

FEDERAL TRADE COMMISSION DECISIONS

Findings, Opinions and Orders

IN THE MATTER OF

AMERICAN MEDICAL INTERNATIONAL, INC., ET AL.

FINAL ORDER, OPINION, ETC. IN REGARD TO ALLEGED VIOLATION OF SEC. 5 OF THE FEDERAL TRADE COMMISSION ACT AND SEC. 7 OF THE CLAYTON ACT

Docket 9158. Complaint, July 30, 1981—Final Order, July 2, 1984

This final order requires a Beverly Hills operator of the nation's third largest chain of proprietary hospitals, among other things, to divest French Hospital in San Luis Obispo, California, to a Commission-approved buyer within twelve months from the effective date of the order. The purpose of the divestiture is to reestablish the facility as a viable competitor in San Luis Obispo County, and respondent is required to take all measures necessary to prevent any deterioration of the hospital's present operating abilities or market value, pending divestiture. The order further requires the company to provide the Commission, for a period of ten years, with advance notification of its intention to acquire any hospital located in the states specified in the order.

Appearances

For the Commission: *L. Barry Costilo, Peter M. Kazon, Sharon Eubanks, Oscar M. Voss, and Judith A. Moreland.*

For the respondent: *William T. Coleman, Jr., Richard C. Warmer, Richard G. Parker, Christopher W. Savage, and Mark D. Plevin, O'Melveny & Myers, Washington, D.C.*

COMPLAINT

The Federal Trade Commission having reason to believe that American Medical International, Inc., and its wholly-owned subsidiary corporation hereinafter also named as respondent, corporations subject to the jurisdiction of the Commission, have acquired the stock or assets of the hospital hereinafter described, in violation of Section 7 of the Clayton Act, as amended (15 U.S.C. 18), and having further reason to believe that respondents have engaged in unfair methods of competition in violation of Section 5 of the Federal Trade Commission

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Act, as amended (15 U.S.C. 45), and that a proceeding in respect thereof is in the public interest, hereby issues its complaint pursuant to the provisions of Section 11 of the aforesaid Clayton Act as amended (15 U.S.C. 21), and Section 5(b) of the Federal Trade Commission Act, as amended (15 U.S.C. 45(b)), stating its charges as follows:

Respondents

1. Respondent American Medical International, Inc., hereinafter "AMI," is a corporation organized and existing under the laws of the State of Delaware, with its principal executive offices at 414 North Camden Drive, Beverly Hills, California.

2. AMI is primarily engaged in the operation and management of proprietary hospitals in the United States and in foreign countries. In AMI's fiscal year 1980, it had total revenues of approximately \$661 million. It owns approximately 64 hospitals in the United States and abroad. It is the third largest proprietary hospital chain in the United States. [2]

3. Respondent AMISUB (French Hospital), hereinafter "AMISUB French," is a wholly-owned subsidiary corporation of AMI, organized and doing business under the laws of the State of California, with its principal office at 414 North Camden Drive, Beverly Hills, California. AMISUB French was established by AMI for the purpose of acquiring and operating French Hospital located in San Luis Obispo, California.

Trade and Commerce

4. At all times relevant herein, the respondents have been and are now engaged in commerce within the meaning of the Clayton Act, as amended, and are corporations whose businesses are in or affecting commerce within the meaning of the Federal Trade Commission Act, as amended. AMI does business in a number of states. AMI and its hospitals in San Luis Obispo County, California, among other things:

- (a) purchase substantial amounts of supplies, equipment and medicines from sources outside of the State of California;
- (b) receive substantial revenues from private and governmental insurers located outside of the State of California; and
- (c) treat some patients who travel from or reside outside of the State of California.

5. AMI, through its wholly-owned subsidiaries, presently owns and operates three of the five general acute care hospitals in San Luis Obispo County, California. These hospitals are Sierra Vista Hospital, Arroyo Grande Community Hospital and French Hospital. AMI's ownership of each of these hospitals was obtained by means of separate acquisitions.

6. General acute care hospitals, hereinafter sometimes referred to as "hospital(s)," are health facilities, other than federally-owned facilities, with an organized medical staff which provide 24 hour inpatient care, including at least the following services: nursing, surgical, anesthesia, laboratory, radiology, pharmacy and dietary services. General acute care hospitals is the relevant product market.

7. San Luis Obispo County, California, and/or parts thereof, are the relevant geographic markets.

8. Barriers to entry into the hospital market in San Luis Obispo County are high. [3]

COUNT I

The Acquisition

9. On July 18, 1979, AMI, through AMISUB French, acquired sole ownership of the assets and related facilities of the proprietary French Hospital in the city of San Luis Obispo, California. It acquired the assets used by French Hospital from Central Coast Hospital Company, a limited partnership; French Hospital Corporation; Central Coast Clinic Company, a limited partnership; and French Medical Clinic, Inc.

10. At the time of this acquisition, French Hospital competed with AMI's Sierra Vista and Arroyo Grande Community hospitals. Sierra Vista was the largest hospital in the city of San Luis Obispo, California with approximately a 43% share of hospital beds in the city, and French Hospital was the second largest hospital in the city with approximately a 34% share of hospital beds in the city. The only other hospital in the city was the nonprofit San Luis Obispo General Hospital, which was operated by the county primarily for indigent patients.

11. At the time of its acquisition by AMI, French Hospital had approximately a 24% share of hospital beds in San Luis Obispo County and AMI's two other hospitals had a combined share of approximately 44% of the hospital beds in the county. AMI's combined share of filled hospital beds in San Luis Obispo County is higher than the figures set forth above.

Effects

12. The effects of the French Hospital acquisition by AMI, through its wholly-owned subsidiary, may be to lessen competition substantially or tend to create a monopoly in the relevant product and geographic markets enumerated in Paragraphs 6 and 7, above, in the following ways, among others:

(a) actual and potential competition has been eliminated among French, Arroyo Grande Community and Sierra Vista hospitals;

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- (b) concentration has been substantially increased;
- (c) already high barriers to entry have been increased and new entry into the market has been foreclosed;
- (d) respondents have obtained a dominant market position; [4]
- (e) patients, physicians, and large group purchasers of hospital services, such as health maintenance organizations, may be denied the benefits of free and open competition based on price, quality, and service in choosing among hospitals.

Violation Charged

13. The acquisition of French Hospital constitutes a violation of Section 7 of the Clayton Act, as amended, and Section 5 of the Federal Trade Commission Act, as amended.

COUNT II

14. The allegations of Paragraphs 1 through 11 of this complaint are incorporated by reference herein.

15. Beginning sometime in the past and continuing to the present AMI, through its wholly-owned subsidiaries, has, with specific intent to exclude competitors and maintain the power to control delivery of hospital services, attempted to monopolize and has otherwise engaged in unfair methods of competition in the market for general acute care hospital services in San Luis Obispo County or parts thereof.

16. In furtherance of the conduct alleged in Paragraph 15, AMI has engaged in the following acts and practices, among others:

- (a) acquired French Hospital;
- (b) prevented a competing national proprietary hospital chain from purchasing French Hospital and offering competition to AMI's two hospitals located in San Luis Obispo County, California; and
- (c) directed or authorized its three hospitals in San Luis Obispo County to take a united position in refusing to compete with each other by offering price and other concessions to Los Padres Group Health, an individual practice association health maintenance organization.

17. The acts and practices referred to in Paragraph 16 are in or affect commerce.

18. The effects, tendency and capacity of the conduct set forth in Paragraphs 15 and 16 are to restrain trade and eliminate [5] competition in the relevant product and geographic markets enumerated in Paragraphs 6 and 7, above, in the following ways, among others:

- (a) create a dangerous probability of monopoly, which would (i) provide respondents with the power to raise prices and exclude com-

petitors, and (ii) reduce respondents' incentives to provide high quality services;

(b) increase already high barriers to entry and foreclose new entry into the market;

(c) provide respondents with a dominant market position;

(d) deny patients, physicians, and large group purchasers of hospital services, such as health maintenance organizations, the benefits of free and open competition among hospitals based on price, quality, and service.

19. The course of conduct and effects alleged in Paragraphs 14 through 18 are continuing and will continue in the absence of the relief herein requested.

Violation Charged

20. The course of conduct and effects alleged in Paragraphs 14 through 18 violates Section 5 of the Federal Trade Commission Act, as amended.

INITIAL DECISION BY

ERNEST G. BARNES, ADMINISTRATIVE LAW JUDGE

JULY 27, 1983

PRELIMINARY STATEMENT

The complaint in this matter issued on July 30, 1981, charging American Medical International, Inc. ("AMI"), a corporation, and AMISUB (French Hospital), a corporation, with violations of Section 7 of the Clayton Act, as amended (15 U.S.C. 18 [1976]), and Section 5 of the Federal Trade Commission Act, as amended (15 U.S.C. 45 [1976]).

Count I of the complaint alleges that AMI, through a wholly-owned subsidiary AMISUB (French Hospital), acquired all the assets and related facilities of the proprietary French Hospital in the city of San Luis Obispo, California. The effects of the acquisition, it is alleged, may be to lessen competition substantially or tend to create a monopoly in the general acute care hospital market in San Luis Obispo County, California, and/or parts thereof, in the following ways, among others:

(a) actual and potential competition has been eliminated among French, Arroyo Grande Community and Sierra Vista hospitals; [2]

(b) concentration has been substantially increased;

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(c) already high barriers to entry have been increased and new entry into the market has been foreclosed;

(d) respondents have obtained a dominant market position;

(e) patients, physicians, and large group purchasers of hospital services, such as health maintenance organizations, may be denied the benefits of free and open competition based on price, quality, and service in choosing among hospitals.

(Complaint, ¶ 13) The acquisition is alleged to violate Section 7 of the Clayton Act, and Section 5 of the Federal Trade Commission Act.

Count II of the complaint alleges that AMI, through its wholly-owned subsidiaries, has, with specific intent to exclude competitors and maintain the power to control delivery of hospital services, attempted to monopolize and has otherwise engaged in unfair methods of competition in the market for general acute care hospital services in San Luis Obispo County, or parts thereof. In furtherance of the aforesaid conduct, it is alleged that AMI has engaged in the following acts and practices, among others:

(a) acquired French Hospital;

(b) prevented a competing national proprietary hospital chain from purchasing French Hospital and offering competition to AMI's two hospitals located in San Luis Obispo County, California; and

(c) directed or authorized its three hospitals in San Luis Obispo County to take a united position in refusing to compete with each other by offering price and other concessions to Los Padres Group Health, an individual practice association health maintenance organization.

(Complaint, ¶ 16) It is alleged that the effects, tendency and capacity of this conduct are to restrain trade and eliminate competition in the general acute care hospital market in San [3] Luis Obispo County, California, and/or parts thereof, in the following ways, among others:

(a) create a dangerous probability of monopoly, which would (i) provide respondents with the power to raise prices and exclude competitors, and (ii) reduce respondents' incentives to provide high quality services;

(b) increase already high barriers to entry and foreclose new entry into the market;

(c) provide respondents with a dominant market position;

(d) deny patients, physicians, and large group purchasers of hospital services, such as health maintenance organizations, the benefits of free and open competition among hospitals based on price, quality, and service.

(Complaint, ¶ 18) This course of conduct and effects thereof are alleged to violate Section 5 of the Federal Trade Commission Act, as amended.

The Notice of Contemplated Relief included with the complaint stated that divestiture of the acquired assets, including subsequent improvements, may be required and that respondents may be prohibited, without prior Commission approval, from making future acquisi-

tions of general acute care hospitals in areas where respondents already own or operate such a hospital.

On October 8, 1981, respondents filed an answer to the complaint admitting some of the complaint allegations, but denying those paragraphs of the complaint that allege violations of law. Respondents affirmatively stated that the complaint failed to state a claim upon which relief can be granted, and that the Commission is without jurisdiction to entertain the complaint allegations in that none of the alleged acts had a substantial effect on interstate commerce.

The first prehearing conference was held on November 13, 1981, and trial commenced on September 20, 1982. Complaint counsel, during the opening statement at the commencement of trial on September 20, 1982, abandoned all claims regarding Los Padres Group Health. (Tr. 74; see Complaint, ¶ 16(c)) Complaint counsel offered a rebuttal case which consisted entirely of documents. Respondents' surrebuttal case was comprised of documents and the testimony of one [4] witness. The last date of trial was March 2, 1983, and the record for the reception of evidence was closed on March 28, 1983. The record consists of 2531 pages of transcript and in excess of 450 exhibits. Complaint counsel called ten witnesses during the case-in-chief and respondents called a total of thirteen witnesses.¹

This proceeding is now before the Administrative Law Judge for decision based upon the complaint, the answer, pleadings, testimony and documentary evidence of record, proposed findings of fact and conclusions of law, and legal memoranda submitted by the parties. These submissions have been given careful consideration and, to the extent not adopted herein in the form proposed or in substance, are rejected as not supported by the record or as immaterial. All motions not heretofore or herein specifically ruled upon, either directly or by the necessary effect of the conclusions in this Initial Decision, are hereby denied.

Having heard and observed the witnesses and after having carefully reviewed the entire record in this proceeding, together with the proposed findings of fact and conclusions of law submitted by the parties, the Administrative Law Judge makes the following findings of fact and conclusions, and issues the Order set out at the end hereof.²
[5]

¹ Respondents' Proposed Findings of Fact and Conclusions of Law ("RPF") identify each witness who appeared during the trial. (RPF 0.16) Complaint counsel prepared a similar listing. (CPF, p. viii-ix) Mr. Charles Reilly, Senior Vice President, AMI, was called as a witness by both complaint counsel and respondents. (RPF 0.16, pp. 6-8) Norman Loftin, Senior Vice President, AMI, who testified in defense, was recalled by respondents as a surrebuttal witness.

² The findings of fact include references to supporting evidentiary items in the record. The supporting evidence cited in each instance is not necessarily all-inclusive of the record evidence. The following abbreviations have been used:

F. - Findings of this Initial Decision followed by the number of the finding(s) being referenced. Refer-

(footnote cont'd)

I. FINDINGS OF FACT

A. *Identity of the Parties*

1. Respondent American Medical International, Inc. ("AMI") is a corporation organized and existing under the laws of the State of Delaware, with its principal executive offices located at 414 North Camden Drive, Beverly Hills, California. (Complaint ¶ 1; Answer ¶ 2) AMI is primarily engaged in the owning, operation and management of general acute care hospitals in the United States and in foreign countries. (Reilly, 737) More than 85 percent of AMI's revenues are derived from its operation of such institutions. (Weisman, 1712-13) AMI also provides health care services through subsidiaries to hospitals and physicians which include medical-technical support services, financial and management services, and health care development services. (CX 10N; Weisman, 1712-13) In AMI's fiscal year 1982, it had total operating revenues of approximately \$1.4 billion and net income of \$78.8 million. (RX 5823 at 32) It owns, operates, or has under construction 72 hospitals in the United States and 24 hospitals abroad. (RX 5823 at 50-51; Reilly, 755; Weisman, 1747-48) AMI is the nation's third largest proprietary hospital chain in terms of domestic hospitals owned. (Reilly, 1797) AMI currently owns and operates three hospitals in San Luis Obispo County, California. They are Sierra Vista Hospital ("Sierra Vista") and French [6] Hospital ("French") located in the city of San Luis Obispo, California, and Arroyo Grande Community Hospital ("Arroyo Grande") located in Arroyo Grande, California. (RX 5823 at 50)

2. Respondent AMISUB (French Hospital) is a wholly-owned subsidiary corporation of AMI, organized and existing under the laws of the State of California, with its principal offices at 414 North Camden Drive, Beverly Hills, California. (Complaint ¶ 3; Answer ¶ 4) AMISUB (French Hospital) was established by AMI for the purpose of acquiring and operating French Hospital. (Complaint ¶ 3; Answer ¶ 4) For purposes of this action, AMI and AMISUB (French Hospital) can be treated as a single entity.³ (Prehearing Conference [Nov. 13, 1981], 3, 36)

ences to the transcript are designated by the name of the witness followed by the transcript page number(s).

- CX - Complaint counsel's exhibits followed by the exhibit number and the referenced page(s).
- RX - Respondents' exhibits followed by the exhibit number and the referenced page(s).
- CPF - Complaint counsel's Proposed Findings of Fact and Conclusions of Law.
- CB - Complaint Counsel's Post-Trial Brief In Support of Its Proposed Findings of Fact and Conclusions of Law.
- RPF - Respondents' Proposed Findings of Fact and Conclusions of Law.
- RB - Brief in Support of Respondents Proposed Findings of Fact and Conclusions of Law.

³ Hereafter "AMI" is used to refer to both AMI and AMISUB (French Hospital).

B. Identity of Other Firms Involved in the Challenged Acquisition

3. Central Coast Hospital Company at the time of the acquisition was a limited partnership organized and existing under the laws of the State of California. (CX 68L) The partnership consisted of both general and limited partners, all but two of whom were physicians. (Friedmann, 1602-03) This partnership owned the land, buildings, and other improvements relating to French Hospital. (Answer ¶ 9(a)) Central Coast Hospital Company had one wholly-owned subsidiary, French Hospital Corporation. The Company and its subsidiary filed separate federal and California state income tax returns. (CX 35S) In the year ending June 30, 1978, Central Coast Hospital Company and its subsidiary, French Hospital Corporation, had total revenues of \$8,171,482 and a combined net income of \$745,160. (CX 35-0)

4. French Hospital Corporation is a corporation organized and existing under the laws of the State of California. (CX 20) French Hospital Corporation operated French Hospital, owned or leased the hospital's equipment, and held the license for the hospital prior to the acquisition. (Answer ¶ 9(c); CX 41B; F. 8) French Hospital Corporation was a wholly-owned subsidiary of Central Coast Hospital Company. (CX 35A) Central Coast Hospital Company leased to French Hospital Corporation the property on which French Hospital is located and the improvements on that property, including the buildings housing the hospital's facilities. (CX 534; CX 730-O-P) [7]

5. Central Coast Clinic Company was a limited partnership organized and existing under the laws of the State of California. (CX 73G) Many of its partners were also partners in Central Coast Hospital Company which owned French Hospital. (Boyd, 363-64) Central Coast Clinic Company owned the land and building adjacent to French Hospital which comprised the French Medical Clinic prior to the acquisition. (CX 41B) Central Coast Clinic Company had one wholly-owned subsidiary, French Medical Clinic, Inc. (CX 41B; F. 6) In the year ending June 30, 1978, Central Coast Clinic Company and its subsidiary had assets valued at \$3,216,603. (CX 35Z5)

6. French Medical Clinic, Inc. was a professional corporation organized and existing under the laws of the State of California. (CX 73B) French Medical Clinic, Inc. owned or leased the equipment used at French Medical Clinic. (CX 41, I) On February 22, 1974, French Medical Clinic, Inc. entered into a Master Lease Agreement with United Medical Leasing Company, Inc., Chicago, Illinois (RPF 14.9), covering a variety of medical equipment. (CX 70Z1-Z2) During 1974, the lessor assigned a part of this lease to a California limited partnership, Fraser Medilease, Pasadena, California. (CX 74A) United Medical Leasing Company, Inc. was the sole general partner in Fraser Medilease.

Lease payments to Fraser Medilease amounted to \$673.27 per month. (CX 74B) French Medical Clinic, Inc. also had a lease with Xerox Corporation. (CX 70Z2) In 1979, French Medical Clinic, Inc. represented to AMI that its total rental costs with United Medical Leasing Company, Inc. would not exceed \$202,587.50 per year. (CX 76) Other documents indicate that French Medical Clinic, Inc. had rental obligations amounting to \$168,108 per year. (CX 49B, I) As of February 1979, French Medical Clinic, Inc. owned equipment valued at \$700,000. (CX 41F, K; CX 35Z5)

7. AMISUB (French Clinic) is a wholly-owned subsidiary corporation of AMI, organized and existing under the laws of the State of California, with its principal offices at 414 North Camden Drive, Beverly Hills, California. (CX 70D-E; CX 70Z37) AMISUB (French Clinic) owns the computerized axial tomographic scanner ("CAT scanner") and x-ray and laboratory equipment AMI purchased from French Medical Clinic, Inc. (CX 70D-F, CX 71A, F)

C. The Acquisition

8. On July 19, 1979, AMI acquired from Central Coast Hospital Company all of the common stock of French Hospital Corporation. (CX 63; CX 68E-G, Z25) That corporation operated French Hospital (Answer ¶ 9(c)); held the license necessary to operate it (CX 85; Friedmann, 1601-02); owned or leased the [8] hospital's equipment (CX 41B);⁴ and held a long-term lease which covered both the property on which French Hospital is located and the improvements on that property, including the French Hospital building itself. (CX 534; CX 730-O-P) In the same transaction AMI also acquired from Central Coast Hospital Company its other assets, excluding cash, cash equivalents, and certain notes receivable. (CX 63; CX 68E, G) Those assets were: (a) the Company's ownership interest in the French Hospital premises leased to French Hospital Corporation, and (b) a vacant lot. (CX 41B; CX 58L; CX 68E, G; CX 534)

9. At the same time AMI purchased from French Medical Clinic, Inc. a CAT scanner and other x-ray and laboratory equipment. (CX 70D-F, W, X-Z-2; CX 78) While the purchase contract designated AMISUB (French Clinic) as the purchaser, AMI paid the entire consideration for the purchase from its own funds. (CX 60; CX 70D-F; CX 73D-F) AMISUB (French Clinic) also that day subleased from French Medical Clinic, Inc. space for use as a CAT scanning and x-ray facility

⁴ French Hospital Corporation held substantial amounts of leased, as well as owned, equipment. French Hospital Corporation held leases of hospital equipment with total original purchase price of approximately \$1.5 million. (See CX 535, [lease agreement with American Financial Leasing & Services Company, Cincinnati, Ohio]; RX 5597L-V)

and a clinical laboratory.⁵ (CX 71A, F) After the acquisition, the CAT scanner, at least, was used in connection with the operation of the hospital. (F. 167, n. 18; see CX 274H; CX 91)

10. The total cost to AMI of the transactions described above was \$10,970,000. AMI issued to Central Coast Hospital Company 220,225 shares of stock, with a fair market value of approximately \$6.5 million. (RX 5851B-D, H-Y; Loftin, 1508; Friedmann, 1594-95) In addition, AMI assumed approximately \$3.9 million in long-term debt of Central Coast Hospital Company. (*Id.*) Finally, AMI paid \$570,000 in cash for the CAT scanner, x-ray, and laboratory equipment. (CX 70E, G; CX 73D-F) By letter dated December 19, 1980, AMI was advised that the Commission was investigating the acquisitions. (CX 1010) [9]

*D. Description of the San Luis Obispo County Area
and Location of Area Hospitals*

11. San Luis Obispo County, California is located midway between Los Angeles and San Francisco. In 1980, it had a population of 155,345. (CX 1064 at II-1) The main center of population in the county is the city of San Luis Obispo, which is also the county seat. (CX 217D) The population of the city in 1980 was 33,684. (CX 1064 at II-1, Data Supp.) The county is 3,184 square miles in size. It is bounded by Monterey County to the north; Santa Barbara County to the south; Kern County and the Temblor Range to the east; and the Pacific Ocean to the west. (CX 217D; RX 5826) The southern boundary between San Luis Obispo and Santa Barbara Counties follows the Cuyama and Santa Maria Rivers. (CX 217D; RX 5826) The topography varies from the relatively flat land in the southern-most section of the Arroyo Grande Valley to the peaks of five mountain ranges. (CX 217D)

12. Both industry observers and health planners have considered the existence of three separate subareas within the county: the North County, the South County, and the Central/Coast Area. (CX 188; CX 192J; CX 255C; CX 217Z10-11) Local health planners have recognized that each subarea should be considered a separate service area for health planning purposes. (CX 217Z10-11; CX 197N; RX 5467Z10; RX 5437Z47)

13. The South County is an area which stretches from Shell Beach in the north, to the Santa Maria River in the south (CX 188; 192J), and encompasses the so-called "5 Cities" of Pismo Beach, Arroyo Grande, Grover City, Oceano, and Nipomo. (CX 192J; CX 197D) Although parts of the South County are connected with the cities of

⁵ AMISUB (French Clinic) leased the CAT scanner and x-ray equipment back to French Medical Clinic, Inc. for several months (CX 79), apparently because French Hospital, unlike the Clinic, had to obtain government approval to operate the CAT scanner. (Boyd, 376; Friedmann, 1601)

Santa Maria and San Luis Obispo by Highway 101, public transportation consists of infrequent Greyhound bus service. (CX 217Z10; *see* RX 5468Z62)

14. The North County area consists of the area from the Cuesta Grade north to the county line. (Boyd, 344; CX 192J; CX 198B; CX 217Z12) Some towns in the north are as much as 45 minutes away from the South County area (CX 736C), and although "[t]he Santa Lucia Mountain Range which lies between the City of San Luis Obispo and the North County offers steep and hazardous grades" (CX 217Z10), automobile travel over a four-lane highway can be accomplished routinely. (Anderson, 255) Public transportation consists of infrequent Greyhound bus service. (CX 217Z10; *see* RX 5468Z62)

15. The Central/Coastal area includes the city of San Luis Obispo, Los Osos, Avila Beach, and Morro Bay. (CX 255C) The city of San Luis Obispo is the center of health services in the county. (CX 255H; RX 5435C) [10]

16. San Luis Obispo County is part of California Health Systems Area 8, over which the Mid-Coast Health Systems Agency has jurisdiction. (CX 1064 at I-1) There are five general acute care hospitals in San Luis Obispo County. (*See* CX 1064 at V-8; Anderson 235) French, Sierra Vista Hospital ("Sierra Vista") and San Luis Obispo General Hospital ("SLO General") are located in the city of San Luis Obispo. (CX 736B) Twin Cities Community Hospital ("Twin Cities") is located in the north area of the county in Templeton, California. (CX 736B; RX 5592) Arroyo Grande Community Hospital is located in the south area of the county in Arroyo Grande, California. (*Id.*)

17. Appendix A, a reproduction of RX 5592, illustrates the locations of the hospitals described in Findings 18-26 *infra*.

18. French Hospital is a 138-bed, general acute care hospital located in the city of San Luis Obispo, California. (CX 736B; Steacy, 144-45) It "has a pleasant and attractive physical plant, a respected and well qualified medical staff, a good employee staff, and is well respected in the community." (CX 306A) French, the second largest hospital in the county, was acquired by AMI on July 18, 1979, and is the focus of this proceeding. (CX 736B; Complaint ¶ 9) The hospital provides most acute care services with the exception of obstetrics. (CX 91; CX 274B)

19. The original French Hospital was a 35-bed facility located on Marsh Street in the city of San Luis Obispo that was owned by Dr. Edison French. (Friedmann, 1565) In 1972, Dr. French opened the new facility at the existing site on Johnson Avenue. The new hospital had 138 beds. (Friedmann, 1565) Dr. French also owned the French Clinic which consisted of a group of doctors who were paid a salary by Dr. French. (Harvey, 1640-41) These physicians had their offices in the French Clinic building adjacent to French Hospital. (Boyd, 363) In late

1975, Dr. French decided to sell the hospital and clinic. (Harvey, 1642) In July, 1976, the hospital was purchased by the Central Coast Hospital Company, a partnership consisting of 17 partners, sixteen doctors from the French Clinic plus Mr. Kenneth Friedmann. (Friedmann, 1569; CX 41B) These doctors also purchased the French Clinic. (Boyd, 364) In 1978, the partnership began negotiations for the sale of the hospital. (Friedmann, 1592) AMI purchased French on July 18, 1979. (F. 8-10)

20. Sierra Vista Hospital is a general acute care hospital located in the city of San Luis Obispo, California. (CX 736B; Steacy, 144-45) Sierra Vista is located approximately two miles from French. (CX 736C) Sierra Vista, the largest hospital in the county, has 172 licensed beds and is owned by [11] AMI. (CX 736B) AMI purchased Sierra Vista in July 1968. (Carlson, 1317-18) At that time, the hospital had 93 licensed beds. (Carlson, 1317) In December 1972, Sierra Vista occupied a patient tower that had been added to the original building, and the number of hospital beds was eventually increased to 172. (Carlson, 1318-20)

21. San Luis Obispo General Hospital is a general acute care hospital located in the city of San Luis Obispo, California. (CX 736B; Steacy, 144-45) SLO General and French are approximately one block apart. (CX 736C) SLO General has 78 licensed acute care beds and is a nonprofit facility owned by San Luis Obispo County. (CX 736B) It also has 14 licensed psychiatric beds. (CX 736B) SLO General has the fewest acute care beds of any hospital in the county. (*Id.*)

22. The occupancy rate at SLO General in 1979 was 37 percent. (RX 5436W) SLO General is viewed in the community as the primary obstetrics facility in the county, with contemporary modalities of practice and lower costs than other area facilities. (RX 5436Z28) SLO General also has a dialysis program that is not duplicated anywhere in the area. (Anderson, 267) Other than for obstetrics, however, few physicians use SLO General on a regular basis because it does not have the modern facilities they need. (Anderson, 305) SLO General, which is run by the county, has the legal obligation of caring for the medically indigent. (Bernhardt, 1298)

23. Arroyo Grande Community Hospital is a general acute care hospital located in San Luis Obispo County in the city of Arroyo Grande, California, about 15 miles south of the city of San Luis Obispo. (CX 736B; Steacy, 144-45) It is the only hospital in the South County area. (*See* RX 5592) Arroyo Grande has 79 acute care beds, one more than SLO General, and is owned by AMI. (CX 736B) It is smaller than AMI's hospitals in the city of San Luis Obispo and not as modern or as well-equipped as AMI's facilities there. (Schwam, 585-86) AMI

acquired Arroyo Grande as part of its 1972 merger with Chanco Medical Industries. (CX 9Z12)

24. Twin Cities Community Hospital is located in San Luis Obispo County in the city of Templeton, California, about 22 miles north of the city of San Luis Obispo. (CX 736B) Twin Cities has 84 licensed beds. (*Id.*) It is a for-profit hospital owned by National Medical Enterprises. (CX 736B) Twin Cities is a general acute care hospital. (Steacy, 144-45) It is the only hospital in the North County area. (*See* RX 5592)

25. Santa Maria, California is in Santa Barbara County, south of San Luis Obispo County. (RX 5826) Marian Medical Center and Valley Community Hospital are both located in Santa [12] Maria, 30 miles from the city of San Luis Obispo. (CX 736B) Marian Medical Center is a general acute care hospital with 125 licensed beds. It is a nonprofit facility owned by the Sisters of St. Francis of Penance and Christian Charity. (CX 736B; Steacy, 143-46) Valley Community Hospital is a general acute care hospital with 48 licensed beds. (CX 736B; Steacy, 148-49) It is a for-profit facility, owned by Summit Health. (CX 736B) Valley and Marian are approximately two miles apart. (CX 736C) These two hospitals serve the same community of patients and have, for the most part, the same medical staff. (Steacy, 149)

26. George L. Mee Memorial Hospital is located in Monterey County in King City, California. This is about 81 miles north of the city of San Luis Obispo. (CX 736B) Mee Memorial has 42 licensed beds and is owned by Southern Monterey County Memorial Hospital, Inc., a nonprofit organization. (CX 736B)

E. *Interstate Commerce*

27. AMI admits that it operates and manages hospitals in the United States and in foreign countries, and that it does business in a number of states. (Answer ¶ 3a, ¶ 5b) At the time AMI acquired French Hospital, AMI owned or leased 44 general acute care hospitals in the United States, located in nine states. (CX 729Z3) AMI also managed three hospitals in Arkansas and Texas. (CX 729Z3-Z4) Between June 1978 and July 1979, when it acquired French Hospital, AMI acquired four domestic hospitals, a computer-aided design and architectural firm, and a prepaid health care program, all of which were located in States other than California. (CX 729Z5-Z7; CX 731B) As of August 31, 1979, AMI provided cardio-pulmonary, diagnostic, and therapeutic services under contracts with hospitals in 40 states. (CX 729Z4) These operations are directed from AMI's headquarters in California. (*See* RX 5823)

28. At the time French Hospital Corporation was acquired by AMI, it had been making payments of \$16,986.75 per month for several years under equipment lease agreements with Provident Bank; those

payments were sent to locations outside California (CX 535; CX 730N; CX 731B) prior to its acquisition by AMI. French Hospital received millions of dollars per year in interstate payments for hospital services rendered. (See F. 30) Those payments were received by French Hospital Corporation. (CX 735A) French Hospital, which was operated by French Hospital Corporation before the acquisition (Answer ¶ 9(c)), occasionally treated patients who did not reside in the state of California. (Answer ¶ 5(d))

29. AMI issued to Central Coast Hospital Company shares of AMI common stock worth approximately \$6.5 million as part of [13] the purchase price for French Hospital. (RX 5851B-C; CX 65; F. 10) AMI obtained approval from the New York Stock Exchange for the listing on that exchange of the stock issued to Central Coast Hospital Company, as required by the contract for the acquisition of French Hospital. (CX 68Z14; CX 69A)

30. French, Sierra Vista, and Arroyo Grande make interstate purchases of substantial amounts of drugs, devices, equipment and supplies, and make interstate payment therefor; and receive substantial interstate payments for hospital services, as set forth in Appendix B. The funds used to cover the hospitals' Medicare reimbursement checks were Treasury funds drawn from the San Francisco Federal Reserve Bank, pursuant to letters of credit issued by the Baltimore, Maryland headquarters of the Health Care Financing Administration. (CX 735B) Some of those Treasury funds originated outside California. (CX 735B) Payments of the hospitals' Medicare reimbursement checks reduce, by the amount of the checks, the amount of Treasury funds transferred at the end of each business day from the San Francisco Federal Reserve Bank to the New York Federal Reserve Bank. (CX 735B) The hospitals' Medicare reimbursements are charged against two trust funds maintained on the books of the United States Treasury, headquartered in Washington, D.C. (CX 735A) A substantial part of the funding for those trust funds comes from payroll taxes and Medicare Part B premiums collected nationwide. (CX 735A-B) A major part of the interstate payments received by French Hospital and the interstate purchases and payments received by the other hospitals that are noted on Appendix B were received prior to AMI's acquisition of French Hospital.

