDACTED**

REDACTED (Baker, Tr. 4628, *in camera*).

REDACTED

(Baker, Tr. 4625-26, *in camera*).

REDACTED

(Baker, Tr. 4628, *in camera*).

REDACTED

(Baker, Tr. 4806-07, *in camera*).

REDACTED

(Baker, Tr. 4806-07, *in camera* (discussing DX 7068 at 44, *in camera*)).

REDACTED

(Baker, Tr. 4807, *in camera*).

1806.

REDACTED

(Baker, Tr. 4744-47 (discussing DX 7068 at 43 (Dr. Baker's second Expert Report), *in camera*), *in camera*; RX 2040 at 1[10], *in camera*).

Response to Finding No. 1806:

This proposed finding is incorrect. **REDACTED**

(Baker, Tr. 4744-47, *in camera* (discussing DX 7068 at 43, *in camera*)). **REDACTED**

(RFF-Reply ¶ 1805).

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[9] RX 2040 is cited to impeach Dr. Baker's testimony both here and when cited in subsequent findings.

[10] 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.

1807. **REDACTED**

(Baker, Tr. 4744-46, *in camera;* RX 2040 at 1, *in camera*).

Response to Finding No. 1807:

This proposed finding is incorrect. **REDACTED**

(Baker, Tr. 4744-47, *in camera* (discussing DX 7068 at 43, *in camera*)). **REDACTED**

(RFF-Reply ¶ 1805).

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*).

Response to Finding No. 1808:

This proposed finding is misleading. (RFF-Reply ¶¶ 700-701).

1809. Pre-merger, Highland Park charged lower actual prices than Evanston. (CCFF 1803-1808).

Response to Finding No. 1809:

This proposed finding is inaccurate and misleading. (RFF-Reply ¶ 1801, 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*).

Response to Finding No. 1810:

This proposed finding is misleading

REDACTED

(RX 1912 at 36, *in camera*).

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*).

Response to Finding No. 1811:

This proposed finding is misleading to the extent it overstates the significance of case mix indices as measures of hospital similarities. (RFF-Reply ¶ 707).

1812.

REDACTED

(Noether, Tr. 6090, *in camera*; RX 1912 at 34, *in camera*).

Response to Finding No. 1812:

This proposed finding is confusing and misleading. The United representative at trial did not testify about this issue. Accordingly, any testimony by Dr. Noether concerning why United took specific action concerning this matter would be pure speculation. In addition, this proposed finding is misleading because **REDACTED**

REDACTED

(Noether, Tr. 6092, *in camera*; RX 1912 at 34, *in camera*).

1813. Dr. Noether's Rate Comparisons Cannot Be Taken at Face Value. (CCFF 1810-1812).

Response to Finding No. 1813:

This proposed finding is inaccurate. (RFF-Reply ¶¶ 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).

Response to Finding No. 1814:

This proposed finding is misleading to the extent that it suggests that this is the extent of Dr. Noether's analysis. Dr. Noether considered ENH's price levels in relation not only to her academic control group but also in relation to her community control group. (Noether, Tr. 6000). In addition, Dr. Noether considered her empirical analysis of price levels in the context of other record evidence. (Noether, Tr. 6105-06, *in camera*).

1815. **REDACTED**

(See Noether, Tr. 6060, *in camera*).

Response to Finding No. 1815:

Respondent has no specific response.

1816. The comparisons performed by Dr. Noether depend upon the hospitals that Dr. Noether selected for her two groups of hospitals. **REDACTED**

REDACTED (Haas-Wilson, Tr. 2697, *in camera*).

Response to Finding No. 1816:

This proposed finding is misleading to the extent it suggests that Dr. Noether's control groups were not appropriate. (RFF-Reply ¶¶ 703-727).

REDACTED

(Haas-Wilson, Tr. 2868-69, *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*).

Response to Finding No. 1817:

This proposed finding is misleading to the extent it suggests that the control groups developed by Dr. Noether and used in Professor Baker's analysis were not appropriate. (RFF-Reply ¶ 1816).

1818. **REDACTED**

(RX 1912 at 147-52 (**REDACTED**
(RX 1912 at 147-49) **REDACTED**
(RX 1912 at 150-52)), *in camera*).

Response to Finding No. 1818:

Respondent has no specific response.

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).

Response to Finding No. 1819:

This proposed finding is irrelevant. The inclusion of these four hospitals in Dr. Noether's academic control group was appropriate. The evidence demonstrated that these four hospitals were viewed as comparable and competitive with ENH. For example, Northwestern Memorial included Christ, Cook County Hospital, ENH, Loyola, Advocate Lutheran General, Northwest Community, Rush, University of Chicago and University of Illinois in the tertiary hospital or academic medical center group of its competitors. (Noether, Tr. 6009; RX 1316 at NMH 9392; RFF ¶¶ 1074, 1078-1079). In addition, Deloitte included these four hospitals in the 10 hospital peer group used to evaluate ENH's chargemaster. (Porn, Tr. 5654; RX 1283 at DC 7). These four hospitals also meet all three criteria used by Dr. Noether to identify her academic control group hospitals. (Noether, Tr. 6000; RFF-Reply ¶¶ 703-727). Finally, prior to selecting her control groups, Dr. Noether did not know the prices charged by each of the hospitals. (Noether, Tr. 6210).

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.)

Response to Finding No. 1820:

This proposed finding is irrelevant. (RFF-Reply ¶ 1819).

1. Dr. Noether Began with an Arbitrary Group of 20 Hospitals

1821. **REDACTED**

(Haas-Wilson, Tr. 2550-51, *in camera*).

Response to Finding No. 1821:

This proposed finding is misleading to the extent it suggests that the criteria Dr. Noether used to select her control groups were not appropriate, or that Dr. Haas-Wilson was not equally "arbitrary" in selecting her control groups. (RFF-Reply ¶¶ 518, 703-727). In addition, this finding is misleading to the extent that **REDACTED**

(Noether, Tr. 5922, 5995-96; Noether, Tr. 6111, *in camera*). Dr. Haas-Wilson did not offer similar industry support for her control group criteria.

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).

Response to Finding No. 1822:

Respondent has no specific response.

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).

Response to Finding No. 1823:

This proposed finding is misleading to the extent it suggests that it is necessary to include all comparable hospitals in a control group. In designing her control groups, Dr. Noether did not attempt to be all-inclusive, only representative. (Noether, Tr. 5997, 6150).

REDACTED

(Haas-Wilson, Tr. 2859, *in camera*). Generally, under-inclusion is safer than over-inclusion because the larger the control group, the greater the risk of having hospitals that are not good

comparisons. (Noether, Tr. 5997-98). **REDACTED**

(Baker, Tr. 4780-81, *in camera*). Dr. Noether did not know the prices of the various hospitals before selecting her control groups. (Noether, Tr. 6210).

REDACTED

(Haas-Wilson, Tr. 2868-69, *in camera*).

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).

Response to Finding No. 1824:

This proposed finding is misleading to the extent it suggests the criteria used by Dr. Noether to identify her control group hospitals were inappropriate. (RFF-Reply ¶¶ 703-727).

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).

Response to Finding No. 1825:

This proposed finding is misleading to the extent that it mischaracterizes Dr. Noether's testimony. Dr. Noether simply testified that it was not the "primary purpose" of the criteria used to develop her control groups to identify hospitals that competed with ENH from the perspective of patients or MCOs. (Noether, Tr. 6174-75). Dr. Noether did testify, however, that her "academic control group includes hospitals that managed care organizations have indicated are similar to ENH." (Noether, Tr. 6175).

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).

Response to Finding No. 1826:

This proposed finding is irrelevant. It was not necessary to include all comparable or competitive hospitals in Dr. Noether's control groups. (RFF-Reply ¶ 1823). In addition, Complaint Counsel offered no evidence to suggest that the inclusion of the "closer" hospitals referenced above would impact the empirical results.

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).

Response to Finding No. 1827:

This proposed finding is irrelevant. It was not necessary to include all comparable or competitive hospitals in Dr. Noether's control groups. (RFF-Reply ¶ 1823).

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).

Response to Finding No. 1828:

This proposed finding is irrelevant. It was not necessary to include all comparable or competitive hospitals in Dr. Noether's control groups. (RFF-Reply ¶ 1823).

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).

Response to Finding No. 1829:

This proposed finding is irrelevant. It was not necessary to include all comparable or competitive hospitals in Dr. Noether's control groups. (RFF-Reply ¶ 1823).

1830. In her expert report, Dr. Noether identifies Christ Hospital as a core competitor of ENH. (Noether, Tr. 6152).

Response to Finding No. 1830:

This proposed finding is irrelevant. It was not necessary to include all comparable or competitive hospitals in Dr. Noether's control groups. (RFF-Reply ¶ 1823).

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).

Response to Finding No. 1831:

This proposed finding is misleading to the extent it mischaracterizes Dr. Noether's testimony. Dr. Noether simply testified, in response to a question from Complaint Counsel, that she could not recall any specific documents that mentioned Loyola and Rush-Presbyterian as competitors of ENH. (Noether, Tr. 6154). In addition, this proposed finding is misleading to the extent it ignores documents and testimony demonstrating that ENH did, in fact, compete with

these two hospitals. (RFF-Reply ¶ 1819). Finally, this proposed finding is misleading to the extent it references Dr. Noether's report, which is not in evidence.

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).

Response to Finding No. 1832:

This proposed finding is misleading. (RFF-Reply ¶ 1831).

1833. Dr. Noether then used her list or 20 hospitals (18 plus Evanston and Highland Park) to develop what she called her academic and community control group hospitals. (Noether, Tr. 6154-55)

Response to Finding No. 1833:

Respondent has no specific response.

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).

Response to Finding No. 1834:

This proposed finding is misleading to the extent it ignores the criteria used by organizations such as Solucient and MedPAC. (RFF-Reply ¶ 1821).

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).

Response to Finding No. 1835:

Respondent has no specific response.

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).

Response to Finding No. 1836:

Respondent has no specific response.

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).

Response to Finding No. 1837:

This proposed finding is misleading. (RFF-Reply ¶¶ 703-727).

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).

Response to Finding No. 1838:

This proposed finding is misleading. (RFF-Reply ¶¶ 703-727). In any event, Complaint Counsel has offered no evidence to suggest that using a different cut-off would change the results of Dr. Noether's empirical analysis.

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)).

Response to Finding No. 1839:

This proposed finding is misleading. (RFF-Reply ¶ 1838).

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).

Response to Finding No. 1840:

Respondent has no specific response.

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).

Response to Finding No. 1841:

This proposed finding is misleading. The criteria Dr. Noether used to select her academic control group were appropriate. (RFF-Reply ¶¶ 703-727).

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).

Response to Finding No. 1842:

This proposed finding is misleading. The criteria Dr. Noether used to select her academic control group were appropriate. (RFF-Reply ¶¶ 703-727). In addition, this proposed finding mischaracterizes Dr. Noether's testimony. Dr. Noether testified that, "based on all of the evidence describing the different hospitals, as well as my general knowledge about what constitutes breadth of service, the top third seemed like a more reasonable cut-off than the top quarter would have." (Noether, Tr. 6166). She "looked at all of the evidence concerning breadth of service and determined that the – just limiting it to the top quarter would have been too strict." (Noether, Tr. 6166). In addition, Dr. Noether testified that while she may have seen the list of hospitals prior to making this determination she did not know the prices of the various hospitals before selecting her control groups. (Noether, Tr. 6210). Finally, Complaint Counsel has offered no evidence to suggest that using a different cut-off would have materially affected the results of Dr. Noether's empirical analysis.

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).

Response to Finding No. 1843:

Respondent has no specific response.

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

(Foucre, Tr. 932-33; Noether, Tr. 6244-45, *in camera*).

Response to Finding No. 1844:

Respondent has no specific response.

1845.

REDACTED

(RX 1912 at 147, 150

REDACTED

), *in camera*).

Response to Finding No. 1845:

This proposed finding is irrelevant. Rush-Presbyterian met all three of Dr. Noether's criteria and, therefore, ENH and Rush-Presbyterian are comparable hospitals. Accordingly, it was appropriate to include Rush-Presbyterian in Dr. Noether's academic control group. (RFF-Reply ¶¶ 703-727).

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).

Response to Finding No. 1846:

This proposed finding is irrelevant. It was not necessary to include all comparable and competitive hospitals in Dr. Noether's academic control group. (RFF-Reply ¶ 1823). In

addition, Complaint Counsel has offered no evidence that the inclusion of Christ Hospital would have materially affected Dr. Noether's empirical results.

1847. **REDACTED**

(Noether, Tr. 6245, *in camera*).

Response to Finding No. 1847:

This proposed finding is irrelevant. It was not necessary to include all comparable and competitive hospitals in Dr. Noether's academic control group. (RFF-Reply ¶ 1846). In addition, Complaint Counsel has offered no evidence that the inclusion of Christ Hospital would have materially affected Dr. Noether's empirical results.

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).

Response to Finding No. 1848:

This proposed finding is irrelevant. It was not necessary to include all comparable and competitive hospitals in Dr. Noether's academic control group. (RFF-Reply ¶ 1846). In addition, Complaint Counsel has offered no evidence that the inclusion of MacNeal Hospital would have materially affected Dr. Noether's empirical results.

1849. The University of Illinois Medical Center is a major academic hospital. (Noether, Tr. 6158).

Response to Finding No. 1849:

Respondents have no specific response.

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).

Response to Finding No. 1850:

Respondents have no specific response.

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).

Response to Finding No. 1851:

Respondents have no specific response.

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).

Response to Finding No. 1852:

Respondents have no specific response.

1853. Yet the University of Illinois Medical Center is not included in Dr. Noether's list of 20 hospitals. (Noether, Tr. 6158).

Response to Finding No. 1853:

This proposed finding is irrelevant. It was not necessary to include all comparable and competitive hospitals in Dr. Noether's academic control group. (RFF-Reply ¶ 1846). In addition, Complaint Counsel has offered no evidence that the inclusion of the University of Illinois Medical Center would have materially affected Dr. Noether's empirical results.

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).

Response to Finding No. 1854:

This proposed finding is irrelevant. Dr. Noether deliberately used three criteria in selecting her academic control group hospitals because any single measure, such as teaching intensity, could be subject to bias. (Noether, Tr. 5993, 6213). These three criteria were appropriate. (RFF-Reply ¶¶ 703-727). Louis A. Weiss did not meet all three criteria, and, therefore, was appropriately classified as an community hospital. (Noether, Tr. 6000; RX 1912 at 60).

1855. Louis A. Weiss Hospital met the MedPAC criteria for a major teaching hospital. (CCFF 1836, 1854).

Response to Finding No. 1855:

This proposed finding is irrelevant. (RFF-Reply ¶ 1854). In addition, this proposed finding is misleading to the extent it ignores that Louis A. Weiss, with only 182 staffed beds, did not meet the Solucient definition of major teaching hospital. (RX 1912 at 60; RFF-Reply ¶ 720).

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).

Response to Finding No. 1856:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶ 1854, 1855).

1857.

REDACTED

(RX 1912 at 148, 151, *in camera*).

Response to Finding No. 1857:

Respondent has no specific response.

b. St. Francis Hospital

1858. St. Francis hospital had more than .25 residents per bed. (RX 1912 at 60).

Response to Finding No. 1858:

This proposed finding is irrelevant. Dr. Noether deliberately used three criteria in selecting her academic control group hospitals because any single measure, such as teaching intensity, could be subject to bias. (Noether, Tr. 5993, 6213). These three criteria were appropriate. (RFF-Reply ¶¶ 703-727). St. Francis did not meet all three criteria, and, therefore, was appropriately classified as an community hospital. (Noether, Tr. 6000; RX 1912 at 60).

1859. St. Francis Hospital met the MedPAC criteria for a major teaching hospital. (CCFF 1836, 1858).

Response to Finding No. 1859:

This proposed finding is irrelevant. (RFF-Reply ¶ 1854). In addition, this proposed finding is misleading to the extent it ignores the fact that St. Francis, with only 268 staffed beds, did not meet the Solucient definition of major teaching hospital. (RX 1912 at 60; RFF-Reply ¶ 720).

1860. In a 1999 competitive analysis done for ENH, St. Francis is identified as a teaching hospital. (CX 595 at 4).

Response to Finding No. 1860:

This proposed finding is irrelevant. (RFF-Reply ¶¶ 1858-1859).

1861. Yet Dr. Noether classified St. Francis as a community hospital and not an academic hospital. (Noether, Tr. 5999; RX 1912 at 60).

Response to Finding No. 1861:

This proposed finding is irrelevant. (RFF-Reply ¶¶ 1858-1859).

1862. **REDACTED**

(RX 1912 at 149, 152, *in camera*).

Response to Finding No. 1862:

Respondent has no specific response.

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**

(Haas-Wilson, Tr. 2594, *in camera*; Amended Glossary of Terms at 4, April 22, 2005).

Response to Finding No. 1863:

Respondent has no specific response except to point out that the referenced glossary, by its terms, was submitted to the Court as a reference only and not as an admission by either party.

1864. **REDACTED**

(Haas-Wilson, Tr. 2594, *in camera*; Amended Glossary of Terms at 6, April 22, 2005).

Response to Finding No. 1864:

Respondent has no specific response except to point out that the referenced glossary, by its terms, was submitted to the Court as a reference only and not as an admission by either party.

1865. **REDACTED**

(Haas-Wilson, Tr. 2594, *in camera*; Amended Glossary of Terms at 6, April 22, 2005).

Response to Finding No. 1865:

Respondent has no specific response except to point out that the referenced glossary, by its terms, was submitted to the Court as a reference only and not as an admission by either party.

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).

Response to Finding No. 1866:

Respondent has no specific response except to point out that the referenced glossary, by its terms, was submitted to the Court as a reference only and not as an admission by either party.

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)).

Response to Finding No. 1867:

This proposed finding is misleading. Case mix index would not have been an effective way to select academic hospitals. (Noether, Tr. 6212). Instead, Dr. Noether chose three appropriate criteria to select her academic control group. (Noether, Tr. 5993, 6149, 6213; RFF-Reply ¶¶ 703-727). Alexian Brothers met only one of these criteria and, consequently, was appropriately classified as a community hospital for purposes of Dr. Noether's analysis. (Noether, Tr. 6000; RX 1912 at 60).

1868. **REDACTED** (RX 1912 at 26, *in camera*).

Response to Finding No. 1868:

This proposed finding is misleading. (RFF-Reply ¶ 1867).

1869. **REDACTED** (RX 1912 at 27, *in camera*).

Response to Finding No. 1869:

This proposed finding is misleading. (RFF-Reply ¶ 1867).

1870. **REDACTED**

(Noether, Tr. 6169; RX 1912 at 44, *in camera*).

Response to Finding No. 1870:

This proposed finding is misleading. (RFF-Reply ¶ 1867).

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).

Response to Finding No. 1871:

This proposed finding is misleading. (RFF-Reply ¶ 1867).

1872. **REDACTED**

(RX 1912 at 148, 151, *in camera*).

Response to Finding No. 1872:

This proposed finding is misleading. (RFF-Reply ¶ 1867).

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)).

Response to Finding No. 1873:

This proposed finding is misleading. Case mix index would not have been an effective way to select academic hospitals. (Noether, Tr. 6212). Instead, Dr. Noether chose three appropriate criteria to select her academic control group. (Noether, Tr. 5993, 6149, 6213; RFF-Reply ¶¶ 703-727). Louis A. Weiss met only one of these criteria and, consequently, was

appropriately classified as a community hospital for purposes of Dr. Noether's analysis. (Noether, Tr. 6000; RX 1912 at 60).

1874. **REDACTED** (RX 1912 at 26, *in camera*).

Response to Finding No. 1874:

This proposed finding is misleading. (RFF-Reply ¶ 1873).

1875. **REDACTED** (RX 1912 at 27, *in camera*)

Response to Finding No. 1875:

This proposed finding is misleading. (RFF-Reply ¶ 1873).

1876. **REDACTED**

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

Response to Finding No. 1876:

This proposed finding is misleading. (RFF-Reply ¶ 1873).

1877. Louis A. Weiss Hospital had a teaching program with over .25 residents per bed. (CCFF 1854).

Response to Finding No. 1877:

This proposed finding is irrelevant. (RFF-Reply ¶ 1854).

1878. Yet Dr. Noether classified Louis A. Weiss Hospital as a community hospital and not an academic hospital. (CCFF 1856).

Response to Finding No. 1878:

This proposed finding is misleading and irrelevant. (RFF-Reply 1854, 1873).

1879. **REDACTED**

(CCFF 1857, *in camera*).

Response to Finding No. 1879:

Respondent has no specific response.

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).

Response to Finding No. 1880:

This proposed finding is misleading. Case mix index would not have been an effective way to select academic hospitals. (Noether, Tr. 6212). Instead, Dr. Noether chose three appropriate criteria to select her academic control group. (Noether, Tr. 5993, 6149, 6213; RFF-Reply ¶¶ 703-727). Northwest Community Hospital met only one of these criteria and, consequently, was appropriately classified as a community hospital for purposes of Dr. Noether's analysis. (Noether, Tr. 6000; RX 1912 at 60).

1881. **REDACTED** (RX 1912 at 26, *in camera*). **REDACTED** (RX 1912 at 26, *in camera*).