31. The Vidar Division of TRW, Inc., which employs approximately 600 persons at its plant in San Luis Obispo, and is the second largest non-governmental employer in the San Luis Obispo area (RX 5435Q), had a health benefits plan for its employees and their dependents, effective April, 1981, which paid 100% of certain hospital charges, and 80% of certain other hospital charges (subject to a deductible and a \$1,000,000 maximum lifetime benefit for major medical expenses)

incurred by an employee or dependent. (CX 561A, G-H, K-L, W-Z3) Benefits under the plan are paid on behalf of the employer by the Travelers Insurance Company. (CX 561B) All Travelers' payments for hospital services to AMI's hospitals in San Luis Obispo County are interstate payments. (CX 734B)

32. Payors that reimburse for hospital services on the basis of the reasonable costs of providing those services—such as Medicare and, until recently, Medi-Cal (*see* F. 33, 158)—will be affected to the extent that this acquisition affects those costs. (*See* F. 33) Third-party payors that [14] reimburse on the basis of hospital charges—*i.e.*, private insurance companies (*see* Guy, 661)—and self-pay patients, will be affected to the extent that this acquisition affects charges. (*See* F. 174-187)

33. The acquisition of French increased the "cost basis" of the hospital for Medicare purposes and therefore the amount of interstate Medicare payments French was entitled to receive. Under Medicare regulations, depreciation of hospital facilities and (for proprietary hospitals only) return on equity capital are "allowable costs" for Medicare reimbursement. (42 C.F.R. 405.415, 405.429 (1982)) The "cost basis" of a particular French asset, for purposes of calculating depreciation and return on equity, is governed by those Medicare regulations. To the extent that AMI claims a higher cost basis for French than that claimed by the previous owners, Medicare reimbursement will be increased. This possibility was recognized by Mr. Steven Takahashi in a May 21, 1979 memorandum (CX 52), written when he was Treasurer and Vice President of AMI. (CX 12Z21) His memorandum estimated that if AMI calculated the cost basis of the assets based on their appraised value at the time of the acquisition, rather than the book value used by the previous owners, there would be an increase in Medicare reimbursement to French of over \$8 million over the 30-year life of the assets. (CX 52A) AMI followed Mr. Takahashi's advice and by fiscal year 1981, the first full fiscal year after AMI's acquisition of French, was claiming a "cost basis" for French's assets (CX 712Z262) which corresponded to the value of those assets as appraised in 1979 (with adjustments for intervening purchase, construction, and disposal of assets). (CX 31Z5; CX 712Z83, Z202) This new "cost basis" was considerably greater than the book value of the assets in the hands of the previous owners. (CX 52A) While hospitals participating in the Medicare program are subject to limitations on reimbursable cost (42 C.F.R. 405.460 [1982]; RX 5828; Schramm, 2278-79; Derzon, 1997-2005, 2054-55; Lave, 947-48, 950), a fairly liberal standard is utilized which can be met by the average hospital. (*See* RX 5828)

34. Until recently, California's Medi-Cal program generally fol-

lowed Medicare reimbursement principles. (Derzon, 2005) Thus, the increase in Medicare reimbursement from the increased "cost basis" of French would be accompanied by a similar increase in Medi-Cal reimbursement. The Federal Government pays a certain percentage of the Medi-Cal reimbursement for those services eligible for Federal subsidy. (42 U.S.C.A. 1396b(a)(1), 1396d(b) (West Supp. 1982)) Those Federal payments are interstate payments. (CX 734A-B) [15]

F. *The Relevant Product Market*

35. General acute care hospitals offer a variety of health services in a single location. In California, to be a general acute care hospital, a facility must offer the following services on a 24-hour basis: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy and dietary services. (*Cal. Health & Safety Code* Section 1250(a) [Deering 1982]; see also RX 5469Q) While some facilities may offer one or two services which hospitals offer, no other facility offers them all. (Steady, 145-47; Lave, 882) The cluster of services offered by general acute care hospitals provides for the complete treatment of patients with a broad range of conditions. (Steady, 146) Thus, the hospital offers a variety of facilities to help diagnose disease (Boyd, 330); it offers facilities for surgery (Boyd, 329-30); it provides nurses who work round-the-clock to carry out the orders left by the doctor and keep the doctor informed of any change in a patient's condition (Boyd, 330); it provides the nurses necessary to administer certain medications to a patient. (Bernhardt, 1281-82; see also Schwam, 565) Most importantly, hospitals provide the equipment and personnel to deal with unexpected, but potentially life-threatening, situations. (Boyd, 335; Schwam, 567-68) While a particular service may be available at some other institution, general acute care hospitals are unique in that they alone offer this whole cluster of services in a single setting. (Lave, 881-82)

36. There is a well-accepted definition of "acute care hospitals" used by health planning organizations, the American Hospital Association, and the State of California, including the California Health Facilities Commission. (Lave, 880-81) This definition draws a distinction between acute care and long-term hospitals and between hospitals and other providers of health care, such as doctors, clinics, and hospices. (Lave, 881) California statutes distinguish general acute care hospitals from other "health facilities" offering inpatient care, such as psychiatric and specialty hospitals, and skilled nursing and intermediate care facilities. "Health facilities" are further distinguished from "clinics" offering only outpatient services. (*Cal. Health & Safety Code* Sections 1200, 1250 [Deering 1982 & Supp. 1983]) Administrators of hospitals also use the term "general acute care hospi-

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tals"; it is a term generally recognized in the industry. (Steady, 143-44; Anderson, 235-36)

37. AMI's primary business is the owning and operating of general acute care hospitals; over 85 percent of AMI's revenues are derived from its operations of such institutions. (Reilly, 737; Weisman, 1712-13) Most important, AMI itself has recognized that its hospitals compete only with other general acute care hospitals. Included in one memorandum analyzing the French acquisition is a chart entitled "Competition—French [16] Hospital." It lists only the other four general acute care hospitals in the county. (CX 38M) In its study of AMI's competition in San Luis Obispo, Friesen International, Inc., an AMI subsidiary, analyzed only other general acute care hospitals. (RX 5435T-Z4) The administrator of Sierra Vista, in referring to his competition, mentioned only other general acute care hospitals. (Carlson, 1327-28)

38. It is "critically important" for doctors to have access to general acute care hospitals. (Schwam, 563; *see also* Boyd, 329; Bernhardt, 1284; Harvey, 1681) Surgeons, for example, require hospitals not only for the surgery itself, but also for the other support staff and services necessary to care for the patient before and after the surgery. (Anderson, 236; Boyd, 330) Only hospitals have the necessary equipment to perform major surgery. (Anderson, 236) Likewise, hospitals are often the only facilities able to perform certain sophisticated tests which doctors require. (Bernhardt, 1231; Schwam, 565)

39. A number of physical ailments can be treated safely only by admitting a patient to the hospital. (Anderson, 236; Boyd, 334; Schwam, 567-69; Bernhardt, 1231; Harvey, 1681) These situations include, among others, patients in need of certain kinds of surgery (Boyd, 334-35; Anderson, 236; Bernhardt, 1231), patients requiring certain diagnostic procedures (Bernhardt, 1231; Harvey, 1679-80), and patients in need of observation or around-the-clock monitoring. (Boyd, 333; Harvey, 1678-79) Almost any patient with acute cardiovascular disease must be admitted to the hospital for treatment. (Harvey, 1681) Patients in need of intravenous medication (Schwam, 568; Bernhardt, 1281-82); and those in need of intensive care services must be admitted to the hospital. (Schwam, 568-69) Also, patients having procedures which require general anesthesia usually will be admitted to the hospital. (Boyd, 332-33; *see* RX 5469Z172)

40. In a number of other situations it is possible to treat a patient without admission to a hospital, but several factors make this option unattractive. In those instances where nursing care is required, a patient could be treated at home only if private duty nurses were employed at great expense. (Boyd, 334, 336; Schwam, 567-68) Even if nurses were hired, it still might be necessary to admit a patient if

complications arose. (Boyd, 335) The risk of unexpected complications makes treating certain conditions on a nonhospital basis extremely risky. (Boyd, 334; Harvey, 1680) Treating other conditions outside the hospital would require a doctor to spend excessive amounts of time with a single patient, thus forcing the doctor to neglect others. (Schwam, 567-68) Finally, even when a patient could be treated at home, it would often be impossible [17] for the doctor to render the same standard of care to the patient as would be possible in the hospital. (Schwam, 567-68)

41. Certain categories of illness can be treated in either the hospital or in a nonhospital setting, such as the doctor's office or the patient's home. (Boyd, 332) However, whether a doctor treats a particular patient with such a condition in the hospital or outside of it will depend on the severity of the illness and whether some "predisposing condition" creating the risk of complications is present. (Harvey, 1677-78; Collins, 1449, 1463-64; Schwam, 564-66) In most instances, patients are admitted to the hospital only when they cannot be treated outside of it. (Boyd, 332; Bernhardt, 1281; Harvey, 1677) A number of factors prevent a patient who could be treated in a nonhospital setting from being admitted to the hospital. First, hospital utilization review and federal reimbursement regulations prevent doctors from admitting patients to the hospital unless it is medically necessary. (Derzon, 1970-71; *see* Stahl, 1381, 1392-93) Second, doctors prefer to have as few patients as possible in the hospital, since they do not wish to spend time unnecessarily making hospital rounds. (Harvey, 1678; *see also* Boyd, 340; Bernhardt, 1285) Third, patients prefer to be at home if possible, and often it is less expensive for a patient to be treated outside the hospital setting. (Bernhardt, 1240-41)

42. Respondents submitted a chart, RX 5794, which purports to show the number of inpatient surgeries performed at French and Sierra Vista which also could have been performed on an outpatient basis. This chart has some basic flaws. First, it does not show whether the patients had "predisposing conditions" which necessitated the procedure being done on an inpatient basis. (Collins, 1449, 1463-64, 1466-69) Second, the chart included as inpatients, patients admitted under Sierra Vista's "one-day stay" program, where patients do not stay in the hospital overnight. (Collins, 1460-61) Finally, there is disagreement concerning which procedures can safely be performed on an outpatient basis. For example, one of the lists upon which respondents' chart is based included heart catheterizations among procedures which could be done on an outpatient basis. (RX 5641Z37) However, a cardiologist testified in this proceeding that heart catheterizations can be done safely only on inpatients. (Harvey, 1679-80)

43. Some ancillary services, such as x-rays and lab tests, which are

rendered to inpatients also are available in a nonhospital setting. Some doctors' offices and clinics offer x-ray procedures and laboratory tests (Schwam, 599-600; Bernhard, 1232), and private labs also are capable of performing many tests. (Stahl, 1403; CX 452B) However, these nonhospital facilities are not used to treat individuals in need of inpatient care. When people needing inpatient care require such [18] services, they use the facilities present in the hospital. (Schwam, 566-67) Doctors never send inpatients out of the hospital for ancillary services when those services are available in the hospital. (Bernhardt, 1283; Schwam, 567)

44. General acute care hospitals also offer certain services which do not require a patient to be admitted to the hospital. Such services include tests, ambulatory surgery procedures, and some emergency room services. However, outpatient procedures account for only a small part of the activity of general acute care hospitals. In San Luis Obispo County, most hospitals derived no more than 13 percent of their adjusted gross revenues from such outpatient services, although SLO General received about 32 percent from such services. Only 7.5 percent of French's adjusted gross revenues were from outpatient services between 1977 and 1980. (CX 1062)

45. In only a few instances are the outpatient services provided by hospitals a substitute for those offered in a nonhospital setting. The most important outpatient service provided by a hospital is the hospital's emergency room. All hospitals in San Luis Obispo County offered full-time emergency room services. (See RX 5469Z88) In some cases, emergency rooms may treat relatively minor problems that probably could be treated in a doctor's office or a clinic. But patients often come to emergency rooms unaware of what is wrong with them, but aware that the full gamut of care is available to them at an emergency room. (See RX 5469Z70) Doctors' offices, which are not open 24 hours a day and cannot provide as broad a range of services as emergency rooms, are therefore not a substitute for a patient who believes he needs emergency care. A patient needing emergency care may use the emergency room because he does not have a regular doctor or is not readily knowledgeable about an available doctor.

46. Hospitals also offer facilities for outpatient surgery, which is surgery which does not require the patient to remain overnight. (Boyd, 333; Collins, 1446-47; RX 5469Z172) Outpatient surgery at hospitals is usually performed on patients who do not require a long period of observation. (Stahl, 1380; RX 5469Z177) Some minor surgery is performed in doctors' offices. (Boyd, 331-32) However, the surgeries done on an outpatient basis in hospitals are usually those procedures which cannot be done in a doctor's office. (See Collins, 1462-63) Also, some patients have tests or x-rays performed on an outpatient basis

at a hospital even though such procedures can also be done outside the hospital. (Bernhardt, 1235) When doctors have their own equipment outside the hospital, they do not use the hospital's equipment. (See Schwam, 566) For those doctors who do not have access to such facilities, [19] however, there is no substitute for the equipment available at the hospital. (Bernhardt, 1235)

47. In San Luis Obispo County the five hospitals are all general acute care hospitals. (Anderson, 235; Steacy, 144-45) While some other institutions offer some of the same type of services, none can offer the essential cluster of services offered by acute care hospitals. Certain diagnostic procedures and simple surgery can be done in physician's offices and clinics; however, no clinic or doctor can offer the full range of tests, especially the more sophisticated tests provided by a general acute care hospital (Schwam, 565), and a number of such procedures cannot be done in doctors' offices. (Boyd 333-34) In addition, no clinic can treat those conditions which require that patients be admitted to the hospital. (See F. 39)

48. Some procedures which are performed in hospitals can be done in "freestanding surgicenters." (RX 5812A-B) No such facility exists in San Luis Obispo County (Anderson, 238; Bernhardt, 1282), and it is unlikely that such a facility will be built. The Mid-Coast Health Systems Agency has noted that existing ambulatory surgical capability in the county's hospitals is currently underutilized, and would recommend that the necessary regulatory approval for such a facility be denied. (CX 1064 at VI-45 to VI-46; see also RX 5469Z174; RX 5821Z61-Z62) In addition, similar facilities such as birthing centers or freestanding renal dialysis centers, do not exist in San Luis Obispo County. (See Lave, 883)

49. The only inpatient psychiatric service offered in San Luis Obispo County is at SLO General, which has 14 beds set aside for psychiatric patients. (CX 1064 at V-64) These beds are licensed separately from the hospital's general acute care beds, and government approval would have to be obtained to shift those beds into service as general acute care beds. (Johns, 1877; *Cal. Health and Safety Code* Sections 437.10(a), 1250.1 [Deering 1982 & Supp. 1983]) Further, these psychiatric services are not considered to be general acute care services (Anderson, 303); the nature of the illness is fundamentally different from the physical illnesses treated in general acute care facilities, and the form of treatment prescribed is different. (Steacy, 147-48)

50. There are home health care services in San Luis Obispo County. These services send nurses periodically to the homes of patients who require continuing care. (Schwam, 600-01) Home health care services provide care only to patients near recovery from their illnesses. (Schwam, 604) They do not offer the round-the-clock care offered by

general acute care hospitals, nor can they perform surgical procedures or other tests. (See generally RX 5469Z318-Z327; Schwam, 600-01)

51. There is one hospice operating in San Luis Obispo County. (RX 5469Z332) This service "provides palliative and [20] supportive care to the terminally ill patients and their families." (RX 5469Z328) In San Luis Obispo County this service is provided to patients in their homes, not in a private facility. (RX 5469Z331-Z333) Furthermore, unlike general acute care hospital services, hospices are long-term as opposed to short-term services (RX 5469Z333-Z335), and the average census of the hospice in San Luis Obispo was only eight patients. (RX 5469Z335) Most importantly, hospices deal only with terminally ill people to give them comfort and rest as long as they survive. (RX 5469Z328) Thus, this service represents a substitute for only a minute portion of the services offered by a general acute care hospital.

52. For the bulk of services offered by general acute care hospitals, demand is relatively inelastic. A person who believes himself seriously ill will go to a hospital, rather than a nonhospital setting, regardless of the cost. Even in less extreme cases, there is little price or quality cross-elasticity of demand between hospital and nonhospital services. (Lave, 882-83)

53. As noted above, some tests and x-rays are available on an outpatient basis both in the hospital and in doctors' offices. (F. 43) In addition, to a limited extent, some surgical procedures could be performed in either a doctor's office or on an outpatient basis at a hospital. (F. 40-42) However, there is virtually no competition for the cluster of services or breadth of care offered by hospitals on an inpatient basis. "[T]here is a core of services which are not offered elsewhere. . . ." (Lave, 882) In other instances, treating the patient outside the hospital is especially dangerous since it raises the risk of complications. (F. 39-40) While there might be adequate sources for some outpatient services to substitute for those offered by the hospital should an increase in price or a reduction in quality occur, no similar substitutes for inpatient care exist. Even if the number of procedures done on an outpatient basis would increase, this would not change the unique nature of the essential core of services offered on an inpatient basis. As one doctor testified, "[C]learly there are some things that will always need to be done in hospitals and certain conditions that need to be treated in hospitals." (Bernhardt, 1283)

G. *The Relevant Geographic Markets*

54. The relevant geographic market defines the area within which market power could be successfully exercised. Determination of the market requires an inquiry into where people go when they need

hospitalization; and what alternatives are available in the event market power is exercised. It also [21] is relevant to look at the perceptions of people in the marketplace to determine the economic realities of the situation. (Lave, 888-89)

55. The origin of patients at hospitals is relevant in determining the relevant geographic market. (Lave, 886; Schramm, 2338) Ronald Rowe, an FTC staff accountant, at complaint counsel's request reviewed patient origin information by ZIP Code submitted by all the hospitals in San Luis Obispo County, plus those in King City (Monterey County) and Santa Maria (Santa Barbara County), and summarized this patient origin data in a series of charts, CX 614 through CX 621. (Rowe, 121-22) These charts showing the residence of patients admitted to hospitals in San Luis Obispo County are summarized in Appendix C. Each hospital in the county drew over 90 percent of its patients from within the county. Only a small percentage of patients came from areas outside the county. French had the highest number of patients from Santa Maria, but they amounted to only 4 percent of all of its admissions. Twin Cities, the only hospital in the North County area, drew only 1.6 percent of its patients from the neighboring county to the north, Monterey County.

56. AMI had concluded that the service areas of French and Sierra Vista were defined by the boundaries of San Luis Obispo County since 90 percent of their patients came from within the county. (CX 255C, F; CX 38Z7-Z8) AMI's wholly-owned subsidiary, Friesen, prepared three studies of AMI hospitals in San Luis Obispo County in 1980-81 and found that most of the patients at AMI's three hospitals were residents of the county. (RX 5435Z29-Z30; RX 5436Z30-Z31; RX 5437Z28-Z29) In addition, according to AMI's and Friesen's studies, few patients come to San Luis Obispo County hospitals from outside the county. (CX 255C; RX 5435Z30; RX 5436Z31; RX 5437Z29) Friesen also concluded that the market of each hospital was limited to patients residing in the county or some portion thereof. For example, with regard to Sierra Vista, Friesen reported:

Current market definition:

Patients of the full range of medical specialties with primary and secondary illnesses and patients with trauma, rehabilitative needs and some tertiary illnesses who live in all parts of San Luis Obispo County.

(RX 5436Z51; *see also* RX 5435Z51; RX 5437Z47)

57. The extent to which residents of San Luis Obispo County leave the county for their hospital care, referred to as outmigration, is a relevant factor in determining whether the [22] county is the proper geographic market. (Lave, 886-88; *see* Schramm, 2340-45; Mittelstaedt, 1084) Outmigration may be due in large part to residents who

need hospitalization while away from the county, or to residents who leave the county to receive care not available in San Luis Obispo County. (Anderson, 240; Lave, 887; Schramm, 2388-89; F. 70)

58. The Health Care Financing Administration studied where Medicare beneficiaries, age 65 and over, were hospitalized. (CX 568) CX 568 summarizes where those residents of San Luis Obispo County who were Medicare beneficiaries over age 65 were hospitalized in 1977. It shows that 85 percent of these individuals were discharged from hospitals within the county.⁶ These outmigration figures were subsequently kept on an Health System Agency (HSA) basis; for HSA 8, which contains San Luis Obispo County, the 1977 outmigration figure is approximately 14 percent, comparable to the county figure shown on CX 568C. (CX 582A) In 1978 and 1979, the outmigration from the HSA remained at about 14 percent. (CX 582B-C) There is no substantial evidence indicating that the experience of the Medicare beneficiaries is atypical. Dr. Schramm stated that since Medicare recipients were older and often retired, they might be less mobile (Schramm, 2344); however, on cross-[23]examination he also stated they might be able to travel more because they had more leisure time (and thus more likely to be hospitalized outside the county during travel). (Schramm, 2389)

59. Similar information also was prepared by the California Department of Health Services relating to the outmigration of Medi-Cal recipients. (CX 594A-C) Medi-Cal is the California program that pays for hospital care for certain indigent persons. (Bernhardt, 1299) CX 594C shows that about 87 percent of hospitalized San Luis Obispo County residents covered by Medi-Cal were discharged from hospitals in the county. (CX 594C)⁷

⁶ These figures are arrived at by adding up the percent of total discharges which took place at San Luis Obispo County hospitals as shown on CX 568C. Paso Robles District Hospital and Atascadero General Hospital were closed when the new Twin Cities hospital opened in 1977. (Schwam, 569-70) The percent discharged from hospitals outside the county is the difference between the total and 100 percent.

Sierra Vista Hospital	36.27%
Arroyo Grande Community Hospital	17.29
French Hospital	14.04
Twin Cities Hospital	11.71
San Luis Obispo General Hospital	4.57
Paso Robles District Hospital	.90
Atascadero General Hospital	.54
Total	85.32%
	100.00%
	-85.32
Percent discharged from hospitals located outside San Luis Obispo County.	14.68

⁷ According to the Mid-Coast Health Systems Agency, the Office of Statewide Health Planning and Development (OSHDP) had determined in 1980 that some outmigration from the HSA was taking place. However, the OSHDP estimated that such outmigration amounted to only 5 percent of patient days. (CX 1064 at V-14)

60. AMI documents suggest that there is little outmigration from San Luis Obispo County. In discussing the service area of French Hospital, an AMI memorandum written prior to the acquisition of French noted that "[T]he population of SLO County is somewhat isolated from other health care facilities," and that the closest facilities outside the county, in King City and Santa Maria, "have less extensive facilities and are less convenient to most SLO County residents." (CX 38Z7) A Friesen chart, RX 5436Z1, prepared by Robert E. Mittelstaedt (a Friesen International, Inc. vice president and consultant to AMI—Mittelstaedt, 997) and his colleague Michael Brunelle (Mittelstaedt, 1189), calculates the market shares of AMI's three San Luis Obispo County hospitals for 1980. (Mittelstaedt, 1191) It concluded that AMI had 77 percent of the patient days attributable to county residents and that "23% of bed days are going elsewhere." (RX 5436Z1) Thus, 23 percent of the bed days were going to non-AMI hospitals, either within or without the county. (Mittelstaedt, 1192) The Friesen charts did not account for the market share of the two non-AMI hospitals within the county, SLO General and Twin Cities. (Mittelstaedt, 1192-93) Allowing a minimal market share for Twin Cities and SLO General, the outmigration would be substantially below 23 percent. (See Mittelstaedt, 1193)⁸ [24]

61. According to charts prepared by Mr. Mittelstaedt for this litigation, approximately 30 percent of San Luis Obispo County residents requiring hospitalization were hospitalized outside the county (RX 5815A), and 23.5 percent of San Luis Obispo County and northern Santa Barbara County residents were hospitalized outside those areas. (RX 5802A) In order to determine the outmigration from San Luis Obispo County, Mr. Mittelstaedt took the rate at which the national population uses hospitals and adjusted it for the fact that California residents use hospitals at a rate equal to 72.8 percent of the national average. (Mittelstaedt, 1087; RX 5815C) He adjusted this figure for the age of the population to get the rate at which individuals within four different age groups were expected to use the hospital. (Mittelstaedt, 1088-89; RX 5815C) This "Adjusted SLO Rate Per 1,000" for each age group was then multiplied by the actual 1980 county population by age group to yield the expected patient days for San Luis Obispo County residents. (Mittelstaedt, 1088; RX 5815C) From the total expected patient days were subtracted the actual number of patient days generated by San Luis Obispo County residents at hospitals in the county. (Mittelstaedt, 1094; RX 5815B) The difference

⁸ At the hearing complaint counsel pointed out that if SLO General and Twin Cities had only a 5 percent market share each, that would mean that only 13% of the patient days were leaving the county. (Mittelstaedt, 1193) Five percent may be low since, in 1978 and 1979, SLO General and Twin Cities had a combined share of inpatient days of county hospitals of approximately 24 percent. (CX 602) If these figures were similar for 1980 there would have been little outmigration from the county.

between these two figures was assumed to be the number of patient days leaving the county. (*Id.*) Similar calculations were made to reach the conclusion that 23.5 percent of patient days were leaving the larger area of San Luis Obispo County and northern Santa Barbara County. (Mittelstaedt, 1089-90; RX 5802)

62. Mr. Mittelstaedt's conclusions, prepared for this litigation (Mittelstaedt, 1184-85, 1197; *see also* Tr. 1179), are inconsistent with the conclusions of the Medicare and Medi-Cal charts, the estimates of the OSHPD, and the chart prepared by Friesen prior to the onset of this litigation. (F. 58-60) The figures arrived at by Mr. Mittelstaedt are based on estimates. (Mittelstaedt, 1180-81) In order to reach the conclusions expressed in RX 5802 and RX 5815, Mr. Mittelstaedt had to make a number of different assumptions with regard to the utilization of hospitals by San Luis Obispo County and northern Santa [25] Barbara County residents. (*See* Mittelstaedt, 1182-89) An actual figure, as opposed to an estimate, could have been arrived at had a different methodology been used. (Mittelstaedt, 1181) One assumption made by Mr. Mittelstaedt was that it was reasonable to use the California utilization rate as the rate at which residents of San Luis Obispo County and northern Santa Barbara County used hospitals. (Mittelstaedt, 1087-89) If residents of San Luis Obispo County used the hospital less than the California average, the number of expected patient days would be too high and the amount of outmigration would appear to be greater than it really is. (Mittelstaedt, 1186-87) CX 533 indicates that HSA 8, which contains San Luis Obispo County, has one of the lowest utilization rate of all HSAs in California, 684 patient days per 1000 population.⁹ (CX 533C) In contrast, the California utilization rate used by Mr. Mittelstaedt in his charts was 843 per 1000, thereby overstating the amount of outmigration from the county. When Mr. Mittelstaedt's charts are recalculated using the utilization rates for the HSA they show an amount of outmigration consistent with other evidence in this case. They show that only 13.96 percent of the patient days generated by San Luis Obispo County residents were in hospitals outside San Luis Obispo County (CX 1001), and that 6.76 percent of the patient days generated by San Luis Obispo County and northern Santa Barbara County residents were in hospitals outside those areas. (CX 1002)

63. Mr. Mittelstaedt attempted to explain the discrepancy between the chart presented at the hearing, RX 5815, and the chart in the Friesen report (RX 5436Z1) by pointing to the fact that different population figures were used and that Friesen did not have information on non-AMI hospitals. (Mittelstaedt, 1193-94) However, Mr. Mittelstaedt admitted that he updated the population figures by

⁹ The utilization rate for HSA 10, which includes Santa Barbara County was also quite low, 711 per 1000.

contacting local officials (Mittelstaedt, 1190; RX 5436Z1), and that at the time the chart in the Friesen report was done he believed it was reliable. (Mittelstaedt, 1190) The fact that he did not have information on patient days at Twin Cities and SLO General does not affect the validity of the 23 percent figure. The additional information would merely show what portion of that 23 percent went to Twin Cities and SLO General. The remaining portion—some number less than 23 percent—then would be the outmigration from the county. (F. 60)

64. Although it is impossible to conclude the precise [26] amount of outmigration from San Luis Obispo County, the record suggests that it was between 5 percent and 14 percent. (F. 58-60) A certain amount of outmigration is expected since some people have no choice but to use hospitals outside the county. Some of these people may go to other areas for services not offered by the area hospitals (Harvey, 1660. F. 70), and some may need care while away from the county. With those exceptions, reliable evidence shows that people will not travel far when they need to be hospitalized. Most people will stay near their homes so they can be visited by their families. (Anderson, 240) When patients' families have to travel a great distance to see a patient in the hospital, it causes a major disruption in the whole family. (Harvey, 1661; CX 217Z11) Furthermore, since doctors usually admit to hospitals near their offices, unless patients travel out of the county to see a doctor, they will inevitably end up in a hospital near their homes. (F. 65-66; CX 217Z11)

65. The location of doctors' offices is a relevant factor in determining the geographic market. (Lave, 888) Nearly every admission to a hospital in San Luis Obispo County was made by a physician whose offices were located in the county. According to a chart introduced by complaint counsel, 99.7 percent of the admissions at the five hospitals in San Luis Obispo County during 1980 were made by physicians whose offices were located in the county. (CX 626) Out of over 22,000 admissions, only 74 patients were admitted by doctors whose offices were located outside the county. (*Id.*)

66. Complaint counsel presented a series of charts which showed the office location of those doctors with active privileges¹⁰ at the hospitals in San Luis Obispo County, Santa Maria, and King City. Most admissions to the hospitals in San Luis Obispo County are made by doctors with active privileges. (Rowe, 115-120; CX 629-CX 633) Virtually all of the admissions made by doctors with active privileges at San Luis Obispo County hospitals were by doctors with offices in the county. Neither Sierra Vista, SLO General, Twin Cities, nor Ar-

¹⁰ A doctor with active privileges at a hospital can admit an unlimited number of patients to that hospital at his discretion. Other privileges limit the number of patients that a doctor can admit. (Schwam, 560-61)

royo Grande had a single patient admitted by an active staff doctor whose office was located outside the county. (CX 629; CX 631-633) 1.5 percent of French's admissions by doctors with active privileges were made by two doctors whose offices were located in Santa Maria. (CX 630) Only one doctor with an office in San Luis [27] Obispo County held admitting privileges at any of the three closest hospitals outside the county. Neither Valley Community Hospital in Santa Maria, nor George L. Mee Memorial Hospital, in King City, had any patients admitted by active staff doctors whose offices were in San Luis Obispo County. (CX 635; CX 636) Marian had one out of ninety-five doctors with active privileges who had an office in San Luis Obispo County. (CX 634) In 1980 this doctor admitted less than one percent of all the patients admitted to Marian Medical Center. (CX 124B; Steacy, 152-53)¹¹

67. The perception of those who work in a market also is a relevant factor in determining the geographic market. (Lave, 888-89) Officials of AMI concluded that San Luis Obispo County represented a distinct service area. (CX 255F; F. 56) A chart contained in an internal memorandum analyzing the French acquisition entitled "Competition—French Hospital," gives the owners and occupancy of those hospitals that presumably were viewed as competitors of French. The chart discusses only the four other hospitals located in San Luis Obispo County. (CX 38M) Friesen also concluded that the market for each hospital was limited to the county or some portion thereof.¹² (RX 5436Z51; RX 5435Z51; RX 5437Z47)

68. The administrator of French Hospital from June 1972 until July 1979, when it was acquired by AMI, testified that French's principal competitors were the other hospitals in the city of San Luis Obispo. (Anderson, 220) Hospitals outside the county were not viewed as competitors. (Anderson, 228) Efforts to attract patients were not directed outside the county because [28] it was believed that there was little hope of getting patients from those areas. (Anderson, 229)

69. Mr. Steacy, the Executive Vice President of Marian Medical Center in Santa Maria for the past seven years, stated that his only competitor was Valley Community Hospital, the only other hospital in Santa Maria. (Steacy, 149-50) The hospitals in San Luis Obispo County were not competitors because they had different medical

¹¹ This doctor also practiced at Arroyo Grande Community Hospital in San Luis Obispo County. (Steacy, 152)

¹² The Friesen reports do make reference to the Santa Maria hospitals in the "Competition" section; however, it is unclear if this is intended to mean that the Santa Maria hospitals were currently competing with San Luis Obispo County hospitals. Friesen states that Arroyo Grande will face increasing competition from Santa Maria hospitals "if the potential Vandenberg expansion, [i.e., around Vandenberg Air Force Base in northern Santa Barbara County] takes place causing growth in Northern Santa Barbara County and south San Luis Obispo County." (RX 5435T) In fact, in the Arroyo Grande plan, Friesen noted with regard to the Vandenberg development, "there is currently little evidence . . . to indicate that any significant impact will be felt in the next three to five years." (RX 5437Z48; see also RX 5437C)

staffs and served different communities. (Steacy, 150-51) Mr. Steacy attempts to keep track of rates at Valley Community Hospital (Steacy, 149), but does not keep track of rates at Arroyo Grande, the hospital in San Luis Obispo County which is closest to Marian. (Steacy, 150) This view is corroborated by other evidence in the record. As complaint counsel's charts show, few patients from the Santa Maria area travel to hospitals in San Luis Obispo County. (F. 55) Other evidence showed that the majority of patients at Santa Maria hospitals came from the northern Santa Barbara County area. (CX 619-20; CX 570U) Valley Community Hospital in Santa Maria drew 90.4 percent of its patients from northern Santa Barbara County area in 1980, and 9.4 percent from San Luis Obispo County. (CX 620) In 1980, Marian Medical Center drew about 86.6 percent of its patients from Northern Santa Barbara County and 11.4 percent from San Luis Obispo County. (CX 619) Most patients who come to Santa Maria hospitals from San Luis Obispo County, are from areas in the extreme southern portion of the county. (CX 619-20) Over half of these patients are from Nipomo, a town close to the county border which accounts for only 3.4 percent of the population of San Luis Obispo County. (U.S. Department of Commerce, Bureau of the Census, [1980 Census of Population, General Population Characteristics—California 6-31, 6-34, 6-36, 6-40])

70. Testimony of doctors in the community supports the view that the county is a separate market. Specialists who received patients through referral stated that most doctors that refer patients to them are located in San Luis Obispo County. (Boyd, 343-44, Schwam, 572; Harvey, 1637) Furthermore, it is very rare for doctors in the county to refer patients to doctors outside the county. When it is done, it is usually patients with unusual medical problems who are referred to major medical centers in the Los Angeles or San Francisco areas, and at Stanford University. (Anderson, 258-60; Boyd, 346, 423-24; Bernhardt, 1253-54, 1286-87; Schwam, 473-74; Harvey, 1660-61)

71. It is relevant to determine if the city of San Luis Obispo is a market or submarket for the purpose of determining the possible anticompetitive effects of AMI's acquisition of French Hospital. (See Lave, 889-90; Complaint ¶¶ 12, 16) There are three separate areas in the county: the North County, the South County, and the Central/Coastal Area, which includes the city of San Luis Obispo. (F. 13-15) The physicians in each [29] area are served by a separate hospital or group of hospitals: Twin Cities serves physicians with offices in the North County; Arroyo Grande serves those in the South county; and French, Sierra Vista and SLO General serve those in the Central/Coastal area. (F. 75-77)

72. AMI has recognized for some time that three such areas existed.

The administrator of Arroyo Grande urged AMI officials to have health planning officials declare the South County area served by Arroyo Grande "a separate and distinct service area." (CX 187C) When AMI sought approval for 39 additional beds for Arroyo Grande in the early 1970's, AMI's administrator of the hospital wrote to health planning authorities that three distinct service areas existed. He stated:

It is my strong feeling that the county needs to be divided into three health care service areas; one being the north part of the county, one the central part of the county, encompassing San Luis Obispo and the third area is the south portion of the county from Shell Beach to the Santa Maria River.

(CX 188; *see also* CX 192J; CX 187C; CX 197N; Schwam, 582-83) The health planning authorities agreed with AMI and designated three separate areas within the county for health planning purposes. (CX 217Z11-Z12) In September 1978, members of Mr. Loftin's staff (an AMI vice president) performed a long-range planning study of Arroyo Grande which indicated that Arroyo Grande was in a separate geographic market. (CX 197; *see* Loftin, 1492) That report noted that there is a "definite philosophical separation between the northern and southern portions of the county." (CX 197D; *see also* CX 197N) Moreover, AMI officials recognized that because of its geographical isolation, Arroyo Grande did not face any substantial competition. The report stated:

It is important to reiterate that our findings clearly pointed to the fact that there is no definable competition for Arroyo Grande Community Hospital. The hospitals south of Arroyo Grande are geographically located too far away to be competition and the facilities, Sierra Vista and French and County, in the north likewise are geographically too far away to be considered direct competition . . .

(CX 197N) [30]

73. AMI also viewed the North County as a separate market. When it sought the right to build a new hospital in Templeton, AMI stated that the proposed facility would serve a distinct area in the northern section of the county. (CX 198B; CX 201 at 22, 28) Furthermore, even though the proposed facility would duplicate some services offered in the city of San Luis Obispo, such duplication was justified, according to AMI, because of the geographical isolation of the North County area. (CX 201 at 33-34)

74. Other witnesses testified that there were three submarkets within the county. (*See* Lave, 889-90) The former administrator of French Hospital who is current administrator at Twin Cities, Mr. Anderson, stated that when he was at French he regarded Sierra Vista and, to a lesser extent, SLO General as his competition for

patients and physicians. (Anderson, 220) Neither Twin Cities nor Arroyo Grande were viewed as competition because they were too far away and served a distinct medical staff and community. (Anderson, 227-28) Furthermore, Mr. Anderson stated that in his current capacity as administrator at Twin Cities, efforts are not made to attract patients to Twin Cities from the city of San Luis Obispo because it is unreasonable to expect patients to travel to Twin Cities for services available in San Luis Obispo. (Anderson, 239)

75. It is the doctors who admit patients and the evidence indicates that doctors usually admit where it is most convenient for them. (See Bernhardt, 1237) Thus, competition among hospitals for doctors tends to be concentrated in the area around the hospital. In San Luis Obispo County, doctors in the North County admit to Twin Cities, doctors in the South County admit to Arroyo Grande, and doctors in the city of San Luis Obispo admit to either French, Sierra Vista or SLO General. A series of charts prepared by Mr. Ronald Rowe, an FTC staff accountant, show that most patients at hospitals in the city of San Luis Obispo were admitted by physicians whose offices were located in the city or the nearby towns of Morro Bay, Los Osos, and Baywood Park. According to these charts 97.7 percent of all of Sierra Vista's admissions were made by physicians with offices in these four communities. (CX 622) A similar percentage, 97.5 percent, of French's admissions came from doctors in the same areas (CX 623), and 98.2 percent of SLO General's admissions were from physicians in these areas. (CX 624) Overall, 97.8 percent of all admissions to the three hospitals in the city were made by doctors with offices in one of these four communities. (CX 622-24)

76. Few doctors with offices in San Luis Obispo admitted patients to either Arroyo Grande or Twin Cities. At least 97 percent of the admissions at Twin Cities in 1980 were made by physicians with offices in the nearby cities of Templeton, Atascadero, and Paso Robles. (CX 632) One doctor on the [31] active staff at Twin Cities did have an office in the city of San Luis Obispo, but he admitted only .9 percent of all of Twin Cities' patients. During that same period, no active staff physician with an office in the South County admitted patients to Twin Cities. (CX 632) Similarly 91.7 percent of Arroyo Grande's admissions were from doctors with offices in the South County area near the hospital. Only about 7 percent of the hospital's admissions were by doctors in the city of San Luis Obispo. (CX 633) Thus, each hospital served a distinct group of doctors whose offices were uniformly located near the hospital to which they admitted patients.

77. It is difficult for doctors to use hospitals which are located at a distance from their offices. Doctors see their patients in the hospital at least once a day; therefore, if doctors whose offices were located in the city of San Luis Obispo tried to use Arroyo Grande or Twin Cities

they would spend too much of their time traveling between their offices and the hospital. (Boyd, 340; CX 197N; *see also* Bernhardt, 1228-29) Doctors who often need to see patients in emergencies could not do so if they had to travel 30 minutes to the patient. (Harvey, 1682-83) In short, the distance to Arroyo Grande and Twin Cities "curtail[s] absolutely expert and good medical supervision and care of . . . patients." (Harvey, 1682) Finally, few of these doctors expected to move their offices from their present location to use these other hospitals. (RX 5435Z16)

78. According to complaint counsel's charts, the largest proportion of patients admitted to the three hospitals in the city of San Luis Obispo were from the city itself or surrounding areas. During calendar year 1980, 51 percent of Sierra Vista's patients were from the three ZIP Codes encompassing San Luis Obispo, Morro Bay, and Los Osos. (CX 614) About 45 percent of French's patients and about 42 percent of SLO General's were from the same three areas. (CX 615; CX 616; *see also* RX 5435Z30)

79. The hospitals in the city of San Luis Obispo attracted a number of patients from the North and South County. For example, in 1980, about 41 percent of Sierra Vista's patients came from these areas. (CX 614) About 44 percent of French's patients and 51 percent of SLO General's came from these areas. (CX 615; CX 616) These patients were coming to the city to see particular doctors who were located in the city (RX 5435Z38; RX 5436Z41; Anderson, 241) and who, as noted above, tend to admit most of their patients to hospitals in the city. (F. 76) Thus, these patients cannot make use of hospitals outside the city unless their doctors move offices, which most did not expect to do (RX 5435Z16), or unless the patient selects a new doctor. [32]

80. There was little outmigration of residents of the city of San Luis Obispo to either Twin Cities or Arroyo Grande for hospital care. Those hospitals relied almost exclusively on patients from their own areas. Eighty percent of Twin Cities' patients were from the towns of Paso Robles, Atascadero, and Templeton alone; ninety percent were from nine towns which health planners identified as being in the North County area. (CX 617; CX 217Z12) Less than one percent of Twin Cities' patients came from the city of San Luis Obispo and the surrounding area. (CX 617) Likewise, most of Arroyo Grande's patients came from the South County area. In 1980, 89 percent of its admissions came from this area. (CX 618) The city of San Luis Obispo and the surrounding area accounted for less than two percent of its admissions. (CX 618)

81. Respondents contend that the concept of a relevant geographic market cannot readily be applied to the circumstances of the hospital industry generally or, in particular, to San Luis Obispo. (RPF 8.1) If

the determination of a relevant geographic market is undertaken, respondents argue the most appropriate approximation is the San Luis Obispo County/Northern Santa Barbara County region. (RPF 8.4, 8.10) Dr. Schramm, respondents' economic expert, stated with regard to defining relevant markets, "it strikes me as inappropriate to think about this case in those terms." (Schramm, 2336) If forced to define a market, however, Dr. Schramm would define it as San Luis Obispo County and the northern part of Santa Barbara County. (Schramm, 2337) Dr. Schramm stated that one basis of his opinion was evidence concerning the service areas of the hospitals, which he said "links to the idea of patient origin," and that "hospitals in Santa Barbara County also experience a good deal of transfer of patients who come in from San Luis Obispo County." (Schramm, 2338; see F. 69) Dr. Schramm also suggested that the proximity of the towns in the area to each other and the fact that Highway 101 connects them was relevant to his opinion regarding the geographic market. (Schramm, 2339) "The fact that there is a county line in there is largely irrelevant." (*Id.*)

82. There is little evidence to support Dr. Schramm's position. First, Dr. Schramm in his market analysis ignored the location of doctors' offices and their patient admitting practices. Second, studies of the service areas of the San Luis Obispo County hospitals, several of which were done by AMI, conclude that the service areas of the hospitals in San Luis Obispo County were limited to the county. (*See, e.g.*, F. 56) The former administrator of French Hospital testified that his primary competition was other hospitals in San Luis Obispo County. (Anderson, 228) Mr. Steacy, an official from Marian Medical Center hospital located in northern Santa Barbara County, testified he did not compete with hospitals within San [33] Luis Obispo County. (Steacy, 149-51) Only a small percentage of patients admitted to Santa Maria hospitals in Northern Santa Barbara County come from San Luis Obispo County, and nearly all of those patients came from communities in the extreme southern portion of the county. (*See* CX 619, CX 620, F. 69) To the extent there has been outmigration of patients from San Luis Obispo County (*see* F. 57-64), evidence demonstrates that Northern Santa Barbara County hospitals received only a portion of that patient load. (*See* F. 69)

83. The only other testimony which suggests that Santa Maria hospitals should be included in the geographic market was adduced from Mr. Carlson, the administrator of Sierra Vista, an employee of AMI. Mr. Carlson stated that, in his opinion, all the hospitals in San Luis Obispo County and northern Santa Barbara County were competitors of Sierra Vista. (Carlson, 1327-28) He defined competitors as "those hospitals [that] have the potential of attracting physicians who

in turn would admit patients from the same area that we serve." (*Id.*) Mr. Carlson's testimony conflicts with testimony of doctors to the effect that they could not practice both in San Luis Obispo and in outlying areas. One doctor stated that it is difficult to take care of the patients when distances are involved. (Harvey, 1682) Indeed, in 1980 Sierra Vista did not have a single patient admitted by an active staff physician with an office in Santa Maria. (*See F. 66*)

H. Barriers To Entry

84. A state "certificate-of-need" is required (except in exceptional circumstances) in California for any project involving any of the following, among other things:

- a) Construction of a new hospital;
- b) Addition of beds to an existing hospital (except for the expansion of a hospital's bed capacity by 10% or 10 beds, whichever is less, not more than once every two years, by a hospital with an occupancy rate over 85%);
- c) Conversion of some or all of a hospital's beds from one bed classification to another (with limited exceptions); or [34]
- d) Any capital expenditures by or for a hospital of more than \$600,000.¹³

(*Cal. Health & Safety Code* Sections 437.10, 437.11(b)(4) (Deering 1982 & Supp. 1983)) Should Congress repeal, allow to terminate, or deny funding for implementation of the National Health Planning and Resources Development Act, as amended (42 U.S.C.A. 300k-1 to 300n-5 (West Supp. 1982)), the state of California will continue to require certificates-of-need for all of the projects described above, except that the threshold for certificate-of-need review of equipment purchases and capital expenditures not otherwise subject to review will be increased. (*Cal. Health & Safety Code* Sections 437.6(f), 437.10(a),(e) (Deering 1982 & Supp. 1983))

85. Applications for certificates-of-need are reviewed both by the state Office of Statewide Health Planning and Development (OSHPD) and local Health Systems Agencies (HSAs). (RX 5821M, Q, V-W; Johns, 1879-82) The applicant must first notify the HSA in its area and the OSHPD of its intention to file an application; 60 days after that notice is given, the application may be filed with the OSHPD and the HSA. (RX 5821Z10-Z14; Johns, 1880) The HSA reviews the application after a public hearing, and makes a recommendation on the application to the OSHPD, which then conducts its own public hearing and decides whether to grant or deny the application. (Johns, 1880-81) Should the applicant or the HSA be dissatisfied with the decision of the OSHPD, either party can appeal to the Advisory Health Coun-

¹³ This threshold will be adjusted periodically for inflation. (*Cal. Health & Safety Code* Section 437.10(e) (Deering Supp. 1983))

cil; should the applicant wish to appeal the Council's decision, it can take the matter into the courts. (Johns, 1881; RX 5821P, Z25-Z26)

86. A certificate-of-need application can be granted only if the project for which a certificate-of-need is sought will meet an unmet community need identified in the Statewide Health Facilities and Services Plan developed by the OSHPD, and meets other criteria, including the following: "The project will not adversely affect the utilization of other facilities offering the same or similar services in the service area." (RX 5821Z43-Z44; Johns, 1876, 1880-82) HSAs, in making their recommendations on certificate-of-need applications, are bound by the same criteria. (Johns, 1880) The purposes of the certificate-of-need process include discouraging the creation of excess capacity and duplicative services, and instead [35] channelling investment into facilities and services that meet identified needs of the community. (Johns, 1879, 1883)

87. There is considerable excess capacity in the general acute care hospitals in San Luis Obispo County. (RX 5835) Thus, it is unlikely that any proposal for an additional hospital, or additional hospital beds, in San Luis Obispo County could meet the criteria for approval of a certificate-of-need. (RX 5821Z43-Z44) The Mid-Coast Health Systems Agency has a policy of recommending denial of any application for addition of new hospital beds in areas with excess capacity. It estimates that San Luis Obispo County will have, for the rest of the decade, over 100 hospital beds more than what will be required for the care of county residents (including capacity to handle random fluctuations in hospital utilization). (CX 1064 at V-28 to V-30; F. 199) AMI has acknowledged that regulatory approval of new beds in the area is unlikely. (*See, e.g.*, RX 5435U; *see also* Reilly, 1795)

88. If new hospital beds were to become necessary in San Luis Obispo County, it is more likely that an existing hospital would be granted permission to add beds than that a new hospital would be approved. The certificate-of-need process is more effective in forestalling new entry into a hospital market than in blocking expansion of existing hospitals; in any event, opposition to a new facility by existing hospitals might significantly delay new entry. (Lave, 843, 875; *see also* RX 5854H, P, V; RX 5855J-K; RX 5856B-C)

89. The state government requires hospitals to meet detailed and extensive standards relating to the quality of care received by patients, including standards for facility construction, sanitation, and the range of services offered. (*See, e.g.*, 22 *Cal. Admin. Code* Sections 70201-70279, 70801-70865 (1979)) In order to treat Medicare or Medicaid patients on a nonemergency basis, hospitals must meet similarly detailed and extensive standards. (42 C.F.R. 405.1011-1235 (1982)) The Joint Commission on the Accreditation of Hospitals (JCAH), a

private organization, also imposes comprehensive standards on the hospitals it accredits. (Schramm, 2276) The result of these standards is to force hospitals to provide a "fairly high minimum level" of service from the start (*see* Lave, 825), and thus to deny a new entrant into the San Luis Obispo hospital market the opportunity to begin operations with a relatively small investment and then later build its operations up to a level comparable to its competitors' operations after obtaining a foothold in the market. [36]

90. The San Luis Obispo area has a great deal of excess bed capacity. (RX 5835; *see* RPF 3.7-3.20; F. 199) In addition, it has relatively few major unmet needs for specialized hospital services. (RX 5435Z11) It is unlikely there will be a *de novo* entrant into the hospital market in San Luis Obispo County in the foreseeable future. (*See* Reilly, 739)

I. Competition in the Hospital Market

91. Americans spent approximately \$286 billion, constituting 9.7 percent of the gross national product, for health care in 1981. Approximately 41 percent, or \$118 billion, of those expenditures were for hospital care. By contrast, in 1960, Americans spent approximately \$12.7 billion on health care, of which only 33.6 percent was for hospital care. In 1975, expenditures for hospital care were approximately \$52.1 billion. By 1981, they had increased to approximately \$118 billion. (U.S. Department of Commerce, Bureau of the Census, *Statistical Abstract of the United States 1982*, pp. 102, 418)

92. Congress recognized in 1974 that the health care industry does not respond to classic marketplace forces:

[T]he health care industry does not respond to classic marketplace forces. The highly technical nature of medical services together with the growth of third party reimbursement mechanisms act to attenuate the usual forces influencing the behavior of consumers with respect to personal health services. For the most part, the doctor makes purchasing decisions on behalf of the patient and services are frequently reimbursed under health insurance programs, thus reducing the patient's immediate incentive to contain expenditures.

S. Rep. No. 1285, 93d Cong., 2d Sess. 39 (1974), *reprinted in* 1974 U.S. Code Cong. & Ad News 7842 at 7878.

93. A significant market feature in the hospital industry is that price plays a less significant role as a competitive variable than in most other industries. Most all transactions for hospital services are covered by third-party financing arrangements. (Derzon, 1978; Friedman, 1581; Loftin, 1515-16) With the advent of Medicare and Medicaid, "the vast majority of patients in the hospital were covered by insurers, third parties [37] and on a cost reimbursed basis." (Lave, 842; *see* Schramm, 2268) Respondents contend that 65 percent of

French's revenues and 65.8 percent of Sierra Vista's revenues in 1982 were paid by Medicare, Medi-Cal and Blue Cross based on costs. (RX 5813A, B) The remaining 35 percent of revenues came from patients who paid charges, and most of these were reimbursed by private insurers. (RX 5813A, B) Complaint counsel's figures for 1981 show the following: Sierra Vista - Medicare, Medi-Cal and Blue Cross 57.2 percent, others 42.8 percent; French - Medicare, Medi-Cal and Blue Cross 53.8 percent, others 46.2%. (CX 1033) The effect of third-party payment is to render patients somewhat insensitive to the prices charged for hospital services (Schramm, 2268-69; RX 5714K), although consumers, predictably, do from time to time express an interest in hospital charges, and are beginning to become more concerned about such charges. (See, e.g., Schwam, 579-80) The evidence is clear, however, that patients seldom choose among hospitals based on their prices. (Derzon, 1982-83; Lave, 917-18; RX 5752; Friedmann, 1581-82; Loflin, 1485, 1515-16; see Harvey, 1639-40; Bernhardt, 1238-40) Under private insurance, Medicare, and Medi-Cal, neither the patient nor the physician is under financial pressure with respect to hospital charges. (Lave, 929)

94. The largest third-party payor is the federal government's Medicare and Medicaid programs. State governments, via their share of the Medicaid program, are also significant purchasers of hospital care. Through the traditional system of city and county hospitals, local governments also function as third-party payors. (Derzon, 1977-78; see F. 132) The next largest third-party payors are nongovernmental insurance organizations. The largest of these is Blue Cross. Following Blue Cross in terms of magnitude of hospital services purchased are commercial insurance carriers. (Derzon, 1977-78; see F. 30) The least significant purchasers of hospital care are individual consumers without insurance. These people are called "self-pay" patients. (Derzon, 1977-78)

95. Each year the Health Care Financing Administration ("HCFA"), the group within the Department of Health and Human Services ("HHS") which administers Medicare and Medicaid, produces figures on the proportion of nationwide hospital bills paid by third-party payors. About 55 percent of hospital costs are borne by the government at all levels. Former HCFA administrator Robert Derzon testified that the most recent set of figures for the proportion of hospital bills borne by all third-party payors combined is "somewhere around 90, 91 percent, possibly 89 percent." (Derzon, 1978) [38]

96. Medicaid and Blue Cross provide full coverage for hospital services. (Guy, 646; Lave, 964-65) Some third-party payors, however, provide for a "deductible" or require a "copayment." A deductible is a sum which the patient must pay "out-of-pocket" before the third-

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party payor will begin to pay for medical care. A copayment is an arrangement under which the insured must pay a certain percentage of the bill for his medical services. (Schramm, 2292-93) Scientific studies of the behavior of consumers faced with these provisions show that a consumer facing a high deductible or copayment will use less medical care than he otherwise would. (Lave, 917) Insurance deductibles and copayments are increasing, causing consumers to be more price conscious. (Lave, 846-48; Schwam, 579-80) Dr. Lave also testified that he knew of no empirical studies which show that deductible or copayment provisions affect patient or doctor choice of hospitals. (Lave, 915)

97. Another significant feature affecting competition in the hospital market is that the largest third-party payors—Medicare, Medicaid and Blue Cross—do not pay on the basis of hospital charges; rather, these payors reimburse hospitals on the basis of costs. (Loftin, 1494-95; Derzon, 1994-95; *see* Steacy, 194) Thus, a cost reimbursed hospital increases its revenue by spending more. (Schramm, 2269; RX 5714K) The result of incurring fewer costs is revenue reduction. (Anderson, 291)

98. Because most patients come into contact with the system so infrequently and because of the rapid technological advances in this field, the consumer lacks information about his own need for medical care, and about the appropriateness of the care he receives. (Schramm, 2271-73) Thus, it is the doctor who makes the basic decisions about the course of care. (Lave, 936, 970; RX 5733D; *see also* RX 5731Q; RX 5714K) Both patients and doctors do not have complete knowledge about the prices of the care which is sought. (Derzon, 1982-83; Loftin, 1515-16) Partly, this is because the pricing of hospital services involves thousands of individual items. (Derzon, 1982-83) More importantly, consumers and doctors lack an incentive to become aware of exact prices because they know that third-party payors will pay the vast majority of the bill. Thus, doctors do not "price shop" for their patients. (Derzon, 1982-83; *see also* Loftin, 1515-16) Dr. Boyd, called by complaint counsel, testified that he does not consider the price of hospital services when he decides what hospital to admit a patient to:

As far as where I'm going to hospitalize the patients, it really doesn't enter into my decision-making because at the present time, since I am not involved in any review activities on hospital bills, I really don't know about hospital charges.