Response to Finding No. 1881:

This proposed finding is misleading. (RFF-Reply ¶ 1880).

1882. **REDACTED** (RX 1912 at 27, *in camera*).

Response to Finding No. 1882:

This proposed finding is misleading. (RFF-Reply ¶ 1880).

1883. **REDACTED** (RX 1912 at 44, *in camera*).

Response to Finding No. 1883:

This proposed finding is misleading. (RFF-Reply ¶ 1880).

1884. Yet Dr. Noether classified Northwest Community Hospital as a community hospital and not an academic hospital. (Noether, Tr. 5999; RX 1912 at 60).

Response to Finding No. 1884:

This proposed finding is misleading. (RFF-Reply ¶ 1880).

1885. **REDACTED**

(RX 1912 at 148, 151, *in camera*).

Response to Finding No. 1885:

Respondent has no specific response.

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)).

Response to Finding No. 1886:

This proposed finding is misleading. Case mix index would not have been an effective way to select academic hospitals. (Noether, Tr. 6212). Instead, Dr. Noether chose three appropriate criteria to select her academic control group. (Noether, Tr. 5993, 6149, 6213; RFF-Reply ¶¶ 703-727). Resurrection Medical Center met only one of these criteria and, consequently, was appropriately classified as a community hospital for purposes of Dr. Noether's analysis. (Noether, Tr. 6000; RX 1912 at 60).

1887. **REDACTED**

(RX 1912 at 26, *in camera*).

Response to Finding No. 1887:

This proposed finding is misleading. (RFF-Reply ¶ 1886).

1888. **REDACTED** (RX 1912 at 27).

Response to Finding No. 1888:

This proposed finding is misleading. (RFF-Reply ¶ 1886).

1889. **REDACTED**

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

Response to Finding No. 1889:

This proposed finding is misleading. (RFF-Reply ¶ 1886).

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).

Response to Finding No. 1890:

This proposed finding is misleading. (RFF-Reply ¶ 1886).

1891. **REDACTED**

(RX 1912 at 148, 151, *in camera*).

Response to Finding No. 1891:

Respondent has no specific response.

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)).

Response to Finding No. 1892:

This proposed finding is misleading. Case mix index would not have been an effective way to select academic hospitals. (Noether, Tr. 6212). Instead, Dr. Noether chose three appropriate criteria to select her academic control group. (Noether, Tr. 5993, 6149, 6213; RFF-Reply ¶¶ 703-727). Rush North Shore met none of these criteria and, consequently, was appropriately classified as a community hospital for purposes of Dr. Noether's analysis. (Noether, Tr. 6000; RX 1912 at 60).

1893. **REDACTED** (RX 1912 at 26, *in camera*).

Response to Finding No. 1893:

This proposed finding is misleading. (RFF-Reply ¶ 1892).

1894. **REDACTED**

(RX 1912 at 27, *in camera*).

Response to Finding No. 1894:

This proposed finding is misleading. (RFF-Reply ¶ 1892).

1895. **REDACTED**

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

Response to Finding No. 1895:

This proposed finding is misleading. (RFF-Reply ¶ 1892).

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).

Response to Finding No. 1896:

This proposed finding is misleading. (RFF-Reply ¶ 1892).

1897. **REDACTED**

(RX 1912 at 149, 152, *in camera*).

Response to Finding No. 1897:

Respondent has no specific response.

1898. **REDACTED**

(DX 1912 at 147-52, *in camera* (**REDACTED**).

(Foucre, Tr. 932-33; Noether, Tr. 6244-45, *in camera*).

REDACTED

(Noether, Tr. 6244-45, *in camera*; Foucre, Tr. 932-33).

Response to Finding No. 1898:

Respondent has no specific response.

1899. **REDACTED**

(RX 1912 at 149, *in camera*).

Response to Finding No. 1899:

Respondent has no specific response.

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)).

Response to Finding No. 1900:

This proposed finding is misleading. Case mix index would not have been an effective way to select academic hospitals. (Noether, Tr. 6212). Instead, Dr. Noether chose three appropriate criteria to select her academic control group. (Noether, Tr. 5993, 6149, 6213; RFF-Reply ¶¶ 703-727). St. Francis met only one of these criteria and, consequently, was

appropriately classified as a community hospitals for purposes of Dr. Noether's analysis. (Noether, Tr. 6000; RX 1912 at 60).

1901. **REDACTED** (RX 1912 at 26, *in camera*).

Response to Finding No. 1901:

This proposed finding is misleading. (RFF-Reply ¶ 1900).

1902. **REDACTED** (RX 1912 at 27, *in camera*)

Response to Finding No. 1902:

This proposed finding is misleading. (RFF-Reply ¶ 1900).

1903. **REDACTED** (RX 1912 at 44, *in camera*).

Response to Finding No. 1903:

This proposed finding is misleading. (RFF-Reply ¶ 1900).

1904. St. Francis Hospital had a teaching program with over .25 residents per bed. (CCFF ¶ 1858).

Response to Finding No. 1904:

This proposed finding is misleading and irrelevant. (RFF-Reply ¶¶ 1858, 1900).

1905. Yet Dr. Noether classified St. Francis Hospital as a community hospital and not an academic hospital. (CCFF 1861).

Response to Finding No. 1905:

This proposed finding is misleading and irrelevant. (RFF-Reply ¶¶ 1858, 1900).

1906. **REDACTED** (CCFF 1862, *in camera*).

Response to Finding No. 1906:

Respondent has no specific response.

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).

Response to Finding No. 1907:

Respondent has no specific response.

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)).

Response to Finding No. 1908:

This proposed finding is misleading and irrelevant. Case mix index would not have been an effective way to select academic hospitals. (Noether, Tr. 6212). Instead, Dr. Noether chose three appropriate criteria to select her academic control group. (Noether, Tr. 5993, 6149, 6213; RFF-Reply ¶¶ 703-727). Advocate North Side met all three criteria and, therefore, was appropriately classified as an academic hospital. (RX 1912 at 60). In addition, this proposed finding is irrelevant. Complaint Counsel has offered no evidence that the exclusion of Advocate North Side from the academic control group would have materially affected Dr. Noether's empirical analysis.

1909. **REDACTED** (RX 1912 at 26, *in camera*).

Response to Finding No. 1909:

This proposed finding is misleading and irrelevant. (RFF-Reply ¶ 1908).

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)).

Response to Finding No. 1910:

This proposed finding is misleading and irrelevant. (RFF-Reply ¶ 1908).

1911.

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).

Response to Finding No. 1911:

This proposed finding is misleading and irrelevant. (RFF-Reply ¶ 1908).

7. Dr. Noether's Academic Control Group Is Not an Appropriate Control Group

1912. **REDACTED**
(Haas-Wilson, Tr. 2698, *in camera*).

Response to Finding No. 1912:

This proposed finding is inaccurate. Using bed size, teaching intensity and breadth of service, Dr. Noether identified a representative group of academic hospitals for comparison with ENH. Dr. Haas-Wilson's criticisms – on the basis of case mix, quaternary services, teaching intensity, bed size, public perception, and customer documents and testimony – are unfounded. (RFF-Reply ¶¶ 705-725).

REDACTED

REDACTED

(Haas-Wilson, Tr. 2868-69, *in camera*).

a. Case Mix and Services Provided

1913.

REDACTED

(Haas-Wilson, Tr. 2698-99, *in camera*).

Response to Finding No. 1913:

This proposed finding is misleading. (RFF-Reply ¶ 707).

1914.

REDACTED

(Haas-Wilson, Tr. 2701-02, *in camera*,).

Response to Finding No. 1914:

This proposed finding is misleading because quaternary services are not clearly defined. (RFF-Reply ¶¶ 710-712).

1915.

REDACTED

(Haas-Wilson, Tr. 2702, *in camera*; CX 6282 at 1-2, *in camera*; Neaman, Tr. 1378).

Response to Finding No. 1915:

This proposed finding is misleading because quaternary services are not clearly defined. (RFF-Reply ¶¶ 710-712).

1916.

REDACTED

REDACTED

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

Response to Finding No. 1916:

This proposed finding is misleading.

REDACTED

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

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).

Response to Finding No. 1917:

Respondent has no specific response.

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

(Haas-Wilson, Tr. 2703-2704, *in camera*).

Response to Finding No. 1918:

This proposed finding is misleading.

REDACTED

(RFF-Reply ¶¶ 713-718).

1919.

REDACTED

(Haas-Wilson, Tr. 2705-06, *in camera*; CX 6282 at 7, *in camera*).

Response to Finding No. 1919:

Respondent has no specific response.

1920.

REDACTED

(Haas-Wilson, Tr. 2706, *in camera*; CX 6282 at 7).

Response to Finding No. 1920:

This proposed finding is misleading.

REDACTED

(RFF-Reply ¶¶ 713-718).

1921.

REDACTED

REDACTED

(Haas-Wilson, Tr. 2706-07, *in camera*; CX 6282 at 7).

Response to Finding No. 1921:

This proposed finding is misleading.

REDACTED

(RFF-Reply ¶¶ 713-718).

1922. **REDACTED**

(Haas-Wilson, Tr. 2707, *in camera*; CX 6282 at 7-8).

Response to Finding No. 1922:

This proposed finding is misleading.

REDACTED

(RFF-Reply ¶¶ 713-718).

b. Teaching Intensity

1923. **REDACTED**

(Haas-Wilson, Tr. 2708, *in camera*).

Response to Finding No. 1923:

This proposed finding is misleading. (RFF-Reply ¶ 719).

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).

Response to Finding No. 1924:

This proposed finding is misleading. (RFF-Reply ¶ 719).

1925. **REDACTED**

(Haas-Wilson, Tr. 2708-09, *in camera*; RX 1912 at 60).

Response to Finding No. 1925:

This proposed finding is misleading. (RFF-Reply ¶ 720).

c. National Recognition

1926. **REDACTED**

(Haas-Wilson, Tr. 2711-12, *in camera*).

Response to Finding No. 1926:

This proposed finding is misleading. (RFF-Reply ¶ 720).

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).

Response to Finding No. 1927:

This proposed finding is false. PHCS's own documents categorize pre-Merger Evanston Hospital as an "Advanced Teaching" hospital. (RX 107 at GWL 859). Indeed, Ballengee authored this very document. (RX 107 at GWL 859). Ballengee inexplicably changed her

description of the hospital at trial. This testimony should be given no weight, and her credibility and reliability as a witness be viewed as extremely suspect. (RFF-Reply ¶ 1080).

1928. Advanced teaching hospitals offered the really high level procedures, such as transplants, burn units, and hyperbaric centers. (Ballengee, Tr. 159).

Response to Finding No. 1928:

This proposed finding is misleading. Evanston Hospital offered the most sophisticated services such as transplants and specialized severe burn treatment, but had to stop these services because it did not have sufficient volume to perform a "first class job." (RFF ¶ 33). In any event, PHCS characterized Evanston Hospital as an advanced teaching hospital. (RFF-Reply ¶ 1927).

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).

Response to Finding No. 1929:

This proposed finding is false. PHCS has always considered Evanston Hospital an advanced teaching hospital. (RFF-Reply ¶ 1927).

1930. ENH is not an advanced teaching hospital. (Ballengee, Tr. 189).

Response to Finding No. 1930:

This proposed finding is false and not supported by reliable evidence. Again, Ballengee personally authored a PHCS document sent to all "PHCS Carriers" that identified ENH as an "advanced teaching hospital." (RFF-Reply ¶ 1927; RX 107 at GWL 859). As a result, this proposed finding should be ignored and the testimony of this witness discredited.

1931. The advanced teaching hospitals typically are significantly more expensive than other hospitals. (Ballengee, Tr. 189).

Response to Finding No. 1931:

Respondents have no specific response. (RFF ¶¶ 103, 656-964, 1110-1164).

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).

Response to Finding No. 1932:

This proposed finding is not based on reliable or credible evidence. (RFF-Reply ¶¶ 1927, 1930).

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).

Response to Finding No. 1933:

This proposed finding is not supported by the record.

REDACTED

(RFF ¶ 101, *in camera*). This proposed finding mischaracterizes Neary's testimony to the extent it attempts to imply that if a hospital does not perform transplants it is not an academic teaching hospital.

In fact, the witness cited by Complaint Counsel would have no reliable basis to make such a determination if that were the definition of an academic teaching hospital. Neary admitted that he had no idea how many discharges at Chicago hospitals were for organ transplants and burns. (Neary, Tr. 640-43). Neary was not even aware that for four years he

worked in Chicago, Evanston Hospital had a burn unit. (Neary, Tr. 643). Neary admitted that ENH competed with, and was an alternative to, Northwestern Memorial. (Neary, Tr. 631). Moreover, Neary has no clinical degree in medicine, so he is ill-equipped to make the determination referenced in this proposed finding. (Neary, Tr. 630).

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).

Response to Finding No. 1934:

This proposed finding is not supported by the record. (RFF-Reply ¶ 1933). According to MedPAC, the federal body that defines such terms, ENH is a "major teaching hospital." (RFF ¶¶ 8, 559, 2168).

1935. Hospitals that offer services that are comparable to Evanston Hospital include Rush North Shore, Condell, Swedish Covenant, and St. Therese. (Neary, Tr. 624).

Response to Finding No. 1935:

This proposed finding is not based on reliable or credible evidence. As defined by MedPAC, ENH, as a fully-integrated system, is categorized as a major teaching hospital. (RFF-Reply ¶ 1934). Neary had no knowledge of whether several hospitals did or did not have discharges in some categories of service. (RFF-Reply ¶ 1933). The reliable evidence in this case was that, using DRG analyses, Evanston Hospital was most comparable to Loyola, University of Chicago, Advocate Northside, Northwestern Memorial, Advocate Lutheran General and Rush Presbyterian. (RFF ¶ 543-546). MCOs even agreed that Evanston Hospital was most comparable to Advocate Lutheran General and competed with Northwestern Memorial for the advanced, tertiary services. (RFF ¶¶ 563-569).

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).

Response to Finding No. 1936:

This proposed finding is incomplete. ENH is affiliated with the Northwestern University Medical School and trains physicians. (RFF ¶¶ 1, 8-9, 12, 34, 297, 431, 2318). According to a DRG analysis, Evanston Hospital is among the most advanced in the Chicago area. (RFF-Reply ¶ 1935).

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).

Response to Finding No. 1937:

This proposed finding is incomplete and repetitive. Evanston Hospital, and the ENH system, after the Merger, was categorized as an academic hospital. (RFF-Reply ¶¶ 1934-1935).

1938. None of the hospitals (Evanston Hospital, Glenbrook Hospital, and Highland Park Hospital) in ENH are academic hospitals. (Dorsey, Tr. 1444).

Response to Finding No. 1938:

This proposed finding is incomplete and not supported by the record. (RFF-Reply ¶¶ 1934-1935). It is undisputed that ENH is affiliated with the medical school at Northwestern University, one of the premier programs in the country. (RFF ¶¶ 1, 8-9, 12, 34, 297, 431, 2318).

c. United

1939. An academic hospital is one that has a medical school as part of the hospital. (Foucre, Tr. 935).

Response to Finding No. 1939:

Respondent has no specific response. (RFF ¶ 101).

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).

Response to Finding No. 1940:

This proposed finding is false and contrary to the evidence as well as Complaint Counsel's own proposed finding number 1939. **REDACTED**

(RFF ¶ 456, *in camera*).

REDACTED

(Foucre, Tr. 1112, *in camera*).

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 it 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).

Response to Finding No. 1941:

Respondent has no specific response.

1942. **REDACTED**

(RX 1912 at 61-63, *in camera*; Noether, Tr. 6070-74).

REDACTED

(Haas-Wilson, Tr. 2728, *in camera*).

Response to Finding No. 1942:

This proposed finding is misleading to the extent it suggests that the results of the analysis of the prices charged by ENH to Blue Cross is inconsistent with learning about demand.

REDACTED

REDACTED (Baker, Tr. 4759, 4699-4700, *in camera*).

REDACTED

(Noether, Tr. 6071, 6074, *in camera*).

REDACTED

(Noether, Tr. 6073, *in camera*).

REDACTED

(Baker, Tr. 4695-96, 4742-43, *in camera*; Noether, Tr. 6071, 6074, *in camera*). **REDACTED**

(Baker, Tr. 4695-96, *in camera*).

REDACTED

(Baker, Tr. 4695-96, 4742-43, *in camera*).

10. Dr. Noether Treated Highland Park Hospital Inappropriately in Her Comparisons

194:

REDACTED

(Haas-Wilson, Tr. 2551-52, *in camera).*

Response to Finding No. 1943:

This proposed finding is confusing because it does not specify whether it refers to pre- or post-Merger. Nevertheless, Respondent agrees that Evanston Hospital and HPH were different hospitals pre-Merger and, accordingly were not potential substitutes for one another in a MCO's network. (CCFF ¶¶ 1798-99). This proposed finding, however, is misleading to the extent it ignores that, **REDACTED**

REDACTED (CCFF ¶ 1945, *in camera*).

REDACTED

1944.

REDACTED

(Baker, Tr. 4638-39, *in camera*).

Response to Finding No. 1944:

This proposed finding is misleading to the extent it ignores that, **REDACTED** (CCFF ¶ 1945). In addition, this proposed finding is misleading because it misstates Professor Baker's testimony.

REDACTED

(Baker, Tr. 4638-39, *in camera*).

REDACTED

(Baker, Tr. 4638-39, *in camera*). Dr. Noether properly compared Evanston Hospital's prices before the Merger to the prices of control groups of both academic and community hospitals. (Noether, Tr. 5993).

1945. **REDACTED** (Noether, Tr. 6192-93; Foucre, Tr. 890; Holt-Darcy, Tr. 1528, *in camera*).

Response to Finding No. 1945:

Respondent has no specific response.

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**

(Holt-Darcy, Tr. 1529, *in camera*).

Response to Finding No. 1946:

Respondent has no specific response.

1947. **REDACTED**

(*See, e.g.*, RX 1912 at 147-52, *in camera*).

Response to Finding No. 1947:

REDACTED

(CCFF ¶ 1945, *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*).

Response to Finding No. 1948:

This proposed finding is misleading. After the Merger, the entire ENH system – which marketed, priced and provided its products and services on a system-wide basis – met the three criteria Dr. Noether used to select her academic control group. (RX 1912 at 60).

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).

Response to Finding No. 1949:

This proposed finding is inaccurate. The control groups developed by Dr. Noether and employed by Dr. Noether and Professor Baker in their empirical analysis are entirely appropriate. (RFF-Reply ¶¶ 1816-1817, 1821-1853; RFF ¶¶ 1065-1096).

REDACTED

(Haas-Wilson, Tr. 2868-69, *in camera*).

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).

Response to Finding No. 1950:

This finding is inaccurate. Dr. Noether did not attempt to be all-inclusive in her control groups. (Noether, Tr. 5997, 6150). **REDACTED**

(Baker, Tr. 4780-81, *in camera*).

REDACTED

(Haas-Wilson, Tr. 2859, *in camera*; Noether, Tr. 5997-98; RFF-Reply ¶¶ 1854, 1857, 1862, 1867-78, 1880-99, 1900-05).

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).

Response to Finding No. 1951:

This proposed finding is misleading. (RFF-Reply ¶¶ 1818, 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,[11] *in camera*), *in camera*).

Response to Finding No. 1952:

This proposed finding is incorrect, badly mischaracterizes Professor Baker's testimony and is not supported by any record evidence. **REDACTED**

(Baker, Tr. 4653-54, 4671, 4811, *in camera*).

REDACTED

(Baker, Tr. 4669-71, *in camera*). **REDACTED**

REDACTED

(Baker, Tr. 4677-4800, *in camera* (*explaining* DX 8047); Haas-Wilson, Tr. 2706, *in camera*).

REDACTED

(Baker, Tr. 4680, *in camera* (*explaining* DX 8047)).

Second, Professor Baker's testimony is the ***only*** expert testimony offered at trial concerning the relevance of his analysis as set forth in his second expert report – a point emphasized by the fact that Complaint Counsel cites only to Professor Baker's testimony in this proposed finding.

REDACTED

(Baker, Tr. 4658, 4671, 4811, *in camera*). The burden of persuasion squarely rests on Complaint Counsel to eliminate all alternative explanations for the post-Merger relative price increases other than market power – including the learning about demand explanation.

REDACTED

(Baker, Tr. 4621, *in camera*; Noether, Tr. 5991; Haas-Wilson, Tr. 2834-35, *in camera*). Complaint Counsel, however, made no effort to offer expert testimony analyzing price levels. Instead, in this finding and elsewhere, Complaint Counsel relies solely on unsupported lawyer-arguments to mischaracterize the results of Professor Baker's analysis and misstate that Professor "flunked" his learning about demand test.

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[11] RX 2040 is cited to impeach Dr. Baker's testimony both here and when cited in subsequent findings.

This bald and conclusory assertion falls far short of properly rebutting Professor Baker's analysis.

Third, even Complaint Counsel's unsupported lawyer proffers are unpersuasive.

REDACTED

(Baker, Tr. 4662-63, *in camera*).

REDACTED

(Baker, Tr. 4663, 4685, *in camera*).

REDACTED

(Baker, Tr. 4663, 4685, *in camera*). Again, there is no expert testimony in the record opining to the contrary.

Finally, Complaint Counsel criticizes Professor Baker for weighting the overall average by the number of claims obtained from the health plans' claims databases.

REDACTED

(Baker, Tr. 4821, *in camera*; Foucre, Tr. 939, 949; Hillebrand, Tr. 1806; Mendonsa, Tr. 481). None of Complaint Counsel's experts who testified at trial criticized Professor Baker for weighting the overall average in this fashion. This criticism by Complaint Counsel, therefore, is yet another unsupported, post-hoc lawyer argument that should be afforded no evidentiary weight whatsoever.

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).

Response to Finding No. 1953:

Respondent has no specific response.

1954. **REDACTED**
(*See* CCFF 1744-1762, *in camera*).

Response to Finding No. 1954:

This proposed finding is incorrect.

REDACTED

(Baker, Tr. 4686-87, *in camera*).

REDACTED

(Baker, Tr. 4692-93, *in camera*).

REDACTED

(RFF-Reply ¶ 1952, *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,[12] *in camera*).

Response to Finding No. 1955:

This proposed finding is incorrect. **REDACTED**

[12] RX 2038 is cited to impeach Dr. Baker's testimony both here and when cited in subsequent findings.

(Baker, Tr. 4691-93, *in camera*). **REDACTED**

(Baker, Tr. 4688, *in camera*). **REDACTED**

(Baker, Tr. 4688-89, *in camera*). **REDACTED**

(Baker, Tr. 4688-92, 4729-30, *in camera*).

REDACTED

(Baker, Tr. 4689, *in camera*). **REDACTED**

(Baker, Tr. 4663, 4685, *in camera*).

REDACTED

(Baker, Tr. 4663, *in camera*).

REDACTED

(Baker, Tr. 4691-92, *in camera*). **REDACTED**

(Baker, Tr. 4692, *in camera*).

REDACTED

REDACTED (Baker, Tr. 4692-93, *in camera*).

1956. **REDACTED**

(Baker, Tr. 4716 (discussing quoted portion of RX 2038 at 3, *in camera*), *in camera*).

Response to Finding No. 1956:

The proposed finding is misleading and incomplete.

REDACTED

(Baker, Tr. 4662-63, *in camera*).

(Baker, Tr. 4730, *in camera*).

REDACTED

(Baker, Tr. 4669-71, *in camera*).

REDACTED

(Baker, Tr. 4810-11, *in camera*). Thus, under this analysis, ENH did not raise its prices above the prices charged by the academic hospitals with which it competes. Again, Complaint Counsel has offered no expert testimony to the contrary.

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

REDACTED (RX 2039 at 4 [13], *in camera*).

Response to Finding No. 1957:

This proposed finding is incorrect to the extent that it suggests that Professor Baker changed his test. **REDACTED**

(RFF-Reply ¶ 1955). **REDACTED**

(RFF-Reply ¶¶ 1952, 1955-1956, *in camera*).

REDACTED

(RFF-Reply ¶¶ 1954-1955, *in camera*).

1958. **REDACTED**

(Baker, Tr. 4739 (discussing RX 2040 at 4, *in camera*), *in camera*).

Response to Finding No. 1958:

This proposed finding is misleading and not relevant to Professor Baker's conclusion that ENH learned about its demand coincident with the Merger.

REDACTED

(RFF-Reply ¶¶ 1954-1955, 1957, *in camera*). No economist retained by Complaint Counsel has given any testimony to rebut Professor Baker's conclusions at trial regarding learning about demand. (RFF-Reply ¶ 1952, *in camera*).

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[13] RX 2039 is cited to impeach Dr. Baker's testimony both here and when cited in subsequent findings.

1959. **REDACTED**

(Baker, Tr. 4743, *in camera*).

Response to Finding No. 1959:

This proposed finding is misleading and incomplete.

REDACTED

(Baker, Tr. 4702, 4644, 4649-50, 4653, *in camera*). Dr. Haas-Wilson conceded the same. (Haas-Wilson, Tr. 2677-78). One possible alternative explanation for a price increase is learning about demand. (Haas-Wilson, Tr. 2488).

REDACTED

(Baker, Tr. 4653-54).

REDACTED

(Baker, Tr. 4671, 4811, 4814, *in camera*).

REDACTED

(Baker, Tr. 4811, *in camera*).

1. United

1960. **REDACTED**

(Baker, Tr. 4739, (discussing RX 2040 at 4, *in camera*), *in camera*).

Response to Finding No. 1960:

This proposed finding is misleading and irrelevant to Professor Baker's conclusion that ENH learned about its demand coincident with the Merger. As discussed above, **REDACTED**

REDACTED (RFF-Reply ¶¶ 1952, 1955, *in camera*).

REDACTED

(RFF-Reply ¶¶ 1952, 1955, *in camera*).

REDACTED

(Baker, Tr. 4674, *in camera*).

1961. **REDACTED**

(RX 2040 at 4, *in camera*).

Response to Finding No. 1961:

This proposed finding is misleading and irrelevant to Professor Baker's conclusion

REDACTED (RFF-Reply ¶ 1960, *in camera*).

1962. **REDACTED**

(Baker, Tr. 4783-84 (discussing RX 2040 at 4, *in camera*), *in camera*).

Response to Finding No. 1962:

This proposed finding is misleading and irrelevant.

REDACTED

(Neaman, Tr. 1283, 1286-87, 1379; Foucre, Tr. 1114, *in camera*; RX 1208 at UHCENH 3380, *in camera*; Ballengee, Tr. 212).

REDACTED

REDACTED (Mendonsa, Tr. 565, *in camera*; Ballengee, Tr. 158-59, 189; Holt-Darcy, Tr. 1590-91, 1592-93, *in camera*).

1963. **REDACTED** (Baker, Tr. 4784-85 (discussing RX 2040 at 4, *in camera*), *in camera*).

Response to Finding No. 1963:

This proposed finding is misleading and irrelevant. (*See* RFF-Reply ¶ 1962).

2. Humana

1964. **REDACTED** (Baker, Tr. 4739 (discussing RX 2040 at 4, *in camera*), *in camera*).

Response to Finding No. 1964:

This proposed finding is misleading and irrelevant to Professor Baker's conclusion that ENH learned about its demand coincident with the Merger. As discussed above,

REDACTED (RFF-Reply ¶¶ 1952, 1955, *in camera*).

REDACTED

(RFF-Reply ¶¶ 1952, 1955, *in camera*).

REDACTED

(Baker, Tr. 4674, *in camera*).

1965. **REDACTED** (RX 2040 at 4, *in camera*).

Response to Finding No. 1965:

This proposed finding is misleading and irrelevant to Professor Baker's conclusion that ENH learned about its demand coincident with the Merger. (RFF-Reply ¶ 1964, *in camera*).

3. Blue Cross

1966. **REDACTED**

(Baker, Tr. 4695, *in camera*).

Response to Finding No. 1966:

Respondent has no specific response.

1967. **REDACTED**

(Baker, Tr. 4759, *in camera*).

Response to Finding No. 1967:

This proposed finding is misleading.

REDACTED

(Baker, Tr. 4759, *in camera*).

When ENH compared Evanston Hospital and HPH's respective contracts with Blue Cross, including Blue Cross' HMO Illinois contracts, it learned that Evanston Hospital had better rates with Blue Cross than HPH. (Sirabian, Tr. 5708, Chan, Tr. 688).

1968. **REDACTED**

(Baker, Tr. 4759, *in camera*).

Response to Finding No. 1968:

This proposed finding is misleading and irrelevant.

REDACTED

(Baker, Tr. 4600-01, Baker, Tr. 4812, *in camera*). Dr. Noether was responsible for synthesizing all of the documentary evidence and testimony, and putting it into the context of an economic opinion. Professor Baker was retained by ENH to conduct an analysis of the magnitude of the price changes that followed the Merger. In particular, he was asked to

determine whether there was a benign explanation for the price change – *i.e.*, whether learning about demand could explain the price change. (Baker, Tr. 4601; RFF ¶ 364).

1969. **REDACTED**

(Baker, Tr. 4820-21, *in camera*).

Response to Finding No. 1969:

This proposed finding is misleading and incomplete.

REDACTED

(Noether, Tr. 6049-50, *in camera*). Further, the data included the three largest MCOs in Chicago and to ENH, which, along with Cigna, comprised 75% of the market.[14] (Hillebrand, Tr. 1725). Blue Cross is the largest insurer in Chicago, has a share of approximately 52-53%, and has about 2 million members in Illinois. (Foucre, Tr. 939, 949; Hillebrand, Tr. 1806; Mendonsa, Tr. 481). Humana is "number two in [ENH's] book of business," and is the third largest MCO in the market, with a share of about 10-11%. (Hillebrand, Tr. 1867-68; Foucre, Tr. 939-40, 949). United has historically been ENH's fourth largest MCO, but is "closing in on number three," and is the second largest insurer in Chicago as measured by membership, with approximately 875,000 current members. (Foucre, Tr. 880-81, 939; Hillebrand, Tr. 1868). Accordingly, Professor Baker analyzed all available data, and such data constitutes a substantial portion of ENH's MCO business.

1970. **REDACTED**
(Baker, Tr. 4821, *in camera*).

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[14] **REDACTED**
(Noether, Tr. 6051, *in camera*).

Response to Finding No. 1970:

This proposed finding is incomplete.

REDACTED

(Baker, Tr. 4821, *in camera*). This is appropriate considering that a MCO like Blue Cross makes up approximately 52-53% of the market. (Foucre, Tr. 939, 949; Hillebrand, Tr. 1806; Mendonsa, Tr. 481). None of Complaint Counsel's experts who testified at trial criticized Professor Baker for weighting the overall average.

1971. **REDACTED**
(Baker, Tr. 4821, *in camera*).

Response to Finding No. 1971:

Respondent has no specific response.

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).

Response to Finding No. 1972:

Respondents have no specific response.

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).

Response to Finding No. 1973:

This proposed finding is misleading to the extent it mischaracterizes Dr. Noether's testimony. Dr. Noether discussed HPH and Evanston Hospital's pre-Merger "market power" in the context of a discussion of a differentiated product markets. In a differentiated product market, like the hospital market, there are no perfect substitutes. (Noether, Tr. 6131-32).

Consequently, all hospitals have *some degree* of market power. (Noether, Tr. 6131). Market power derived this manner is not anticompetitive.

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).

Response to Finding No. 1974:

This proposed finding is misleading to the extent it suggests that ENH was unique in not having a perfect substitute. In a differentiated product market there are no perfect substitutes. (Noether, Tr. 6131-32).

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).

Response to Finding No. 1975:

This proposed finding is misleading to the extent that **REDACTED**

(Baker, Tr. 4759, 4699-4700, *in camera*).

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).

Response to Finding No. 1976:

Respondent has no specific response.

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).

Response to Finding No. 1977:

Respondent has no specific response.

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).

Response to Finding No. 1978:

Respondent has no specific response.

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).

Response to Finding No. 1979:

Respondent has no specific response.

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).

Response to Finding No. 1980:

Respondent has no specific response.

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).

Response to Finding No. 1981:

This proposed finding is misleading to the extent it suggests the "market power" referred to in the proposed finding is anticompetitive.

REDACTED (Noether, Tr. 6060, *in camera*; Baker, Tr. 4669-71; RFF ¶¶ 1110-1136, 1148-1155). The factual evidence demonstrated that, before the Merger, Evanston Hospital was not pricing at competitive levels. To the contrary, in many instances, it was priced below HPH. (RFF ¶¶ 656-693). Finally, the evidence demonstrated that, after the Merger, ENH did not price above competitive levels (i.e. ENH did not exercise anticompetitive market power). (RFF ¶¶ 1110-1136, 1148-1155).

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).

Response to Finding No. 1982:

This proposed finding is misleading to the extent it suggests that the appropriate comparison group for the analysis of Evanston Hospital/ENH's pricing is Dr. Noether's minimum geographic market. Dr. Noether concluded that Evanston Hospital's closest competitors in product space were not necessarily the same as Evanston Hospital's closest competitors in geographic space. Rather, before the Merger, Evanston Hospital's closest substitutes in product space were other academic/tertiary care facilities such as Dr. Noether's academic control group hospitals. (Noether, Tr. 6160-61, 6196).

1983.

REDACTED

(Noether, Tr. 5928; Noether, Tr. 6238, *in camera*).

Response to Finding No. 1983:

Respondent has no specific response.

a. Rush North Shore Medical Center

1984.

REDACTED

(RX 1912 at 149, 152, *in camera*).

Response to Finding No. 1984:

Respondent has no specific response.

1985.

REDACTED

(Noether, Tr. 6241, *in camera*).

Response to Finding No. 1985:

Respondent has no specific response.

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).

Response to Finding No. 1986:

This proposed finding is irrelevant and misleading. Case mix index is not an effective way to select appropriate comparison hospitals (i.e. academic hospitals). (Noether, Tr. 6212). Instead, Dr. Noether chose three appropriate criteria to select a control group of hospitals comparable to ENH – her academic control group. (Noether, Tr. 5993, 6149, 6213; RFF-Reply ¶¶ 703-727). Rush North Shore did not meet any of these criteria and, consequently, was appropriately classified as a community hospital for purposes of Dr. Noether's analysis. (Noether, Tr. 6000; RX 1912 at 60).

1987. **REDACTED** (RX 1912 at 26, *in camera*).

Response to Finding No. 1987:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶ 1986).

1988. **REDACTED**

(RX 1912 at 27, *in camera*).

Response to Finding No. 1988:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶ 1986).

1989. **REDACTED**

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

Response to Finding No. 1989:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶ 1986).

b. St. Francis Hospital

1990. **REDACTED**

(RX 1912 at 149, 152, *in camera*).

Response to Finding No. 1990:

Respondent has no specific response.

1991. **REDACTED**

(Noether, Tr. 6242, *in camera*).

Response to Finding No. 1991:

Respondent has no specific response.

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).

Response to Finding No. 1992:

This proposed finding is misleading and irrelevant. This proposed finding is misleading to the extent it ignores that St. Francis, with only 268 staffed beds, did not meet the Solucient definition of major teaching hospital. (RX 1912 at 60; RFF-Reply ¶ 720). Dr. Noether chose three appropriate criteria to select a control group of hospitals comparable to ENH – her academic control group. (Noether, Tr. 5993, 6149, 6213; RFF-Reply ¶¶ 703-727).

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).

Response to Finding No. 1993:

This proposed finding is irrelevant and misleading. Case mix index is not an effective way to select appropriate comparison hospitals (i.e. academic hospitals). (Noether, Tr. 6212). Instead, Dr. Noether chose three appropriate criteria to select a control group of hospitals comparable to ENH – her academic control group. (Noether, Tr. 5993, 6149, 6213; RFF-Reply

¶¶ 703-727). St. Francis met only one of these criteria and, consequently, was appropriately classified as a community hospital for purposes of Dr. Noether's analysis. (Noether, Tr. 6000; RX 1912 at 60).

1994. **REDACTED** (RX 1912 at 26, *in camera*).

Response to Finding No. 1994:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶ 1993).

1995. **REDACTED** (RX 1912 at 27, *in camera*).

Response to Finding No. 1995:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶ 1993).

1996. **REDACTED** (RX 1912 at 44, *in camera*).

Response to Finding No. 1996:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶ 1993).

c. Advocate Lutheran General Hospital

1997. **REDACTED** (RX 1912 at 149, 152, *in camera*).

Response to Finding No. 1997:

Respondent has no specific response.

1998. **REDACTED** (Noether, Tr. 6240-41, *in camera*).

Response to Finding No. 1998:

Respondent has no specific response.

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).

Response to Finding No. 1999:

This proposed finding is misleading to the extent it ignores that Advocate Lutheran General also met the other two criteria, bed size and breadth of service, for inclusion in Dr. Noether's academic control group. (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)).

Response to Finding No. 2000:

This proposed finding is irrelevant and misleading. Case mix index is not an effective way to select appropriate comparison hospitals (i.e. academic hospitals). (Noether, Tr. 6212). Instead, Dr. Noether chose three appropriate criteria to select a control group of hospitals comparable to ENH – her academic control group. (Noether, Tr. 5993, 6149, 6213; RFF-Reply ¶¶ 703-727). Advocate Lutheran General met all three of these criteria and, consequently, was appropriately classified as an academic hospital for purposes of Dr. Noether's analysis. (Noether, Tr. 6000; RX 1912 at 60).

2001. **REDACTED** (RX 1912 at 26, *in camera*).

Response to Finding No. 2001:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶ 2000).

2002. **REDACTED**

(RX 1912 at 27, *in camera*).

Response to Finding No. 2002:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶ 2000).

2003. **REDACTED**

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

Response to Finding No. 2003:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶ 2000).

d. Resurrection Medical Center

2004. **REDACTED**

(RX 1912 at 149, 152, *in camera*).

Response to Finding No. 2004:

Respondent has no specific response.

2005. **REDACTED**

(Noether, Tr. 6242, *in camera*).

Response to Finding No. 2005:

Respondent has no specific response.

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).

Response to Finding No. 2006:

This proposed finding is irrelevant and misleading. Case mix index is not an effective way to select appropriate comparison hospitals (i.e. academic hospitals). (Noether, Tr. 6212). Instead, Dr. Noether chose three appropriate criteria to select a control group of hospitals

comparable to ENH – her academic control group. (Noether, Tr. 5993, 6149, 6213; RFF-Reply ¶¶ 703-727). Resurrection Medical Center met only one of these criteria and, consequently, was appropriately classified as a community hospital for purposes of Dr. Noether's analysis. (Noether, Tr. 6000; RX 1912 at 60).

2007. **REDACTED** (RX 1912 at 26, *in camera*).

Response to Finding No. 2007:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶ 2006).

2008. **REDACTED** (RX 1912 at 27, *in camera*).

Response to Finding No. 2008:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶ 2006).

2009. **REDACTED**

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

Response to Finding No. 2009:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶ 2006).

e. Lake Forest Hospital

2010. **REDACTED**

(RX 1912 at 148, 151, *in camera*).

Response to Finding No. 2010:

Respondent has no specific response.

2011. **REDACTED** (Noether, Tr. 6240-41, *in camera*).

Response to Finding No. 2011:

Respondent has no specific response.

2012. **REDACTED** (RX 1912 at 44, *in camera*).

Response to Finding No. 2012:

This proposed finding is irrelevant and misleading. Instead, Dr. Noether chose three appropriate criteria to select a control group of hospitals comparable to ENH – her academic control group. (Noether, Tr. 5993, 6149, 6213; RFF-Reply ¶¶ 703-727). Lake Forest Hospital met none of these criteria and, consequently, was appropriately classified as a community hospital for purposes of Dr. Noether's analysis. (Noether, Tr. 6000; RX 1912 at 60).

f. Condell Medical Center

2013. **REDACTED**

(RX 1912 at 148, 151, *in camera*).

Response to Finding No. 2013:

Respondent has no specific response.

2014. **REDACTED** (Noether, Tr. 6241-42, *in camera*).

Response to Finding No. 2014:

Respondent has no specific response.

2015. **REDACTED** (RX 1912 at 44, *in camera*).

Response to Finding No. 2015:

This proposed finding is irrelevant and misleading. Case mix index is not an effective way to select appropriate comparison hospitals (i.e. academic hospitals). (Noether, Tr. 6212). Instead, Dr. Noether chose three appropriate criteria to select a control group of hospitals comparable to ENH – her academic control group. (Noether, Tr. 5993, 6149, 6213; RFF-Reply ¶¶ 703-727). St. Francis met only one of these criteria and, consequently, was appropriately classified as a community hospital for purposes of Dr. Noether's analysis. (Noether, Tr. 6000; RX 1912 at 60).

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).

Response to Finding No. 2016:

Respondent has no specific response.

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).

Response to Finding No. 2017:

This proposed finding is inaccurate and misleading. (RFF-Reply ¶¶ 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).

Response to Finding No. 2018:

Respondent has no specific response.

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).

Response to Finding No. 2019:

Respondent has no specific response.

2020. **REDACTED** (Ballengee, Tr. 166-69, 171; Mendonsa, Tr. 530, *in camera*).

Response to Finding No. 2020:

This proposed finding is not supported by the evidence.

REDACTED (RFF ¶¶ 3, 656-657, 663-665, 667-669; RFF ¶¶ 658-662, 666, *in camera* (learning through internal pricing analysis), 670-680, 682-683, 685; RFF ¶¶ 30, 32, 681, 684, 686-690, *in camera*)).

This proposed finding is not even supported by the testimony of the only two witnesses cited for the proposition. **REDACTED** (RFF-Reply ¶¶ 1187, 1194). **REDACTED** (RFF-Reply ¶¶ 1053, 1085-1086)

REDACTED (RFF-Reply ¶ 1250).

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).

Response to Finding No. 2021:

This proposed finding is misleading. (RFF-Reply ¶¶ 1017, 1019, 1794).

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).

Response to Finding No. 2022:

Respondent has no specific response. (RFF-Reply ¶¶ 1315, 1410).

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).

Response to Finding No. 2023:

This proposed finding is vague, misleading and not supported by the cited evidence. Spaeth expressed his opinion that MCOs, by their very nature, attempt to pay less for more services. (RFF-Reply ¶ 1325). The first sentence of this proposed finding is not supported by the cited evidence.

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).

Response to Finding No. 2024:

This proposed finding is vague, not supported by the record, and misleading. (RFF-Reply ¶¶ 1322-1323).