Boyd, 359-60) [39]

99. The financial survival of hospitals depends on their ability to earn revenues by filling their beds with patients. (Lave, 844) Excess

capacity in the hospital industry, compounded by the recession and other factors, has forced hospitals to take competitive actions such as advertising, recruiting physicians to join their staffs, and some price-cutting for particular services to try to fill empty hospital beds. (Lave, 823, 844-45) This competition between hospitals exists even though the hospital industry is subject to significant governmental and private regulation. (See RPF 2.20-2.35) Except in some states (not including California), the government does not control hospital charges. (Derzon, 2183; Schramm, 2372) The extensive regulation of the quality of hospital services that keeps that quality at least at a fairly high minimum level (Lave, 825) does not foreclose competition to provide even better services to patients. (See, e.g., F. 101-02) Certificate-of-need regulation of competition in the area of capital expenditures does not suppress competition, but rather channels competition into other areas (Lave, 842-43), such as price and service improvements (CX 1050X), and also spurs competition for certificates-of-need. (See F. 124)

100. Mr. Robert A. Derzon, one of respondents' expert witnesses, was co-director of a project conducted by the consulting firm of Lewin & Associates to compare the economic performance of investor-owned and not-for-profit hospitals. (Derzon, 1938, 2081) CX 1030, "The Lewis Report", is the third volume of that study, entitled "Two Case Studies of Competition Between Hospitals". It was published in 1981. (Derzon, 2081; CX 1030 at inside title page) The Lewis Report is based on case studies of two different communities, each of which was initially served by a single non-profit hospital, but which became two-hospital towns with the entry of a new hospital operated by an investor-owned group. (Derzon, 2083-84) The report maintained the confidentiality of the participants in the case studies by using fictitious names. (Derzon, 2084) Names and other details were changed to disguise the location of the communities studied. Some quotations are composites of statements made by several individuals, but the information presented is otherwise factual. (CX 1030 at i) One of the communities studied was called "Cherokee", the existing non-profit hospital there was called "Houghton Memorial Hospital," and the new investor-owned hospital was called "Magnolia General Hospital." (CX 1030 at 1.4) The other community, "Lee County," was initially served by non-profit "Tanzer Memorial Hospital," and later by for-profit "Fort Benedict General Hospital." [40] (CX 1030 at 1.5) The report studied the issue of competition between hospitals through these case studies of what happened when a for-profit hospital entered a market previously served by a single non-profit hospital. (CX 1030 at i) Mr. Derzon participated in selecting the communities to be studied, helped determine what questions his staff should ask and what data they should obtain, super-

vised the writing of the report in its entirety (in conjunction with the president of Lewin and Associates), reviewed the work, and edited those parts he felt to be objectionable or inaccurate. (Derzon, 2082-83, 2089, 2098-99)

101. Doctors are the persons who admit patients to a hospital. Therefore, hospitals "compete for the affection and attention of physicians . . . because physicians bring them patients." (Derzon, 1981; see Lave, 826; Mittelstaedt, 1030; F. 102-105) Hospitals compete for physician patronage by offering the kind and quality of services and support personnel desired by physicians. (Lave, 826-27) An example of this strategy is the "Selective Centers of Excellence Strategy" proposed by AMI subsidiary Friesen, and adopted by AMI management, for AMI's Brookwood Medical Center. (CX 1060L) This plan called for the development of OB/GYN, oncology, cardiovascular surgery, and private psychiatry—specialties in which Brookwood already provided high-quality services—into "premier" services that would attract physicians away from competing hospitals. (CX 1060I) Friesen anticipated that the "premier" OB/GYN service would attract dissatisfied physicians from Brookwood's major competitors. (CX 1060-O-P)

102. Other examples of how hospitals seek to use new or better services in competing for physicians' patronage are reported in the Lewin Report. (CX 1030) "Tanzer Memorial Hospital" sought to forestall creation of a competing hospital by dissident physicians on its medical staff by beginning planning for an intensive care unit. (CX 1030 at 2.11) The dissident physicians proceeded to open a new hospital because, in the words of one dissident, Tanzer's board and administrator "were not thinking about modern medicine," and provided "second-rate" medical care. (CX 1030 at 2.11) When the new hospital was established, Tanzer made service additions of the sort desired by specialists. (CX 1030 at 2.33)

103. Hospitals also seek to attract physicians through purchasing hospital equipment desired by physicians and needed by their patients. (Lave, 826; Schramm, 2299) The ability of physicians to obtain the equipment they need at a hospital influences where they admit their patients. (See, e.g., CX 1030 at 3.12-3.13; F. 135-138) In addition, hospitals [41] attempt to provide a favorable working environment for physicians. That was a major strategy of the for-profit "Magnolia Hospital" studied in the Lewis Report. Magnolia provided physicians with spacious, quiet, and well-lit physician dictation and chart review areas, which contrasted with a general lack of quiet space for doctors at its non-profit competitor. (CX 1030 at 3.6) Magnolia also assigned blocks of operating room time to its most active surgeons, so that the surgeons could minimize preparation time and work with nurses

familiar with their procedures. This policy was responsive to the complaints of surgeons about the "first come, first served" rule for scheduling operations at Magnolia's non-profit competitor. (CX 1030 at 3.10-3.11)

104. Hospitals also attract physicians by offering them financial incentives to shift their practices. Friesen recommended that AMI's Memorial Hospital of Tampa pursue this strategy by recruiting physicians and offering them subsidized office space. (CX 1055B) The Lewin Report also discussed hospitals' use of loans, subsidized office space, and income guarantees for physicians as competitive strategies. (CX 1030 at 1.14-1.15, 1.19, 2.13, 2.15, 3.9-3.10) Finally, hospitals seek to further their physicians' professional advancement by building a staff of physicians who can learn from each other about modern medical techniques and by offering them continuing education to help them keep up-to-date. (Lave, 826-27)

105. Hospitals try to influence the patients' choice of a hospital. Patients occasionally select the hospitals to which they will be admitted, and make their selections on the basis of both price and nonprice considerations. For some hospitalizations, patients are aware of the need for hospitalization a few days, if not longer, in advance of their admission to the hospital. (Lave, 867-68) This is particularly true for "elective surgeries," which can be deferred when necessary or to suit the patient's convenience. (See, e.g., Schramm, 2296; CX 1056B) For these hospitalizations, the patient has some time to make inquiries about the price, quality and convenience of various hospitals. (Lave, 867-68) Friesen's October 1982 strategic plan for AMI's Memorial Hospital of Tampa reported the results of a community survey indicating that 35 percent of those surveyed would ask their physicians to admit them to a specific hospital if they needed hospitalization, and another 54 percent would ask for a specific hospital, but would go to the hospital the physician preferred. (CX 1055F) Some physicians will ask their patients where they wish to be hospitalized. (CX 1030 at 3.8; Anderson, 241-42) When patients ask to be admitted to a particular hospital, their physicians generally will honor those requests if possible. [42] (See, e.g., Anderson, 233-34; Boyd, 337, 357-59, 382; Bernhardt, 1238) While some patients may express an interest in the hospital to which they will be admitted, it is the physician who usually determines the hospital to which patients are admitted. (See F. 65, 75-77). Dr. Boyd testified that "[t]he decision as to where the patient is admitted is primarily the physician's." (Boyd, 361; see also Boyd, 338, 381, 418-19) Dr. Harvey testified that his patients "don't express a preference" for a particular hospital. "Without question I think they rely upon my judgment as to what would be the best place for them to be admitted." (Harvey, 1638) Dr. Schwam testified that pa-

tients "almost never" express a preference for a particular hospital. (Schwam, 578-79)¹⁴ Dr. Bernhardt testified that it is "relatively rare" for his patients to express a preference for a particular hospital and that his patients typically follow his recommendation that they be admitted at Sierra Vista. (Bernhardt, 1237-38)

106. There are some patients who pay part or all of their hospital bills, and so have an incentive to use less-expensive hospitals. First, there are persons who do not have any health insurance. According to a study by the U.S. Department of Health and Human Services, prepared during the early days of the Carter Administration (Schramm, 2288), approximately 12.6 percent of the population has no health insurance coverage at all, and a substantial number of people who have some health insurance coverage do not have enough insurance to cover all of the cost of hospitalization. (Lave, 868-69) Second, people have insurance policies with co-payment and deductible provisions. (Lave, 869) Some policies have co-payment provisions where the policy covers only a certain percentage of the patient's charges, or an allowance towards certain hospital charges. A co-payment provision requiring that the patient pay roughly 20 percent of his hospital expenses is typical for commercial insurance policies. (Derzon, 1986-87, 2013; *see also* F. 96) A co-insurance provision appears in at least one Blue Cross group policy, which is offered to California state employees. (CX 583J-L) Those who lack health insurance coverage and those who have to pay a part of their hospital bills are somewhat [43] price-sensitive. (Lave, 869) Studies of the effects of changes in co-payments and deductibles in health insurance policies indicate that when consumers face a 10 percent increase in what they have to pay for medical care in general, and hospital care in particular, their utilization of those services will decrease by 2 percent. In other words, the price elasticity of demand for those services is -0.2. (Lave, 863) This estimate was corroborated by the Health Insurance Study, an experiment sponsored by the Federal Government and conducted by the RAND Corporation, to determine how consumers' usage of health care services is affected by the price they have to pay for it. (Lave, 863-64, 915-16; RX 5752A-G) The decreased usage of services is attributable to both shorter hospital stays and decisions to forego hospitalization altogether. (Lave, 865) In recent years, the percentage of the population that must pay all or part of their hospital bills has been increasing due to: 1) unemployment associated with the current recession, which deprives those who lose their jobs of health insurance (Lave, 846-47); and 2) a trend toward increased deductibles and co-

¹⁴ Testimony by Drs. Schwam and Harvey should be viewed in light of the fact that there is only one hospital in the South County, where Dr. Schwam practices, and there is only one hospital—French—in the San Luis Obispo area where Dr. Harvey, a cardiologist, can send patients for cardiac catheterization and cardiac surgery. (Harvey, 1634)

payments in health insurance policies. (Lave, 847; *see also* CX 728A-Z49)

107. Those who pay for all or part of their care may be aware of the relative charge levels of different hospitals. First, hospitals develop reputations for their general level of charges, as former patients talk about their hospital stays. If a hospital has charges patients believe to be excessive, that fact affects the hospital's reputation. (Lave, 848; Carlson, 1360-62; Friedmann, 1580-82) Second, hospitals' general levels of charges are sometimes reported in the press. For example, a newspaper in Salinas, California reported data obtained from the California Health Facilities Commission, including comparative hospital charges. (CX 338B) Mr. Kenneth Friedmann, former controller of French Hospital, testified that the local newspaper would periodically report on the more "visible" charges of the local hospitals, such as room rates and emergency room and operating room charges. (Friedmann, 1582) Room rates, which on average account for about 45 percent of total hospital charges, are particularly "visible." (Derzon, 2100-01; Guy, 635; Lave, 862)

108. Nonprice considerations also affect which hospitals patients prefer. Patients care about the quality of care provided by a hospital, including such things as responsiveness of nurses, quality of the food, and waiting time for various tests. (Lave, 829) Hospitals also seek to make patients comfortable, by providing such things as carpeted floors, color televisions, private rooms and private baths. (CX 1030 at 3.16; CX 1060I) [44]

109. The percentage of the population that is price-sensitive to some degree is large enough to encourage some price competition between hospitals. As Dr. Lave testified:

They [consumers who are price-sensitive as to hospital services] represent an appreciable proportion of the potential patients for any hospital. And I think that it would be very difficult in this time of excess beds for any hospital to decide that it was going to simply pay no attention to that group.

And so hospitals, I think, have that group precisely in mind when they are trying to worry about setting prices.

(Lave, 869)

110. Hospitals sometimes set low prices on some of their services as part of a deliberate competitive strategy to attract patients. (*See* Lave, 852) The Lewin Report discusses "conscious price competition" between the two hospitals in "Lee County," as evidenced by the new for-profit hospital's policy of holding its room and board charges below those of the established non-profit hospital, and of keeping the differences between the two hospitals' ancillary charges per patient day

unusually low. (CX 1030 at 2.38) The Lewin Report also discussed the strategy of the for-profit hospital in "Cherokee" to promote usage of its new emergency room:

Magnolia's administrator, replied in the local newspaper, [to charges that Magnolia 'flouted' certificate-of-need regulations in opening its new emergency room], 'We are opening the emergency department at the request of the community and we are moving toward being a full service hospital. Our rates will compare favorably with Houghton Hospital.' Magnolia's pricing strategy and the controversy raised by the local officials which advertised the unit's opening resulted in a quick growth in visit volume.

(CX 1030 at 3.18)

111. Hospitals also recognize that charging high rates can result in loss of business to competitors. Friesen discussed this subject in the strategic plans it prepared for AMI's Community Hospital of Santa Cruz, in Santa Cruz, California, and [45] AMI's Circle City Hospital, in Corona, California. In the Santa Cruz situation, Friesen noted that AMI's hospital lost money on room and board, and earned subnormal profits on ancillary services. (CX 1054N) Friesen attributed AMI's inability to set rates sufficient to cover its costs and achieve its profit objectives to "the two hospitals competitive situation in Santa Cruz which does not permit Community [Hospital of Santa Cruz] to adjust rates as easily as other region hospitals." (CX 1054N) In the Circle City strategic plan, Friesen examined the rates of Circle City in comparison to those of other local hospitals (CX 1059D) and other AMI Western Region hospitals. (CX 1059H) One conclusion Friesen drew from that data is that "Circle City is approaching the 'rate ceiling' at which its growth in market share could be impeded by overly aggressive rate increases." (CX 1059H) This reduced growth in AMI's market share would occur because some patients would use competing hospitals if Circle City went over the "rate ceiling." (Loftin, 2525) In AMI's response to comments on its application for a certificate-of-need to build a new hospital in Yuma, Arizona, AMI argued that:

[A] review of YRMC's [Yuma Regional Medical Center] rate increases indicates that YRMC has difficulty in managing hospital cost without a second hospital in Yuma. Perhaps, a second hospital in Yuma will make YRMC more conscious of the need to contain hospital costs.

(CX 1051M) In addition, the administrator of Sierra Vista felt that a hospital with a reputation for exorbitant prices might well lose patients. (Carlson, 1360-63) Hospital administrators are aware of the visible rates of their competitors. (Steacy, 149-50; Loftin, 1495-96)

112. Hospitals also compete to appeal to potential patients' non-price preferences. The most important way of doing this is to provide high quality services. (Lave, 829) The Lewin Report notes that the

competing hospitals in the case studies sought to attract patients by opening new services and offering attractive patient rooms, among other things. (CX 1030 at 1.16, 1.20-1.21, 2.16-2.17, 2.47, 3.16-3.17) Friesen suggested that AMI's Brookwood Medical Center convert semi-private rooms into private suites to attract patients. (CX 1060I-J) Hospitals also use public relations efforts, such as advertising, allowing community groups to hold meetings in hospitals facilities, and holding "health fairs" to influence patients' preferences among hospitals. (Lave, 829-30; CX 1030 at 1.16, 1.20, 2.19, 2.24; CX 1054U; F. 157) [46]

113. Health maintenance organizations ("HMOs"), self-insured businesses, and "preferred provider plans" act as "group purchasers" of hospital services for their subscribers and employees. They bargain with hospitals to secure hospital services at the lowest cost. (Lave, 833) HMOs receive a fixed fee from subscribers in return for providing their health care. Since hospital care is probably the largest single component of the expenditures of an HMO (Lave, 833), HMOs that do not have their own hospitals have an incentive to negotiate with hospitals for hospital care at the lowest cost; to not only save them money, but also to help them compete against other HMOs. (Lave, 833, 850) They also are interested in making sure that their subscribers receive only the hospital care they require. (Lave, 834) HMOs that do own their own hospitals also contract for hospital services to a limited extent. (See Guy, 679)

114. Beginning in about 1978 or 1979, there has been a rapid growth of HMOs in California, particularly HMOs other than the dominant Kaiser and Ross-Loos HMOs. (Guy 639, 641) The approximate percentages of the California population enrolled in HMOs increased from 15% in 1975 to 22% in 1982. (Guy, 641-42) About 7 percent of the total California population is enrolled in HMO's other than Kaiser. (Guy, 679-80) These HMOs have begun to negotiate with hospitals for preferred rates. (Guy, 639) The result was that, not only were Kaiser and Ross-Loos getting discounts, but also by about 1978, discounting to attract the business of other HMOs started to occur. (Guy, 642) At least three AMI hospitals in California engaged in such discounting for the business of HMOs. The "Health Net" HMO received discounts of between 10 and 15 percent of charges from those three hospitals, and another HMO received a discount ranging from 26 to 28 percent (depending upon volume of HMO patient days) from one of the hospitals. (CX 393; CX 414B-D, E-G, H-J) Friesen's strategic plan for AMI's El Cajon (California) Valley Hospital recommended that the hospital seek the business of HMOs that do not have their own hospitals. (CX 1057B)

115. Some large businesses "self-insure" for employee health bene-

fits by paying their employees' health care expenses themselves. (Lave, 833) Such self-insured businesses purchase hospital services for their employees, much like HMOs that do not own hospitals. (Lave, 833) Another type of "group purchaser" of hospital services is the "preferred provider plan." There is no generally accepted definition of the term (Derzon, 2155), but one common characteristic is that preferred provider plans limit the choice of hospitals and other health care providers to be used by their subscribers, and in particular limit the subscribers to lower-priced hospitals. [47] (Schramm, 2360) There are preferred provider plans in California. (Derzon, 2154; Schramm, 2360, 2421),

116. In the last three or four years, self-insured businesses have received discounts from hospital rates for their employees' care in California. (Guy, 639) This trend began in Southern California, but eventually encompassed virtually the entire state. (Guy, 643-44) Friesen's strategic plan for AMI's Palm Beach Gardens (Florida) Community Hospital noted that Pratt and Whitney, a large area employer that is self-insured for health benefits (CX 1058B), and that aggressively seeks to control the cost of health benefits (CX 1058B-D), was asking its employees' physicians not to admit them to the hospital (CX 1058B), in part because Pratt and Whitney's medical director believed the hospital's rates were excessive. (CX 1058C). Friesen recommended that the hospital seek to repair its relationship with Pratt and Whitney, and, upon the company's request, consider giving it a discount in return for a higher volume of patients. (CX 1058D) Another Friesen study suggested that AMI's El Cajon (California) Valley Hospital pursue a strategy of developing similar relationships with local employers. (CX 1057B) The Lewin Report noted in one of its case studies that the two hospitals studied competed for a county contract to care for indigent patients. (CX 1030 at 2.20-2.21)

117. In 1982, the California Legislature enacted three bills permitting the Medi-Cal program to contract for inpatient hospital services. (CX 589A, I-J; CX 590A, J-M, R-W, Z20-Z21; CX 599U-X, Z6-Z13, Z43; Guy, 619, 622, 685) The Medi-Cal program has obtained from the U.S. Department of Health and Human Services waivers of certain federal statutes so that the Medi-Cal program may begin contracting for inpatient hospital services with selected hospitals. (CX 593; CX 592D-Z18; Guy, 630-32; 42 U.S.C.A. 1396n(b) (West Supp. 1982)) Such contracting has already begun. (Guy, 655; Derzon, 2023) The objective of Medi-Cal contracting is to stimulate competition among hospitals for Medi-Cal patients, which did not exist before. (Guy, 632-33; see F. 122)

118. At the federal level, in 1979, the idea of "competitive solutions" to the growth of the Medicare and Medicaid budgets was discussed

among government policymakers; such solutions involved major structural change of hospital financing mechanisms, among other things, to promote competition in the hospital industry. (Schramm, 2318-20) This activity at the federal level grew out of efforts by Prof. Alain Enthoven and others beginning in the mid-1970's. (Lave, 907) "Competitive solutions" were also presented to, and considered [48] by, the California Legislature around 1978 when the Legislature considered enacting bills providing for state regulation of hospital rates. In 1982, when the legislation authorizing Medi-Cal contracting was enacted, California had severe financial problems in balancing its budget. (Guy, 614) The legislation was enacted on an emergency basis, requiring a two-thirds vote of the legislature. (Guy, 615; CX 559J; CX 590Z21; CX 599Z43) Contracting for Medi-Cal inpatient hospital services with selected hospitals is anticipated to save the state government more than \$200 million per year. (Guy, 664)

119. The responsibility for implementing Medi-Cal contracting until June 30, 1983 is vested in a special hospital negotiator (currently Mr. William Guy), appointed by the Governor of California and operating out of the Governor's office. (Guy, 609; CX 590R-S; CX 592P) Under Medi-Cal contracting, the special hospital negotiator negotiates contracts with hospitals to provide inpatient hospital services to Medi-Cal patients. (CX 590R-S) On July 1, 1983, the California Medical Assistance Commission will assume responsibility for Medi-Cal contracting; the special hospital negotiator will become the executive director of that Commission. (Guy, 621; CX 589I-J; CX 590S; CX 592I) The transfer of authority will not significantly affect how Medi-Cal contracting is conducted. (Guy, 663)

120. The special hospital negotiator may select the hospitals with which he will contract through competitive bidding, negotiations, or other methods of procurement. (CX 590A; CX 592L) The selection process for contracting in a Health Facilities Planning Area (HFPA) where there are no existing Medi-Cal contracts begins when the negotiator contacts the hospitals in the HFPA to determine which hospitals would be interested in negotiating contracts. (Guy, 647-48; CX 592L) After a series of discussions with interested hospitals, the negotiator will decide which of those hospitals will receive contracts. (Guy, 650) Once the negotiator has contracted for at least 100 percent of the bed capacity required for Medi-Cal patients in an area, the negotiator can "close" the area, and notify noncontracting hospitals that they are no longer eligible to serve Medi-Cal beneficiaries. (Guy, 650-51; CX 592K-L) Such noncontracting hospitals may be paid for inpatient services rendered to Medi-Cal patients only: 1) in case of an emergency; 2) when a patient whose home is an excessive distance (defined as 30 minutes' travel time, or normal community travel time,

whichever is greater) from a contracting hospital chooses to go to a noncontracting hospital closer to home; or 3) when other minor exceptions to contracting requirements apply. (Guy, 653-54; CX 592I-K) [49]

121. The cost to the state of the services to be provided under a contract will be "a strong driving force in the equation." (Guy, 632) The negotiator will prefer contracts with "per diem" rates (a fixed amount per Medi-Cal inpatient day), but alternative methods of payment will be considered. (Guy, 625-26) The negotiator, Mr. Guy, also will prefer a contract of perpetual length with a 120-day cancellation clause. (Guy, 649) The negotiator will consider the financial ability of hospitals under consideration to carry out their contracts (Guy, 660), and whether the rates offered by the hospital include or exclude payment for hospital-based physicians. (Guy, 649) In addition, the negotiator is required to consider factors such as beneficiary access, and to give special consideration to hospitals that have handled a disproportionate share of Medi-Cal patients in the past. (CX 599Z7; Guy, 686) The state will prefer that a contract cover all services Medi-Cal patients might need, which means that a contracting hospital either must provide all services itself or arrange for other hospitals to provide services it does not provide. (Guy, 662) As a result, hospitals will be negotiating with other hospitals on prices of hospital services. (Guy, 662)

122. The success of Medi-Cal contracting in achieving cost savings for the state of California depends in large part on competition among hospitals for Medi-Cal contracts. As Mr. Guy stated: "[c]ompetition is what we need within the negotiating environment to drive the most cost-effective rate for the state." (Guy, 666) The possibility that a hospital can gain or lose patients, depending on whether or not it receives a Medi-Cal contract, gives the state "leverage" in negotiations:

It is the basic desire for the patient flow that creates the strongest issue in negotiation. Are you prepared to give up patients? Are you prepared to keep the same number of patients or would you like additional patients? Obviously a hospital with a low occupancy would usually prefer additional patients. And, as a result, automatically creates a leverage in negotiation.

(Guy, 660) Conversely, lack of competition limits the state's options. Mr. Guy testified that the state might be able to work out "capitation" arrangements with some "sole providers," in "very rural areas," whereby the hospital becomes responsible for providing hospital care to the Medi-Cal population in its area, and the state pays a fixed amount per person covered. (Guy, 626-27) In other areas, however, the "lack of [a] competitive [50] environment" would lead the state to

“walk away from” those areas. (Guy, 629) In those areas, the existing cost-based Medi-Cal reimbursement system would continue to apply. (Guy, 629; CX 592K, Z5-Z18; CX 593)

123. The legislation authorizing Medi-Cal contracting for inpatient hospital services also permits Blue Cross and commercial insurance companies to contract with selected hospitals for hospital services for their subscribers. (Guy, 668-69; CX 589F-H; CX 599-O-S) This legislation removes a requirement in prior law that prevented insurers from restricting the freedom of their subscribers to choose hospitals. (Guy, 669-70) Blue Cross of California has announced a preferred provider plan, effective January 1, 1983, which will involve negotiations on a price basis with individual hospitals. (Schramm, 2421) Increasingly, third-party payors, particularly preferred provider plans, are attempting to require their insureds to use lower-priced hospitals. (Schramm, 2360) The economic pressures that led California's insurance companies to support the legislation permitting them to negotiate prices with hospitals may lead them to take advantage of that option. (Guy, 672) As described by Mr. Guy:

The heavy development in California of the HMOs have [sic] eroded a fair amount of the marketplace of the insurance industry in California. Coupled with the heavy movement toward self-insurance where the employer could negotiate rates with hospitals, . . . did not escape the intention [sic] of the insurance industry. . . . They needed a product to offer in that marketplace that was something between the HMO and the 'purer fee for service.' They realized that they were being blocked off from that development because of the law. You added to the fact that the state was getting ready to launch into a negotiated competitive base for Medi-Cal, and the insurance industry acted quite naturally when they said, me, too. . . .

(Guy, 671)

124. In order to expand capacity, add new services, or make major equipment purchases, hospitals must obtain “certificates-of-need” from local planning authorities. (Lave, 830-31; see F. 84) Since the planning authorities may limit the number of certificates-of-need to be awarded for any particular program or for expansions of bed capacity, hospitals compete with each other to identify the kinds of facilities and services their [51] communities need, and to apply for and obtain certificates-of-need to build and operate those facilities and services. (Lave, 830-32) In its strategic plan for AMI's Community Hospital of Santa Cruz, Friesen urged AMI to oppose the application of Dominican Hospital, Community's sole competitor (CX 1054P), for a certificate-of-need for additional beds. (CX 1054B) Friesen warned that “[i]t is necessary to show that [AMI is] directly addressing community needs, not simply objecting to Dominican's analysis,” and

suggested that AMI might do so by offering new or expanded services. (CX 1054B)

125. Competition between hospitals reduces and limits the amount hospitals can charge. (F. 111) Mr. Victor Kolodziej, AMI Vice President and Financial Director for AMI's Pacific Southwest Region (CX 1072G-H), argued that this would occur in Yuma, Arizona if AMI were permitted to build a new hospital there to compete with the established hospital:

What we are talking about is a deescalation in the build up of rates in the future; that what should happen within the competitive mold is that rates will not increase as they have in the past. It's not the reduction of rates themselves; it's a deescalation in the inflation of rates.

They will not cut rates. We would not cut rates, but rates would not increase as rapidly in the future.

Competition also affords "group purchasers" of hospital services opportunities to bargain with hospitals to further lower charges. For example, Mr. Guy, California's Medi-Cal negotiator, recognized that the state's bargaining position in negotiating contracts for Medi-Cal inpatient hospital services, and therefore the opportunities to reduce the amount the state would have to pay for those services, depends upon competition for those contracts. (F. 122)

126. A related benefit of price competition is that it provides an additional incentive for hospitals to operate efficiently so that they can operate profitably while charging competitive rates. (Lave, 849; *see also* Lave, 902) Mr. Ronald Porter, Group Vice President of AMI and Regional Director for AMI's Pacific Southwest Region (CX 1072H), emphasized this benefit in arguing to a panel of the Western Arizona Health Systems Agency that AMI should be permitted to build a new hospital in Yuma, Arizona:

We believe that if efficiency is introduced into the marketplace, into our facility, it will allow [52] us the opportunity to have rates which are lower or at the top end to be that of Yuma Regional Medical Center and that we believe that competition in this case will force both facilities to be very mindful. I think it will force both facilities to become efficient.

(CX 1072V)

127. Competition between hospitals forces hospitals to anticipate, and respond to, the needs and desires of patients, physicians, and their communities. Physicians have some leverage over a hospital if they can admit their patients elsewhere should they become dissatisfied with a hospital. Mr. Kenneth Ono, an Operations Assistant with AMI's Pacific Southwest Region (CX 1072H), and a former adminis-

trator of a hospital in Hawaii (CX 1072M), described how physicians there felt about this aspect of competition:

[T]here were two hospitals there, and one of the comments physicians used to make was, "Oh, it's really a hassle going back and forth" [O]n the other hand they said, "We like it when there's competition," because . . . they can indicate to the administrator about the progressive new things that are being done in one hospital and why can't they be done in another. . . .

(CX 1072M) The Lewin Report also noted that physicians in the communities studied benefited from the opening of a second hospital in each of those communities because that increased their leverage vis-a-vis the hospitals. (CX 1030 at 1.30, 3.14) Competition also gives hospitals an incentive to identify community needs early, and to promptly apply for certificates-of-need for services to respond to those needs. (Lave, 832) Competition benefits patients by keeping hospitals and their employees "on their toes." (Lave, 835; CX 1030 at 1.29-1.30, 2.47, 3.42) The result of keeping hospitals "on their toes" was summarized by Dr. Lave:

I think that the primary effect of non-price competition is to keep institutions on their toes, to keep them from becoming ossified in what it is that they are doing; to try and look for new opportunities, and to try and take a look for new ways of serving physicians and patients; to keep them from simply sitting back and responding when physicians or people in the community say that they need something but instead to aggressively go [53] out and try to find out what the market looks like, what people will want. That is very good for the whole community.

(Lave, 835) A doctor supporting AMI's proposal to build a new hospital in Yuma, Arizona, described the effect of this kind of competition on the quality of hospital care:

I believe that Yuma Regional Medical Center is a good community hospital. In the past four years there have been significant improvements. Nevertheless, it is my belief that these improvements would have occurred sooner had there been competition in the area. Of more importance, as medicine changes, so must the entire medical community and I believe that competition will clearly help to keep both hospitals closer to the forefront of medicine.

(CX 1050X)

128. Another benefit of competition is that there is a wider range of choices available to patients. For example, competition has stimulated the trend toward innovative obstetrical services and policies—including things which some parents desire, even if they are not necessarily associated with high-quality medical care. (Lave, 836-37) The Lewin Report observed that consumers in the communities studied generally appreciated the expanded choices available to them

because of competition. (CX 1030 at 1.29–1.30, 3.42) It also noted that the poor in those communities benefited from the increased availability of services brought by competition. (CX 1030 at 1.30) Competition also forces hospitals to develop expertise in their areas of “comparative advantage.” Competition encourages hospitals to develop particular areas of expertise where they have a “special role in the community.” (Lave, 838–39) The strategy of “Selective Centers of Excellence” adopted for AMI’s Brookwood Medical Center (CX 1060I–L), and discussed above (F. 101), is an example of a hospital pursuing its “comparative advantage.” Finally, competition for certificates-of-need for new facilities and services presents health planning authorities with the opportunity to solicit competing applications, so that they may have more options as to where a new facility or service ought to be located. (Lave, 832)

129. Competition among hospitals produces substantial benefits to patients and their physicians, and improves the quality of hospital care. Dr. Lave, complaint counsel’s expert [54] witness, presented the following overview of the benefits and costs of nonprice competition:

There are always adverse effects of competition. When anybody looks at it, when a Soviet planner looks at competition, he sees excessive capacity being built in one place, some other capacity sitting idle in another place, he sees luxury here that need not be present and so on.