2025. **REDACTED** (Chan, Tr. 820, *in camera,* CX 1099 at 1-67, *in camera*).

Response to Finding No. 2025:

Respondent has no specific response. (RFF-Reply ¶ 1321).

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).

Response to Finding No. 2026:

This proposed finding is not supported by the evidence. (RFF-Reply ¶¶ 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).

Response to Finding No. 2027:

Respondent has no specific response.

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).

Response to Finding No. 2028:

Respondent has no specific response.

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).

Response to Finding No. 2029:

Respondent has no specific response.

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).

Response to Finding No. 2030:

Respondent has no specific response.

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).

Response to Finding No. 2031:

This proposed finding is inaccurate and misleading. (RFF-Reply ¶¶ 1983-2030).

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

In the matter of	)	
	)	Docket No. 9315
Evanston Northwestern Healthcare Corporation,	)	**Public Record**

RESPONDENT'S REPLIES TO COMPLAINT COUNSEL'S PROPOSED FINDINGS OF FACT

VOLUME IX of XI

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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*).

Response to Finding No. 2032:

This proposed finding is inaccurate, misleading and not supported by the evidence. Respondent has set forth substantial evidence of improvements in the quality of care in the ENH system as a whole, i.e., "throughout the system," as that term is used in Respondent's second amended answer. Complaint Counsel's suggestion that it is somehow Respondent's burden to come forward with evidence of quality improvements throughout the system is wrong as matter of law and was never assumed by Respondents. Indeed, Respondent's Answer and the amendments thereto consistently and expressly did not assume any burdens of proof with respect to any of the defenses. Respondent produced substantial, unrefuted testimony of quality improvements at HPH after the Merger. And Complaint Counsel offered no credible evidence of any declines in quality attributable to the Merger at either Evanston or Glenbrook Hospitals. (Chassin, Tr. 5196, 5138-41, 5363-64; 5275-76; RFF ¶¶ 1250, 1228-1229, 1506; 2004, 2058, 2204, 2247). This evidence alone would be sufficient to demonstrate quality improvements in the ENH system overall, although it is not Respondent's burden. Even if Respondent was required to produce evidence of actual improvements caused by the Merger at each of the three campuses at ENH – which Respondent is not required to do – that requirement has been easily satisfied.

Even under the administrative data that Dr. Romano relied on, for example, in 2004, ENH as a whole outperformed the top 100 teaching hospitals by 11.4% in Solucient's risk-adjusted patient safety index. (RX 2032 at 5-7; CX 1947; Romano, Tr. 3405; RFF ¶ 2191).

(REDACTED) (O'Brien, Tr. 3667, *in camera*; RFF ¶ 2191). Similarly, under Dr. Romano's administrative data, after the Merger, the median performance of risk-adjusted mortality at ENH as a whole decreased from –18.0% in 2001 to –0.38% in 2004 as compared to the median performance of the top 100 major teaching hospitals. (RX 2032 at 5-7; CX 1947; Romano, Tr. 3405; RFF ¶ 2191). The fact that such Solucient's use of administrative data demonstrates improvements contrary to Dr. Romano's results using similar data is further proof that such data is unreliable for assessing quality of care.

In addition, the evidence showed substantial quality improvements in 16 major clinical areas at HPH as well as other dramatic improvements at Glenbrook and Evanston Hospitals, such as the introduction of a fully-functional electronic medical record that improved quality of care at all three ENH hospitals. (Chassin, Tr. 5138-41, 5363-64; RFF ¶¶ 1228-1229, 2004, 2058).

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).

Response to Finding No. 2033:

This proposed finding is inaccurate, misleading and not supported by the evidence.

(REDACTED)

(Chassin, Tr. 5271-72, 5278-83, 5280-81, 5269, 5294, 5297, 5329-30, 5595-96; RX 2043; Chassin, Tr. 5299; RX 1571 at ENHL PK 52193; RX 1985, *in camera*; RFF ¶¶ 1483-1504, 1622). For example, Dr. Chassin compared HPH's performance with respect to major surgical complications for cardiac surgery against a national comparison sample and found that, overall, HPH's rate of major complications were lower than the national benchmark. (Chassin, Tr. 5299; RX 1571 at ENHL PK 52193; RFF ¶ 1622). In addition, the evidence showed that ENH is the only hospital in the Chicago area that has accomplished such a broad implementation of a complete, electronic medical record across inpatient and ambulatory care areas and, further, that systems like Epic continue to be rare in community hospitals such as HPH. (Wagner, Tr. 3985, 3999-4000, 4082; Ankin, Tr. 5071-72; Chassin, Tr. 5368; Romano, Tr. 3334; RX 1423 at 7; RFF ¶¶ 2105-2109, 2118-2120, 2211).

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).

Response to Finding No. 2034:

This proposed finding is misleading, incomplete and not supported by the evidence.

(REDACTED)

(Baker, Tr. 4619-20, 4646, 4795-96, *in camera*; Haas-Wilson, Tr.

2637, *in camera*; RFF ¶ 1004). However, this estimate is inherently conservative, as ENH's prices must be adjusted to account for the improvement in the quality of the services being offered. (Baker, Tr. 4604-06; RFF ¶ 1157). The evidence at trial established that ENH's quality improved proportionately faster than other area hospitals in critical areas. (Chassin, Tr. 5278-83; RX 2043; RFF ¶¶ 2205-2216).

(REDACTED)

(Baker, Tr. 4629-30, 4658-61, 4663-64, 4667-68, 4799, *in camera*; Baker, Tr. 4606; RFF ¶¶ 1156, 1161, *in camera*; RFF ¶ 1158).

In addition, Dr. Chassin, as well as ENH fact witnesses, compared quality of care at HPH and Evanston Hospital with contemporaneous changes in peer group hospitals in the State of Illinois, as well as nationally, during the pre- and post-Merger periods. For example, Dr. Richard Silver, ENH Chairman of the Department of Ob/Gyn presented evidence that ENH, as a whole, outperformed a national comparison peer group with respect to both ENH's Cesarean section rate and operative vaginal delivery rate throughout the pre- and post-Merger periods.

(REDACTED)

(RX 1769 at ENHL PK 5873, *in camera*).

(REDACTED)

(RX 1769 at ENHL PK 5873, *in camera*).

In addition, ENH is the only hospital in the Chicago area that has a gynecologic preoperative review program.

(REDACTED)

(Chassin, Tr. 5269, 5271-72, 5278-83, 5294, 5297, 5308, 5329-30, 5594-96; RX 2043; Wagner, Tr. 3996-97; RX 1733; Silver, Tr. 3823-25, 3924, *in camera*; RX 1985, *in camera*; RFF ¶¶ 1483-1504, 1614, 1664, 2212-2214, 2208, 2210; RFF-Reply ¶ 2033).

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.[17]

Response to Finding No. 2035:

This proposed finding is, in part, inaccurate and it mischaracterizes the duties of the identified ENH witnesses and is not supported by the evidence. In footnote to this proposed finding, Complaint Counsel misidentifies several ENH witnesses as being merely administrators including, Drs. Michael Ankin, Leon Dragon, Bruce Harris, Stanley Kent, Todd Rosengart, Richard Silver, Thomas Victor, Arnold Wagner, and nurse Heidi Krasner. While several of these individuals do have important administrative responsibilities, they are, in fact, primarily

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[17] 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.

responsible for the provision of clinical services within their respective departments and/or areas. (Silver, Tr. 3768; RFF ¶ 1241). Further, several of these witnesses did, in fact, provide quality-related testimony pertaining not only to HPH but to ENH as a whole with respect to, for example, cardiac surgical complications, Epic and patient outcomes in obstetrics and gynecology ("Ob/Gyn"). (Wagner, Tr. 3976-77; 3996-97; RX 1733; Silver, Tr. 3823-25, 3924; Rosengart, Tr. 4522-24; RFF ¶¶ 1624, 2212-2214, 2208, 2210).

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).

Response to Finding No. 2036:

This proposed finding is inaccurate and is not supported by the evidence. Dr. Chassin analyzed domains of care, in which improvements were demonstrated at both Evanston and Glenbrook Hospitals, in addition to HPH.

(REDACTED)

(Chassin, Tr. 5265-67, 5270, 5279-82 (*discussing* DX 8079), 5282; RX 2043; RX 1985, *in camera*; RFF ¶¶ 1489-1504; RFF-Reply ¶¶ 2033-2035).

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).

Response to Finding No. 2037:

This proposed finding is inaccurate and is not supported by the evidence. Dr. Chassin analyzed over 16 major areas of clinical services at HPH, including the largest-volume service, Ob/Gyn, which was utilized by approximately one-third of all patients who were admitted to HPH before the Merger. (Chassin, Tr. 5196, 5138-41, 5363-64; RFF ¶ 1250, 1228-1229, 2004, 2058). Dr. Chassin's analysis evaluated the effect of the Merger on these 16 clinical areas, which constituted a majority of the major services rendered to HPH patients before and after the Merger. (Chassin, Tr. 5196, 5138-41, 5363-64; RFF ¶¶ 1250, 1228-1229, 2004, 2058).

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).

Response to Finding No. 2038:

Respondent objects to this proposed finding to the extent it implies that Respondent carries the burden of proof on this issue. Moreover, as more fully discussed at RFF-Reply ¶¶ 2032-2037, 2045, this proposed finding is inaccurate and is not supported by the cited evidence. For example, there is substantial evidence of improvements in quality of care at HPH as a result of the Merger. (Chassin, Tr. 5196, 5138-41, 5363-64; RFF ¶¶ 1250, 1228-1229, 2004, 2058; RFF-Reply ¶¶ 2032-2037, 2044-2045).

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).

Response to Finding No. 2039:

This proposed finding is misleading. As discussed in RFF-Reply ¶ 2040, with respect to clinical quality, Dr. Noether relied on the testimony of Dr. Chassin and Dr. Patrick Romano, Complaint Counsel's quality of care expert, both of whom found quality improvements in several areas at HPH post-Merger. (Noether, Tr. 6016-18; RFF ¶ 2219). With respect to non-clinical quality, which includes things such as amenities, service and convenience, Dr. Noether reviewed and analyzed the evidence regarding that aspect of quality of care. (Noether, Tr. 6016).

2040. Dr. Noether never compared changes in quality at Highland Park Hospital with changes in quality at other hospitals. (Noether, Tr. 6183).

Response to Finding No. 2040:

This proposed finding is inaccurate and is not supported by the cited evidence. Dr. Noether testified that she did not explicitly compare changes in quality. However, she relied on Dr. Chassin's testimony, which documented a number of different areas in which quality improved substantially at HPH. (Noether, Tr. 6017, 6183). Further, with respect to clinical quality, Dr. Noether relied on the testimony of Drs. Chassin and Romano, both of whom found quality improvements in several areas at HPH. (Noether, Tr. 6016-18; RFF ¶ 2219). With respect to non-clinical quality, which includes things such as amenities, service and convenience, Dr. Noether reviewed and analyzed the evidence regarding that aspect of quality of care. (Noether, Tr. 6016).

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).

Response to Finding No. 2041:

This proposed finding is inaccurate and is not supported by the cited evidence. Dr. Chassin testified that he had no knowledge of the prices at ENH. (Chassin, Tr. 5447). Dr.

Romano did not provide any opinion concerning HPH's financial capacity to implement any of the quality improvements put in place. (Romano, Tr. 3288). Further, the evidence documented the cost of the numerous improvements that ENH implemented at HPH, the value of which totaled in excess of $120 million. (Neaman, Tr. 1250; O'Brien, Tr. 3523).

2042. Dr. Chassin could not comment on the pricing of hospital services at ENH or Highland Park Hospital after the merger. (Chassin, Tr. 5447).

Response to Finding No. 2042:

Respondent has no specific response. (RFF-Reply ¶ 2041).

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).

Response to Finding No. 2043:

This proposed finding is misleading. When Evanston Hospital and HPH signed the letter of intent in June of 1999, ENH widely distributed press releases to news agencies and MCOs detailing ENH's plans for capital expansion and quality enhancement at HPH. (RX 563; Hillebrand, Tr. 1857-58). For example, RX 564 is a copy of the press release sent to Blue Cross Blue Shield. (RX 564). Hillebrand further testified that the initiation of cardiac surgery at HPH was a point of discussion during meetings with MCOs. (Hillebrand, Tr. 1858-59). In addition, MCOs such as **(REDACTED)**

(RX 1208 at UHCENH 3394-98, *in camera*). Further, the topic of capital improvements was also discussed during the contract renegotiations.

(REDACTED)

(Mendonsa, Tr. 537, *in camera*).

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)

), *in camera*).

Response to Finding No. 2044:

This proposed finding is incorrect. Evidence at trial established that ENH's quality improved proportionately faster than other area hospitals in critical areas. (Chassin, Tr. 5278-83; RX 2043; RFF ¶¶ 2205-2216).

(REDACTED)

(Baker, Tr. 4629-30, 4657-61, 4663-64, 4667-68, 4799, *in camera*; Baker, Tr. 4606; RFF ¶¶ 1156, 1158, 1161).

(REDACTED)

(Baker, Tr. 4663, *in camera*).

(REDACTED)

(Baker, Tr. 4648, *in camera*). A comprehensive explanation for ENH's price changes to individual buyers is discussed in RFF ¶¶ 738-923.

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)).

Response to Finding No. 2045:

This proposed finding is inaccurate and is not supported by the evidence. Dr. Chassin presented an analysis of quality of care improvements that were quantifiable and demonstrated a statistically significant effect of the Merger on quality of care as with, for example, the undeniable impact of the Merger on the use of critical process measures to treat patients with heart attack at HPH. (Chassin, Tr. 5279-80 (*discussing* DX 8079); RFF ¶¶ 1495-1504). Dr. Romano himself admitted that his analysis of quality was not comprehensive. (Romano, Tr. 3244; RFF ¶ 2219). Indeed, Dr. Romano's analysis of the high-volume obstetrical service was based on indicators that were not comprehensive and overlooked many important processes of care. (Romano, Tr. 3395-96; RFF ¶ 1334). Further,

(REDACTED) (Romano, Tr. 3308-09, 3317-18, 3327, 3332-33, 3390-93; Romano, Tr. 3067-68, 3109-11, 3160, 3178-79, 3194-98, 3228-29, *in camera*; RFF ¶ 2219). For the reasons more fully discussed in the following replies to Complaint Counsel's proposed findings of fact, Complaint Counsel's expert, Dr. Romano, relied heavily on indicators that were lacking validity and, further, were not intended by their developers to be definitive measures of quality. (Chassin, Tr. 5251; RX 2010 at 19-22; RX 2007

at 26; RFF ¶ 2276; RFF-Reply ¶ 2165 (more fully discussing AHRQ's indicators relating to nursing services)).

In fact, the Agency for Healthcare Research and Quality's ("AHRQ") indicators were intended for use as a screening tool, to "serve as a first-round flag of potential quality problems, which should be investigated further b y other methods, such as chart review." (RX 2007 at 26; RFF ¶ 2246). AHRQ itself acknowledges the problems associated with its indicators, all of which are created solely from administrative data. (Chassin, Tr. 5179).

(REDACTED)

(Romano, Tr. 3093, 3211-12, 3216-34, *in camera*; RFF ¶ 2247).

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).

Response to Finding No. 2046:

Respondent has no specific response.

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).

Response to Finding No. 2047:

Respondent has no specific response.

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).

Response to Finding No. 2048:

Respondent has no specific response.

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).

Response to Finding No. 2049:

Respondent has no specific response.

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).

Response to Finding No. 2050:

Respondent has no specific response.

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).

Response to Finding No. 2051:

This proposed finding is inaccurate and is not supported by the evidence. Respondent does not dispute that AHRQ puts forth 46 indicators of quality of care. However, these indicators are not valid measures because they are not a definitive source of information about quality of care but, rather, are to be used with caution as a screening tool in evaluating initial quality problems. (Romano, Tr. 3255-56; RX 2004 at 29; RX 2007 at 26; Chassin, Tr. 5583-84; RX 2004 at 27-30; RX 2010 at 19-23; RFF ¶¶ 2223, 2246).

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).

Response to Finding No. 2052:

Respondent has no specific response.

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)).

Response to Finding No. 2053:

This proposed finding mischaracterizes the evidence.

(REDACTED)

(Chassin, Tr. 5582-83; Romano, Tr. 3244, 3255-56; Romano Tr. 3093, 3211-12, 3216-34, 3127-28, *in camera*; RX 2004 at 29; RFF ¶ 2219, 2221, 2223, 2245, 2247; RFF-Reply ¶ 2045).

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)).

Response to Finding No. 2054:

This proposed finding mischaracterizes the evidence. (RFF-Reply ¶ 2053).

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*).

Response to Finding No. 2055:

Respondent has no specific response.

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).

Response to Finding No. 2056:

This proposed finding is inaccurate and mischaracterizes the evidence. Dr. Romano did not evaluate Evanston Hospital and ENH as a whole. Rather, he narrowly focused on selective dimensions of care – complications and mortality – by relying almost exclusively on quality indicators designed to provide only an initial assessment of quality and predicated on flawed administrative data. (Romano, Tr. 3255-56; RX 2004 at 29; RFF ¶¶ 2221-2247; RFF-Reply ¶¶ 2053-2054).

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).

Response to Finding No. 2057:

This proposed finding mischaracterizes the evidence. Dr. Romano did not evaluate the change in performance generally at HPH and Evanston Hospital and the ENH system as a whole. Rather, he looked narrowly at patient outcomes – patient satisfaction, complications and mortality – by relying almost exclusively on flawed administrative data and unrepresentative and methodologically flawed patient satisfaction surveys. (Romano, Tr. 3255-56; RX 2004 at 29; Chassin, Tr. 5243-46, 5250-51, 5249; RX 2031; RFF ¶¶ 2221-2247, 2248-2253; RFF-Reply ¶¶ 2053-2054, 2056).

(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*).

Response to Finding No. 2058:

This proposed finding is inaccurate and is not supported by the evidence. The evidence established substantial improvements in quality of care at HPH following the Merger as reflected in its structures, processes and outcomes of patient care. For example, ENH improved the structure of care at HPH by expanding physician coverage in key clinical areas affecting a large number of patients admitted to HPH – including Ob/Gyn, the emergency department ("ED"), intensive care services and pharmacy services. (RFF ¶¶ 1276-1292, 1690, 1911, 1958-1963). Additional, major structural improvements in quality included the implementation of a complete electronic medical record (Epic), as well as expansion and upgrading of HPH's clinical service areas – including the ED, patient rooms and construction of the Ambulatory Care Center

("ACC"). (RFF ¶¶ 1516, 1892-1910, 2004). The evidence demonstrated additional and statistically significant improvements in quality of care at HPH. (Chassin, Tr. 5279-80 (*discussing* DX 8079); RFF ¶¶ 1495-1504).

(REDACTED) (Romano, Tr. 3308-09, 3317-18, 3327, 3332-33, 3390-93; Romano, Tr. 3067-68, 3109-11, 3160, 3178-79, 3194-98, 3228-29, *in camera*; RFF ¶ 2219, *in camera*).

(REDACTED)

(Romano, Tr. 3127-28, *in camera*; Chassin, Tr. 5582-83; RFF ¶¶ 2245-2247). AHRQ itself, the developer of these indicators, cautions that they are not to be used as definitive measures of quality problems but, rather, should be used merely as a screening tool. (RX 2007 at 26; RFF ¶ 2246).

(REDACTED)

(Romano, Tr. 3093, 3211-12, 3216-34, *in camera*; RFF ¶ 2247).

Dr. Chassin found that the slight dip in NRMI data (e.g, the use of aspirin) at Evanston Hospital in 2000 was not the result of any diversion of resources from Evanston to HPH around the time of the Merger. (Chassin, Tr. 5275). Dr. Romano cited no specific evidence, and Dr. Chassin found there was no such evidence, showing that the putative decline in quality at Evanston Hospital was due to any diversion of resources to HPH after the Merger. (Chassin, Tr. 5275-76; RFF ¶¶ 1506, 2204; RFF-Reply ¶ 2087). Further,

(REDACTED) (Chassin, Tr. 5271; RX 2043; RX 1985, *in camera*).

(Chassin, Tr. 5271; RX 2043; RX 1985, *in camera*; RFF ¶¶ 1494, 1497, *in camera*).

In addition, **(REDACTED)** (RX 2043; RX 1985, *in camera*). **(REDACTED)**

(RX 2043; RX 1985, *in camera*; RFF ¶ 1494, *in camera*).

Dr. Chassin found that, in only one time period, 2002, the door-to-dilation time at Evanston Hospital was slower than at like hospitals, but that it only affected approximately 16 patients, which is so small a sample size that such a measurement cannot lead to definitive conclusions about quality. (Chassin, Tr. 5555, 5592-93, 5595). Dr. Romano also found an ostensible decline at Evanston Hospital based upon the AHRQ heart attack mortality indicator, but for the reasons more fully discussed at RFF-Reply ¶ 2060, this indicator is based upon administrative data and thus lacks sufficient clinical detail. (Romano, Tr. 3204-05). Finally, "relative to other indicators, a higher percentage of the variation occurs at the provider (i.e., hospital) level rather than the discharge level." Thus, "...some of the observed differences in provider performance likely do not represent true differences." (RX 2004 at 55; *see also* RFF-Reply ¶ 2105).

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 benefited patients in terms of improved outcomes. (Romano, Tr. 3008).

(REDACTED)

(Romano, Tr. 3192, *in camera*).

Response to Finding No. 2059:

This proposed finding is misleading and not supported by the evidence. Under the definition of quality of care used by both quality experts in this case, increasing the likelihood of desired health outcomes is a quality improvement. (Chassin, Tr. 5143-44; Romano, Tr. 3251; RFF ¶¶ 1167, 1169). Dr. Romano himself conceded that there were, in fact, significant

improvements in quality of care at HPH several clinical areas, including

(REDACTED)

(Romano, Tr. 3332-33, 3390-93, 3327, 3308-09, 3317-18; Romano Tr. 3067-68, 3109-11, 3160-61, 3178-79, 3194-98, 3228-29, *in camera*; RFF ¶ 1231). Further, Dr. Romano agreed that some structural improvements in quality (e.g., expansion of physician coverage) do not require evidence of outcomes to demonstrate that quality has improved. (Romano, Tr. 3251-52, 3389-90; Chassin, Tr. 5145; RFF ¶ 1178). There are also weaknesses associated with outcome measures that limit their usefulness in drawing conclusions about quality of care. (Romano, Tr. 3253; Chassin, Tr. 5153-54; RFF ¶¶ 1172, 1178-1179).

(REDACTED) (Romano, Tr. 3235, *in camera*; RFF-Reply ¶ 2165).

Dr. Romano's analysis of 13 out of 14 of the AHRQ indicators, which are based on flawed administrative data, showed no statistically significant changes and was, thus, inconclusive. (Romano, Tr. 3093, 3204-05, 3211-12, 3216-34; RFF ¶ 2247). Finally, the AHRQ indicators, which were developed as merely a screening tool, are not definitive measures of quality of care and, thus, Dr. Romano's analysis of quality using these indicators is itself not definitive or comprehensive. (Chassin, Tr. 5251; RX 2010 at 19-22; RX 2007 at 26; RFF ¶ 2276; RFF-Reply ¶ 2165 (more fully discussing AHRQ's indicators relating to nursing services)).

(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 system wide 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).

Response to Finding No. 2060:

Respondent does not dispute the first sentence. The remainder of this finding is misleading and not supported by the evidence. For the reasons more fully set forth in RFF-Reply ¶¶ 2032-2034, 2036-2037, even under Dr. Romano's administrative data, the evidence showed substantial improvements in the median performance of risk-adjusted mortality (e.g., outcomes) at ENH as a whole between 2001 and 2004 as compared to the median performance of major teaching hospitals, as well as improvements in HPH's mortality rates for isolated CABG and PCI in comparison to national benchmarks. (RX 2032 at 5-7; CX 1947; Chassin, Tr. 5308, 5329-30, 5594-96, 5297; Romano, Tr. 3405; RFF ¶ 2191; RFF-Reply ¶¶ 2032, 2034). ENH as a whole also outperformed the Top 100 teaching hospitals by 11.4% in Solucient's 2004 risk-adjusted patient safety index. (RX 2032 at 5-7; CX 1947; Romano, Tr. 3405; RFF ¶ 2191).

(REDACTED) (O'Brien, Tr. 3667, *in camera*; RFF ¶ 2191). With respect to risk-adjusted rates of complications (i.e., another outcome), ENH as a whole compared with the median and best quartile of the winner (benchmark) group. (RX 2032 at 8). The winner group includes all hospitals selected as Top 100 hospitals. (RX 2032 at 4). The fact that such Solucient's use of administrative data demonstrates improvements contrary to Dr. Romano's results using similar data is further proof that such data is unreliable for assessing quality of care.

(REDACTED)

(Chassin, Tr. 5269, 5271-72, 5278-83, 5294, 5297, 5329-30, 5595-96; RX 2043; Chassin, Tr. 5299; RX 1571 at ENHL PK 52193; RX 1985, *in camera*; RFF ¶¶ 1483-1504; 1622; RFF-Reply ¶¶ 2033, 2064). Dr. Romano, in fact, conceded that he found evidence of clear improvement in heart attack processes of care at HPH from the pre- to post-Merger periods. (Romano, Tr. 3006-07).

Dr. Romano cited no specific evidence, and Dr. Chassin found there was no such evidence, showing that the putative decline in quality at Evanston Hospital was due to any diversion of resources to HPH after the Merger. (Chassin, Tr. 5275-76; RFF ¶¶ 1506, 2204; RFF-Reply ¶ 2087).

(REDACTED)

(Chassin, Tr. 5182-84; Romano, Tr. 3093, 3217, *in camera*; RFF-Reply ¶ 2062).

2061.

(REDACTED)

(Romano, Tr. 3090-93, 3210-11 (discussing DX 7034A at 1, *in camera*), *in camera*).

Response to Finding No. 2061:

This finding is misleading and ignores additional, relevant evidence.

(REDACTED)

(Chassin, Tr. 5182-84; Romano, Tr. 3217, *in camera*; RFF-Reply ¶ 2062).

(REDACTED)

(Chassin, Tr. 5182-84; Romano, Tr. 3093, 3217; RFF-Reply ¶ 2062, Romano, Tr. 3379, 6368-69, *in camera* (discussing that the ostensible

is not an increase in the actual mortality rate but, rather, is actually an increase in the difference in differences values) Further, all of AHRQ's measures are based on flawed administrative data, and are not intended to be used as a definitive source of information about quality of care. (Chassin, Tr. 5251; RX 2010 at 19-22; RX 2007 at 26; RFF ¶ 2276; RFF-Reply ¶ 2165 (more fully discussing AHRQ's indicators relating to nursing services)).

2062. **(REDACTED)**

(Romano, Tr. 3093, 3204, 3212-13, 6303-04 (discussing DX 7034A at 1, *in camera*), *in camera*).

Response to Finding No. 2062:

This finding is misleading and ignores additional, relevant evidence.

(REDACTED)

REDACTED

(Chassin, Tr. 5182-84; Romano, Tr. 3217, *in camera*).

(REDACTED)

(Romano, Tr. 3379, 6368-69, *in camera* (*discussing* DX 7034-A, *in camera*)).

2063.

REDACTED

(Romano, Tr. 3077, 3093, 3215, (discussing DX 7034A at 1, *in camera*), *in camera*).

REDACTED (Romano, Tr. 3078-79 (discussing DX 7033 at 10, *in camera*), *in camera*).

Response to Finding No. 2063:

This proposed finding is misleading and ignores additional, relevant evidence. For the reasons more fully discussed at RFF-Reply ¶ 2062,

(REDACTED)

(Chassin, Tr. 5182-84; Romano, Tr. 3217, *in camera*; RFF-Reply ¶ 2062). Further, the AHRQ measure of heart attack mortality is not a definitive source of information about quality of care and was only intended to be used as a first-round flag of *potential* quality problems that require further investigation by other methods, such as chart review. (RX 2007 at 26).

(REDACTED) (Romano, Tr. 3087, 3093-96, 3204-05, 3215-17, 3458, *in camera*; Romano, Tr. 3244-45, 3373, 3411).

2064.

(REDACTED)

(Romano, Tr. 3204, 3214-15 (discussing DX 7034A at 1, *in camera*), *in camera*).

Response to Finding No. 2064:

This proposed finding is misleading and not supported by the evidence.

REDACTED

(Chassin, Tr. 5182-84; Romano, Tr. 3217, *in camera*; RFF-Reply ¶ 2062).

REDACTED

(Chassin, Tr. 5269, 5271-72, 5278-83, 5294, 5297, 5329-30, 5595-96, RX 2043; Chassin, Tr. 5299; RX 1571 at ENHL PK 52193; RX 1985, *in camera*; RFF ¶¶ 1483-1504; 1622).

2065.

REDACTED

(Romano, Tr. 3211-12 (discussing DX 7034A at 1, *in camera*), *in camera*).

Response to Finding No. 2065:

This proposed finding is contradictory, inaccurate and is not supported by the evidence. Complaint Counsel already conceded in CCFF ¶ 2063 that "the care of heart attack patients improved at Highland Park Hospital after the Merger" and, thus, the evidence of that quality improvement stands as an admission. For the reasons more fully set forth in RFF-Reply ¶¶ 2033-2037, 2064,

REDACTED

(Chassin, Tr. 5269, 5271-72, 5278-83, 5294, 5297, 5329-30, 5595-96; RX 2043; RX 1571 at ENHL PK 52193; RX 1985, *in camera*; RFF ¶¶ 1483-1504; 1622).

2066.

REDACTED
(Romano, Tr. 6303-04 (discussing DX 440 at 28, *in camera*), *in camera*).

Response to Finding No. 2066:

This proposed finding is unsupported by the evidence.

REDACTED

(Chassin, Tr. 5182-84; Romano, Tr. 3093, 3217, *in camera*; RFF-Reply ¶¶ 2060-2062, *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).

Response to Finding No. 2067:

This proposed finding is unsupported by the evidence. Dr. Romano cited no specific evidence that there was any actual diversion of resources from Evanston Hospital to HPH with respect to the treatment of heart attack patients. (Chassin, Tr. 5275-76; RFF ¶¶ 1506, 2204; RFF-Reply ¶ 2087). In addition, Dr. Chassin found no evidence to support Dr. Romano's hypothesis that quality at Evanston Hospital declined because resources were purportedly diverted from Evanston Hospital to HPH. (Chassin, Tr. 5276; RFF ¶ 1506). Accordingly, this proposed finding is based on pure speculation.

2068.

REDACTED
(Romano, Tr. 3081, *in camera*). (Romano, Tr. 6323, *in camera*).

Response to Finding No. 2068:

Respondent has no specific response.

2069.

REDACTED
(Romano, Tr. 3067-69, *in camera*).

Response to Finding No. 2069:

Respondent has no specific response.

2070.

REDACTED
(Romano, Tr. 3069, 3080-81, 6319, *in camera*).

Response to Finding No. 2070:

Respondent has no specific response.

2071. Heart attack patients may be treated with aspirin or beta blockers:

1.

REDACTED
(Romano, Tr. 3080, *in camera*).

2.

REDACTED
(Romano, Tr. 3081, *in camera*).

3.

REDACTED
(Romano, Tr. 3069, *in camera*).

4.

REDACTED
(Romano, Tr. 3070-71, *in camera*).

Response to Finding No. 2071(1)-(4):

Respondent has no specific response.

2072.

REDACTED
(Romano, Tr. 3071-72, *in camera*).

Response to Finding No. 2072:

This proposed finding overlooks additional, relevant evidence on this issue. The generally accepted door-to-dilation time for treating patients with a heart attack is 120 minutes, which comes from JCAHO, Medicare and a variety of other bodies that make recommendations in this area. (Chassin, Tr. 5593; RFF ¶ 1507).

2073.

REDACTED

(Romano, Tr. 3072 (discussing DX 441 at 82, *in camera*), *in camera*).

Response to Finding No. 2073:

This proposed finding is inaccurate and mischaracterizes the evidence on this issue. For example, in 2001 and 2003, HPH was virtually identical to like hospitals, meaning that under an accepted standard used to measure door-to-dilation time of 120 minutes, there were differences of only two to five minutes. (Chassin, Tr. 5592-93; RFF ¶ 1507). These differences are not clinically significant. (Chassin, Tr. 5592-93; RFF ¶ 1507). Overall, assuming Dr. Romano's data are correct, HPH was within the acceptable time frames for door-to-dilation time in 2001 and 2003, and in 2002, HPH was only slightly over that based on just 16 cases, which is too small a sample size from which to draw any generalized conclusions about that quality measure for that particular year. (Chassin, Tr. 5593-94; RFF ¶ 1508).

2074. Based upon NRMI data:

1.

REDACTED

(Romano, Tr. 3081-82 (discussing DX 441 at 83, *in camera*), *in camera*).

Response to Finding No. 2074(1):

Respondent does not dispute the first sentence of this proposed finding. The remainder of this proposed finding misstates the evidence.

REDACTED (Chassin, Tr. 5271; RX 2043; RX 1985, *in camera*). **REDACTED** (Chassin, Tr. 5271; RX 2043; RX 1985, *in camera*; RFF ¶¶ 1494, 1497, *in camera*). In addition,

REDACTED (RX 2043; RX 1985, *in camera*). **REDACTED** (RX 2043; RX 1985, *in camera*; RFF ¶ 1494, *in camera*).

REDACTED

(RX 2043; RX 1985; *in camera*; RFF ¶ 1505).

2.

REDACTED (Romano, Tr. 3083 (discussing DX 441 at 84, *in camera*), *in camera*).

Response to Finding No. 2074(2):

Respondent does not dispute the first sentence of this proposed finding. The remainder of this proposed finding misstates the evidence.

REDACTED

(Chassin, Tr. 5272; RX 2043; RX 1985, *in camera*). **REDACTED**

(Chassin, Tr. 5272, 5282-83; RX 2043; RX 1985, *in camera*).

REDACTED

REDACTED (RX 2043; RX 1985; *in camera*; RFF ¶ 1505).

3.

REDACTED

(Romano, Tr. 3083-84 (discussing DX 441 at 85, *in camera*), *in camera*).

Response to Finding No. 2074(3):

Respondent does not dispute the first sentence of this proposed finding. The remainder of this proposed finding misstates the evidence. For example, both before and after the Merger,

REDACTED

(Chassin, Tr. 5272, 5282-83, 5547-48; RX 2043; RX 1985, *in camera*; RFF ¶ 1494, *in camera*; CCFF ¶ 2071(3) , *in camera*).

4.

REDACTED

(Romano, Tr. 3071-72, *in camera*).

Response to Finding No. 2074(4):

This proposed finding is repetitive and restates evidence already cited in CCFF ¶ 2072. (RFF-Reply ¶ 2072).

i. **REDACTED** (Romano, Tr. 3083-84 (discussing DX 441 at 86, *in camera*), *in camera*).

Response to Finding No. 2074(4)(i):

This proposed finding is misleading and mischaracterizes the evidence. For example, Dr. Chassin also found that the door-to-dilation time was not significantly longer at Evanston

Hospital for years 1999, 2001 and 2003 as compared to like hospitals. (Chassin, Tr. 5555, 5591-93). In addition, Dr. Chassin found that, in only one time period, 2002, the door-to-dilation time at Evanston Hospital was slower than at like hospitals, but that it only affected approximately 16 patients, which is so small a sample size that such a measurement cannot lead to definitive conclusions about quality. (Chassin, Tr. 5555, 5592-93, 5595).

ii. **REDACTED**

Tr. 3070-71, *in camera*).

REDACTED

(Romano, Tr. 3072 (discussing DX 441 at 82, *in camera*), *in camera*).

Response to Finding No. 2074(4)(ii):

This finding is repetitive and restates evidence in CCFF ¶ 2073. (RFF-Reply ¶ 2073).

iii. **REDACTED**

(Romano, Tr. 3079, *in camera*).

Response to Finding No. 2074(4)(iii):

This proposed finding misstates the cited evidence.

REDACTED

(Romano, Tr. 3079, *in camera*).

REDACTED

(Romano, Tr. 3079, *in camera*).

2075. **REDACTED**

(Romano, Tr. 6324-25, *in*

camera).

REDACTED

(Romano, Tr. 6324, *in camera*).

Response to Finding No. 2075:

Respondent does not dispute that NRMI changed the definitions relating to heart attack patients in 2000. (Chassin, Tr. 5274). But this proposed finding is misleading. Dr. Chassin found that the change in NRMI data elements made the year 2000 unreliable to base comparison on, because there were only 26 reported cases in 2000, whereas in previous years there had been between 150 and 200 cases. (Chassin, Tr. 5274-75). The major revision in NRMI in 2000 resulted in some dislocation in reporting. (Chassin, Tr. 5274-75).

(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*).

Response to Finding No. 2076:

This proposed finding is inaccurate and mischaracterizes the evidence. Dr. Chassin specifically found that the opening of the cardiac surgery program at HPH was a quality improvement in the care given to HPH patients. (Chassin, Tr. 5289; RFF ¶ 1565). Further, Dr. Romano conceded that the opening of the cardiac surgery program at HPH did, in fact, improve quality of care because, for example, it improved access to CABG procedures to residents of Lake County and reduced geographic disparities within the Chicago Metropolitan Statistical Area. (Romano, Tr. 3275; RFF ¶ 1566). In addition, the introduction of the cardiac surgery program is a benefit to Evanston Hospital as well because Dr. Rosengart – who also performs surgery at Evanston Hospital and who has considerable, cutting-edge research interests – was

recruited to Evanston Hospital to help introduce the cardiac surgery program to HPH. (RFF ¶¶ 1586-1590, 1592).

Dr. Romano, who himself acknowledged in his initial expert report that ENH provided excellent care to its CABG and interventional cardiology ("PCI") patients during the post-Merger period, testified at trial that ENH provided good care to its PCI patients and that it was comparable to that of peer institutions. (Romano, Tr. 3275-76; RFF-Reply ¶ 2087).

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).

Response to Finding No. 2077:

Respondent has no specific response.

2078. **REDACTED**

(Romano, Tr. 3217-18, *in camera*).

Response to Finding No. 2078:

This proposed finding is misleading.

REDACTED

(Romano, Tr. 3217-18, *in camera*). As discussed more fully in RFF-Reply ¶ 2076, Dr. Romano found that ENH provided good care to its CABG and PCI patients. (Romano, Tr. 3275-76; RFF-Reply ¶ 2087).

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*).

Response to Finding No. 2079:

This proposed finding is misleading, inaccurate and mischaracterizes the evidence. This proposed finding fails to distinguish ENH's rates of minor complications from major complications.

REDACTED

(Chassin, Tr. 5299-300; Rosengart, Tr. 4510; RX 1411 at ENHL PK 51288, *in camera*; RFF ¶¶ 1617, 1619). Dr. Romano himself acknowledged that

REDACTED

(Romano, Tr. 3053-55, *in camera*; RX 1411 at ENHL PK 51288; RFF ¶ 1623, *in camera*). Minor complications, such as leg infections, are not life-threatening. And Dr. Rosengart regards the rates of minor complications at ENH as very good and as evidence of good performance. (Rosengart, Tr. 4510, 4515; RFF ¶¶ 1617, 1624).

In addition, the rates of leg-wound infections reported in Society of Thoracic Surgery ("STS") data may be influenced by the fact that these infections are only reported within 30 days of surgery if the patient returns to the hospital for follow-up, which most ENH cardiac surgery patients do. (Rosengart, Tr. 4512, 4514-15; RFF ¶ 1627). The leg wound infection rate is low at ENH and the literature and medical research in cardiac surgery show leg wound infection rates within 30 days of surgery occur within 10-20% of patients nationally. (Rosengart, Tr. 4514-16; RFF ¶ 1626). Separate and apart from the rates of major and minor complications,

REDACTED

(Rosengart, Tr. 4523; Chassin, Tr. 5294; RX 1400 at ENHL PK 54798-806; RX 1411 at ENHL PK 51180. *in camera*).

2080.

REDACTED

(Romano, Tr. 3053-54 (discussing DX 440 at 15, *in camera*), *in camera*).

Response to Finding No. 2080:

This proposed finding is misleading and misstates the cited evidence. For reasons that are more fully set forth in RFF-Reply ¶ 2079, Dr. Romano

REDACTED

(Romano, Tr. 3053-55, *in camera*; Rosengart, Tr. 4510; RX 1411 at ENHL PK 51288, *in camera*; RFF ¶¶ 1617, 1623; RFF-Reply 2079). This proposed finding fails to distinguish minor from major complications, although the evidence established that ENH's performance with respect to minor complications was also good. (Rosengart, Tr. 4510, 4515; RFF ¶¶ 1617, 1624; RFF-Reply ¶ 2079).

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).

Response to Finding No. 2081:

This proposed finding mischaracterizes the evidence. While there are studies showing a relationship, on average, between cardiac surgical volumes and patient outcomes, volume by itself cannot directly influence mortality. (Chassin, Tr. 5291-92; Romano, Tr. 3277; RFF-Reply ¶¶ 2082-83). In addition, there is variability in outcomes at a given level of volume and there are

many low volume cardiac surgery programs that have very low mortality. (Chassin, Tr. 5291-92; Romano, Tr. 3277; RFF-Reply ¶¶ 2082-83). It mischaracterizes the evidence to assert that HPH had problems generating volumes associated with optimal outcomes because HPH functions as part of the ENH cardiac surgery program – a single program – whose combined volumes exceed 500 cases annually. (Rosengart, Tr. 4452-53; RFF ¶ 1599; RFF-Reply ¶ 2083).

REDACTED

(Chassin, Tr. 5533-34; Rosengart, Tr. 4511; RX 1411 at ENHL PK 52188, *in camera*). HPH's cardiac surgical outcomes – with zero mortality for the past two and a half years – have, in fact, been superb, separate and apart from its volumes. (Rosengart, Tr. 4502-05; RFF ¶ 1643).

Finally, Complaint Counsel's point in this proposed finding cuts against its proposed remedy of divestiture. If HPH were divested from ENH, then HPH would have insufficient volume to sustain a cardiac surgery program. (RFF ¶¶ 2490-2497).

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).