There is always something in competition that gets people who don’t understand it irritated because it always looks as if this could be done more efficiently if we had somebody in charge who could give the orders. The fact is that over time these relatively minor excesses that come about because of competition are disciplined by the marketplace and help to keep the competitors on their toes and to lead to a greater efficiency.

So that this is just as true with respect to hospitals as it is with other areas of the economy. I think that on balance this kind of nonprice competition is extremely productive both in terms of the quality of patient care that one would see as defined by health professionals and the quality of patient care as patients would view it, which is probably just as important as the quality of care as defined by health professionals.

(Lave, 839–40) The benefits of nonprice competition are reinforced by the fact that the certificate-of-need process imposes at least some control on competition for new equipment and facilities, which might otherwise become “somewhat destructive,” and by the regulatory safeguards preventing quality of care from falling below a fairly high minimum level. (Lave, 825, 843; see RPF 7.14–7.16) AMI Group Vice President Ronald Porter, arguing before a panel of the Western Arizona Health Systems Agency, in support of AMI’s application for approval of a new hospital in Yuma, Arizona, expressed succinct evaluation of the benefits of competition: “Competition is good. Com-

petition is healthy for the Yuma community.” (CX 1072T) Finally, the Lewin Report summarizes how consumers in the communities it studied felt about the competition resulting from the entry of a new hospital:

Each reader will make his own decision as to whether benefits [of hospital competition in the cases studied] to this point have outweighed the [55] costs. Consumers to date feel they have, which is the market test.

(CX 1030 at 1.32)

J. Hospital Competition in San Luis Obispo County

130. Prior to AMI's acquisition of French, San Luis Obispo County presented a situation in which many of the types of competition previously described could and did flourish. The county was well-supplied with physicians (*see* RX 5435Z16), and since all the hospitals had open privileges, these doctors could practice at any one of the five hospitals in the county. (Anderson, 224; *see* Boyd, 327) In addition, there was substantial excess capacity throughout the period preceding the acquisition. In 1978, for example, the average occupancy rate for all five hospitals in the county was only 54.2 percent. (RX 5835) Furthermore, the hospitals had particular strengths and weaknesses, so patients and physicians were presented with a number of choices among the hospitals. (F. 131-133)

131. The city of San Luis Obispo was the hub of health care services in the county. (CX 255H) It contained the largest hospitals in the county, Sierra Vista with 172 acute care beds, and French with 138 acute care beds. (CX 736B) Both hospitals offered a wide range of services. Sierra Vista, which was considered one of AMI's finest hospitals (CX 307), had an active emergency room and offered CAT scanning, nuclear medicine and ultrasound. (CX 283J-L) French also offered a number of specialized services, including CAT scanning, cardiac catheterization, and pediatrics. (CX 271B, D; Boyd, 375-76) In addition, it was recognized for the quality of its nursing staff and the quality of food served to patients. (Loftin, 1480-81; Anderson, 223)

132. SLO General, also in the city of San Luis Obispo (CX 736B), was heavily subsidized by the county (CX 41C; *see* Bernhardt, 1304), was the choice of people without health insurance and those who relied on the county to pay for their health care. (Boyd, 359; Schwam, 576-77) SLO General was not as modern as French and Sierra Vista and was considered by many doctors as inferior to French and Sierra Vista. (F. 135) SLO General is the hospital of choice for obstetrics; it was the first hospital to offer facilities for natural childbirth. (RX 5436Z28)

Periodically, there had been discussions concerning closing SLO General. (CX 41C; Bernhardt, 1260)

133. There were also two hospitals outside the city of San Luis Obispo. Twin Cities was the only hospital in the North County, from where it drew almost all of its patients. (F. 55) [56] Twin Cities did not offer as many services as French or Sierra Vista. For example, it did not have a separate pediatric department, and had no cardiac catheterization or CAT scanning capability. (See CX 288J) In addition, it had only 84 beds, fewer than either French or Sierra Vista. (CX 736B) Arroyo Grande is the only hospital in the South County. It had only 79 beds. (CX 736B) It had neither a CAT scanner nor an obstetrics department. (CX 266B; CX 268I) In addition, it was not as well-equipped as the hospitals in the city of San Luis Obispo. (Schwam, 585)

134. Prior to AMI's acquisition, competition between the hospitals in the county took place primarily between French and Sierra Vista. First, the hospitals competed to attract doctors to admit to their facility. (Anderson, 232) Dr. Boyd testified:

Q. When you choose to admit a patient to one hospital, obviously to the exclusion of others, how does your choice affect that hospital to which the patients is admitted?

A. Of course, it affects their cash flow very directly. The decision as to where the patient is admitted is primarily the physician's and so the hospital is very interested in attracting the physicians to admit patients.

(Boyd, 361) Second, there was pressure on each hospital to satisfy the needs of the doctors who were already admitting there, since they could always admit patients to one of the other hospitals. Mr. Anderson, the former administrator at French, explained:

Obviously I didn't want my patients going to Sierra Vista or any other hospital for that matter. So we did try to create an environment which would encourage [doctors] to continue bringing their patients to French Hospital.

(Anderson, 231) This competition for doctors gave the hospitals an incentive to provide the best health care possible. (Carlson, 1321, 1328)

135. Hospitals compete for physicians by offering them the kind of equipment and services that the physician believes his patients will need. (Lave, 826) Whether a hospital has necessary equipment is a major factor in a doctor's decision where to admit patients. (Boyd, 337; Bernhardt, 1288) Hospitals in San Luis Obispo purchased equipment physicians [57] needed in order to ensure that they would continue to use their facilities. For example, Sierra Vista's administrator noted:

One area of marketing that we have always tried to pursue is that of provision of

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equipment as necessary and as requested by the Medical Staff. One of these items was a duodenoscope and an inflatable tourniquet for use in the Emergency Room. These are both a result of direct requests from physicians which we were able to rapidly process.

(CX 453B) At another time, he noted that the hospital's revenue from ancillary services had been increased as a result of "satisfying the requests and requirements of the Medical Staff for equipment and services." (CX 318A; *see also* Carlson, 1321) French also attempted to attract physicians by providing improved services and needed equipment. Such competition had taken place with regard to certain ophthalmology equipment. According to one witness:

The hospital, the partners, tried to improve the services to attract more physicians to admit their patients to French Hospital. I think that the most notable example would be with the ophthalmologists.

They obtained additional equipment that the ophthalmologists wanted and, as a result, now most of the ophthalmology is being done at French Hospital as opposed to the fact that it used to be done at Sierra Vista Hospital.

(Boyd, 368; *see also* Bernhardt, 1250) SLO Hospital was less successful in attracting doctors to practice there. SLO General was viewed as the primary obstetric facility since it offered "contemporary modalities of practice," including natural childbirth. (RX 5436Z28) It was the hospital of choice for obstetrics. (Boyd, 386, 420) And, at certain periods, the hospital also had certain other facilities, such as a burn unit and a renal dialysis unit, which other hospitals did not have. (Anderson, 267) It was the hospital of choice among physicians whose patients required these services. (Schwam, 576-77) With these exceptions, however, SLO General did not compete significantly for physicians with French and Sierra Vista. Most doctors did not practice at SLO General because it lacked necessary equipment and services or because the equipment it did have was inferior to that available in other hospitals. It was "anachronistic" and its operating rooms were "primitive." (Stahl, 1404) Mr. Anderson testified: [58]

Most of the physicians did not use San Luis Obispo General on a regular basis because they lacked the facilities that they desired.

(Anderson, 305; *see also* Anderson, 226; Boyd, 338) Dr. Bernhardt also testified that he would try not to use SLO General for certain procedures not usually done there. (Bernhardt, 1238) He noted a number of deficiencies in the equipment available at the hospital. He stated:

It is very outdated in its equipment. The No. 1 weakness is the x-ray department. It is quite inadequate in what it can do; no scanning equipment or angiograms or things

of that nature. It has a small and in-constantly [*sic*] used intensive care unit which isn't too hot, basically. . . . You don't feel like they are up to the speed in terms of what is going on.

(Bernhardt, 1243) The John James Report came to a similar conclusion about SLO General. (RX 5022Z43) Dr. Boyd noted:

Mr. James is referring to the fact that the equipment at General Hospital was not up to the standards of the other hospital and the staff, medical staff, had expressed to him that that is why they weren't taking patients there.

(Boyd, 395)

136. Although few doctors from outside the city of San Luis Obispo regularly used the hospitals there, the possibility that these doctors might admit some patients there imposed some competitive pressure on hospitals in the outlying areas. The existence of French as an independent hospital provided a way of bringing pressure to bear on the Arroyo Grande administration when new equipment was needed. Dr. Schwam testified:

[M]odernizing Arroyo Grande Hospital and stimulating administration to get what we thought was adequate equipment has always been a problem. . . .

* * * * *

So the medical staff had a certain amount of leverage in a sense because we could always point [59] to French Hospital in terms of equipment that we felt that we needed and that we were not getting. Some members of the medical staff even stated that they would take their patients to French Hospital if certain basic equipment was not forthcoming.

(Schwam, 585; *see also* Schwam, 593) Dr. Schwam did not generally admit patients to French, but he used that option as a way of "alerting administration that we wanted progressive changes." (Schwam, 585-86) AMI recognized this competitive pressure. In a report prepared by the staff of AMI Vice President Norman Loftin (Loftin, 1492) concerning Arroyo Grande, it was noted that "among the physicians in the community, French is used over Sierra Vista, another American Medical International Hospital, because of the philosophy that subtly suggests to the corporation that it invest in the same quality and level of care in both Arroyo Grande and Sierra Vista." (CX 197G; *see also* CX 197N)

137. Competition for doctors, especially between French and Sierra Vista, resulted in the hospitals' purchasing needed equipment and improving the quality of services. For example, competition for doctors through the provision of equipment had a major impact on how the present French Hospital was equipped when it was built. The equipment in the original French hospital was described as "very

poor" (Boyd, 354), and the hospital generally was considered by doctors to be the worst of the three hospitals in the city. (Boyd, 351) The equipment at Sierra Vista, on the other hand, was described as "superior." (Boyd, 352) When the new French Hospital was built in 1972, the administration "tried to furnish the necessary instruments and the equipment that would encourage physicians to use French Hospital." (Anderson, 232) For example, special equipment for neuro-surgery was provided so that a neurosurgeon in the city would use French for his surgery. (Anderson, 233)

138. Prior to 1970, Dr. Boyd and Dr. Cletsoway, two urologists, admitted their patients to Sierra Vista. (Boyd, 340) Dr. Boyd had been Chief of Staff at Sierra Vista and later held the same position at French and SLO General. (Boyd, 342) When the new French Hospital was being built, Dr. French asked Dr. Boyd and Dr. Cletsoway what urology equipment the hospital should be equipped with, and their suggestions were incorporated into the facility. (Boyd, 340-51) As a result of this new equipment, Dr. Boyd and Dr. Cletsoway began admitting more patients to the new French Hospital. (*Id.*; see also Anderson, 233) When Dr. Boyd and Dr. Cletsoway switched patients to French, this reduced the revenue which Sierra Vista received. In order to recapture this business, the hospital bought new equipment. Dr. Boyd testified: [60]

Sierra Vista Hospital decided to upgrade their equipment in order to move us back, and they acquired some new equipment but it wasn't as good equipment as French had.

So we told them we wouldn't come back until they had as good equipment as French. It think it took about two weeks and they had the other equipment, so that they had exactly the same equipment as French had.

(Boyd, 356)

Subsequently, the third hospital in the city, SLO General, also purchased the new equipment in order to attract Dr. Boyd. (Boyd, 356) However, it took approximately a year-and-a-half for it to get the equipment, during which time Dr. Boyd did not use the hospital for urological surgery. (*Id.*) Thus, as a result of the competition for Dr. Boyd's patients, the urology equipment was substantially upgraded at all the hospitals in the city.

139. Dr. Harvey noted another instance in which the competition between the hospitals resulted in equipment being upgraded. When Dr. Harvey arrived in San Luis Obispo, both French and Sierra Vista owned primitive forms of an important diagnostic tool used in cardiology, a Swan-Ganz catheter. (Harvey, 1685) Shortly after his arrival, French upgraded its equipment at Dr. Harvey's request. Within weeks Sierra Vista and SLO General also purchased those items,

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again, at Dr. Harvey's urging. (Harvey, 1685-86) Dr. Harvey noted it was important for him as a cardiologist to have this relatively inexpensive piece of equipment. (Harvey, 1685)

140. The quality of nursing was one area in which the hospitals competed. French Hospital was distinguished by the quality of its nursing and the level of its staffing. Although the original French Hospital was a poor facility overall, the nursing care was "remarkably good . . . it was almost like being taken care of by mother at home." (Boyd, 349) The nursing care at the present French was also excellent. French was also the first hospital to offer "total patient care," a nursing method which utilized more registered nurses and fewer nurses' aides. (Collins, 1433) French's higher nurse-patient ratio gave it a competitive advantage over other hospitals in town. (Anderson, 221) An AMI official acknowledged that one of French's strengths prior to the acquisition was its excellent nursing care. (Loftin, 1481) The nursing care at Sierra Vista was [61] described as inferior to French, at least partly due to the fact that Sierra Vista suffered from nursing shortages. (Boyd, 378; Bernhardt, 1256) An internal AMI memorandum in April 1978 described the "chronic nursing problems" identified by the new Director of Nursing. These problems were:

[P]rimarily, an inadequate number of proficiently trained nurses to cope with a high census, patients being refused entry to ICU/CCU due to inappropriate or unsafe (State Criteria) staffing levels, nurses reportedly worked harder for salaries earned, concern for the performance of nursing school graduates. . . .

(CX 308B) Nursing at SLO General was considered to be quite good. (Bernhardt, 1242) However, the relatively low utilization rate affected the staff's capability to deal with problems that might arise, and this affected the extent to which doctors used the hospital. (Bernhardt, 1297)

141. These differences in the quality of nursing care affected doctors' decisions where to admit patients. Nurses in the intensive care units of SLO General were less experienced with certain problems than nurses at the other hospitals. (Bernhardt, 1297-98) As a result, doctors were less likely to admit certain patients to that hospital. (*Id.*) Another doctor stated that he used French because the equipment was superior and because "the patients got excellent nursing care in addition to that. So I thought one of my patients could receive excellent care." (Boyd, 361; *see also* Boyd, 338) Competitive pressure was one reason that French continued to keep nursing levels high, despite pressure to cut them considerably. In 1978, two studies were done at French which recommended reducing the level of nursing. (*See* Collins, 1440-41) Although staffing levels were reduced somewhat, they

were never reduced to a level as low as that recommended by these two groups. (Collins, 1441) The decision to leave the nursing levels high resulted, at least in part, from the owners' fear that reducing staffing levels would cause certain doctors to go elsewhere. For example, one recommendation was to reduce staffing in the operating room; however, such a reduction would have meant staffing only two operating rooms, instead of four. (Boyd, 373) Had such a reduction been made, some surgeons would have scheduled operations at other hospitals. (Boyd, 374)

142. French also competed for physicians through its pediatric department. It was considered "outstanding" and "the best pediatric department in town." (Boyd, 376) Therefore, most of the pediatricians in town used the service at French. (*Id.*) In [62] addition, French competed by virtue of its CAT Scanner which was superior to the one at Sierra Vista. (Boyd, 355)

143. Hospitals compete for physicians by providing a qualified medical staff with which their doctors can associate. (Lave, 826-27) Doctors want to be associated with a first-rate hospital. (Carlson, 1323) This ensures that patients will receive proper care and gives doctors the opportunity to learn new techniques. (Lave, 826-27) French worked hard to attract quality physicians to practice there. During the period that the physicians owned French, they brought a number of new specialists into the French Clinic. In bringing in these physicians, the French Clinic doctors were interested "in the expertise they would bring to our role as being as complete as possible in the practice of medicine." (Harvey, 1697) When French was purchased from Dr. French, offers were made to physicians from outside the French Clinic group. (Bernhardt, 1247) In early 1978, three physicians accepted limited partnerships in the facility. (Boyd, 365-66; Anderson, 224) In October, 1978, offers were made to eight other physicians, two of whom accepted. (CX 732; Boyd, 365-66; Anderson, 225-26; Friedmann, 1587)

144. The loss of physicians to French concerned Mr. Carlson, the administrator of Sierra Vista. After the first offering of French partnership shares in 1978, Mr. Carlson reported to Mr. Loftin that "[a]n unknown factor in physician utilization of the hospital is the increasing number of physicians who have been invited to buy into French Hospital." (CX 317B) By October 1978, when the second offering was made, Mr. Carlson was even more concerned. He wrote that:

Because of doctor ownership, past increases in the number of physicians and possible future additions to the Clinic makes that hospital an increasingly formidable competitor for the limited number of patients in the area.

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145. Hospital competition for doctors had several beneficial effects. First, supplying doctors with equipment which they needed resulted in all three hospitals purchasing up-to-date and necessary equipment. (F. 135-139) In other cases, it caused the hospitals to establish a "comparative advantage," such as French's nursing staff and its pediatric department. (F. 140-142) Secondly, competition for doctors resulted in each hospital having a well-qualified medical staff who took pride in the particular hospital they were associated with and who were [63] likely to support the hospital by admitting patients there. This resulted in the quality of care remaining high. Dr. Boyd stated:

In each of the institutions there was pride and loyalty to the institution. The French physicians on the French medical staff felt . . . a real pride in that hospital and tried to maintain as high a quality as possible.

(Boyd, 367) In addition, the hospitals had an interest in promoting this bond between the doctors and the hospital because it meant that doctors were less likely to switch to another hospital. Dr. Bernhardt noted this fact:

It is just, I don't know, almost a fellowship thing. If you are at Sierra Vista, that is sort of your home base. If you were from French, that is your home base. It is like switching churches, I guess. It was sort of [an] identity thing.

(Bernhard, 1251)

146. Competition for doctors did not have any serious adverse effects on patients or the quality of care, nor did it result in the purchase of unnecessary equipment, or encourage unnecessary hospital admissions. Some equipment which was purchased was relatively inexpensive and easy to obtain. (Harvey, 1686) French and AMI had procedures whereby they reviewed doctors' requests for equipment in order to ensure that it was necessary, financially feasible, and useful to more than one individual. (Carlson, 1324; Loftin, 1489; Friedmann, 1574-75) Furthermore, such requests were reviewed by committees so that there is "a consensus before we expend significant amounts of money. . . ." (Carlson, 1324) Each hospital balanced its need to keep physicians satisfied with other financial considerations, including the return to the hospital. (See Friedmann, 1575) Finally, the health planning laws further inhibit unnecessary expenditures by hospitals since some equipment cannot be purchased without a certificate-of-need, and such certificates will not be granted if unnecessary duplication or low utilization will result. (Lave, 842-43; see F. 84-88)

147. It was asserted that doctor ownership of French resulted in a

conflict of interest since the doctor-owners benefited from admissions. (See Bernhardt, 1247; RPF 10.41-10.47) There is no reliable evidence that doctor ownership of French resulted in patients being admitted unnecessarily to the hospital. Dr. Harvey testified: [64]

Q. Do you believe that, in fact, partners at French Hospital were admitting patients unnecessarily?

A. I think we had bent over backwards not to, quite frankly.

(Harvey, 1698; see also Boyd, 377-385) Dr. Stahl, who as pathologist examined tissue removed during surgery to determine whether or not it was diseased, stated that there has not been any change in the amount of undiseased tissue which he has seen since the hospital was acquired by AMI. (Stahl, 1416) There is also no reliable evidence that doctor ownership resulted in patients being kept in the hospital for an unnecessarily long time. Mr. Mittelstaedt prepared several charts which purported to show that the average length of stay at French had decreased since the doctors sold the hospital. (Mittelstaedt, 1067; RX 5744) This chart failed to account for the fact that a number of physicians retired or took sabbaticals when the hospital was sold and others devoted less time to their practice. (Stahl, 1417-18; Harvey, 1698-1700) In fact, Mr. Mittelstaedt admitted that when one such doctor was excluded from his charts, there was very little change in the length of stay. (Mittelstaedt, 1177-79) The hospital length of stay has been declining in recent years nationwide. (Mittelstaedt, 1179) In addition, there are a number of factors that safeguard patients, including the medical ethic instilled in medical students; the tissue and other staff committees; accreditation review; peer review (Derzon, 1948, 1971; Schramm, 2277); and continuing licensing requirements. (Schramm, 2302-03)

148. Much evidence was received about the existence of "polarization" in the medical community which prevented competition for doctors from taking place. (Carlson, 1238-29; Loftin, 1485-86; Friedmann, 1588) According to this contention, there were two groups of physicians in San Luis Obispo; those associated with French Clinic who admitted exclusively to French, and others who would admit only to Sierra Vista. (See Friedmann, 1575-77, 1588; Loftin, 1482) Due to the animosity between the two groups, it was argued that no doctor would switch from one hospital to the other. Apparently the source of this animosity went back to the late 1950's, although according to Mr. Mittelstaedt, "it was not clear that people even remembered why such polarization had existed in the past." (Mittelstaedt, 1031) According to Mr. Friedmann, the polarization supposedly had as its cause the fact that in the 1950's Dr. Edison French bought and closed

down Mountain View Hospital, thereby alienating the physicians who had formerly practiced there. (Friedmann, 1576-77) These physicians subsequently formed Sierra Vista Hospital. (Friedmann, 1577) [65]

149. The competitive effect of physician polarization in San Luis Obispo is marginal. First, it is not unusual for doctors to be affiliated with a single hospital. (Derzon, 1981) In most cases, it is easier for a doctor to have all inpatients in a single hospital near his office. (Bernhardt, 1237, 1285-86; see Harvey, 1682-83) Secondly, it was not true that each hospital was exclusively supported by a discrete group of doctors. Some of the doctors who supported French did not have an ownership interest in the hospital. (*Compare* CX 56H-K with CX 38Z11) According to one of respondents' charts, RX 5740, in fiscal year 1978, only 60 percent of French's admissions came from doctors who were general partners in Central Coast Hospital Company. In fiscal 1979, which ended prior to the acquisition, only 53 percent of French's admissions came from these doctors.¹⁵ RX 5740 refers only to general, not limited, partners. (Mittelstaedt, 1066) However, it seems unlikely that the limited partners made up the remaining admissions since several of them, including Drs. Boyd, Cletsoway, Kettlekamp, McAdams and Tedone tended to admit evenly between French and Sierra Vista. (See Boyd, 409; see also Boyd, 364-66; Anderson, 224, 226; CX 56J) Other doctors who were members of the French Clinic also used hospitals other than French. "[T]o be honest with you, especially with the hemotologists, oncologists and gastrointerologists [who were part of French Clinic] . . . [they] admitted most of their patients elsewhere." (Harvey, 1697; see also Anderson, 248-49) Also, doctors who admitted to Sierra Vista switched to French. A memorandum written shortly before the acquisition was completed notes that "French may have persuaded a couple of doctors to patronize their facility," and then lists the names of five doctors. (CX 56F)

150. Much of the so-called polarization in the community could have resulted from competition which existed among doctors for patients. There was "intense competition" among physicians for patients. (Friedmann, 1586-87) This competition increased the animosity which existed among doctors in the community. For example, Dr. Bernhardt noted: [66]

[T]he [French] Clinic was very expensive. Right after they bought the hospital they brought in new physicians, and some of us felt a little threatened by that. They were bringing in competitors.

¹⁵ In fiscal year 1978, 2281 of French's 3771 total admissions came from doctors with an equity interest in the hospital; the next year, 2234 of its 4152 admissions were from such doctors. (RX 5740)

(Bernhard, 1246) Competition between doctors was exacerbated by the existence of two clinics in the county, the French Clinic and the San Luis Medical Clinic. (Boyd, 352) Not surprisingly, the San Luis Clinic doctors admitted primarily to Sierra Vista, instead of using the hospital owned by members of the rival French Clinic. (Mittelstaedt, 1032–33) Furthermore, these rivals tended to disparage each other. For example, questions about Dr. Edison French's capabilities were "played up most by those who didn't practice with him." (Bernhardt, 1245) Indeed, the existence of this competition between doctors, which presumably still continues, explains why some residual polarization exists today. (See Stahl, 1387)

151. Although it is doctors who admit patients to hospitals, in some few instances patients influence where they will be admitted. This occurred in San Luis Obispo. A number of witnesses noted that patients have an impact on where they are hospitalized. Mr. Anderson explained:

Patients are people . . . for whatever reason they may have a preference for not going to a hospital or wanting to go into another hospital. They may well express this desire to their attending physician.

I assume everything else being equal, that the physician would honor the patient's request. . . .

(Anderson, 233; *see also* Steacy, 152–53) "Where the patient prefers to go" was the primary consideration of at least one doctor in San Luis Obispo in deciding where to hospitalize patients. (Boyd, 337) Other physicians instructed their receptionists to give patients in need of hospitalization the option of going to either French or Sierra Vista. (Anderson, 242) In those instances when a patient expressed a preference, doctors usually attempted to honor it, if possible. (Bernhardt, 1238; Boyd, 382) Patients had various reasons for preferring particular hospitals. Sometimes a patient would have been in the hospital before, and whether they had had a good or bad experience would influence where they wished to go. (Boyd, 357) Many people preferred to go to French, "since Dr. French had a very loyal following." (Boyd, 359) A small proportion of people preferred to go to SLO General. (Boyd, 357) Usually, it was indigents (Schwam, 577), people responsible for their own [67] hospital bills (Boyd, 359), and county employees who liked to go there. (Bernhardt, 1241)

152. Some patients were sensitive to price. The recessionary economy had the effect of reducing admissions to the hospital. (Carlson, 1364–65) Some patients expressed their concern about price, and some asked their doctor where it would cost the least to be hospitalized. Dr. Boyd estimated that in twelve years of practice only about 10 patients

(approximately 1 percent) had requested one hospital over another based on price. He acknowledged, however, that unless a patient expressly mentions price, a doctor cannot tell whether price influenced a patient's choice of a hospital. (Boyd, 408-09, 429-30) One doctor estimated that "at least 20 percent of the patients that I proposed hospitalization to express concern about hospital charges." (Schwam, 579) A substantial number of people who worked in San Luis Obispo County, and their families, were covered by group health benefit plans that have "copayment" provisions requiring them to pay a substantial part of their hospital bills. Brochures for 12 such plans appear in the record. Those plans require covered patients to pay "co-payment" for all or some types of expenses for short-term hospital stays (subject to deductibles, and limitations on co-payments for "catastrophic" expenses) at rates ranging from 10 percent to 30 percent, with a 20 percent rate being typical. (CX 555I-K, O-Q, Z51; CX 557C-D; CX 558D, F; CX 559A, Z16, Z82; CX 561G-H, K, X-Z23; CX 562D, M-Q; CX 563Z13-Z15, Z22, Z216-Z217; CX 583F-G, J-K, N-O, S(a)-T) Those 12 plans cover at least approximately 2750 employees, and their families, in the San Luis Obispo area. (CX 556A; CX 557A; RX 5435Q)

153. Since it is difficult for a patient to determine in advance how much his or her hospital stay will cost (Steacy, 191), patients tend to be aware of only the more general price information or the more visible charges. Two doctors who gave patients a choice of Sierra Vista or French informed patients in advance that "in all likelihood" French would be more expensive. (Anderson, 242) General price information was also disseminated through the newspapers. Periodically, the local newspaper reported on the hospital charges in the community. "That is, they would take and do a little box type affair in the paper with corresponding articles on health care and show the visible, like room rate, the operating room charge, the emergency fee charge, that type of thing." (Friedmann, 1582; *see also* Schwam, 580-81; CX 338B) Since patients are aware of only general price information, it was important for hospitals to maintain their reputation as reasonably-priced hospitals. If a hospital had a reputation for exorbitant [68] prices, it might well lose patients. (*See* Carlson, 1360-62; *see also* Friedmann, 1580)

154. The hospitals in San Luis Obispo were careful about their rates in those areas about which patients were likely to be most knowledgeable. Hospital administrators and AMI officials checked room rates both within the county and in other areas. (Loftin, 1495) Mr. Friedmann, who was in charge of pricing at French prior to the acquisition, kept track of room rates at hospitals in the county and throughout the

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state. (Friedmann, 1580) Mr. Friedmann suggested that such examinations had a competitive purpose. He testified:

There is natural tendency to examine these rates in the sense that certainly you don't want to be terribly out of line or competitively out of line in the sense of, if I were overly high, I would know that maybe I have a problem within my facility as to my costs that had to be examined. Plus from a public relations standpoint, you don't want to be the highest priced show possibly in town.