Response to Finding No. 2082:

This proposed finding is inaccurate and mischaracterizes the evidence. The American Heart Association ("AHA") and the American College of Cardiology promulgate clinical practice guidelines that discuss certain volume thresholds for cardiac surgery. However, they do not specifically identify, or even recommend, a minimum volume threshold for cardiac surgical

procedures. Nor do they set any such minimum standard for the number of procedures. (Chassin, Tr. 5296-97). The AHA/ACC guideline for cardiac surgery, in fact, sets forth that no absolute standard for a minimum performance can be constructed because many cardiac surgery programs at low volumes have very good outcomes due to very high quality of care. (Chassin, Tr. 5296-97). Volume is not a direct measure of the quality or outcomes of care with respect to cardiac surgery because volume does not cause mortality and, further, many low-volume programs, in fact, have very low mortality rates. (Chassin, Tr. 5291-92; RX 2007 at 206). AHRQ itself acknowledges the limitations of using volume as a measure of quality because, for example, "volume is *at best* a quite noisy reflection of true quality or performance differences." (RX 2007 at 21 (emphasis added)). Further, "causes of the relatively weak relationship between volume and quality include the confounding role of surgeon volume (not captured presently in Healthcare Cost and Utilization Project ("HCUP") data), differences in the severity and complexity of cases treated, and differences in training and experience that are not reflected in volume." (RX 2007 at 21). Thus, it is important to consider more direct measures of hospital performance to help determine the quality of care. (RX 2007 at 21).

REDACTED

(Chassin, Tr. 5533-34; Rosengart, Tr. 4511; RX 1411 at ENHL PK 51288, *in camera*).

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)).

Response to Finding No. 2083:

This proposed finding is inaccurate, misleading and mischaracterizes the evidence. The ENH open heart surgery program is an adult cardiac surgery program with a volume between

500 and 600 open heart procedures per year. (Rosengart, Tr. 4452-53; RFF ¶ 1598). The evidence established that the cardiac surgery that takes place at Evanston Hospital and HPH is part of a single program, the ENH cardiac surgery program, whose combined volumes exceed 500 cases annually. (Rosengart, Tr. 4452-53; RFF ¶ 1599).

REDACTED

(Chassin, Tr. 5533-34; Rosengart, Tr. 4511; RX 1411 at ENHL PK 51288, *in camera*). Further, the ACC/AHA does not set a standard for a minimum number of cardiac surgical procedures at a particular hospital. (Chassin, Tr. 5296-97; RFF-Reply ¶ 2082). As discussed more fully in RFF-Reply ¶ 2082, it is also important to consider more direct measures of hospital performance than procedure volume to help determine the quality of care. (RX 2007 at 21).

Finally, regardless of the surgical volumes at the HPH cardiac surgery site, its outcomes have been superb, with zero mortality for the past two and a half years. (Rosengart, Tr. 4502-05; RFF ¶ 1643; RFF-Reply ¶ 2081).

2084.

REDACTED

(Romano, Tr. 3063, *in camera*).

REDACTED

(Romano, Tr. 3064-65, *in camera*).

Response to Finding No. 2084:

Respondent has no specific response to the first sentence. The remainder of this proposed finding, however, mischaracterizes the cited evidence and misstates additional evidence in the record. The evidence established that HPH established and maintained excellent outcomes – with zero mortality for isolated CABG for the past two and a half years – regardless

of its cardiac surgical volumes. (Rosengart, Tr. 4502-05; RFF ¶ 1643; RFF-Reply ¶¶ 2081, 2083). HPH operates as a part of ENH's cardiac surgery program, which is not a low-volume program but, instead, involves 500 cases annually. (Rosengart, Tr. 4452-53; RFF ¶ 1599; RFF-Reply ¶¶ 2081, 2083). Finally, there is additional evidence that informs the question of whether low volume cardiac surgical programs can achieve high-quality outcomes. (Chassin, Tr. 5291-92; Romano, Tr. 3277; RFF-Reply ¶¶ 2082-2083).

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).

Response to Finding No. 2085:

Respondent has no specific response to the first three sentences. This proposed finding, however, is misleading and misstates the evidence on this issue. The State of Illinois has chosen to structure its cardiac surgery programs in a particular way. (Rosengart, Tr. 4460-61). The evidence at trial established that the State of Illinois' approach to cardiac surgery programs has resulted in improved local access to cardiac surgery. (Rosengart, Tr. 4460-61). To maintain adequate surgical volumes, ENH has combined its programs such that each individual surgeon performs surgery at multiple cites and, for example, Dr. Rosengart performs 100 cardiac surgeries at HPH and close to another 100 at Evanston Hospital. (Rosengart, Tr. 4460). For additional information concerning the actual volume of ENH's cardiac surgery program see RFF-Reply ¶¶ 2081, 2083.

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).

Response to Finding No. 2086:

This proposed finding mischaracterizes the cited evidence and, further, contains inadmissible hearsay statements not attributable to a known source. Respondent objects to this proposed finding as it is based on hearsay within hearsay and has not been specifically admitted into evidence. (JX 1 ¶ 5). The statement at issue is: "Cardiac surgery at HPH is a bad idea, Evanston will lose efficiencies, two dedicated staffs will have to be trained and maintained, and resources across the board will be spread too thin." (CX 1998 at 21). The cited evidence does not indicate how many Evanston Hospital cardiologists had this specific concern or, indeed, whether the alleged concern, which is not attributed to any particular individual, was actually held by more than one person. (CX 1998 at 21). Further, this proposed finding ignores contrary evidence in the same source indicating that locating the cardiac surgery program at HPH would be desirable and provide a convenience to patients and their families. (CX 1998 at 21). The cited evidence is dated January 6, 2000, before the first cardiac surgery procedure was performed at HPH in June 2000 and, thus, there is no evidence that any of these concerns were, in fact, borne out following the successful implementation of the cardiac surgery program at HPH. (CX 1998 at 1; RX 879 at ENH GW 3252; RFF ¶ 1565). This proposed finding is attributed to a cardiologist; there is no cited evidence that a cardiac surgeon at Evanston Hospital held similar views. (CX 1998 at 21). Finally, Dr. Romano cited no specific evidence that there was any actual diversion of resources from Evanston Hospital to HPH with respect to the treatment of heart attack patients. (Chassin, Tr. 5275-76; RFF ¶¶ 1506, 2204).

(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*).

Response to Finding No. 2087:

This proposed finding is misleading and is not supported by the evidence. ENH successfully introduced a new high-quality interventional cardiology program at HPH, which was a major improvement in quality of care. (Chassin, Tr. 5307; RFF ¶¶ 1661-1664). This conclusion is based on the very low mortality rate from elective percutaneous coronary interventions ("PCIs"), the acceptable mortality rate for emergent PCIs, the achievement of reasonable volumes, the implementation of the ability to treat acute heart attack patients on site emergently with PCI, and the effect of the entire program on treatment patterns for patients with acute heart attacks. (Chassin, Tr. 5308; RFF ¶ 1662). The mortality rate for elective PCI procedures at HPH is 0.6%, which is comparable to national benchmarks. (Chassin, Tr. 5308; RFF ¶ 1664).

REDACTED

(Chassin, Tr. 5265-67, 5270, 5279-82 (*discussing* DX 8079); RX 2043; RX 1985, *in camera*; RFF ¶¶ 1489-1504, 2036; RFF-Reply ¶¶ 2033-2035).

Further, Dr. Romano, who himself acknowledged in his initial expert report that ENH provided excellent care to its CABG and PCI patients during the post-Merger period, testified at trial that ENH provided good care to its PCI patients and that it was comparable to that of peer institutions. (Romano, Tr. 3275-76).

2088.

REDACTED

(Romano, Tr. 3218, *in camera*).

Response to Finding No. 2088:

This proposed finding is misleading and inaccurate. The mortality rate for elective PCI procedures at HPH is 0.6%, which is comparable to national benchmarks. (Chassin, Tr. 5308; RFF ¶ 1664; RFF-Reply ¶ 2087).

REDACTED

(Romano, Tr. 3275-76, *in camera*; CCFF ¶ 2088, *in camera*). Dr. Chassin, in contrast, did find evidence of quality improvements with respect to the interventional cardiology program at HPH; specifically, that angioplasty mortality at HPH was very comparable to national benchmarks; that HPH had achieved annual PCI volumes of approximately 350 cases since the first full year of the program in 2001; and that the new PCI program was conceived of, launched and implemented at HPH in a high-quality way. (Chassin, Tr. 5307-08; RFF ¶¶ 1661-1664; RFF-Reply ¶ 2087). Thus, Dr. Chassin did find evidence of quality improvements with respect to interventional cardiology generally, and PCI mortality in particular, at HPH after the Merger. (Chassin, Tr. 5307-08; RFF ¶¶ 1661-1664; RFF-Reply ¶ 2087).

(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**

(Romano, Tr. 3188-89, 3226-28, 3231-32, *in camera*).

Response to Finding No. 2089:

This proposed finding is inaccurate, misleading and overlooks additional evidence that contradicts the cited evidence. **REDACTED**

REDACTED

(Silver, Tr. 3823-25 (*discussing* DX 7037 at 1-2); Chassin, Tr. 5419-20; RFF ¶¶ 1328, 2213).

REDACTED

(Romano, Tr. 3187-88, *in camera*). For

REDACTED

(Romano, Tr. 3228-29, *in camera*).

Finally, for calendar year 2004, approximately 200 women at both HPH and Evanston Hospital had urgent or emergent care provided by the in-house obstetrician. (Silver, Tr. 3787). The fact that 200 women had deliveries that previously would have gone unattended by an attending physician, is objective data that quality of care has been improved. (Silver, Tr. 3854).

2090.

REDACTED

(Romano, Tr. 3222-3, *in camera*).

Response to Finding No. 2090:

Respondent does not dispute that Dr. Romano examined the areas identified in CCFF ¶ 2090.

REDACTED

(Chassin, Tr. 5414-17, *in camera*; RFF ¶¶ 1335-1336, *in camera*). These indicators do not adequately evaluate the improvements in obstetrical services because the indicators for birth trauma, third and fourth degree perineal

lacerations, neonatal mortality and vaginal birth after a Cesarean section ("VBAC") rates were not comprehensive and overlooked many important processes of care, as Dr. Romano himself conceded. (Romano, Tr. 3396; Chassin, Tr. 5417, *in camera*; RFF ¶1334; RFF ¶¶ 1335-1336 , *in camera*; RFF-Reply ¶ 2045).

2091. **REDACTED**

(Romano, Tr. 3189, 3231-32, *in camera*).

Response to Finding No. 2091:

This proposed finding is incomplete. Based on the evidence discussed in RFF-Reply ¶ 2093, neonatal mortality is not an appropriate measure from which to draw conclusions about the quality of obstetrical care at ENH. (Chassin, Tr. 5596-97; RFF ¶ 1337; RFF-Reply ¶ 2093). Nonetheless, **REDACTED**

(Romano, Tr. 3189, *in camera* (*discussing* DX 7037 at 6-9); RFF ¶ 1331; RFF-Reply ¶ 2093).

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).

Response to Finding No. 2092:

Respondent has no specific response except to note that the referenced glossary, by its terms, was submitted to the Court as a reference only and not as an admission by either party.

2093. Dr. Chassin agreed that neonatal mortality rate is a very important measure. (Chassin, Tr. 5466). **REDACTED** (Romano, Tr. 3188-89, *in camera*). **REDACTED** (Romano, Tr. 3224, *in camera*).

Response to Finding No. 2093:

This proposed finding is misleading and overlooks additional evidence that contradicts this proposed finding. The evidence showed that Dr. Chassin did not examine neonatal mortality because he did not find risk-adjusted data that would have allowed him to track quality in a meaningful way pre- and post-Merger. (Chassin, Tr. 5596; RFF ¶ 1337). To obtain meaningful data would have required a large-scale chart review because administrative data by themselves do not allow one to make such judgments. (Chassin, Tr. 5596-97; RFF ¶ 1337). Even if risk-adjusted data on neonatal mortality were available, that outcome would be very rare in a low-risk obstetric service like HPH's. (Chassin, Tr. 5597; RFF ¶ 1180). Accordingly, it would be questionable whether one could make meaningful comparisons on this outcome pre- and post-Merger. (Chassin, Tr. 5597; RFF ¶ 1180). The AHRQ indicator that Dr. Romano employed to assess birth trauma rates received a "-" for coding validity, which means there is published evidence that the indicator, in fact, lacks validity for this domain of validity. (RX 2010 at 18-22). The birth trauma indicator also had no published evidence of construct validity for processes of care. (RX 2010 at 21-22).

Finally,

REDACTED

(Romano, Tr. 3189, *in camera* (*discussing* DX 7037 at 6-9, *in camera*); RFF ¶ 1331; RFF-Reply ¶ 2091).

2094.

REDACTED

(Romano, Tr. 3230-32, *in camera*).

Response to Finding No. 2094:

This proposed finding is misleading and inaccurate. For the reasons more fully discussed in RFF-Reply ¶ 2093, neonatal mortality is not a particularly valid measure of obstetrical care, unless it is adequately risk-adjusted, which requires a lot of clinical detail not available in administrative data, and thus, cannot be used to draw meaningful conclusions about quality of obstetrical care. (Chassin, Tr. 5597; RFF ¶¶ 1180, 2228-2230; RFF-Reply ¶ 2093).

2095.

REDACTED

(Romano, Tr. 3187-88 (discussing DX 7037 at 3, *in camera*), *in camera*).

REDACTED

(Romano, Tr. 3187-88 (discussing DX 7037 at 3, *in camera*), *in camera*).

Response to Finding No. 2095:

This proposed finding overlooks additional evidence that contradicts the cited evidence.

REDACTED

(Silver, Tr. 3825 (*discussing* DX 7037 at 2); Chassin, Tr. 5419-20, *in camera*; RFF ¶¶ 1328, 2213). In addition,

REDACTED

(Chassin, Tr. 5420, *in camera*).

REDACTED

(Romano, Tr. 3187-88, *in camera*).

2096. **REDACTED**

Romano, Tr. 3226-28, *in camera*).

Response to Finding No. 2096:

This proposed finding overlooks additional evidence that contradicts the cited evidence.

REDACTED

(Silver, Tr. 3825 (*discussing* DX 7037 at 2, *in camera*); Chassin, Tr. 5419-20, *in camera*; RFF ¶¶ 1328, 2213, *in camera*). In addition, {the

REDACTED

(Chassin, Tr. 5420, *in camera*; RFF ¶ 1328, *in camera*; RFF-Reply ¶ 2095).

2097.

REDACTED

(Romano, Tr. 3228, *in camera*).

Response to Finding No. 2097:

This proposed finding is misleading and overlooks additional evidence in the record that demonstrates an improvement in this area. For example,

REDACTED (RX 1769 at ENHL PK 5873, *in camera*; RFF ¶ 1329, *in camera*). In addition, in assessing the very same outcome,

REDACTED

(Romano, Tr. 3228-29, *in*

camera).

REDACTED

(Chassin, Tr. 5419, *in camera*; RFF ¶ 1328).

REDACTED

(Chassin, Tr. 5419, *in camera*; Romano, Tr. 3228, *in camera*; RFF ¶ 1328, *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** (Romano, Tr. 3232-34, *in camera*).

Response to Finding No. 2098:

This proposed finding is misleading, not supported by the evidence and duplicative of CCFF ¶ 2165. Dr. Romano's conclusions with respect to the effect of the Merger on the quality of nursing services at HPH are not valid because conclusions on that issue cannot be drawn from patient satisfaction data or from the data he used to analyze AHRQ's patient safety indicators ("PSI"). (Chassin, Tr. 5251; RFF ¶ 2276; RFF-Reply ¶¶ 2098-2101). Many of the PSIs that Dr. Romano used to assess nursing services were lacking in validity. (Chassin, Tr. 5251; RX 2010 at 19-22; RFF ¶ 2276).

REDACTED

(Romano, Tr. 3232-35, *in camera*; RX 2010 at 19-20).

AHRQ's own guide to the PSIs notes that the published evidence shows that the indicator,

decubitis ulcer, lacks validity for coding, which reflects how accurately the information about that complication was captured on a discharge abstract or Medicare claim. (RX 2010 at 18-19). In addition, that same indicator received a zero rating for construct validity for explicit and implicit processes, which meant that there was no published evidence regarding this domain of validity (referring to processes of care that can affect this outcome, decubitis ulcers). (RX 2010 at 18-19). Similarly, there is no published evidence for construct validity (implicit or explicit processes) for the failure to rescue indicator. (RX 2010 at 18-19). The selected infections due to medical care has no published evidence of validity for any of the domains of validity: coding, construct explicit or implicit processes, or staffing (if valid, this measures shows that hospitals that increase the nursing hours per day should have fewer adverse events.) (RX 2010 at 18-20). Thus, for three out of the four AHRQ indicators that Dr. Romano used to assess nursing services at HPH and ENH, there is no published evidence of validity regarding these indicators and, further, for some there is evidence that the indicator actually lacks validity. (Chassin, Tr. 5251; RX 2010 at 18-20).

REDACTED

(Romano, Tr. 3235, *in camera*; RFF-Reply ¶¶ 2105-2107, 2165).

REDACTED

(Romano, Tr. 3232-35, *in camera*).

2099.

REDACTED
(Romano, Tr. 3232-35, *in camera*).

Response to Finding No. 2099:

Respondent has no specific response.

2100.

REDACTED

(Romano, Tr. 3233-34, *in camera*).

Response to Finding No. 2100:

This proposed finding is inaccurate. For the reasons more fully set forth in RFF-Reply ¶ 2098, AHRQ's own guide to the patient safety indicators makes clear that there is no published evidence for construct validity (implicit or explicit processes) for the failure to rescue indicator. (RX 2010 at 18-20). AHRQ's Guide to the PSIs indicates that the failure to rescue indicator received a zero rating (i.e., there is no published evidence regarding this domain of validity) for construct validity for both explicit and implicit processes. (RX 2010 at 18-20).

REDACTED

(Romano, Tr. 3233-34, *in camera*).

2101.

REDACTED

(Romano, Tr. 3232-33, *in camera*).

Response to Finding No. 2101:

This proposed finding is inaccurate. For the reasons more fully set forth in RFF-Reply ¶ 2098, AHRQ's own guide to the PSIs for decubitis ulcers (e.g., pressure sores) makes clear that there is no published evidence of construct validity for explicit and implicit processes, which meant that there was no published evidence regarding this domain of validity (referring to

processes of care that can affect this outcome, decubitis ulcers). (RX 2010 at 18-19). In addition, the published evidence, in fact, shows that decubitis ulcer lacks validity for coding, which reflects how accurately the information about that complication was captured on a discharge abstract or Medicare claim. (RX 2010 at 18-19).

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 (Romano, Tr. 3117, 3121-22, *in camera*).

(Romano, Tr. 3123, 3214, 3218-22, *in camera*).

Response to Finding No. 2102:

Respondent does not dispute that HPH's integration into ENH, an academic teaching hospital, is a quality improvement. (Chassin, Tr. 5376; RFF ¶ 1329, *in camera* (

REDACTED

)). The remainder of this proposed finding is not supported by the evidence. In fact, the evidence showed that, after the Merger, even based upon the kind of administrative data that Dr. Romano relied on, the median performance in risk-adjusted mortality at ENH as a whole decreased from –18.0% in 2001 to –0.38% in 2004 compared to the median performance for major teaching hospitals. (RX 2032 at 5-7; CX 1947; Romano, Tr. 3405; RFF ¶

2191). The evidence showed that the median performance in risk-adjusted mortality for the ENH hospitals compared with the median and best quartile of the winner (benchmark) group in Solucient's 2004 Top 100 Hospitals report. (RX 2032 at 7). The ENH hospitals are in the major teaching hospital category in Solucient's report. (O'Brien, Tr. 3544-45; RFF ¶ 2190; RX 2032 at 6). In addition, in 2004, ENH, as a whole, outperformed the Top 100 teaching hospitals by 11.4% in Solucient's risk-adjusted patient safety index. (RX 2032 at 5-7; CX 1947; Romano, Tr. 3405; RFF ¶ 2191). The fact that such Solucient's use of administrative data demonstrates improvements contrary to Dr. Romano's results using similar data is further proof that such data is unreliable for assessing quality of care.

REDACTED

(Chassin, Tr. 5182-84; Romano, Tr. 3217, *in camera*).

REDACTED

(Romano, Tr. 3219, *in camera* (*discussing* DX 7034A- at 5, *in camera*)).

Further, the tools with which Dr. Romano attempted to ascertain risk-adjusted mortality at HPH, AHRQ's quality indicators, were lacking validity as quality measures, are intended only to be a first-round screen of *potential* quality issues and, therefore, are not a definitive source of information about quality issues at HPH because they are based solely on administrative data created for billing purposes. (Chassin, Tr. 5251; RX 2010 at 19-22; RX 2007 at 26).

2103.

REDACTED (Romano, Tr. 3118, *in camera*).