(Friedmann, 1580) Documents show that AMI was concerned with room rates in the county. An Arroyo Grande planning document includes a survey of room rates, but only those in the county. (CX 191H-I) A memorandum analyzing the upcoming French acquisition similarly notes only those rates at hospitals within the county (CX 38N), the same hospitals that are referred to as French's competition. (CX 38M) Another AMI memorandum suggests that there was room for Sierra Vista to adjust its rates, based on a study of room rates at hospitals in the county. (CX 479; *see also* CX 480)

155. Evidence indicates that competition also had an effect on other charges that were likely to be "visible" to consumers, the operating room and the emergency room fees. (*See* Friedmann, 1582) In Spring of 1978, the installation of a new computer allowed French to change from a per-hour operating room charge to a unit pricing system. (Friedmann, 1582, 1625-26) As a result, operating room charges were changed so that the "front-end charge" was reduced but, due to various "weighting factors," the total revenue could be increased. (Friedmann, 1583) This change did, however, result in lower operating room fees for some patients. (Friedmann, 1626) The reduction in the "front-end charge" was "the actual visible fee . . . that would normally be published, for instance in the paper." (Friedmann, 1583) French reduced another visible charge, the emergency room charge. Doctors used the French emergency room on weekends instead of opening up their offices. Usually there was a charge [69] for the use of the emergency room, but it was waived when doctors saw patients under these circumstances. Mr. Friedmann stated that the reduction was just for weekends, but it may have been more than that since Dr. Bernhardt stated it applied to "off-hours." (Bernhardt, 1248-49) This change in charges may not have had an effect on doctors' admission patterns, but it did affect patients' choice of doctors. (Friedmann, 1585) The change was "more of a patient-getting technique for the members of the French Medical Clinic than anything else." (*Id.*) Since doctors in the Clinic often admitted to French (Friedmann, 1588; *see* Bernhardt 1249-50), any increase in patients from such a move would ultimately redound to the hospital's benefit in the form of increased census. There was concern at Sierra Vista about the competitive moves

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French Hospital. In a letter to Mr. Loftin, a local physician who practiced at Sierra Vista noted the changes in fee schedules and stated: "It is . . . becoming apparent that this hospital [French] is attempting to generate competition . . . and thus is become [sic] extremely competitive with Sierra Vista Hospital." (CX 737) The doctor went on to state that AMI should consider changing its emergency room fees "to be competitive. . . ." (*Id.*) Mr. Loftin replied on February 12, 1979, while AMI was considering the acquisition of French (CX 738; see CX 38): "We have been aware of the competitive moves of French Hospital and will most certainly work to counteract these." (CX 738)

156. There is evidence that hospitals attempted to offer high quality care so as to satisfy patients. (Lave, 829) The doctors at French "tried to maintain as high a quality as possible." (Boyd, 367) An AMI Quality Assurance report notes that Sierra Vista physicians recognized that they were competing with physicians at other hospitals to provide the best possible care. The report notes:

Almost without exception the physicians expressed their concern about being in competition with other hospitals in San Luis Obispo area and indicating that they had the wherewithall to do a more effective job in delivering health services than any of the competition.

(CX 307) The hospitals also competed for patients by offering needed services that were not available at other hospitals in the area. In 1975, French Hospital, which was still owned by Dr. French at that time, set up a heart catheterization laboratory. (Harvey, 1648) This lab allowed cardiologists to diagnose heart disease (*Id.*), and meant that patients in need of this service were treated in San Luis Obispo rather than having to go elsewhere. This program was viewed by French as a [70] way of competing with Sierra Vista since it was a source of referrals. (Anderson 221) A few years after the heart catheterization program was instituted, French also instituted a heart surgery program. (Harvey, 1653) Mr. Anderson noted that they regarded the service as one which would give the hospital increased census since it was not available elsewhere. (Anderson, 222) SLO General competed to a limited extent by offering facilities for natural childbirth. Many patients desired this type of service (Boyd, 420) and, as a result, most deliveries in the county were done at that hospital. (Bernhardt, 242; Anderson, 265)

157. Dr. Lave noted that hospitals compete through public relations, particularly by offering their facilities for various meetings and community activities:

try to tend to see the hospital not as this formidable place where you go to die but

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instead [as] a place where you feel more comfortable with. And then, when their physician asks do you have any hospital preference or simply says I will hospitalize you, the patient will say I prefer to go to hospital X.

(Lave, 830) Evidence shows that both French and Sierra Vista competed in this manner. French hired a public relations manager who began a series of educational seminars for patients on health issues. Mr. Friedmann stated that he believed that this would increase the number of patients for the medical clinic group and that "a direct derivative would be . . . that the hospital would get maybe additional census because the physicians now saw a greater number of patients than they did previously. . . ." (Friedmann, 1586) Sierra Vista also engaged in such educational programs. Sierra Vista had an auditorium which was used by a number of organizations for educational programs. (See CX 317B; CX 319B) Furthermore, Sierra Vista started its own series of programs similar to that at French. In one report Mr. Carlson noted that the hospital was beginning "a series of educational programs for the community under the direct sponsorship of the hospital. The majority of programs held in the hospital have been sponsored by the various agencies putting on the programs; however, I feel that additional areas of interest to the public should be addressed by the hospital." (CX 318B)

158. Prior to AMI's acquisition of French, a number of different types of third-party payors covered the medical expenses of residents of San Luis Obispo. Some patients were covered by third-party payors which reimbursed hospitals on the [71] basis of the hospital's reasonable costs. (Mittelstaedt, 1167; see Derzon, 1994-96) Such cost-based payors included Medicare, Medi-Cal and Blue Cross of Southern California. (Guy, 610; RX 5435Z41; RX 5436Z44) Those payors not cost-based reimburse hospitals on the basis of actual charges. (Mittelstaedt, 1168) In addition, there are several employers in San Luis Obispo County that are "self-insured." (F. 183) Excess capacity was high in San Luis Obispo County which should create a competitive situation. (Lave, 823; see also Guy, 660) In 1978, the average occupancy at hospitals in the county was 54.2 percent. (RX 5835) The occupancy at French was 48.1 percent, far lower than the 65 percent rate at Sierra Vista. (*Id.*) Furthermore, there is evidence that the recessionary economy was resulting in lower admissions to local hospitals as patients put off some discretionary surgery. (See Carlson, 1364-65) Thus the possibility existed that hospitals might well have considered giving one of the self-insured groups a discount in order to get its business, as has happened in other areas. (See F. 116) As other alternative purchaser programs, such as HMOs and the new state Medi-Cal program began or expanded, hospitals in San Luis Obispo County, a

French in particular, might have felt pressure to compete for that business. (See F. 113-122)

159. Hospitals cannot institute certain new services or purchase some equipment without first acquiring a certificate-of-need. (Lave, 830; see F. 84) Since the number of CONs that will be granted can be limited, hospitals often compete to be the first to get a CON and thereby get a competitive advantage. (Lave, 831) Competition for CONs took place in San Luis Obispo. In 1975, French set up a heart catheterization program.¹⁶ (Harvey, 1650) This program gave French a competitive advantage. (See Anderson, 222) AMI recognized that such a program was advantageous to French. AMI might have considered beginning such a program had it not purchased French Hospital. In noting the advantages of buying French, for example, one memorandum states that the acquisition "would remove the need for Sierra Vista to develop a competitive service." (CX 38C) Had Sierra Vista attempted to start either a heart catheterization lab or a heart surgery program, it would have had to obtain a certificate-of-need. (Harvey, 1687) It is unlikely it could have received one, however, since the services at French were underutilized. (See CX 1064 at v 48, v 53; Harvey, 1659) [72]

K. Evidence of AMI's Intent in Purchasing French Hospital

160. After the doctors purchased French in 1976, there were increasing efforts to increase the census at the hospital. (Boyd, 369-70) To that end, the partners brought in new doctors to the French Clinic and the hospital. (CX 56F; F. 143) In addition, French cut charges for some of its services (F. 155) and added some new services. (F. 159) These changes apparently had effect. In 1978, French's average occupancy was 48.1 percent, as opposed to 46.8 percent the year before. (RX 5835) This increase is significant in view of the fact that the average length of stay was declining. (See CX 56F-G) For the first four months of 1979 occupancy was 49.6 percent, even though the average length of stay had declined. (CX 56G) During that period the number of admissions had increased 11 percent over what they had been during the first four months of 1978. (*Id.*)

161. AMI officials were aware of the moves of French Hospital and were concerned about them. In June 1978, after French partnership offerings were made to some doctors in the city (F. 143), Mr. Carlson, the administrator of Sierra Vista, reported to Mr. Loftin, who at that time was Vice-President and Director of AMI's Western Region, that an unknown factor in physician utilization of the hospital is the increasing number of physicians who have been invited to buy into

¹⁶ French actually received a certificate-of-exemption rather than a certificate-of-need. (CX 109A-F; Anderson,)

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French Hospital." (CX 317B) In December 1978, after an offering was made to a second group of physicians, Mr. Carlson again noted his concern. He wrote to Mr. Loftin:

A problem of major concern is that of competition from French Hospital. Because of doctor ownership, past increases in the number of physicians and possible future additions to the Clinic makes [sic] that hospital an increasingly formidable competitor for the limited number of patients in the area. Although the census has remained at approximately the same level, additions to the Clinic could have significant adverse effects on Sierra Vista Hospital.

(CX 318B) Mr. Carlson was concerned that patients who went to doctors at the French Clinic would now be admitted to French instead of Sierra Vista. Mr. Carlson testified:

I was concerned because if additional physician owners were included at French Hospital that they would have an incentive to admit patients, their patients to that facility, and they would be [73] patients that perhaps would have been seen at Sierra Vista.

(Carlson, 1329)

162. One doctor who practiced at Sierra Vista also was concerned about competition from French, and he conveyed his concern in a letter to Mr. Loftin, with a copy to Mr. Carlson. In January 1979, this doctor noted:

It is also becoming apparent that this hospital [French] is attempting to generate competition in the way of decreased surgery operating room fees, decreased hospital room fees and decreased laboratory and emergency room fees, and thus is become [sic] extremely competitive with Sierra Vista Hospital.

(CX 737) The doctor urged AMI to consider "the possibility that [a] decrease in fees [by Sierra Vista] to be competitive would be in order. . . ." (CX 737) Mr. Loftin also feared that Sierra Vista could lose patients to French (Loftin, 1538) and, in replying to the doctor's letter, he indicated that he, too, was concerned with French's competitive moves. (CX 738) Other services offered by Sierra Vista faced competition from French. Sierra Vista operated a reference lab prior to the acquisition. The lab was slow to get business, however, due to "a number of factors including prices from both local competitors and the major labs in Los Angeles." (CX 452B) One such "local competitor" was French Hospital, which subsequently established a price schedule lower than Sierra Vista's. (CX 319B) In January, 1979, Mr. Carlson noted that Sierra Vista would "need to take action soon to combat this development." (CX 319B)

163. In September, 1978, Mr. Carlson learned that French Hospital was for sale and he communicated that information to Mr. Jim Mus

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ka, who was involved with the acquisition of hospitals for AMI. (Carlson, 1339) Mr. Carlson, who earlier had expressed concern about some of French's competitive moves, indicated that he favored an AMI acquisition of French. (Loftin, 1548) Mr. Muska was an Assistant Vice President who reported to Mr. Loftin and Mr. Danko, both of whom were Vice Presidents. (Loftin, 1541, 1553) Mr. Friedmann, who handled negotiations for French, also contacted Mr. Loftin. (Loftin, 1500) On January 25, 1979, Mr. Loftin, then a Vice-President of AMI and director of the company's Western Region (Loftin, 1476-77), requested that a general letter of intent be issued for the purchase of French Hospital. (See CX 38B) The letter of intent binds the company, with a few possible exceptions, to purchase the hospital. (Reilly, 1859) Mr. Loftin's request was [74] made to the Contract Development Committee (CDC). (CX 38B) The CDC, which consisted of all but one of the members of the corporation's Executive Committee, met on a weekly basis to review development projects. (Weisman, 1734-35) The CDC then submitted proposals for approval to the Executive Committee or in some cases to the entire Board of Directors. (Reilly, 1832) Mr. Friedmann, who negotiated on behalf of the owners of French, had informed Mr. Loftin that National Medical Enterprises was also interested in the hospital. (Friedmann, 1593) Although negotiations with NME may actually have broken off prior to the beginning of discussions with AMI, Mr. Friedmann never informed AMI officials of this. (Loftin, 1508; Friedmann, 1627) Mr. Loftin's request for a letter of intent to purchase French was clearly motivated, at least in part, by his fear that if AMI did not move quickly, National Medical Enterprises, the owner of Twin Cities Community in Templeton and the fourth largest proprietary hospital chain in the country (CX 608), would purchase French Hospital. Mr. Loftin wrote:

We do know that National Medical Enterprises is also currently interested in French and that preliminary discussions have been held. Due to this fact, we would like to proceed as soon as possible.

(CX 38B)¹⁷ An anticompetitive intent of AMI also is suggested in another contemporaneous document written by Mr. Loftin. In replying to the doctor who wrote to him concerning the increasing competition from French (F. 162), Mr. Loftin wrote:

¹⁷ Mr. Loftin, in testimony during this proceeding, explained his statement in CX 38 concerning National Medical Enterprises as follows:

In my discussions with Mr. Friedmann and other members of the partnership, there was quite an interest in pushing this process as fast as possible; that if AMI was not going to buy it, then most certainly it would have been unfair to drag it on if there was even a small potential that one of the other companies might be interested. (Loftin, 1509)

We have been aware of the competitive moves of French Hospital and will certainly work to counteract these. [75]

(CX 738) Mr. Loftin knew at the time he wrote this letter that AMI was negotiating to purchase French. (See CX 38B) In fact, by the time he wrote his reply he had already requested that a letter of intent be issued. (Compare CX 38B with CX 738)

164. On February 9, 1979, Mr. Dennis Danko, a Vice President of AMI, who had the responsibility "to identify potential acquisitions" for AMI (Loftin, 1514), wrote a memorandum to the CDC which indicated that AMI should purchase French "thus controlling health care services, . . ." (CX 41D) Mr. Danko also referred to the anticipated \$11 million purchase price as "a premium price" which he thought could be justified. He wrote:

[W]ith the French acquisition, AMI would become the prime, if not the only, provider of health care services in the area. This may be viewed by some in the medical community and others negatively. However, in the long run the positives would overcome the negatives. There also exists a real possibility that with or without French, the local county-owned hospital (114 beds) may close. Currently, one-half of its bed complement is not in operation; it has lost its JCAH accreditation [*sic*]; and the county is supposedly subsidizing the hospital in excess of \$1.0M/yr. Note that this hospital is predominately providing O.B. services at this point, plus hemo.

While it is true that if we do not acquire French, our health care centers in the San Luis Obispo County region will continue to operate on a viable basis; however, we face a choice of paying a premium price, thus controlling health care services, while meeting our earnings expectations, or continue to struggle to capture basically the same patient load with French, or another operator such as N.M.E., who may purchase French. It would be my recommendation that we proceed with the acquisition as outlined.

(CX 41C-D) Mr. Danko's memorandum was sent to the CDC,¹⁸ which was composed of members of the corporation's Executive [76] Committee, which along with the Board of Directors, approved the acquisition. (Weisman, 1735)

165. Mr. Danko, a Vice President of AMI at the time of the French acquisition, was "responsible for the identification, analysis and acquisition of community hospitals throughout the United States." (CX

¹⁸ Mr. Weisman, President of AMI who was also a member of the Board of Directors and a member of both the CDC and the Executive Committee, indicated he would have seen this memorandum. (Weisman, 1710, 1734, 1740) Mr. Weisman testified in this proceeding that in making the statement about "controlling health care services" in San Luis Obispo, Mr. Danko probably meant:

I think what he was talking about was, in essence, flowing from what local health planning and what our own people had been thinking, in terms of the strained utilization levels at Sierra Vista, the underutilization level at French, the ability to take these two circumstances under a common ownership and in a controlled environment and create an infinitely better situation thereafter, as I have discussed a few minutes ago, than presently existed.

(Weisman, 1741)

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4A)¹⁹ Analysis of possible acquisitions, such as that contained in CX 41, was clearly one of his responsibilities. The French acquisition was one of seven acquisitions in which Mr. Danko participated at AMI. (CX 5) At the time of the French acquisition, Mr. Danko served as a liaison between the regional directors and the CDC, which had ultimate responsibility for recommending that acquisitions be approved. (Reilly, 742) In the course of his duties, regional directors often submitted information to Mr. Danko for his review. (See, e.g., CX 38C; CX 49B) Mr. Danko was at one [77] of the first meetings held with Mr. Friedmann concerning the acquisition of French, and he was present at subsequent meetings as well. (Loftin, 1501; CX 28B, D) Mr. Danko continued to be involved throughout the negotiations. (CX 54A; Loftin, 1547) A number of important memoranda concerning the acquisition were sent to Mr. Danko, as well as to Mr. Loftin. (CX 34B; CX 35A) Mr. James Muska, who was also involved in the acquisition of French, had a dual reporting role to both Mr. Loftin and Mr. Danko. (Loftin, 1553) Mr. Danko ultimately signed the letters of intent requested by Mr. Loftin. (See CX 59; CX 60) The letters of intent were important since signing of the letters indicates that "the deal for all practical purposes has been brought to a significant percentage of its fruition." (Reilly, 1859)

166. Mr. Loftin, as did Mr. Weisman (*see* n. 18, *infra*), attempted to show that Mr. Danko's opinion as expressed in CX 41 should be accorded little weight. (Loftin, 1511-14) Mr. Danko's memorandum was clearly within his responsibilities. (CX 4A; F. 165) Both Mr. Loftin and Mr. Danko were AMI Vice Presidents at the time of the acquisition. (Loftin, 1511) Although Mr. Loftin made more money than Mr. Danko (Weisman, 1737), he also had been with the company longer than Mr. Danko. (CX 4A; CX 61) Furthermore, Mr. Danko was given a raise by the Board of Directors shortly after the French acquisition closed (*see* CX 6D), so there is no indication that the company was displeased with his work.

167. The consideration for AMI's purchase of French Hospital and related assets was \$10,970,000. This included the 220,225 shares of stock, with a fair market value of approximately \$6.5 million, and the assumption of approximately \$3.9 million in long-term debt. (F. 10) RX 581B-D, H-Y; Loftin, 1508, Friedmann, 1594-95) Included in the acquisition was a CAT scanner and other x-ray and laboratory equipment purchased from French Medical Clinic, Inc. (F. 10) This equipment was purchased to be used with AMI's operation of the hospi-

¹⁹ Mr. Danko resigned at the same time that responsibility for analysis of acquisitions was shifted to the new corporate Development staff, headed by Mr. Reilly. (Reilly, 742-43) There was some overlap in Mr. Reilly's responsibilities and Mr. Danko's since an AMI report expressed concern that "there be no slippage during the transfer of responsibility from Denny [Danko]" to Mr. Reilly. (CX 1027F)

tal.²⁰ (See F. 9) [78]

168. Mr. Danko, in his February 9, 1979 memorandum, stated that the price paid by AMI for French was a premium price:

In summary, I view French as a viable, productive acquisition. The \$11.0 million purchase price for the hospital equates to nearly \$80,000/bed, a premium price. However, the necessary bottom line can be met and exceeded.

(CX 41C)

169. In reviewing the transaction, reference is often made to the "net equity price." This term refers to the value of the AMI stock given in connection with the transaction. (Loftin, 1549) Thus, the net equity price of the French acquisition was \$6.5 million dollars. (See RX 5851D)²¹ This is at least a million dollars more than AMI's analysts recommended paying. On December 11, 1978, Mr. Lossett, Financial Director of the Western Region and an Assistant Vice President of AMI (CX 12Z21), wrote a memorandum to Mr. Loftin after reviewing various financial information about French. Mr. Lossett reported to Mr. Loftin, was generally responsible for putting together financial analyses, and produced work upon which Mr. Loftin would rely. (Loftin, 1549) Mr. Lossett concluded that "the acquisition of French Hospital is a viable proposition on a net equity purchase price between \$4 million and \$5 million dollars." (CX 33A)²² About a week after Mr. Lossett wrote his memorandum, Mr. Muska also put together a memorandum reviewing the financial statements of French Hospital. (CX 35A) Mr. Muska, an AMI Assistant Vice President at the time (Loftin, 1544), suggested a net equity purchase price of approximately \$6 million, still lower than the net equity price actually paid by AMI. More importantly, Mr. Muska included not only the hospital in this estimate, but also the French Clinic and the Atascadero Clinic, neither of which were ultimately purchased by AMI. (CX 35A, H) By April, Mr. Lossett had a chance to review more information about the hospital and had identified certain areas which constituted "either a problem or a deteriorating trend." (CX 49I) As a result, Mr. Lossett cautioned against paying too much for the hospital. He stated that the "hospital appears to be an excellent buy at a net equity price of \$5.3 million. It [79] is less attractive at \$6.3 million." (CX 49K)²³ Ultimately, AMI paid \$6.5 million net equity price. (RX 5851D) Respondents argue that the "tentative acquisition price"

²⁰ According to state health planning documents, in 1978 more than half of the CAT scans performed at French were on patients admitted to French. (RX 5469Z243) After the acquisition, a substantial number of CAT scans were performed on inpatients. (CX 274H) In fact, AMI advertised that French had a CAT scanner. (CX 91)

²¹ This \$6.5 million dollar figure does not include the equipment purchased from the Clinic.

²² This figure did not include the equipment purchased from the Clinic.

²³ The accompanying documents indicate that this price included only the hospital and equipment ultimately bought from the Clinic, not the entire clinic itself. (See CX 49)

set forth in Mr. Lossett's memo was \$12.43 million (CX 49J), which included \$5.3 million in debt assumption. (CX 49Q) In the end, respondents state, AMI paid \$10.4 million, including only \$3.9 million in assumed debt. Therefore, according to respondents, AMI paid more than \$1 million less than Mr. Lossett contemplated. (RB, p. 164) Respondents are quoting only the long-term debt assumed by AMI in the acquisition. Mr. Lossett included in his analysis \$1,030,000 in current liabilities and also \$400,000 in capital improvements. (CX 49Q) Respondents assumed the current liabilities at the time of the acquisition. (CX 68Z27; CX 59) If you take Mr. Lossett's tentative acquisition price of \$12,430,000 and subtract \$700,000 ancillary equipment, \$1,030,000 current liabilities, and \$400,000 in capital improvements, the tentative purchase price becomes \$10.3 million. (CX 49J, Q) AMI actually paid \$10.4 million. (F. 10) Further, Mr. Lossett, on December 11, 1978, had valued the Central Coast Hospital Company equity value at only \$4,335,000. (CX 33F)

170. The partners owning French Hospital would have been willing to take substantially less than AMI ultimately paid. In late 1977, approximately a year before the first AMI contacts concerning French, another group, the Vesper Society, had expressed an interest in purchasing French. (See CX 21A-B; CX 23) After these negotiations fell through, the owners of French gave Mr. Friedmann a mandate to handle any future negotiations himself and only to come forward with a "true offer." (Friedmann, 1589) As a guideline, the partners told Mr. Friedmann that \$150,000 per partnership unit was "the least they would be willing to accept." (Friedmann, 1589-90) The original partners who had bought the hospital in 1976 paid \$20,000 for a share (Friedmann, 1630); thus, this "floor price" of \$150,000 per unit (see Friedmann, 1589-90) would already have represented a substantial appreciation in the shares. Had AMI purchased the hospital for this floor amount, it would have cost \$4.96 million, less than half of what AMI ultimately paid.²⁴ In fact, AMI paid about \$315,000 per partnership [80] share,²⁵ more than double the least acceptable price the partnership had indicated it would accept.

171. Complaint counsel prepared a chart showing the cost to AMI of hospital acquisitions it made between 1978 and 1980 for which the purchase price was publicly available. (CX 1034) Respondents added information for French Hospital and other hospitals for which public information was unavailable. (RX 5850) According to these charts, the average cost to AMI of hospitals acquired during this period was

²⁴ This figure is arrived at by multiplying \$150,000 by 33, the number of full partnership units that existed, according to Mr. Friedmann. (Friedmann, 1603)

²⁵ This figure is arrived at by dividing the price paid for the shares of the corporation, \$10.4 million, by 33 units. This comes to \$315,151.52. This figure is corroborated by Dr. Boyd, who stated that he was paid approximately \$80,000 for his quarter share, which would translate to \$320,000 for a full share. (See Boyd, 384)

\$67,070. (*Id.*) The per bed cost of French Hospital, including equipment purchased from the clinic, was approximately \$79,500,²⁶ or over \$12,000 per bed more than the average price paid by AMI during 1978–1980.

172. Mr. Weisman and Mr. Loftin of AMI testified that in their opinion the price AMI paid for French cannot be described as “premium.” Mr. Weisman does not believe the price paid per bed was unusually high compared to the typical per bed price that he has seen. (Weisman, 1734–35, 1740–41) Mr. Loftin testified that he had recommended that AMI pay \$600,000 more for the hospital than the \$10.4 million price ultimately paid. (Loftin, 1511–13) Mr. Derzon likewise testified that he does not believe that AMI paid a premium price. Mr. Derzon believes that the price was comparable to prices being paid for other [81] hospital facilities at about that time.²⁷ (Derzon, 2047–49; *see also*, Anderson, 273; Friedmann, 1594–95) Mr. Derzon prepared a chart, RX 5803, which showed the purchase price and size of general acute care hospitals acquired between 1980 and 1982. The information contained in RX 5803 came from a trade publication, *Modern Healthcare*. (RX 5803B) Not all hospitals listed in *Modern Healthcare* were included since some did not have the number of beds reported. (Derzon, 2048) Furthermore, *Modern Healthcare* reports acquisitions only to the extent it can get information. (Derzon, 2048) *Modern Healthcare* had no information concerning acquisitions during 1979 when AMI acquired French (Derzon, 2050), although several acquisitions took place during that period. (*See* CX 608; CX 1034) Mr. Derzon did not attempt to find out what AMI paid for hospitals, although that information would have been available to him. (Derzon, 2124–25) Based on RX 5803, Mr. Derzon testified, “My conclusion is that I don’t believe that AMI paid a remarkably high price for this hospital and I dare say I don’t think it got a steal either.” (Derzon, 2049)

173. During 1980 AMI paid more than \$79,500 per bed in three separate transactions: AMI purchased Mission Bay Memorial Hospital in San Diego, California for \$97,493 per bed; Medical Arts Hospital in Dallas, Texas for \$80,801 per bed; and West Alabama General Hospital in Northport, Alabama for \$85,256 per bed. During the period 1978–1982, the average cost per bed for all hospitals acquired by AMI was \$67,070.²⁸ (CX 1034; RX 5803; RX 5850) Mr. Danko’s memo-

²⁶ This figure is arrived at by dividing the total cost to AMI of purchasing the hospital, \$10.97 million (F. 10) and dividing by 138, the number of beds at French. (RX 5850) The cost of the equipment purchased must be included in the total price, since the equipment was purchased for hospital utilization. (*See* n. 20, *supra*)

²⁷ Mr. Derzon has never acted as a consultant to purchasers of hospitals concerning what they should pay for a hospital, nor had he ever been directly involved in the purchase or sale of a hospital. (Derzon, 2127–29)

²⁸ The \$67,070 average price per bed AMI paid for hospitals it acquired from 1978 to 1982 (other than those it acquired in acquisitions of multihospital systems) includes the price of the French acquisition, which probably should not be included since it is the transaction in issue. (CX 1034; RX 5850) Excluding French Hospital, AMI paid \$65,954 per bed on average for those hospitals.

randum reference to an \$11 million purchase price equating to nearly \$80,000 per bed as a "premium" price, also referenced that at that price "the necessary bottom line can be met and exceeded." (CX 41C) AMI is a profit-making entity; its officers and directors are charged with responsibility to provide a fair return on the invested capital of AMI shareholders. (Reilly, 737) Thus, AMI [82] was concerned that the acquisition of French Hospital meet its profit objectives. (CX 33; CX 35; CX 38) Contemporaneous documents indicate the French acquisition would meet AMI's profit objectives at the price paid:

In summary, the acquisition of [French] appears to be a unique opportunity for AMI. It would be immediately profitable, achieve our rate of return objective and provide additional growth.

(CX 38F; *see also* CX 38B)

L. *Competitive Effects of the Acquisition*

174. AMI's acquisition of French Hospital has produced extremely high concentration in the hospital market in both the city and county of San Luis Obispo. Concentration can be measured either by AMI's market share, the market share of the two largest firms in the market, or the Herfindahl-Hirschman Index, which takes account of the market shares of all of the firms in the market.²⁹ (*See Lave, 892-93*) Market shares for inpatient hospital services can be computed on the basis of hospital beds or inpatient days (Lave, 893), or gross revenues for inpatient services. (*See Mittelstaedt, 1080-82; RX 5800A-D*) Market shares computed on the basis of inpatient days best depict the position of firms in the market. (Lave, 893) Market shares for all general acute care hospital services can be computed on the basis of gross hospital revenues. (*See Mittelstaedt, 1080-82; RX 5800A-D*)

175. Appendix D presents, for both the city and the county of San Luis Obispo, the market share of AMI, the market share of the two largest firms in the city and in the county, and the Herfindahl-Hirschman Index. The market shares and the Herfindahl-Hirschman Index figures listed on the chart are computed on the basis of 1979 inpatient days, 1979 hospital beds, 1980 gross inpatient revenues, and 1980 gross hospital revenues (including outpatient revenues). The Justice Department's Merger Guidelines indicate that the Department is likely to challenge mergers which increase the Herfindahl-Hirschman Index more than 100 points where the post-merger index is above 1800 points. (47 FR 38493, 38497 [June 30, [83] 1982]) For the city, the

²⁹ The Herfindahl-Hirschman Index is computed by squaring the percentage market share of each firm in the market, then adding up those squares. (Lave, 894) The index can range from a value near zero to an upper bound of 10,000. (Lave, 894)

Index was increased from 3996 to 7097 based on gross hospital revenues; the county increase was from 3518 to 5507.

176. The concentration statistics do not reveal the full extent of AMI's dominance of the market. (Lave, 892, 895) AMI's only competitor in the city of San Luis Obispo is SLO General. It is not a formidable competitor because it is relatively old, smaller than either French or Sierra Vista, and, with the exception of its obstetrics department, lacks the modern and sophisticated equipment, and in some areas the high-quality nursing services, necessary to attract doctors (F. 132, 135), and is preferred by fewer patients than French or Sierra Vista. (Boyd, 358) The only other non-AMI hospital in San Luis Obispo County is Twin Cities. This hospital is small, does not offer the range of services offered by French or Sierra Vista, and is inconveniently located for many residents of the county. (Lave, 896-97; Anderson, 227-28; F. 14, 24, 133) As a result SLO General and Twin Cities do not offer effective competition to AMI's hospitals in San Luis Obispo County. (Lave, 896-97) Because of the substantial barriers to the construction of new hospitals in San Luis Obispo County, particularly by firms not already operating in the area (see F. 84-88), it is very unlikely that AMI will face any competition for the foreseeable future other than that offered by SLO General and Twin Cities.

177. AMI's acquisition of Arroyo Grande in 1972, which occurred four years after AMI's acquisition of Sierra Vista in 1968, increased AMI's share of inpatient days in San Luis Obispo County in 1972 from 31.7 percent to 44.7 percent. (CX 613A; RX 5804) Its subsequent acquisition of French further increased AMI's share of inpatient days in San Luis Obispo County from 55.6 percent to 75.5 percent. (F. 175) Apart from market share changes caused by acquisitions, and the replacement of old hospitals with larger facilities, there has been little volatility or fluctuation in the market shares of firms operating hospitals in San Luis Obispo County. (RX 5804)

178. Prior to the acquisition AMI's conduct was restrained to some extent by the fact that French Hospital was available as a non-AMI alternative to patients. (F. 152-155) Subsequent to the acquisition this restraint was lacking. As Dr. Lave explained:

AMI has tremendous power to maintain its prices, to get its prices and say to other people, well, of course you can always travel many miles at great inconvenience to you and to your family and be hospitalized somewhere else but in the meantime we have this hospital here. [84]

There is quite a substantial price premium that would be associated with their ability to be able to control these three hospitals in the county.

(Lave, 901-02) SLO General will not be able to restrain AMI's ability

to charge a non-competitive price because it offers inferior services and thus is not a "hospital of choice" for many patients. (Lave, 896; F. 132, 135) Mr. Danko, in his memorandum of February 9, 1979 recommending the acquisition of French Hospital, noted that if the acquisition were not made, AMI would have to "continue to struggle to capture basically the same patient load with French, or another operation such as [National Medical Enterprises], who may purchase French. (CX 41D)

179. AMI's ability to charge a non-competitive price will have an adverse impact on patients and insurance companies. A small percentage of patients pay their own hospital bills (RX 5638); other patients pay part of hospital charges as a result of deductibles and co-payment provisions in their health insurance policies (see F. 96, 106, 158); many insurance companies pay for services on the basis of what hospitals charge. In fiscal year 1981, 46.2 percent of the revenues French collected, and 42.8 percent of the revenues Sierra Vista collected, were attributable to self-pay patients and insurance companies. (CX 1033) These individuals and companies can do little to avoid paying excessive hospital charges. (Derzon, 2013-14) As a result of AMI's power over price, AMI now has less incentive to operate its hospitals efficiently. (Lave, 902) Third-party payors that reimburse hospitals for their costs of providing care (including Medicare, and to some extent Blue Cross) may have to pay more for hospital services provided by AMI, especially since AMI's acquisition of French increased the cost basis that can be used in computing hospital costs.

180. Prior to the acquisition, AMI hospitals and French Hospital engaged in various forms of nonprice competition to attract physicians and their patients, or to retain the patronage of those physicians and patients already using their facilities. (F. 134-158) With the French acquisition, these hospitals no longer compete against each other in this way. The administrator of French after the acquisition, Mr. Lauran Bowytz, recognized that such competition had ended. In 1980, he was interviewed by a representative of AMI subsidiary Friesen. (CX 730G-I) He noted that he cannot compete along traditional lines, such as by recruiting doctors, or "steal[ing] from S[ierra] V[ista]" because "competition is AMI." (CX 295W) An AMI Quality Assurance Report for Sierra Vista also recognized that competition between Sierra Vista and French would be curtailed: [85]

For many years Mr. Carlson and his forces have challenged the French Hospital and won the battle, now *that* activity has to be curbed and a balance of cooperation mixed with healthy competitiveness has to be reached. . . .

(CX 425F) (Emphasis in original)

181. Prior to the acquisition, the hospitals in San Luis Obispo competed by exploiting their strengths and developing those aspects of their services in which they had a "comparative advantage" over the others; the result of this was to give patients a choice between hospitals with different strengths and weaknesses. (*See, e.g.*, F. 140, 142) As a result of the elimination of competition between AMI hospitals and French, physicians lost some of their "leverage" to promote improvements in hospital services. As Dr. Lave explained:

Up until the acquisition, French offered [a] major point of threat, a major one that physicians practicing outside of French, at Arroyo Grande or Sierra Vista, or [San Luis Obispo] General could use on their hospital administrator in order to induce some kind of change, some improvement in behavior. Those effects are very important effects in terms of non-price competition and they were terribly important in disciplining hospital administrators in other hospitals. And when French was acquired a lot of that went away.

(Lave, 899-900)

182. The existence of French as a non-AMI option for Arroyo Grande's physicians allowed them to bring pressure on the administration of Arroyo Grande to upgrade equipment and facilities. (Schwam, 586-87) AMI itself recognized that this leverage existed. (CX 197G, N) With the acquisition of French, the physicians could not threaten to take patients to French if the physicians were dissatisfied with Arroyo Grande. (*See* Schwam, 585) Dr. Schwam explained:

So [I] and other members of the medical staff felt that having French Hospital as an independent entity was valuable in keeping our hospital—I won't call it up to the state of the art, [it is] still really quite behind—but at least keeping it roughly in range. When French Hospital was acquired by AMI that leverage was lost.

(Schwam, 585-86) [86]

183. AMI's acquisition of French deprived various group purchasers of hospital services of much of their leverage in negotiating discounted charges and other concessions with hospitals in the San Luis Obispo area. HMOs, employers who are self-insured for employee health benefits, and preferred provider plans can act as group purchasers of hospital services, and have negotiated discounts with hospitals in California. (F. 116) Several large employers in San Luis Obispo County are, or soon will be, self-insured completely, or in substantial part, for employee health benefits. (Guy, 694; CX 555A, Z1-Z2; CX 557A-B; CX 561A-B, F; RX 5435Q) One of the non-governmental employers, TRW, Inc., uses an insurance company to administer its benefits plan. (*See* CX 561) Another is Sears, Roebuck & Co., which insures for some of its employee health benefits with its subsidiary, Allstate Insurance Co. (*See* CX 555) While there are no HMOs currently operating in San

Luis Obispo County (Schramm, 2310), one did operate there at one time (RX 5435Z10), and it is possible that another HMO could come to San Luis Obispo in the future. In addition, recent California legislation permits the Medi-Cal program, Blue Cross, and private insurance companies to negotiate prices with hospitals. (F. 123) When these organizations negotiate with hospitals in the San Luis Obispo area, they will be in a much less favorable bargaining position than they would be if AMI had not acquired French Hospital. (Lave, 901) In fact, Friesen has noted "HMO Formation" as a threat to AMI's hospitals. (RX 5435Z52)

184. AMI's ability to hinder the California Medi-Cal program by preventing or impeding the negotiation of cost-saving contracts with hospitals in the San Luis Obispo area is illustrative of the injury possible to group purchasers of hospital services.³⁰ Had AMI not acquired French Hospital, the state Medi-Cal negotiator would have had three hospitals to negotiate with in the city of San Luis Obispo. Thus, the state would have had some leverage in negotiations and could have created some competition among the hospitals. (Guy, 667-68) French Hospital's very low occupancy rate (RX 5835) would have given the hospital an incentive to outbid the other hospitals in [87] order to get a Medi-Cal contract. Mr. Guy, California's Medi-Cal negotiator, described how a hospital's low occupancy rate enhances the state's bargaining position:

Obviously if the hospital has a low occupancy they are a prime candidate [for a Medi-Cal contract], all other things being equal, because they have the capacity and obviously would have some desire for a larger patient flow.

It is the basic desire for the patient flow that creates the strongest issue in negotiation. Are you prepared to give up patients? Are you prepared to keep the same number of patients or would you like additional patients? Obviously a hospital with a low occupancy would usually prefer additional patients. And, as a result, automatically creates a leverage in negotiation.

(Guy, 660) Mr. Guy, who was generally familiar with the hospitals in the San Luis Obispo area (Guy, 665-66), and had conducted a preliminary review of the area with his staff (Guy, 688-90), concluded that AMI's acquisition of French Hospital may have left the state in a position where any attempt to negotiate Medi-Cal contracts in the area would be pointless:

Q. How, if at all, does AMI's ownership of those three hospitals in [San Luis Obispo] county affect your negotiating posture?

³⁰ Respondents argue that the Medi-Cal contracting plan is likely to fail because of the hardships it will impose both on hospitals and on patients. (Derzon, 2022-27; Schramm, 2312-13) This is opinion only, and is contrary to the expectations of the State of California.

1

Initial Decision

A. As it deals with the two hospitals out of the three in the City of San Luis Obispo, it makes it extremely difficult to think in terms of negotiation, because there, frankly, is not a competitive base.

Since the City of San Luis Obispo is the largest unit within that area it would appear that negotiation in that area would hardly be productive for the state and, therefore, would tend to eliminate the possibility for any meaningful negotiations within the entire area.

Q. When you say it appears it will not be productive for the state, what do you mean?

A. Well, if the major facilities which you need in order to meet the terms of the law are owned by a single entity, you hardly have an opportunity for competition. Competition is what we need within [88] the negotiating environment to drive the most cost-effective rate for the state.

If it appeared that all we were going to be involved in from the state level was an exercise, then our time would be better spent somewhere else. And in San Luis Obispo it would appear that it would be an exercise; therefore, we would not attempt a negotiation there. We have nothing to negotiate with.

(Guy, 666-67)

185. Mr. Guy's assessment of the state's poor bargaining position in the San Luis Obispo area is supported by a review of the limited alternatives to AMI's hospitals. SLO General cannot supply the number of beds that, according to preliminary estimates, will be required to care for all Medi-Cal patients in the county. (Guy, 688-89) Furthermore, the state will most likely want to contract with at least one hospital in the area other than SLO General to avoid making SLO General a "Medi-Cal hospital." (Guy, 703) SLO General lacks the modern equipment and facilities physicians feel they need to serve their patients. (F. 132, 135) Twin Cities is inconvenient for, and rarely used by, patients and their physicians other than those in the North County area of San Luis Obispo County. (F. 14, 24, 73, 76, 133) In contracting for hospitals to serve the Medi-Cal population in the central and the southern part of San Luis Obispo County, where most Medi-Cal patients in the county are hospitalized (RX 5814), the state will have little choice but to negotiate with AMI. Respondents contend that Mr. Guy is able to negotiate with hospitals in nearby Santa Maria, Marian Medical Center and Valley Community Hospital, to serve San Luis Obispo Medi-Cal patients, and the absence of an independent bid from French Hospital is not reasonably likely to result in a substantial lessening of competition. This is particularly so, according to respondents, since Mr. Guy testified that three hospitals would provide a sufficient competitive base for negotiation. (Guy, 668) The "30-minute access rule" which respondents reference, only sets the maximum distance that the state of California may force a Medi-Cal patient to travel to obtain hospitalization at a Medi-Cal "contracting hospital" (CX 592J-K, U; CX 593); it does not mean that the state will regard any facility within a 30-minute drive as reasonably accessible or that the Medi-Cal negotiator's threat to force Medi-Cal p

tients to use a facility 30 minutes away from their homes will necessarily be a credible threat that enhances the state's negotiating position. Mr. Guy's testimony is contrary to respondents' position. Mr. Guy was interested in negotiating with hospitals in San Luis Obispo County. (Guy, 666-67) [89]

186. AMI's acquisition of French also foreclosed the possibility of competition between French and AMI's other hospitals in San Luis Obispo County for certificates-of-need, thus reducing the incentives of those hospitals to promptly respond to community needs, and reducing the options available to health planning authorities as to which hospital should offer a new service or program. (Lave, 900; see F. 159)

187. AMI took steps to make charges uniform at all of its hospitals in the San Luis Obispo area after it acquired French. In 1980, for example, a memorandum to administrator Mr. Laurant Bowytz at French Hospital recommended that the charges for certain items be changed. It noted that "these price changes will establish uniformity for the San Luis Obispo area." (CX 301A; see also CX 302A) In the Friesen report for French Hospital, Friesen noted as an "action item" to "standardize fee structure for AMI hospitals." (RX 5435Z69) On another occasion, Mr. Bowytz took advantage of the lack of restraint on AMI's pricing conduct by raising charges in order to compensate for a low patient census. (RX 5378AA) In another instance, Mr. Bowytz noted that he was implementing increases for purposes other than to cover certain costs. (CX 51A)

M. Health Planning Laws and Policy

188. Congress noted in connection with its finding that "the health care industry does not respond to classic marketplace forces:"

Investment in costly health care resources, such as hospital beds; coronary care units or radioisotope treatment centers is frequently made without regard to the existence of similar facilities or equipment already operating in an area. Investment in costly facilities and equipment not only results in capital accumulation, but establishes an ongoing demand for payment to support those services. There is convincing evidence from many sources that overbuilding of facilities has occurred in many areas, and that maldistribution of high cost services exists.

S. Rep. No. 1285, 93d Cong., 2d Sess. 39, *reprinted in* 1974 U.S. Code Cong. & Ad. News 7842 at 7878) In 1979 Congress amended the 1974 "National Health Planning and Resources and Development Act (NHPDA)" in part as follows:

... Congress finds that the effect of competition on decisions of providers respecting supply [90] of health services and facilities is diminished. The primary source of lessening of such effect is the prevailing methods of paying for health services by public and private health insurers, particularly for inpatient health services and other

institutional health services. As a result, there is duplication and excess supply of certain health services and facilities, particularly in the case of inpatient health services.

42 U.S.C. 300k-2(b)(1) (Supp. IV 1980)

For health services, such as inpatient health services and other institutional health services, for which competition does not or will not appropriately allocate supply consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the exercise of their functions under this subchapter take actions (where appropriate to advance the purposes of quality assurance, cost effectiveness, and access and the other purposes of this subchapter) to allocate the supply of such services.

Id. at 300k-2(b)(2)

189. Health planning is defined as "a set of assumptions and statistical methods used for the purpose of designing an optimal or rational mix of services for providing health care in a given area." (Johns, 1866) The Federal Government's involvement in health planning began in 1946 when Congress established the Hill-Burton program which was designed to increase hospital construction to alleviate what was viewed as insufficient hospital capacity. (Johns, 1969-71) The building of new hospitals was to be stimulated through a series of grants to the states, which in turn were obligated to prepare plans indicating where there was insufficient capacity. (*Id.*) In the early 1960's, another grant program was instituted which provided funds to local groups of citizens who came together to do voluntary health planning at the local level. (Johns, 1870) In 1965, Congress passed the Comprehensive Health Planning Act which provided funds for comprehensive health planning councils that could be established by local citizens. While establishment of the councils was voluntary, the legislation required that if such councils were established, they had to include consumers as well as health care providers. (Johns, 1870-71) The current system of health planning was established by Congress in 1974 when it enacted NHPRDA. (42 U.S.C. 300k *et seq.* (1976 & Supp. IV 1980); Johns, [91] 1871) This legislation set up a series of mandatory Health Systems Agencies (HSAs) which cover every area in the country. (*Id.*)

190. An HSA is responsible for health planning within each area. (Johns, 1872) HSAs are private, rather than governmental, organizations. Most are set up as independent, nonprofit corporations. (Johns, 1904) Congress required that the HSAs be made up of both providers and consumers, with consumers being the majority. (Johns, 1904) No government official or agency chooses the particular individuals who sit on the board, other than to make a determination that the consumer members are representative of the local population. (Johns, 1905)

In the NHPRDA, Congress required HSAs to perform certain specific functions. (42 U.S.C. 300k-1, 3001-4(c)(1)(A) (1976 & Supp. IV 1980)) These functions are to produce health systems plans; to conduct project reviews, including certificate-of-need reviews; to do "Proposed Uses of Federal Funds" reviews; and to conduct other reviews as requested by other agencies. (Johns, 1872)

191. A health systems plan is a document prepared by the HSA which discusses the health care needs and goals of the health system area. (See Bernhardt, 1265) The document is prepared by HSA staff and presented in draft form at public hearings. (Johns, 1873) The document is revised in response to comments received and then is approved by the HSA. (Johns, 1873) It is approved at the state level and then by federal officials who review it for "scope, quality, and consistency with federal planning policies." (Johns, 1873) Health system plans often make general recommendations concerning how certain goals should be achieved. (See Johns, 1913-15) The HSA, however, has no power to enforce these recommendations. (Johns, 1913) Furthermore, plans do not make recommendations about specific institutions. (Johns, 1913-14) In fact, with regard to recommendations concerning how excess capacity should be reduced, the plans do not mention specific hospitals by name. (Johns, 1914)

192. HSAs are also required to produce documents called Annual Implementation Plans ("AIPs"). (Johns, 1915) The AIPs are supposed to take the recommendations contained in the health systems plan and discuss when and how they should be implemented. "These recommendations [in the AIP] usually take the form of committees should be formed, meetings should be held, studies should be undertaken and so forth." (Johns, 1915) Like the health system plans, AIPs do not specify which hospitals should undertake any of the steps specified in the plans. (Johns, 1915)

193. The other major function HSAs have is making recommendations on certificates-of-need ("CON") applications. [92] Each state is required to have a CON program; before a provider can undertake certain projects, it must first receive a CON. (Johns, 1876-78; F. 84) The granting of a CON represents a judgment by the state that a proposed project is consistent with local needs and state policies. (Johns, 1876) Projects requiring CONs (except in exceptional circumstances) include new hospitals, expansions of bed capacity at existing hospitals (except for small increases by hospitals with high occupancy rates), transfer of beds from one license classification to another, and other major capital expenditures for a hospital. (See F. 84) Federal law does not compel states to require a CON for a change of ownership not also involving changes in services or bed capacity. (42 U.S.C.A. 300m-6(d)(1) (West Supp. 1982)) California law expressly exempts acquisi-

tions of hospitals from CON review of capital expenditures. (*Cal. Health & Safety Code* Section 437.10 [Deering Supp. 1983]; see also RX 5821Z5; Johns, 1915)

194. Although Congress allowed the planning authorities veto power over the addition of unneeded new health care facilities through the CON process, reductions in unneeded existing facilities and services were to be implemented through the voluntary efforts of providers:

[T]he apparently modest initial means of implementing health plans, seeking the assistance of individuals and entities in the health service area to do so, is in fact the most important method available . . . [T]he agency must be willing to seek the cooperation of established health entities in the community including physicians, hospitals, and HMOs.

(H.R. Rep. 1382, 93d Cong., 2d Sess. 60. See Conf. Rep. No. 1640, 93d Cong., 2d Sess. 69, 73 (1974), reprinted in 1974 U.S. Code Cong. & Ad. News 7971 (at 7979, 7983))

195. In California the state planning agency, required by the NHPRDA, is the Office of Statewide Health Planning and Development ("OSHPD"). This office passes on certificate-of-need applications and produces a statewide health plan which makes policy recommendations concerning health care needs of the state. (Johns, 1875, 1881) This office has no power to enforce its recommendations. (Johns, 1913) California also has an Advisory Health Council which performs the functions which the NHPRDA specifies are to be performed by a Statewide Health Coordinating Council (SHCC). Members of the Council are not appointed in the manner prescribed in the federal legislation. (Johns, 1906) California has fourteen HSAs. (CX 533B) HSA 8, [93] the Mid-Coast HSA, includes the counties of San Luis Obispo, Monterey, San Benito and Santa Cruz. (RX 5466F-G, T,Z7)

196. The CON process is initiated when a provider submits to the HSA and OSHPD a letter of intent which describes the contemplated project and the magnitude of the expenditure involved. After 60 days, the application for the project may be filed with the HSA and the OSHPD. (RX 5821Z10-Z14; Johns, 1880) The HSA has 45 days to review the application. Usually, the HSA will set up a review panel which will hold public meetings at which the applicant and the agency may make presentations. (Johns, 1880) This panel makes findings with respect to whether the application fulfills the 16 criteria for a CON specified in legislation. (Johns, 1820) The panel's recommendation is reviewed by the HSA which ultimately recommends approval, disapproval, or approval with modification of the application. The HSA's recommendation is then reviewed by the state. (Johns, 1880-

81) The state has several levels of review. A hearing officer reviews the application and takes into account the HSA's recommendation. (Johns, 1881) That decision is then reviewed by the Director of OSHPD who makes the final decision. If he makes a decision different from the HSA's, he must issue a written decision explaining the reason. His decision is appealable, by either the HSA or the applicant, to the state Advisory Health Council. The Council's decision may be appealed in court. (Johns, 1881; RX 5821P, Z25-Z26)

197. The OSHPD and other organizations have consistently noted that extensive excess capacity exists throughout the state. According to one estimate, there are about 10,000 excess beds in the state. (Johns, 1912) In addition, it was also determined that there were excesses in "nearly every conceivable type of service in the state." (Johns, 1912-13) Nearly every HSA notes the existence of excess capacity in its health systems plan and makes some general recommendations concerning its elimination. (Johns, 1915) Excess capacity can be reduced in a number of ways; through conversion of facilities, consolidation of facilities, or closure of facilities. (Johns, 1910) Health systems plans almost never recommend any specific action which institutions should take. (Johns, 1913-15) In most instances where capacity has been reduced, however, it has resulted from the unilateral action of a facility. (Johns, 1926-27)

198. AMI did not consult the Mid-Coast Health Systems Agency (MCHSA) or the HSA which oversees San Luis Obispo County, concerning AMI's plans for French Hospital. Although MCHSA did not have to approve AMI's acquisition of French (Bernhardt, 1275; Johns, 1891), providers often confer informally with HSAs concerning their plans for their institutions. (Johns, 1917) Such consultation is especially common when a hospital is contemplating action which requires a CON. (Johns, 1917-18) [94] While AMI's purchase of French did not require a CON, a consolidation of French and Sierra Vista would. (Mittelstaedt, 1097; *see* Johns, 1916) No one from AMI ever discussed its plans for French at any HSA meeting. (*See* Bernhardt, 1296-97)

199. Prior to the acquisition of French, the MCHSA had determined in the 1978-1983 Health Systems Plan and the 1979-1984 Health Systems Plan that excess beds existed and would exist in the future. The 1978-1983 Plan, for example, noted that by 1983, San Luis Obispo County would have an excess of 169 medical-surgical beds (RX 5466Z178); 12 perinatal beds (RX 5466Z275); and 19 intensive care/coronary care beds. (RX 5466Z260) The 1979-1984 Health Plan also found an excess in medical/surgical beds (RX 5467Z190); pediatric beds (RX 5467Z225); intensive care/coronary care beds (RX 5467Z280); and perinatal beds. (RX 5467Z295) MCHSA has long con-

sidered consolidation of services as a solution to the problem of excess capacity. (See, e.g., RX 5460Z39, Z42, Z47, RX 5461Z1-Z6, Z11-Z14, Z30; RX 5462Z11, Z12, Z15, Z17; RX 5466P, Z57, Z181, Z209-Z211, Z265-Z266, Z283-Z285, Z290-Z291) Two MCHSA plans particularly emphasize the point. (RX 5466, the "Health Systems Plan 1978-1983;" and RX 5461, the "Annual Implementation Plan 1979-80")

200. The HSA had no policy concerning how the excess capacity which it identified should be reduced. The primary response of the MCHSA to its finding of excess capacity was to set up a task force to study the problem. (RX 5466Z181) Among the duties of the task force, according to the 1978 plan, were:

Prepare recommendations for action to reduce excess hospital capacity to include, but not be limited to, consolidation of services and/or delicensure of beds.

(RX5466Z182) The 1979 Plan again points to the task force in response to the problem of excess capacity. (RX 5467Z193-Z194) Dr. Bernhardt, the one member of the Mid-Coast HSA who testified in this proceeding could not remember the task force ever making any report. (Bernhardt, 1296) Another recommendation was directed at preventing future increases in excess capacity. The 1979 Plan stated:

All inpatient health facilities will be encouraged to consider, before expansions of services or beds the conversion of existing excess resources to fill shortages.

(RX 5467Z181) The 1979-1980 Annual Implementation Plan, which describes how the above recommendation was to be implemented, [95] notes that low occupancy at area hospitals will improve "through the Agency's stated policy to encourage conversion of excess beds to services with shortages, as well as mergers." (RX 5461Z63) Dr. Bernhardt, a member of the MCHSA, could not recall any specific discussions of what was meant by this section. (Bernhardt, 1293-94) According to Dr. Bernhardt, "'merger' wasn't used much at all that I can recall. Consolidation was a term that was predominantly used." (Bernhardt, 1294)

201. Finally, the MCHSA itself did not contemplate consolidation of particular facilities in writing its plans. The annual implementation plans and health system plans never focused on particular hospitals or facilities. (Bernhardt 1273-74) "There were broad discussions about these [bed] excesses. It never got down to specifics in any way at all." (Bernhardt, 1271-72, see also Bernhardt, 1268)

202. One of the charges of the task force which was set up was to prepare recommendations concerning delicensure of beds. (RX 5466Z182) Since acquiring French Hospital, AMI has not closed any beds. (Boyd, 426) The consolidation of French and Sierra Vista set out

in the study prepared by Mr. Mittelstaedt for this proceeding (RX 5614; *see, e.g.*, F. 208) also would not result in any reduction in beds. There are currently 138 beds at French and 172 at Sierra Vista. After the proposed consolidation, there will still be the same total number of beds at each hospital. (*See* RX 5614M) Further, no individual service will experience a net reduction in beds; the excess beds will be moved from one hospital to another. For example, in 1985 San Luis Obispo County is anticipated to have an excess of 116 medical/surgical beds. (RX 5469Z21) The proposed consolidation of French and Sierra Vista contemplates reducing the number of medical/surgical beds at French by 18 and increasing them by the same amount at Sierra Vista. (RX 5614L-M) In 1985 there is anticipated an excess of nine perinatal or obstetric beds.³¹ (RX5469Z21) AMI proposes to move the 12 existing obstetric beds at Sierra Vista to French. (RX 5614L-M; Bernhardt, 1305) In 1985 there is anticipated an excess of 10 pediatric beds (RX 5469Z21); AMI plans to supplement the 10 beds at French with 6 additional beds now at Sierra Vista. (RX 6514L-M) Finally, in 1985 there is anticipated an excess of 15 ICU/CCU beds. (RX5469Z21) AMI plans no change in the 8 ICU/CCU beds which exist at each hospital. (RX 5614L-M) [96]

N. Efficiencies or Benefits from the Acquisition

203. Respondents offered evidence that the acquisition of French has created the potential for far-reaching cost savings which could be effected by implementation of recommendations set forth in a study entitled "Cost Savings Expected From Consolidation of French and Sierra Vista Hospitals." (RX 5614A-S) The study indicates that this consolidation could result in annual operating cost savings of at least \$12,200,000.³² In addition to these monetary savings, an enhancement in the quality of care is expected. The study was prepared by employees of AMI and its wholly-owned subsidiary, Friesen, under the direction of Mr. Mittelstaedt, a Vice President of Friesen. (Mittelstaedt, 997-98, 1042-43, 1158) The study was prepared in connection with this proceeding, and AMI's counsel helped formulate the questions to be addressed by the study. (Mittelstaedt, 1042, 1126-27)

204. The study estimated the operating cost savings of consolidation by comparing the unit costs of particular ancillary and support services provided at both hospitals, then assuming that the services could be provided at one location for both hospitals at the lower unit cost. (Mittelstaedt, 1044-45) The study also estimated the costs of personnel whose positions would be eliminated upon consolidation. (Mittel-

³¹ The Plan indicates that obstetric and perinatal beds are the same. (RX 5469Q)

³² The figures cited for cost savings were derived by taking the figures listed in RX 5614 (\$1,242,000 for annual operating cost savings and \$12,739,955 for capital cost savings) and subtracting certain amounts discussed by Mr. Mittelstaedt in his testimony. (Mittelstaedt, 1059, 1123-24)

staedt, 1048-49, 1051-52) The largest portion of savings would result because of capital expenditure savings made possible by consolidation. This figure was arrived at by comparing the cost of the capital improvements needed to maintain Sierra Vista as a "first-rate hospital," should there be no consolidation, with the capital costs of consolidating French and Sierra Vista. (RX 5614D-F, R) The anticipated annual operating cost savings of \$1,238,000 per year represents a total operating expense reduction of approximately 5 percent, a reduction "completely consistent" with past experience, and "an underestimate" of the savings which could be achieved in this case. (Mittelstaedt, 1052-53, 1123-24; RX 5614K) Further, respondents contend the \$1.238 million per year operating cost savings does not include savings which likely will be achieved from increased patient volumes [97] arising out of consolidation (Loftin, 1529-31; Weisman, 1744-45; Schramm, 2401-02), and that future cost savings will inevitably occur because there will be no need in the future for two departments to purchase the same equipment where the consolidated patient volume only justifies one. (*See, e.g.*, Stahl, 1406-07)

205. According to respondents, implementation of Friesen's recommendations would result in higher volumes in each of the consolidated specialty areas, which would enhance the quality of care. Higher volumes make it more feasible for a hospital to upgrade its equipment and to recruit and train expert support personnel. Higher volumes also allow physicians and support staff to specialize in a particular area and to sharpen their skills. (Bernhardt, 1279-80; Carlson, 1341-43; Stahl, 1405-06; Loftin, 1529; Harvey, 1674-75; Derzon, 2071-74) The operating rooms at Sierra Vista and French suffer from overutilization and underutilization, respectively. Consolidation would allow the patient load at the two hospitals to be smoothed out, thus solving the utilization problems now experienced at both facilities. This would reduce the space-constrained conditions at Sierra Vista and would allow support staff at French to sharpen their skills through increased experience. (Carlson, 1338-39; Stahl, 1409-11) Consolidation of French and Sierra Vista would result in merger of the two medical staffs, which would allow greater sharing among staff physicians of information regarding the quality of care provided by physicians. (Stahl, 1411-13)

206. The record indicates that consolidation of services between hospitals is unlikely to be achieved without common ownership. As a practical matter hospitals simply are not willing to give up services to other independently-owned hospitals. (Johns, 1899-902; Derzon, 2075-76) Mr. Weisman, AMI's President, and Mr. Loftin, AMI's Vice President, are not aware of any instance in which services at two hospitals not under common ownership have been realigned in a

fashion similar to that proposed by Friesen for Sierra Vista and French. In Mr. Weisman's judgment, it is not realistic to assume that such a realignment could take place in the absence of common ownership because the owner of each facility would be concerned about giving up a valuable service. (Loftin, 1532-33; Weisman, 1758-59) Mr. Derzon knows of no instance in which the type of wide-ranging consolidation proposed by Friesen has taken place between two independently-owned hospitals. The fact that hospitals attempt to preserve their revenue flows and physician loyalties precludes consolidation of important services between noncommonly-owned hospitals. (Derzon, 2075-76) Dr. Bernhardt, a former member of MCHSA, is not aware of two independently-[98]owned hospitals anywhere which have consolidated services to the extent described in the Friesen report. (Bernhardt, 1277-78)

207. In approximately June, 1980, Mr. Mittelstaedt was informed that AMI had requested Friesen to study AMI's three hospitals in San Luis Obispo County. Mr. Mittelstaedt was given full responsibility for the project. (Mittelstaedt, 1004-05) RX 5435, RX 5436, and RX 5437 are Friesen's Strategic Plans for the three AMI hospitals in San Luis Obispo County. (Mittelstaedt, 1024)

208. With respect to Sierra Vista and French, Friesen recommended "consolidation of the two facilities under common management while retaining the operation of the two separate physical facilities." (Mittelstaedt, 1027; *see also* Mittelstaedt, 1037-38; RX 5435Z60, Z61, Z66, Z67; RX 5436Z63, Z64, Z70, Z71) Under this strategy, the operations of French and Sierra Vista would be merged under a single administrator and a single hospital name, the medical staffs of the two facilities would be unified into a joint medical staff, and services would be divided "to the extent possible" between the two facilities. Among the services which would be located exclusively at French are pediatrics, obstetrics, clinical laboratory, ophthalmology, cardiology, and pathology. Among the services which would be located exclusively at Sierra Vista are trauma, orthopedics, neurosurgery and oncology. Both facilities would continue to provide medical/surgical services as well as intensive care and coronary care services. (Mittelstaedt, 1028; RX 5435Z50, RX 5436Z63)

209. Consolidation of French and Sierra Vista as recommended by Friesen would require the preparation of detailed implementation plans and formal approval of the Executive Committee of AMI's Board of Directors, as well as the Boards of Directors of French and Sierra Vista. (Loftin, 1534-36; Weisman, 1746) According to AMI, this matter of consolidation has not been put to the Executive Committee because of the present litigation. Disentangling the two hospitals in the event they were consolidated and AMI subsequently ordered to

divest French would be costly to AMI. Further, it would disrupt the community. In particular, it would disrupt the physicians who would have oriented their practices in accord with the distribution of services recommended by Friesen, and would then have to readjust in the event of divestiture. (Mittelstaedt, 1021, 1027-28; Carlson, 1343-44; Loftin, 1528-29, 1534-35; Weisman, 1745-46; RX 5378A, B)

210. Complaint counsel contend that consolidation of French and Sierra Vista might not occur, assuming AMI is permitted to keep French Hospital. First, there is no showing that those individuals who would have to authorize the over \$8 million for [99] the consolidation would act to do so.³³ There is no way of knowing what the view of the Committee or local boards would be as to how the company's money should be spent. (See Loftin, 1534-35) Second, AMI management does not always agree with the conclusions of Friesen (Loftin, 2497), nor does it necessarily follow Friesen's recommendations. (Loftin, 2492) Third, a number of practical barriers stand in the way of a consolidation of the scope Friesen recommends. No consolidation on this scale has even been done before. (Derzon, 2075) A number of doctors told Friesen that it was their belief that AMI did not have the "guts" to tackle some of the tough issues associated with a consolidation.³⁴ (RX 5435Z68; Mittelstaedt, 1100-01) Doctors who currently practice at one hospital will fight the idea of their specialty being moved to the other. (Bernhardt, 1306) Finally, should AMI decide to consolidate French and Sierra Vista, AMI would have to obtain approval from the local HSA and the state before making most of the capital expenditures required to consolidate the hospitals. (Mittelstaedt, 1097) Government approval is subject to a number of contingencies beyond AMI's control, including how much delay there might be before governmental approval is granted or denied. (Mittelstaedt, 1089-99; see F. 85, 196) Since consolidation is one of MCHSA's goals, it can be expected that MCHSA will work with AMI at some plan of consolidation, but not necessarily that proposed by Friesen. (See F. 202)

211. RX 5614 states that if consolidation occurs, approximately \$1.2 million in operating expenses will be saved. It is questionable whether economies of scale, such as are envisioned by RX 5614, can actually be gained through consolidation. Dr. Schramm, respondents' economic expert, has noted that there is inconsistent evidence concerning whether [100] economies of scale exist for hospitals. He has noted that "[w]hen combined, existing research suggests that the economies of

³³ Testimony elicited in this proceeding from AMI's top officials, Mr. Weisman and Mr. Loftin, was to the effect that they would recommend implementation of the Friesen consolidation plan. (Weisman, 1746; Loftin, 1534) Mr. Weisman testified that he would "unequivocally and enthusiastically" support the proposal. (Weisman, 1747)

³⁴ At the August, 1981 presentation of Friesen's findings and recommendations to the French and Sierra Vista medical staffs, some support was expressed by local physicians for the concept that French and Sierra Vista be consolidated. (Mittelstaedt, 1020; see Mittelstaedt, 1028; Bernhardt, 1279-80; Stahl, 1405; Loftin, 1531-32; Harvey, 1274-76) Drs. Stahl and Harvey's specialties would benefit from the proposed consolidation.