Response to Finding No. 2103:

This proposed finding is not supported by the evidence. While this proposed finding might be true in another circumstance, here Respondent set forth substantial evidence of the benefits of improved access to academic activities involving residents and medical students at Evanston Hospital and how, for example, the integration of the clinical staffs provided HPH physicians the opportunity to upgrade their skills by becoming part of an academic enterprise that challenged them to teach residents, participate in more educational conferences and keep up with the latest developments in healthcare. (Chassin, Tr. 5373-74; Silver, Tr. 3818). The evidence showed that HPH physicians from, for example, Ob/Gyn, pathology, radiology, emergency medicine, cardiology, cardiac surgery and anesthesiology rotate through all three campuses. (Silver, Tr. 3765-66, 3819; RFF ¶ 2150). The upgrade in physician skills and the access to academic practice are structural changes that improved the quality of the HPH staff. (Chassin, Tr. 5377). As a result of the integration of the medical staffs and the academic focus that ENH brought to HPH, the quality of care improved at HPH. (Chassin, Tr. 5373).

(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*).

Response to Finding No. 2104:

This proposed finding is not supported by the evidence. The difference-in-differences approach that Dr. Romano employed in this case has severe limitations, particularly the way that Dr. Romano applied it. (Chassin, Tr. 5187). One of the most important limitations with Dr. Romano's use of this approach is that it fails to take trends into account because it is basically a before and after test. (Chassin, Tr. 5187-88). Breaking up the pre- and post-Merger periods into

two blocks is misleading because if you looked at the same data as a continuous trend, you would see a change in the positive direction. (Chassin, Tr. 5187-88).

A second limitation of the difference-in-differences analysis that Dr. Romano applied is the "close to zero problem." (Chassin, Tr. 5188-89). This problem arises when one hospital has a rate for some condition that is close to zero, for example 0.3%, and the control group hospital has a rate during the pre-Merger period of 1.0%. (Chassin, Tr. 5188-89). The control hospital can drop from 1.0% to 0.5%, a 50% drop, but the one hospital, which started at 0.3%, cannot drop below 0% and, as a result, will always look worse in comparison. (Chassin, Tr. 5188-89). This particular problem with the difference-in-differences approach is not limited to situations in which the rate for a condition is close to zero. (Chassin, Tr. 5188-89).

A third problem of Dr. Romano's approach is that it looks at absolute changes in hospitals. (Chassin, Tr. 5189). For example, Dr. Romano looked at absolute changes in percentage points for the control hospitals and how many percentage points the subject hospitals changed, without taking into account the relative magnitude of those percentage changes. (Chassin, Tr. 5189-90). A two percentage point change in the mortality of a control hospital might only be a 25% drop in its actual mortality, while the same two percentage point change in mortality for the subject hospital might, in fact, be as much as a 70% drop in its mortality. (Chassin, Tr. 5189-90). Thus, the relative change is a vital part of understanding the significance of these changes. (Chassin, Tr. 5190).

All of these problems identify situations in which the higher performing hospital can appear to look worse under a difference-in-differences analysis as compared to the control hospitals which are actually performing much worse. (Chassin, Tr. 5190).

REDACTED

REDACTED

(Romano, Tr. 6312, *in camera*).

REDACTED

REDACTED

(Romano, Tr. 3204-09, 6311-12, 6326, *in camera*).

REDACTED

(Romano, Tr. 3204-05, *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).

Response to Finding No. 2105(1)-(3):

Respondent has no specific response to the first sentence. The remainder of this proposed finding is misleading and not supported by the evidence. It is misleading because, for the reasons more fully discussed at RFF-Reply ¶¶ 2106-2107, 2093,

REDACTED (RX 2010 at 18-22; Chassin, Tr. 5582-83; Romano, Tr. 3093, 3211-12, 3216-34, 6369, *in camera* (*discussing* DX 7138 at 6)).

In addition, AHRQ represents that these quality indicators "must be used cautiously because the administrative data on which they are based *are not collected for research purposes or for measuring quality of care, but for billing purposes*." (RX 2004 at 20 (emphasis added)). AHRQ itself states that the mortality indicators, ("IQIs"), provide information to individual hospitals with which "further study" may, for example, uncover problems in data collection that can be remedied or "determine that additional *clinical* information is required to understand the quality issues, *beyond what can be obtained through billing data alone*." (RX 2004 at 20 (emphasis added)). Thus, the AHRQ indicators are not a definitive source of information about quality of care at ENH but, rather, were intended to be used only as first-round flag of *potential* quality problems that should be investigated by other methods, such as chart review. (RX 2007 at 26).

Further, for each of the mortality indicators mentioned in CCFF ¶ 2105(1)-(3), AHRQ has published information concerning known biases that can affect the link between the indicator and healthcare quality. (RX 2004 at 20). For example, for both the pneumonia mortality and stroke mortality indicators, concerns have been identified in the literature related to selection bias and confounding bias. (RX 2004 at 27). Selection bias results when a substantial percentage of

care for a condition is provided in an outpatient setting and, as a result, the subset of inpatient cases *may be unrepresentative*. (RX 2004 at 20 (emphasis added)). In addition, confounding bias is when patient characteristics may substantially affect performance on a measure and may vary systematically across areas. (RX 2004 at 20). The acute myocardial infarction indicator has identified concerns in the literature for information bias and confounding bias. (RX 2004 at 26). Information bias arises when quality indicators are based on information available in hospital discharge data sets, but some missing information may actually be important to evaluating the outcomes of hospital care. (RX 2004 at 20). In fact, there are concerns identified in the literature for known biases with respect to all of the mortality indicators that Dr. Romano relied on. (RX 2004 at 25-27).

The guidance documents for AHRQ's quality indicators for both complications (PSI) and mortality ("IQI"), to which Dr. Romano was a contributing author on the core project team, (RX 2010 at ii; RX 2004 at 6), identify several areas in which a particular indicator lacks validity for attempting to measure quality at the hospital, or provider-level. (RX 2004 at 67-69). For example, there are no studies that have examined the construct validity of in-hospital mortality from congestive heart failure. (RX 2004 at 67). Construct validity refers to whether the indicator performs well in identifying true (or actual) quality of care problems. (RX 2004 at 67). Although processes of care have been shown to decrease mortality on a patient level, the effect of care on provider-level (i.e., hospital level) mortality rates *are unknown*. (RX 2004 at 67 (emphasis added)). The AHRQ mortality indicators, however, are measured at the hospital or provider-level. (RX 2004 at 12).

In addition, the evidence showed that AHRQ's stroke mortality indicator may lack construct validity for identifying actual quality problems because only a small percentage of

patients are given thrombolytic drug therapy and, as a result, this treatment is likely to have only a modest impact on hospital mortality. (RX 2004 at 69). Further, as compared to other indicators, a higher percentage of the variation occurs at the provider level for both pneumonia and stroke mortality and, thus, some of the observed differences in provider performance *likely do not represent true differences*. (RX 2004 at 69, 75 (emphasis added)).

REDACTED

(Romano, Tr. 3087, 3093-96, 3204-05, 3215-17, 3458, *in camera*; Romano, Tr. 3244-45, 3373, 3411; RX 2004 at 20). An examination of data missing from hospital discharge data sets (i.e., administrative data) may help to improve indicator performance. (RX 2004 at 20). However, there is no evidence in the record that

REDACTED

(Romano, Tr. 3087, 3093-96, 3204-05, 3215-17, 3458, *in camera*; Romano, Tr., 3244-45, 3373, 3411,).

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).

Response to Finding No. 2106:

This finding is misleading and not supported by the evidence. To be clear, face, or consensual validity is not based upon an empirical data analysis. (RX 2010 at 10). In contrast,

construct validity refers to whether the indicator performs well in identifying true (or actual) quality problems and is based upon a review of the literature, clinician panels and empirical analyses. (RX 2010 at 10, 17). Construct validity for processes of care is thus a reflection of a particular indicator's validity with respect to processes and that particular outcome. (RX 2010 at 18). Dr. Romano agrees that consensual validity is generally a lower level of validity than validity based upon empirical studies. (Romano, Tr. 6342; RX 2007 at 467). Construct validity is one of the domains of validity that was subject to empirical analysis by AHRQ. (RX 2010 at 17-18).

For the reasons more fully discussed at RFF-Reply ¶ 2107, decubitis ulcers, failure to rescue, and selected infections due to medical care are lacking in construct validity for processes of care. (Chassin, Tr. 5251; RX 2010 at 18-20; Romano, Tr. 6369 (*discussing* DX 7138 at 6)). For an outcome measure to be valid, it must have a proven relationship to processes of care that can be modified to affect that outcome. (Chassin, Tr. 5148; RFF ¶¶ 1190, 2107).

REDACTED (Romano, Tr. 6369, *in camera* (*discussing* DX 7138 at 6); RX 2010 at 18-22). A zero means that there is no published evidence regarding that domain of validity. (RX 2010 at 18; RFF-Reply ¶ 2107). Thus, the indicators that Dr. Romano used, because they lack published evidence of construct validity for processes of care, and because they are based on flawed administrative data, cannot be used as proof of quality problems. (RX 2010 at 18-20; Chassin, Tr. 5251; Romano, Tr. 3204-05; *see also* RFF ¶¶ 2223, 2246-47).

AHRQ's own guide to the patient safety indicators, explicitly states that birth trauma, selected infections, decubitis ulcers, and failure to rescue all receive a zero for construct validity

related to processes of care, which means that there is no published evidence regarding this domain of validity. (RX 2010 at 18-20; Romano, Tr. 6369 (*discussing* DX 7138 at 6)). In addition, the indicators for birth trauma and decubitis ulcers receive a "-" for coding validity, which means there is published evidence that the indicator, in fact, lacks validity for this domain of validity. (RX 2010 at 18-19). Coding reflects how accurately the information about that complication was captured on a discharge abstract or Medicare claim. (RX 2010 at 18). Only one of the five AHRQ indicators in this finding (post-operative hip fracture) has any evidence of validity related to processes of care, but such validity is limited. (RX 2010 at 18-20).

(Romano, Tr. 3235, *in camera*).

REDACTED

(Romano, Tr. 6369, *in camera* (*discussing* DX 7138 at 6); RX 2010 at 18-22). A zero means that there is no published evidence regarding that domain of validity. (RX 2010 at 18; RFF-Reply ¶ 2107).

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.

Response to Finding No. 2107:

This finding is inaccurate, misleading and not supported by the substantial evidence on this issue. As is more fully discussed at RFF-Reply ¶ 2122, for an outcome measure to be valid it must have a proven relationship to processes or structures that can be modified so that the outcome is affected. (Chassin, Tr. 5148; RFF ¶ 1190).

REDACTED

(Romano, Tr. 3232-33, *in camera*). However, for three out of the four

AHRQ indicators that Dr. Romano used to assess nursing services at HPH and ENH, there is no published evidence of validity regarding these indicators and, further, for some there is evidence that the indicator actually lacks validity. (Chassin, Tr. 5251; RX 2010 at 18-20). In addition, the AHRQ indicator for birth trauma also has no published evidence regarding construct validity for processes of care. (RX 2010 at 21). In addition, the six separate AHRQ indicators for the various forms of obstetric trauma (e.g., vaginal delivery with instrument, vaginal delivery without instrument, obstetric trauma with third degree with instrument, obstetric trauma with third degree vaginal delivery without instrument, obstetric trauma Cesarean delivery, and obstetric trauma with third degree Cesarean delivery), all had no published evidence of construct validity for processes of care. (RX 2010 at 21-22). There are at least nine additional indicators for complications for which there is no published evidence of construct validity for either implicit or explicit processes of care – including, for example, post-operative wound dehiscence, transfusion reaction, post-operative sepsis, foreign body left during procedure; iatrogenic pneumothorax, and others. (RX 2010 at 18-22).

REDACTED

(Romano, Tr. 6369, *in camera* (*discussing* DX 7138 at 6); RX 2010 at 18-22). A zero rating means that there is no published evidence regarding that domain of validity. (RX 2010 at 18).

REDACTED

(Romano, Tr. 3235, *in camera*; RX 2010 at 18-20).

For the reasons more fully discussed at RFF-Reply 2105(1)-(3), there are identified biases for each of the mortality indicators (i.e., IQIs) that Dr. Romano relied on as well. (RX 2004 at 16-18).

REDACTED

(Romano, Tr. 3087, 3093-96, 3204-05, 3215-17, 3244-45, 3458, *in camera*; Romano, Tr. 3373, 3411; RFF-Reply ¶ 2105).

REDACTED

(Romano, Tr. 6369, *in camera* (*discussing* DX 7138 at 6); RX 2010 at 18-22; Chassin, Tr. 5251). Many additional AHRQ indicators for complications are also lacking in construct validity for processes of care and, thus, there is ample evidence identifying which of the AHRQ indicators lack validity as well as the reasons that they are invalid. (RX 2010 at 18-22; RFF-Reply ¶ 2107).

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).

Response to Finding No. 2108:

Respondent has no specific response.

2109. **REDACTED**
(Romano, Tr. 6314-15, *in camera*).

Response to Finding No. 2109:

Respondent has no specific response.

2110.

REDACTED

1.

REDACTED

(Romano, Tr. 6315-16 (discussing DX 7135 at 1, *in camera*), *in camera*).

Response to Finding No. 2110(1):

This proposed finding is misleading and omits additional evidence on the issue. The evidence showed that the JCAHO measure for heart attack mortality, which is the measure more likely to reflect reality because it employs the more typical risk-adjustment process, logistic regression, was headed in the opposite direction as the AHRQ measure, and showed evidence of a benefit at HPH. (Chassin, Tr. 5182-84; Romano, Tr. 3217). The JCAHO method of risk-adjustment is the more typical kind of risk-adjustment method employed in the field of health services and clinical research. (Chassin, Tr. 5183-84). The AHRQ indicators relied on by Dr. Romano are based on a much more crude means of risk-adjustment. Accordingly, the JCAHO measure is a better reflection of reality than the AHRQ measure. (Chassin, Tr. 5184). Fourteen of the eighteen indicators that Dr. Romano relied on were AHRQ indicators. (Romano, Tr. 3093, 3211-12, 3216-34; RFF ¶ 2247).

2.

REDACTED

(Romano, Tr. 6317-18 (discussing DX 7135 at 2, *in camera*), *in camera*).

Response to Finding No. 2110(2):

This proposed finding is misleading and omits additional evidence on the issue. For the reasons more fully stated in RFF-Reply ¶ 2110(1), the AHRQ indicators did not reflect reality as well as the JCAHO measures, due to differences in the risk-adjustment models employed by AHRQ and JCAHO. (Chassin, Tr. 5183-84). In addition, Dr. Romano also found evidence of statistically significant improvement using the JCAHO indicator for obstetric trauma. (Romano, Tr. 3397; RFF ¶ 1332).

2111. **REDACTED** (Romano, Tr. 3206, *in camera*).

Response to Finding No. 2111:

This proposed finding mischaracterizes the evidence. For example, this proposed finding omits evidence that administrative data are mostly intended for billing purposes and reporting to regulatory agencies. (Chassin, Tr. 5172-73; RFF ¶ 2222). Further, there are no valid quality measures that can be constructed from administrative data in this case. (Chassin, Tr. 5175; RFF ¶ 2224).

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).

Response to Finding No. 2112

This proposed finding is inaccurate, misleading and mischaracterizes the evidence.

REDACTED

(Chassin, Tr. 5175; RFF ¶ 2224, *in camera*). In addition,

REDACTED (Romano, Tr. 3207-08, *in camera*; Romano, Tr. 3256-57; Chassin, Tr. 5175-82; RFF ¶ 2224, *in camera*). Administrative data lacks sufficient clinical detail, contains few valid measures of structure or process, and fails to account for the difference between co-morbid conditions that patients have before they come to a hospital and complications suffered after they begin to receive care. (Romano, Tr. 3257-58; Chassin, Tr. 5176-77; RFF ¶¶ 2225, 2229-2236). As a result, administrative data are often poorly risk-adjusted. (Romano, Tr. 3259-65, 3272-74; Chassin, Tr. 5177-79; RFF ¶ 2236). In fact, AHRQ's indicators that Dr. Romano relied on were intended for use as a screening tool, to serve as a "first-round flag of potential quality problems, which should be investigated further by other methods, such as chart review." (RX 2007 at 26; RFF ¶ 2246). AHRQ itself acknowledges the problems associated with its indicators, all of which are created solely from administrative data. (Chassin, Tr. 5179). Another limitation of Dr. Romano's reliance on administrative data is that one cannot reliably make judgments about an individual hospital's quality, as Dr. Romano has done in this case, by looking at the particular characteristics of patients admitted to individual hospitals based on administrative data. (Chassin, Tr. 5179; RFF ¶ 2239).

In addition, Dr. Chassin did not rely solely on information obtained through interviews but, rather, he actively sought corroborating information from numerous additional sources, including qualitative as well as quantitative data available through clinical registries such as STS and NRMI. (Chassin, Tr. 5159, 5198, 5269, 5329-30, 5595-97, RX 2043; RX 208 at ENHL PK 17285; RFF ¶¶ 1199, 1210, 1255). The methods used by Dr. Chassin to conduct his assessment in the changes in quality at HPH after the Merger were entirely consistent with the methods used

by Dr. Chassin when he was Commissioner of Health in the State of New York. (Chassin, Tr. 5190-91).

Difference in Differences and Risk Adjustment

2113.

REDACTED

(Romano, Tr. 3203-05, *in camera*).

Response to Finding No. 2113:

This proposed finding is inaccurate. For the reasons more fully discussed at RFF-Reply ¶ 2104, the evidence showed that Dr. Romano's reliance on and particular application of the difference in differences approach suffered from severe limitations that resulted in the higher performing hospital appearing to look worse under a difference in differences analysis as compared with the control hospitals. (Chassin, Tr. 5187-91; RFF ¶ 2104). In addition, the difference in differences analysis is further limited by the fact that it is based on flawed administrative data, which lack the clinical detail available from other data sources. (Romano, Tr. 3204-05).

2114. **REDACTED**

(Romano, Tr. 3204, *in camera*).

Response to Finding No. 2114:

Respondent has no specific response.

2115.

REDACTED

(Romano, Tr. 3204-05, *in camera*).

Response to Finding No. 2115:

Respondent has no specific response.

2116.

REDACTED

, (Romano, Tr. 3205-07, *in camera*).

Response to Finding No. 2116:

Respondent does not dispute the first sentence. The remainder of this proposed finding is misleading and not supported by the evidence. There are three important deficiencies in using administrative data for risk adjustment. (Chassin, Tr. 5176-77). The evidence showed that the coding of administrative data are unreliable because they suffer from variation and inaccuracy in coding among different hospitals. (Chassin, Tr. 5177). Therefore, even when clinical information is present, one cannot rely on it to be accurately coded. (Chassin, Tr. 5177; Romano, Tr. 3264-65, 3272-74). The fact that administrative data are unreliably coded may lead to erroneous estimates associated with co-morbid disease and bias risk-adjusted models used to compare outcomes. (Romano, Tr. 3259). In fact, Dr. Romano agreed that roughly half of post-operative complications go unreported in administrative data because of poor documentation, errors, or restrictive coding practices. (Romano, Tr. 3264). Dr. Romano never conducted an analysis of the differences in coding practices between Evanston Hospital and HPH pre-Merger. (Romano, Tr. 3266-67).

2117.

REDACTED

(Romano, Tr. 3208-09, *in camera*).

Response to Finding No. 2117:

This proposed finding is misleading and not supported by the evidence. The evidence showed that there are three important deficiencies in using administrative data for risk-adjustment including: variations in coding; lack of clinical detail; and inability to distinguish complications from co-morbid (i.e., pre-existing conditions). (RFF ¶¶ 2228-2238). The key failing of administrative data is that the data does not account for any difference in many complications that occur before and after admission. (Chassin, Tr. 5177). Proper risk-adjustment always avoids including complications that occur after admission. (Chassin, Tr. 5177). Therefore, administrative data cannot be accurately risk-adjusted to measure real changes in quality. (Chassin, Tr. 5177-78; Romano, Tr. 3273).

2118. **REDACTED**

(Romano, Tr. 3209, *in camera*).

Response to Finding No. 2118:

This proposed finding is not supported by the evidence. There are variations in coding practices across hospitals and the evidence showed that such variations may bias risk-adjusted models used to compare outcomes. (Romano, Tr. 3259, 3265). Significantly, Dr. Romano never conducted an analysis of the differences in coding practices between Evanston Hospital and HPH pre-Merger. (Romano, Tr. 3266-67).

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).

Response to Finding No. 2119:

This proposed finding is misleading and not supported by the evidence. Dr. Chassin's testimony was that Dr. Romano, in applying the difference-in-differences approach to compare the subject hospitals to control hospitals, did not look at a continuous trend of data across the pre- and post-Merger periods. (Chassin, Tr. 5187-89; RFF ¶ 2104).

REDACTED (Romano, Tr. 6312, *in camera*).

2120.

REDACTED

(Romano, Tr. 6311-12, *in camera*).

REDACTED (Romano, Tr. 6312, *in camera*).

Response to Finding No. 2120:

This proposed finding is misleading and not supported by the evidence for the reasons more fully discussed at RFF-Reply ¶ 2104.

REDACTED

(Romano, Tr. 6311-12, *in camera*).

2121.

(Romano, Tr. 6326, *in camera*). **REDACTED**

REDACTED (Romano, Tr. 6328, *in camera*).

Response to Finding No. 2121:

This proposed finding is not supported by the evidence. For the reasons more fully discussed at RFF-Reply ¶ 2104, Dr. Romano's use of absolute differences in the difference-in-differences model can understate the relative changes in the subject hospitals for a given condition in comparison to the control hospitals. (Chassin, Tr. 5187-90; RFF-Reply ¶ 2104).

(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).

Response to Finding No. 2122:

This finding is misleading and misstates the evidence. As fully discussed at RFF-Reply ¶¶ 2128-2132, there are weaknesses associated with outcome measures that can limit their usefulness in assessing healthcare quality. Moreover, this finding exaggerates the importance of outcome measures. (Chassin, Tr. 5152-53, 5145; Romano, Tr. 3253; RFF ¶¶ 1175-1181).

REDACTED

(Chassin, Tr. 5582-83; Romano, Tr. 3244, 3255-56; Romano Tr. 3093, 3211-12, 3216-34, 3127-28, *in camera*; RX 2004 at 29; RFF ¶¶ 2219, 2221, 2223, 2245, 2247; RFF-Reply ¶¶ 2045, 2053). For an outcome to be a valid measure of quality, it must have a proven relationship to processes or structures that can be modified so that the outcome is affected. (Chassin, Tr. 5148; RFF ¶ 1190).

REDACTED

(Romano, Tr. 3232-33, *in camera*). However, for three out of the four AHRQ indicators that Dr. Romano used to assess nursing services at HPH and ENH, there is no published evidence of validity regarding these indicators and, further, for some there is evidence that the indicator actually lacks validity. (Chassin, Tr. 5251; RX 2010 at 18-20).

REDACTED

REDACTED

(Romano, Tr. 3235, *in camera*).

2123. Respondent did not show that there was a significant improvement in outcomes after the merger. (Romano, Tr. 3008, 2991-92, 2996).

Response to Finding No. 2123:

This proposed finding is misleading, inaccurate and misstates the evidence. Respondent has, in fact, set forth substantial evidence of improvements in outcomes following the Merger including, but not limited to, improvements in mortality for isolated CABG at HPH; improvements in mortality for PCI at HPH; improvements in major cardiac surgery complications for ENH as a whole; improvements in ENH's patient safety index; and improvements in ENH's risk-adjusted mortality rate overall. (RX 2032 at 5-7; CX 1947; Romano, Tr. 3405; Rosengart, Tr. 4502-05; RFF ¶¶ 1643, 2191). For additional discussion of this evidence of improvements in outcomes after the Merger, see RFF-Reply ¶¶ 2032-2034.

REDACTED

(Chassin, Tr. 5582-83; Romano, Tr. 3244, 3255-56; Romano, Tr. 3093, 3211-12, 3216-34, 3127-28, *in camera*; RX 2004 at 29; RFF ¶¶ 2219, 2221, 2223, 2245, 2247; RFF-Reply ¶¶ 2045, 2053).

2124. In the quality of care field, terms that are used include "outcome measures," "structural measures," and "process measures." (Romano, Tr. 2986).

Response to Finding No. 2124:

This proposed finding misstates the evidence. Structure, process, and outcome measures are not merely terms but, rather, they are components of the generally accepted definition of

quality of care. Experts in the field of healthcare quality assessment investigate structure, process and outcomes as the three different classes of quality measures to determine if there has been a quality improvement. (Chassin, Tr. 5144-45; Romano, Tr. 3251; RFF ¶ 1171).

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).

Response to Finding No. 2125:

Respondent has no specific response.

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).

Response to Finding No. 2126:

Respondent does not dispute the first sentence of this proposed finding. The remainder of this proposed finding is misleading and ignores the record evidence. For example, Dr. Romano agreed that the expansion of obstetrician coverage to include nighttime coverage, even in the absence of outcome data, is a structural change that was also a quality improvement. (Romano, Tr. 3251-52). Some of the most important dimensions of a hospital's capacity to provide high-quality care consist of structural measures including, but not limited to, the specific training and the expertise of the professionals put in place to deliver the processes of care, as well as medical equipment used in laboratory or radiology services. (Romano, Tr. 2986-87, 3251; Chassin, Tr. 5145; RFF ¶ 1172).

2127. Dr. Chassin admits that structural changes are "very remote from the actual outcomes that we like to see delivered." (Chassin, Tr. 5152).

Response to Finding No. 2127:

This proposed finding is inaccurate and misleading. Dr. Chassin's testimony was that structural measures (not "structural changes," as this proposed finding states), like all quality measures, have both strengths and weaknesses. (Chassin, Tr. 5152; RFF ¶ 1175). Complaint Counsel has omitted findings that discuss the weaknesses of the other classes of quality measures including, for example, outcome measures. Respondent, in contrast, candidly cited evidence in its initial findings discussing the strengths and limitations of all three categories of quality measures. (Chassin, Tr. 5152-53; RFF ¶¶ 1175-1180). In addition, Dr. Romano concedes that structural changes – even in the absence of outcome data – constitute a quality improvement. (Romano, Tr. 3251-52). Further, the absence of certain structural dimensions of quality, such as the absence of in-house obstetrician coverage, creates the risk of adverse outcomes which is, by definition, a quality problem. (Chassin, Tr. 5586; RFF ¶ 1291).

2128.

REDACTED

(Romano, Tr. 6333-34, *in camera*).

Response to Finding No. 2128:

This proposed finding is misleading. Specifically, in its accreditation process, JCAHO considers and rates a hospital on approximately 1,200 explicit aspects of hospital activities, which are called elements of performance. (Chassin, Tr. 5157; RFF ¶ 1186). Three-quarters of the elements are structural, and the remaining quarter involves process measures. (Chassin, Tr. 5157; CCFF ¶ 2300).

REDACTED

(Romano, Tr. 6333-34).

REDACTED (Romano,

Tr. 6337, *in camera*).

REDACTED

(Romano, Tr. 6335-36, *in camera*;

Chassin, Tr. 5157).

REDACTED

(Chassin, Tr. 5157; Romano, Tr. 6337, *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).

Response to Finding No. 2129:

Respondent does not dispute the accuracy of the cited evidence. Respondent adds, however, that both Drs. Chassin and Romano relied on the Institute of Medicine's ("IOM") definition of quality of care – that quality in healthcare is defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with the state of current professional knowledge. (Chassin, Tr. 5141; Romano, Tr. 3250-51; RFF ¶¶ 1165, 1167). This definition is generally accepted by experts as the most authoritative definition of quality and, further, was specifically accepted as the definition of healthcare quality by the experts for both parties in this case. (Chassin, Tr. 5143; Romano, Tr. 3250-51). Before the IOM came up with this definition, there was no other classification that was as widely accepted as authoritative in the study of the quality of medical care. (Chassin, Tr. 5142-43). The IOM definition is thus the relevant definition of quality of care in this case because it is the one relied on by both parties' quality experts. (Chassin, Tr. 5143; Romano, Tr. 3250-51).

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).

Response to Finding No. 2130:

This proposed finding is misleading. That patients care about their outcomes is not in dispute. However, good quality of care cannot just be about good outcomes because despite the best medical care, bad outcomes frequently happen to patients. (Chassin, Tr. 5144). Similarly, good outcomes may occur despite poor quality care, as patients are often resilient to mistakes or errors made by providers. (Chassin, Tr. 5144). The definition of healthcare quality reflects the balance that must be made when evaluating quality of healthcare; that is, whether the structure, process, or other means of delivering care is likely to increase the probability of good outcomes. (Chassin, Tr. 5144; RFF ¶ 1170). And if the outcome cannot be affected by a change in process or structure, then it is not a measure of quality of care because there is nothing that can be done to make the outcome better. (Chassin, Tr. 5148; RFF ¶ 1190).

REDACTED

(Romano, Tr. 3235, *in camera* (emphasis added);

Chassin, Tr. 5597; RFF ¶ 1180).

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).

Response to Finding No. 2131:

This proposed finding is misleading and inaccurate with respect to the NRMI data. NRMI data contain four highly valid process measures of care related to the care of heart attack

patients. (Chassin, Tr. 5264, 5267-68, 5279; RFF ¶ 1484). Further, for the reasons more fully discussed in RFF-Reply ¶¶ 2128-2130, this finding exaggerates the importance of outcomes by completely ignoring the process measures that ENH monitors (e.g., the four NRMI process measures of heart attack care) as well as the close to 1,200 structure and process measures that are required for JCAHO's hospital accreditation process. (Chassin, Tr. 5264, 5267-68, 5279; Chassin, Tr. 5157; Romano, Tr. 6337; RFF ¶¶ 1186, 1484).

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).

Response to Finding No. 2132:

Respondent does not dispute the first sentence of this proposed finding. The second sentence, however, is misleading and not supported by the evidence. As discussed more fully at RFF-Reply ¶ 2093, Dr. Chassin did not examine neonatal mortality because he did not find risk-adjusted data that would have allowed him to track quality in a meaningful way pre- and post-Merger. (Chassin, Tr. 5596; RFF ¶ 1337; RFF-Reply ¶ 2093). Even if risk-adjusted data on neonatal mortality were available, that outcome would be very rare in the low-risk obstetric services provided by HPH. (Chassin, Tr. 5597; RFF ¶ 1180). Accordingly, it would be questionable whether one could make meaningful comparisons on this outcome pre- and post-Merger. (Chassin, Tr. 5597; RFF ¶ 1180).

REDACTED

(Romano, Tr. 3395-96; Chassin, Tr. 5417, *in camera*, RFF ¶¶ 1334-1336; RFF-Reply ¶ 2045).

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).

Response to Finding No. 2133:

This proposed finding is inaccurate and misstates the nature of Press Ganey, Associates, Inc. ("Press Ganey") Data. First, Press Ganey surveys patients on numerous areas having nothing to do with clinical quality; so-called amenities such as custodial courtesy and the cleanliness of the room. (Romano, Tr. 3339-40; Neaman, Tr. 1365-66; RFF ¶ 2249). Second, Press Ganey's survey methods are poor and its response rate is extremely low. (RFF ¶¶ 2249, 2256-68). Finally, the referenced glossary, by its terms, was submitted to the Court as a reference only and not as an admission by either party.

2134. **REDACTED** (Romano, Tr. 3098, 3109-10, 3116-17, 3127, 3136-38, *in camera*).

Response to Finding No. 2134:

This proposed finding is inaccurate. None of the patient satisfaction data that Dr. Romano relied on – either the Press Ganey data or the Rhea & Kaiser marketing survey – contains reliable information from which valid conclusions on patient satisfaction can be drawn about any areas of care at ENH. (Chassin, Tr. 5243, 5249-51; RFF ¶¶ 2248, 2251, 2254-2255). Dr. Chassin did not conduct an assessment of patient satisfaction because there were no reliable data available from which to draw conclusions about this issue. (Chassin, Tr. 5243, 5249; RFF ¶

2252). Press Ganey's response rates – about 20% – are too low to draw any valid conclusions. (Chassin, Tr. 5244; RFF ¶ 2257). Dr. Romano conceded that the low response rate of 20% was suboptimal because it increased the possibility of bias in the survey results. (Romano, Tr. 3346; RFF ¶ 2258). In addition, Press Ganey suffers from other methodological weaknesses such as a ceiling effect, which limits the possibility of higher responses, and the use of mean scores. (Chassin, Tr. 5245-46; RFF ¶ 2262, 2264). For these reasons, Press Ganey data could not be used to assess patient satisfaction to compare the changes in quality of care at HPH during the pre-Merger to the post-Merger period. (Chassin, Tr. 5246-47; RFF ¶ 2266).

2135. **REDACTED** (Romano, Tr. 3098, 3109-10, 3116-17, 3127, 3136-38, *in camera*).

Response to Finding No. 2135:

This proposed finding misstates the evidence and is misleading. For the reasons stated in RFF-Reply ¶¶ 2133-2134, Dr. Romano did not rely on any reliable patient satisfaction data from which meaningful conclusions can be drawn. (Chassin, Tr. 5243, 5249-51; RFF ¶¶ 2248, 2251, 2254-2255; RFF-Reply ¶ 2134).

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).

Response to Finding No. 2136:

This proposed finding is misleading and inaccurate for the reasons more fully set forth in RFF-Reply ¶¶ 2133-2135. In addition, Press Ganey data could not be used to assess patient satisfaction to compare the changes in quality of care at HPH during the pre-Merger to the post-Merger period. (Chassin, Tr. 5246-47; RFF ¶ 2266).

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 benefited Highland Park Hospital, and 19% felt that the merger actually hurt Highland Park Hospital. (Romano, Tr. 3423).

Response to Finding No. 2137:

This proposed finding is misleading and misstates the evidence on this issue. Dr. Romano conceded that the Rhea & Kaiser marketing survey should be used cautiously because it is based on a small sample size. (Romano, Tr. 3361; RFF ¶ 2269). Further, the actual survey methods were not described in the Rhea & Kaiser survey summary, including how patients were selected and their responses obtained. (Chassin, Tr. 5250; RX 2031 at ENH DL 6550; RFF ¶ 2270). The proportion of patients who answered questions about their impressions of improvement in specific services was very small including, for example, only 26 patients using HPH's oncology services and 24 patients using HPH's maternity service. (Chassin, Tr. 5250; Romano, Tr. 3361; RX 2031 at ENH DL 6566; RFF ¶ 2270). Moreover, those patients who responded to the questions were surveyed up to two years after their episodes of care; patient satisfaction literature has established that patients' impressions of their care experience must be taken within a few weeks of that experience to ensure accuracy. (RFF ¶ 2271). Because of these methodological weaknesses, the Rhea & Kaiser marketing survey is not a valid measure of patient satisfaction at ENH. (Chassin, Tr. 5249; RFF ¶ 2254).

(a) Patient Satisfaction with Nursing Services Declined at Highland Park and Evanston Hospitals After the Merger

2138.

REDACTED (Romano, Tr. 3136-37 (discussing DX 441 at 70, *in camera*), *in camera*).

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**
(RX 1326 at ENHE JG 015731, *in camera).*

Response to Finding No. 2138:

This proposed finding is inaccurate and misleading for the reasons more fully set forth in RFF-Reply ¶¶ 2133-2137. For the reasons more fully discussed at RFF-Reply ¶¶ 2133-2137, Dr. Romano did not rely on any valid or reliable measures of patient satisfaction and, thus, could not draw conclusions about the effect of the Merger on patient satisfaction with nursing services. (Chassin, Tr. 5251; RFF ¶ 2276).

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).

Response to Finding No. 2139:

This proposed finding mischaracterizes the cited evidence. Dr. Chassin found no reliable data with which to analyze patient satisfaction with nursing care or any other domain of care at ENH and, thus, he did not rely on Press Ganey or the Rhea & Kaiser marketing survey as a source of information about patient satisfaction. (Chassin, Tr. 5251; RFF ¶ 2276).

(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*).

Response to Finding No. 2140:

For the reasons more fully set forth in RFF-Reply ¶¶ 2133-37, this proposed finding is misleading, inaccurate and not supported by the evidence. In addition to the methodological weaknesses associated with Press Ganey data, the available patient satisfaction data for oncology services are also not valid because they included only inpatient services, thus completely omitting the experiences of oncology patients who use HPH's oncology services on an outpatient basis. (Romano, Tr. 3366-67; Chassin, Tr. 5373; RFF ¶ 2275). Further, the vast majority of cancer care today is handled on an outpatient basis, so the number of patients at HPH who would be hospitalized for cancer care is very, very small. (Chassin, Tr. 5373).

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**

REDACTED (Romano, Tr. 3103 (discussing DX 441 at 105, *in camera*), *in camera*).

4.

REDACTED

(Romano, Tr. 3104, *in camera*).

Response to Finding 2141(1)-(4):

For the reasons more fully set forth in RFF-Reply ¶¶ 2133-2137, this proposed finding is misleading, inaccurate and not supported by the evidence. In addition to the methodological weaknesses associated with Press Ganey data, the available patient satisfaction data for oncology services are also not valid because they included only inpatient services, thus completely omitting the experiences of oncology patients who use HPH's oncology services on an outpatient basis. (Romano, Tr. 3366-67; Chassin, Tr. 5373; RFF ¶ 2275; RFF-Reply 2240).

2142.

REDACTED

(Romano, Tr. 3104-05, *in camera*; CX 6300).

Response to Finding No. 2142:

This proposed finding is misleading. This proposed finding omits the fact that the Rhea & Kaiser marketing survey contained responses for only 26 patients using HPH's oncology services. (Chassin, Tr. 5250; Romano, Tr. 3361; RX 2031 at ENH DL 6566; RFF ¶ 2270). There was no valid data from which to draw valid conclusions about patient satisfaction with oncology services at HPH after the Merger. (Chassin, Tr. 5373; RFF ¶ 2277).

(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

REDACTED (Romano, Tr. 3127 (describing DX 441 at 1-50 ( ), *in camera*), *in camera*). REDACTED

Response to Finding No. 2143:

This proposed finding misstates the evidence and is misleading. For the reasons stated in RFF-Reply ¶¶ 2133-2134, Dr. Romano did not rely on any reliable patient satisfaction data from which meaningful conclusions can be drawn. (Chassin, Tr. 5243, 5249-51; RFF ¶¶ 2248, 2251, 2254-2255; RFF-Reply ¶ 2134).

(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*).

Response to Finding No. 2144:

This proposed finding is misleading and mischaracterizes the evidence. First, Dr. Romano examined Press Ganey data for inpatient use of HPH's emergency services, thus omitting important information for HPH's outpatient services. (Romano, Tr. 3365-66; Chassin, Tr. 5372-73; RFF ¶ 2272). Because approximately 80% of the patients who use HPH's emergency room are treated on an outpatient basis, Dr. Romano's analysis of patient satisfaction with emergency services at HPH failed to take into account the experiences of the vast majority of patients who utilized HPH's ED. (Romano, Tr. 3365; Harris, Tr. 4213; RFF ¶ 2273).

Second, the inpatient Press Ganey data relied on by Dr. Romano pertaining to emergency services was limited to only a single quarter's worth of data post-Merger. (Romano, Tr. 3365;

RFF ¶ 2274). Dr. Romano agreed that more data would be required before reaching conclusions on patient satisfaction with emergency services. (Romano, Tr. 3364-65; RFF ¶ 2274).

2145.

REDACTED

(Romano, Tr. 3116-17 (discussing DX 441 at 107, *in camera*), *in camera*).

Response to Finding No. 2145:

This proposed finding misstates the evidence and is misleading. For the reasons stated in RFF-Reply ¶¶ 2133-2137, Dr. Romano did not rely on any reliable patient satisfaction data from which meaningful conclusions can be drawn. (Chassin, Tr. 5243, 5249-51; RFF ¶¶ 2248, 2251, 2254-2255; RFF-Reply ¶ 2134).

(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*).

Response to Finding No. 2146:

This proposed finding is misleading. ENH monitors patient satisfaction data, in part, because JCAHO requires them to do so. (Neaman, Tr. 1366; RFF ¶2250). Although it is important for hospitals to have a general understanding of how patients perceive the hospital's service, patient satisfaction surveys do not reflect real clinical care or clinical outcomes. (Neaman, Tr. 1366). Press Ganey does not provide reliable data with respect to patient satisfaction because of the survey's methodological weaknesses, which is one reason that Dr. Chassin does not employ Press Ganey data at Mount Sinai Hospital, where the Survey Research Center reports to him. (Chassin, Tr. 5244-45; RFF ¶ 2252).

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).

Response to Finding No. 2147:

This proposed finding is misleading. For the reasons more fully discussed in RFF-Reply ¶¶ 2146-2147, ENH surveys its patients' satisfaction because the Joint Commission requires hospitals to take such action. (Neaman, Tr. 1366). In addition, JCAHO scores are important because they are basically a requirement for receiving Medicare payments. (Neaman, Tr. 1366-67).

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*).

Response to Finding No. 2148:

This proposed finding is misleading. For the reasons more fully discussed in RFF-Reply ¶ 2147, ENH surveys its patients on patient satisfaction, in part, because the Joint Commission requires hospitals to take such action. (Neaman, Tr. 1366). Press Ganey data reflects patients' perceptions of their care; it does not reflect real clinical care or outcomes. (Neaman, Tr. 1366; RFF ¶ 2250). Further, the record evidence stands undisputed that the Press Ganey instrument is a methodologically weak and suboptimal means of assessing patient satisfaction because, for example, its response rates are too low to draw valid conclusions. (Chassin, Tr. 5245-47; Romano, Tr. 3347; RFF ¶ 2258).

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).

Response to Finding No. 2149:

This proposed finding is misleading, inaccurate and misstates the evidence. This proposed finding omits additional data sources on which Dr. Chassin relied and, further, exaggerates Dr. Chassin's reliance on interviews with informants. The evidence established that Dr. Chassin relied on a variety of sources to obtain information about quality of care at HPH before and after the Merger, including an analysis of contemporaneous documents, clinical reviews by external bodies, two site visits, and a review of clinical and other objective data concerning quality of care. (Chassin, Tr. 5159, 5164, 5192-93; RFF ¶¶ 1199, 1239). Further, Dr. Chassin relied on a multitude of sources and looked for consistency among the sources in the course of his quality assessment. (Chassin, Tr. 5165; RFF ¶ 1208).

REDACTED

(Chassin, Tr. 5159, 5265-67, 5270, 5279-82 (*discussing* DX 8079), 5282; RX 2043; RX 1985, *in camera*; Chassin, Tr. 5294; RX 1400 at ENHL PK 54798-806, *in camera*; RFF ¶¶ 1489-1504; RFF-Reply ¶¶ 2033-2035).