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scale attached to hospital size and, presumably, to the size of any hospital entity however formed, may be illusive." (CX 1048P) Dr. Schramm also has written:

[C]onsolidations undertaken to achieve efficiency, economic security, operating surpluses and improved capabilities for meeting future demands may be ill-advised. The consolidation process itself is complicated, costly and uncertain. Those contemplating a merger should recall that the return-to-scale efficiencies expected in many mergers are never realized.

(CX 1048T)³⁵ AMI did not take any significant steps toward consolidation of French and Sierra Vista services during the 17 months between AMI's acquisition of French and the time it learned of the FTC's investigation of the acquisition. (Mittelstaedt, 1005-06, 1014; CX 1010) After the acquisition was completed, Friesen reported to AMI that consolidation would produce "somewhat, not enormously, potential lower costs," and "modest" increased profitability. (RX 5435C, Z61; Mittelstaedt, 1109) The administrator of Sierra Vista, in an August 1981 [101] memorandum, also indicated that he did not expect major cost savings to be achieved through consolidation:

It was my hope that our long range plans would permit consolidation of some services with the eventual objective of at least a slight decrease in the rate at which expenses are increasing. Even though such cooperative efforts would not necessarily be of major dollar savings, they would have been at least symbolic of our united efforts to hold down costs.

(CX 1063A)

212. Mr. Mittelstaedt made a number of questionable assumptions in his study which affect his results. To calculate the operating cost savings resulting from consolidation, Mr. Mittelstaedt compared the unit costs of particular services provided at each hospital, then assumed that the service could be provided at one location for both hospitals at the lower unit cost. (Mittelstaedt, 1044) In some instances the service would be moved from the lower cost hospital to the higher cost hospital. (See F. 215) There is no explanation why the formerly high-cost hospital will suddenly be able to deliver the service at a new, lower cost. Also, Mr. Mittelstaedt looked only at the unit cost for one year even though information for the preceding year and the subse-

³⁵ Dr. Schramm also cautioned that consumers may see less of the benefits of consolidation than of its costs:

[T]he merger movement [in the hospital industry] must be seen in the light of consumer satisfaction. Clearly, absolute consumer choices suffer as consolidations advance. This is traditionally rationalized by citing reductions in unit prices that follow consolidation. Interestingly, however, prices do not always reflect the savings of consolidation and artificial price settings must be controlled through regulation. The apparent risk in consolidation from the consumer perspective is that prices may not reflect true savings. The costs of consolidation are expressed as both higher market prices and lost flexibility in the market. Moreover, consumers generally are deprived of product choice even though, as is often argued, the quality of products and services may improve.

quent year was available. (Mittelstaedt, 1126) In addition, a portion of the savings are due to more effective purchasing arrangements. (Mittelstaedt, 1049-50) Consolidation is not necessary to achieve these savings; joint purchasing involving separately-owned hospitals is fairly common in California. (Johns, 1920) Furthermore, Mr. Mittelstaedt has not taken into account any difference in quality at either hospital. (See F. 218) Although one service may now be delivered more cheaply than it was before, it may previously have been more expensive because the service was of higher quality. In terms of consumer satisfaction, there may be a net loss. Food service would be one example. (See F. 218)

213. RX 5614 ignores the cost of capital for the expenditures required to consolidate French and Sierra Vista. Approximately \$8.7 million in renovations and new construction (in 1982 dollars) is required to effect the consolidation set forth in RX 5614.³⁶ If AMI financed the consolidation project [102] at 10%, the average cost of capital to AMI (Mittelstaedt, 1214), the annual cost of capital for the consolidation would be at least \$870,000. Mr. Loftin acknowledged that capital costs would affect the feasibility of the project. He stated that he could not prepare a financial projection for this project because he did not yet know what the cost of money would be. (Loftin, 1535) RX 5614 also does not consider the cost of depreciation on newly-constructed facilities and renovations built in the course of consolidation. Depreciation is usually treated as an expense. (See CX 38H, J-K) Depreciation on the \$2,103,400 of new construction³⁷ over 40 years would be approximately \$52,585 per year. (See 38J.) If the renovations were also depreciated on the same basis, there would be an additional expense of almost \$165,000. The capital expense and depreciation expense will reduce the potential savings from \$1.2 million to about \$160 thousand.

214. RX 5614 assumes that consolidation of the emergency rooms at French and Sierra Vista would eliminate the need for French's contract with a physician group to provide medical coverage at its emergency room, and thereby save \$204,000. (RX 5614H; Mittelstaedt, 1048-49) This savings assumes that the physician group covering Sierra Vista's emergency room, which is also under contract (Mittelstaedt, 1048), could handle an increase in the number of emergency room visits of more than 50%. It also assumes that the Sierra Vista physician group would handle the increase in emergency room visits at Sierra Vista without insisting on greater compensation for its ser

³⁶ RX 5614 estimates the capital expenditures required to perform the consolidation to be \$8,160,045. (F 5614D-E) In fact, the consolidation will cost more since AMI did not include approximately \$540,000 required to expand central service space for a consolidated storage facility. (Mittelstaedt, 1059)

³⁷ This includes the new construction shown on RX 5614 (see RX 5614N, P), and also the \$540,000 required for the new consolidated storage facility. (Mittelstaedt, 1059)

vices. RX 5614 also states that consolidation would make it unnecessary to have certain supervisory personnel at both Sierra Vista and French (for example, two administrators or two directors of nursing), and so permit the elimination of 12 supervisory positions, with annual savings of approximately \$419,000. (RX 5614C-D, J) This estimate assumes that a single supervisor could perform the function previously performed by two supervisors. It also assumes that each supervisor in charge [103] of activities at both hospitals (for example, the director of nursing or the x-ray chief) will have an assistant who can routinely exercise responsibility for on-the-spot decisions when the supervisor is not present. (Mittelstaedt, 1132-34) This cost savings projected by RX 5614 would be diminished to the extent that the supervisors and assistants whose responsibilities are increased as a result of the elimination of supervisory positions ask for, and receive, increased compensation for their efforts—a possibility acknowledged by Mr. Mittelstaedt. (Mittelstaedt, 1129-31) Additionally, the annual cost savings through elimination of supervisory positions would be less than the projected \$419,000 in the first three years following consolidation, since RX 5614 assumes it would take at least three years to implement the personnel reductions. (RX 5614J; Mittelstaedt, 1108)

215. The projected operating cost savings for laboratory tests ignore the need to maintain two laboratories even after consolidation. RX 5614 projects annual cost savings of \$160,000 on the assumption that all laboratory tests performed at French and Sierra Vista could be performed at one laboratory facility located at French. (RX 5614A, H; Mittelstaedt, 1047-48) Mr. Mittelstaedt predicted that switching Sierra Vista's lab work to French will achieve those savings even though French's per unit cost for lab work is much higher than Sierra Vista's. (See RX 5614H) Also, as Mr. Mittelstaedt acknowledged in his testimony, it would still be necessary to have a "stat" laboratory at Sierra Vista to perform tests where results are needed immediately. (Mittelstaedt, 1057) Mr. Mittelstaedt's testimony about the economies of increased volume at a centralized facility (Mittelstaedt, 1048) suggests that "stat" tests performed at Sierra Vista will be more expensive after consolidation than before. This added expense offsets some or all of whatever savings might occur by having the remainder of Sierra Vista's laboratory tests performed along with French's tests at French.

216. RX 5614 does not account for the administrative expenses of carrying out the consolidation of French and Sierra Vista, for example, processing a CON application. There would be a great number of decisions AMI would have to make to perform the variety of tasks required by consolidation. (Mittelstaedt, 1134; RX 5435Z68) Mr. Mittelstaedt asserted that there would be no costs to AMI involved in

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aving its employees spend their time making those decisions. (Mittelstaedt, 1134-35)

217. RX 5614 concludes that consolidation of French and Sierra Vista will permit AMI to save \$38,000 per year by consolidating the contracts of the hospitals with outside laundry firms. RX 5614 assumes, without explanation, that the [104] same volume of laundry would cost less under one contract for both French and Sierra Vista than under two separate contracts with the same laundry. There is nothing in RX 5614, or elsewhere in the record, explaining why it is necessary for both French and Sierra Vista to be owned by AMI to gain whatever advantages there may be to joint purchasing of laundry services, nor is there any explanation why this savings already has not been realized by AMI since institution of joint purchasing of laundry services would be simple to commence and to terminate if necessary.

218. RX 5614 concluded that, through consolidation, \$89,000 could be saved through purchasing food supplies for French at the price paid by Sierra Vista. (RX 5614H) This conclusion does not take into account the possibility that French uses food supplies of higher quality than those Sierra Vista uses, or offers a menu requiring more expensive food than Sierra Vista uses. (Mittelstaedt, 1113-114)

219. French and Sierra Vista are two miles apart. (CX 736C) RX 5614 does not take into account the costs of transporting personnel and goods between French and Sierra Vista after consolidation. The supervisors listed on RX 5614, some of whom would be in charge of activities at both French and Sierra Vista after consolidation might have to periodically shuttle back and forth between the facilities. It would also be necessary to transport specimens back and forth between Sierra Vista and the consolidated clinical laboratory and pathology department at French (RX 5614), and to deliver supplies from the central inventory facility at one hospital to the other hospital after consolidation. (Mittelstaedt, 1050)

220. In at least one instance, an item of operating cost savings was double-counted in the computation of the total estimated operating savings. The cost savings projected for emergency services at RX 5614H included savings on emergency room supplies—a \$4,000 item listed again as a separate operating cost saving at RX 5614I. (Mittelstaedt, 1121-23) Mr. Mittelstaedt conceded that this item was counted twice. (Mittelstaedt, 1123-24)

221. Most of the savings projected in RX 5614 are from capital cost savings, which it suggests, will be in excess of \$12.7 million. (RX 5614E-F) This figure represents the difference between the \$20 million in capital improvements required to maintain Sierra Vista as a first-rate independent hospital if consolidation does not occur, &

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the \$8.1 million required to consolidate services at both facilities. (RX 5614E-F) As noted above, there are obstacles to any consolidation which may prevent its being completed. Further, if AMI were not [105] to spend \$20.9 million to renovate Sierra Vista, then no savings would be achieved by consolidating with French instead. There are a number of reasons why AMI may not spend \$20 million plus to renovate Sierra Vista. First, there is no proof that such expenditures are necessary. Of the \$20.9 million in capital expenditures, over \$17 million are expenditures which AMI claims are needed at once. (RX 5614E) However, these expenditures would remedy problems which AMI has left unsolved for some period of time. (Mittelstaedt, 1139-42) All of these problems existed before AMI acquired French, but AMI has not found it necessary to make such expenditures up to this time. Sierra Vista is already a first-rate hospital (Mittelstaedt, 1142), and the changes suggested in RX 5614 supposedly are necessary to maintain it as a "first-rate hospital." (RX 5614R) Mr. Mittelstaedt admitted that more modest changes could be instituted which would maintain the status quo at Sierra Vista. (Mittelstaedt, 1105, 1152) The suggested changes might improve the facility,³⁸ but one may reasonably question how dire the need for such changes really is. Secondly, assuming *arguendo* that such changes are needed, AMI may not be willing to spend almost \$21 million to make them. This expenditure presumably would have to be approved by the corporation's Executive Committee (Weisman, 1746), and this committee may be reluctant to recommend an investment of this size for a hospital which is in an area that "does not present an ideal situation in terms of market growth and development," and where "[g]rowth in the community is not expected to be high enough to justify major capital expenditures across the board of AMI hospitals." (RX 5435Z66) In fact, AMI could probably build a new hospital for less than \$20.9 million. In April, 1981, AMI Executive Vice President R. Bruce Andrews told a group of security analysts:

we are still building hospitals at costs averaging \$50,000-\$60,000 per bed, fully equipped, particularly in rural or semi-rural areas.

[430Q) Using Mr. Andrews' figures, AMI could build a new Sierra Vista, from the ground up—with the 50 bed addition contemplated by 5614—for approximately \$13 million, or \$7 million less than the proposed renovation of Sierra Vista.

2. AMI would need a certificate-of-need to make the changes envisioned by RX 5614. (Mittelstaedt, 1145) AMI may [106] not re-

³⁸ The study does not weigh the possible benefits to the public from a "renovated" Sierra Vista versus a "newly built" Sierra Vista.

ceive approval for such action. California's health planning authorities strive to prevent unnecessary investment in hospital facilities. (See Johns, 1883) They will closely scrutinize such a large proposed capital expenditure (Johns, 1879-1883), both as to whether the improvements are really necessary and whether more modest improvements (see Mittelstaedt, 1152) would be sufficient. In addition, more than \$3.1 million of the proposed capital expenditures, for addition of 50 beds in the late 1980's, may not be approved.³⁹ San Luis Obispo County is overbedded and is likely to remain so for some time in the future. California's health planning authorities are thus unlikely to approve additional beds in the area. The original Friesen reports for San Luis Obispo noted that the HSA "did not see a need for additional beds in the San Luis Obispo County planning area. . . . Any program involving the addition of beds will be difficult." (RX5435U) It can be expected that the HSA would follow the policy which it had previously announced (CX 1064 at V-22), and withhold approval for additional beds until utilization of existing beds in other area hospitals improved. It is undoubtful whether Sierra Vista's utilization will grow enough, absent consolidation, to require additional beds. Sierra Vista had only a 70% occupancy rate in calendar year 1981, and no consistent trend of increased occupancy during the preceding years. (RX 5835) It therefore has room to grow without having to increase its bed capacity. Also, RX 5614 concludes that the 50 beds are required on the assumptions that utilization of hospital inpatient services will increase as the population grows and that Sierra Vista's share of the area's patients will remain the same. (Mittelstaedt, 1063) The first assumption is suspect given testimony by respondents' witnesses that there is a trend toward decreasing length of stay for inpatients. (Mittelstaedt, 1179) Furthermore, growth in utilization of inpatient services is questionable given the decreasing rate of hospitalization per 1,000 population in San Luis Obispo County (RX 5775), and a slowdown in the rate of population growth in the County. (See CX 38Z9-Z16)

223. To the extent that AMI spends less than \$21 million to renovate Sierra Vista, the alleged savings realized by [107] consolidating are correspondingly reduced. It is in AMI's interest to make these capital costs appear as high as possible to accentuate the supposed savings to be realized from consolidating with French. This could explain some of the inconsistencies between the \$20.9 million figure and other evidence in the record. For example, AMI has already applied for a certificate-of-need for a more spacious emergency room

³⁹ The cost of those 50 beds exceeds the \$3,100,000 estimated at RX 5614S because there would be expenditure during an earlier stage of renovation to "stress" a building to permit addition of the floor housing the 50 beds. (Mittelstaedt, 1063) Should those 50 beds be deleted from AMI's construction plans, it would be unnecessary to stress the building to accommodate those beds.

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at Sierra Vista. (Carlson, 1344-45) This project may obviate the need for part of the construction program outlined at RX 5614R-S, particularly the \$900,000 temporary relocation of the emergency room and the \$11,500,000 for new construction. Secondly, most of the \$20.9 million would go for new construction which would cost \$160 (in 1982 dollars) per square foot. (RX 5614N)⁴⁰ The Friesen reports, which were also overseen by Mr. Mittelstaedt, projected the cost of new construction at \$120 per square foot (in 1981 dollars). (RX 5435Z65) It seems unlikely that the \$40.00 per square foot difference is due entirely to one year of inflation.

224. AMI states that since the French acquisition, it has implemented a number of shared services among its hospitals in San Luis Obispo County which have resulted in cost savings. (Carlson, 1330, 1347; Loftin, 1521-22) At the time of the acquisition, French had neither echocardiography equipment nor ultrasound equipment. Sierra Vista had relatively new echocardiography equipment but no ultrasound equipment. Arroyo Grande had ultrasound equipment of limited capability but no echocardiography equipment. (Loftin, 1522; RX 5642A) In February, 1980, AMI instituted a mobile echocardiography and ultrasound service for its three San Luis Obispo county hospitals. (CX 454B; CX 455B; RX 5364A; Loftin, 1523-24) AMI purchased a van and ultrasound equipment and moved Sierra Vista's echocardiography equipment from the hospital to the van. (Loftin, 1522-23) The mobile van service was for the most part limited to the three AMI hospitals. From time to time, however, at a physician's request, the mobile van serviced SLO General and Twin Cities. (Loftin, 1524-25; Harvey, 1671-72; CX 456B) The mobile echocardiography and ultrasound services operated over a period of approximately two years. (Loftin, 1526; Harvey, 1669-70, 1673-74; RX 5364A; RX 5613) The service was terminated approximately September 1, 1982 because each [108] hospital had developed a demonstrated need for its own ultrasound and echocardiography equipment. (Carlson, 1336-37; Loftin, 1525; Harvey, 1672-73)

225. This mobile van service is not a benefit resulting from the acquisition. In fact, the service may have been impractical. The fact the service lasted only two years before each hospital went back to its own equipment indicates it was of doubtful utility. (See CX 1011A-C) More importantly, an acquisition was not necessary for the hospitals to share this service. AMI has a subsidiary whose business is providing mobile diagnostic services, such as were provided in San Luis Obispo County, to hospitals. (RX 5823 at 52; see Harvey, 1694)

226. In August, 1980, French, Sierra Vista and Arroyo Grande

⁴⁰ is the price for new construction needed as part of the consolidation with French. (RX 5614N) It is assumed cost is the same for new construction required under the plan to renovate Sierra Vista.

implemented a joint system for maintenance of biomedical equipment. The new program involved the joint hiring of skilled biomedical technicians to service the over 1,000 pieces of biomedical equipment at the three hospitals. (CX 460A; Carlson, 1330-31) Before implementing this service, the hospitals called for a service representative who oftentimes had to travel from Los Angeles or San Francisco. This would lengthen the time that the equipment would be unavailable. Such "downtime" was not only expensive but disruptive and potentially dangerous to patients who needed the equipment. (Carlson, 1330-31, 1337-38) The availability of local biomedical technicians allows the hospitals to operate safely with fewer pieces of redundant backup equipment. (CX 228B) Hospitals in many communities not under common ownership share biomedical equipment repair services, either by jointly operating such a service or (more frequently) by jointly contracting with another firm to obtain the service. (Mittelstaedt, 1102-05) Such an arrangement could have been possible had French not been acquired by AMI.

227. A joint reference laboratory for physicians was established by AMI at French. A reference laboratory is a facility to which physicians send various patient samples from their offices for analysis. (Carlson, 1333-34; Stahl, 1400-01) Couriers are sent to physicians' offices to collect samples and to bring them to the central office at French for processing. They are then transported to the appropriate AMI hospital laboratory—*i.e.*, the laboratory which has the capability to perform the needed test—for analysis. (Carlson, 1333-34; Stahl, 1402) The reference laboratory provides services primarily to outpatients, rather than to hospitalized patients. (Stahl, 1401) It is questionable whether the reference lab is a benefit resulting from the acquisition of French Hospital. The reference lab benefits those patients who have tests in their doctors' offices. (*See* Stahl, 1401) Second, reference labs existed in San Luis Obispo prior to the acquisition. Sierra [109] Vista had a reference lab prior to the acquisition. (Carlson, 1333) The acquisition may actually have had a detrimental effect on reference lab services since prior to the acquisition French operated a competing reference lab which had lower prices than Sierra Vista. (CX 319B)

228. Common ownership of French and Sierra Vista has enabled the hospitals to avoid some duplication of services. An example concerns cardiac rehabilitation programs at each hospital. When French established a cardiac rehabilitation program in late 1981 in connection with its developing cardiovascular specialty, Sierra Vista already had such a program. The directors of the French and Sierra Vista programs agreed to minimize unnecessary duplication. It was agreed that French's cardiac rehabilitation program would offer service

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French's inpatients and to all outpatients in the area. Sierra Vista's cardiac rehabilitation program would, by contrast, service only inpatients at Sierra Vista. (CX 331A, B; CX 333C) No estimate of dollar savings is available. The French Hospital administrator merely noted that this type of approach will enable the hospitals to "present a united front when dealing with the lay and medical communities." (CX 331B)

229. French, Sierra Vista, Arroyo Grande, and AMI's hospital in Visalia, California, share computer services. A computer is centrally located at Sierra Vista with terminals at the other three hospitals. Each hospital inputs its financial and patient data and prints its bills from the same computer. This eliminates the need for a separate computer at each hospital. (Carlson, 1332-33, 1353) Respondents do not indicate the amount of savings through having one computer serve four hospitals; nor is it demonstrated why shared data-processing services of the kind offered by AMI subsidiary Professional Hospital Services (RX 5823 at 53) could not achieve much or all of those cost savings without common ownership of French and the other three hospitals. Moreover, the 140-mile distance between San Luis Obispo and one of the AMI hospitals sharing the computer (Carlson, 1332-33) suggests that French could have shared computer services with many multihospital systems that operated hospitals in California.

230. Common ownership of three hospitals in San Luis Obispo County has also enabled AMI to engage in joint hiring. An example is the hiring of a cardiovascular anesthesiologist for French and Arroyo Grande. The anesthesiologist previously associated with French's cardiac surgery team resigned in October, 1981. At that time, Arroyo Grande was looking for additional anesthesiology support. The two hospitals joined efforts and successfully recruited a cardiovascular anesthesiologist. (RX 5377A) Also, AMI has recently expanded [110] its purchasing agreement so that savings related to joint purchasing are already being realized (Mittelstaedt, 1051, 1119), and additional savings in this area are expected. (RX 5614)

O. Evidence Relevant to the Remedy Being Requested.

231. The Notice of Contemplated Relief served with the complaint included, but is not limited to (1) a requirement that AMI divest the assets acquired in the French Hospital acquisition, and (2) a requirement that for a period of ten years, AMI obtain Commission approval prior to making any future acquisition of any general acute care hospital located within the marketing area of a hospital owned or operated by AMI or one of its subsidiaries.

2. In complaint counsel's post-trial brief, the relief which complaint counsel seeks has been made somewhat more specific. (See CB, pp. 105-09) Complaint counsel now requests an order

complete divestiture of all assets that AMI acquired from Central Coast Hospital Company, French Hospital Corporation of San Luis Obispo, and French Medical Clinic, Inc., together with any subsequent improvements. The divestiture shall be subject to the prior approval of the Federal Trade Commission. Pending divestiture, AMI shall take all measures necessary to maintain French Hospital in its present condition and to prevent any deterioration, except for normal wear and tear, of any of the assets to be divested so as not to impair French Hospital's present operating abilities or market value.

233. The requirement for prior Commission approval of future acquisitions of general acute care hospitals by AMI also has been made more specific by complaint counsel. Complaint counsel now seek an order that, for a period of ten (10) years, AMI shall not, without the prior approval of the Federal Trade Commission, directly or indirectly acquire any hospital located in the states of Oregon, California, Texas, Oklahoma, Missouri, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, South Carolina, or North Carolina, if:

(1) The hospital to be acquired is within a Standard Metropolitan Statistical Area ("SMSA") in which AMI already operates a hospital and in which AMI, immediately after the acquisition, would operate hospitals that combined have a twenty (20) percent or more share of the licensed general acute care hospital beds; or [111]

(2) The hospital to be acquired is not within an SMSA but is in a county in which AMI already operates a hospital and in which AMI, immediately after the acquisition, would operate hospitals that combined have a twenty (20) percent or more share of the licensed hospital beds; or

(3) The hospital to be acquired is (a) not within an SMSA but is within thirty (30) miles of a hospital which AMI already operates in another county, and (b) the hospital to be acquired and any hospital(s) that AMI operates combined have a twenty (20) percent or more share of the licensed hospital beds in the area within thirty (30) miles of the midpoint between the hospital to be acquired and any hospital operated by AMI.

Provided, however, That no acquisition shall be subject to this prohibition if the consideration to be paid for the hospital, including assumption by AMI of liabilities of its present owners, does not exceed one million dollars.

234. In 1980 there were 5,830 community hospitals in the United States with a total of 988,000 beds. Seventy percent of these beds are owned by private, non-profit entities. Another 21 percent are owned by state or local governmental bodies. Only 8.8 percent are owned by for-profit entities. That 8.8 percent includes all hospitals owned by entities such as doctor or other investor groups, :

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well hospitals owned by for-profit multi-hospital systems such as AMI. (RX 5718; RX 5719) In 1972, 6.5 percent of the beds in community hospitals were controlled by for-profit entities. In 1980, that had grown to 8.8 percent. (RX 5719)

235. The five largest proprietary hospital chains, Hospital Corporation of America, Humana, AMI, National Medical Enterprises, and Lifemark acquired a total of 192 general acute care hospitals in the years 1975-1981. (CX 608; Silvia, 794-95) During their fiscal year 1975, these firms acquired a total of three hospitals; in their fiscal year 1981, they acquired a total of 80 hospitals. (CX 608) Other firms are also engaged in acquiring hospitals. These firms include about a dozen smaller proprietary hospital chains and a number of large non-profit hospital chains. In addition, some large hospitals seek to acquire other hospitals in their local areas. (Weisman, 1720-21; Reilly, 1796-97) Hospital acquisitions are most frequent in the "Sunbelt" area of the United States. The large proprietary hospital chains, including AMI, operate predominately in the "Sunbelt" (Derzon, 2184-86), an area notable for its rapid population growth and its relatively unrestrictive regulation of hospitals. (CX 430J-K; Derzon, 2185; Weisman, 1747-48) [112]

236. AMI currently owns, operates or has under construction 75 hospitals in the United States. (Weisman, 1747-48; but see F. 1) Nearly all of these hospitals were obtained through acquisition. (Reilly, 771, 1845; Weisman, 1748; CX 613) AMI has acquired 19 general acute care hospitals since 1980. (CX 613A-D; Reilly, 1845) Furthermore, AMI will continue to grow by acquiring hospitals. In 1980, AMI's president stated that the objective of the company was to acquire between four and six hospitals a year, but that it might make acquisitions at a more rapid rate if the right opportunities presented themselves. (CX 430A, C, L, W) All of the hospitals AMI currently owns, operates, or has under construction are located in the states of Oregon, California, Texas, Oklahoma, Louisiana, Missouri, Arkansas, Mississippi, Alabama, Florida, Georgia, South Carolina, and North Carolina. (RX 5823 at 50-51) AMI has only acquired one hospital not located in these 12 states, and it was subsequently sold. (CX 613A-D) These states are almost all in the "Sunbelt."

237. A hospital typically is owned by one of three groups: a government entity, a non-profit religious or charitable organization, or a for-profit investor group. (RX 5718; Reilly, 753-54) Because of advances in hospital technology and increases in construction costs required for renovating or replacing an aging facility, establishing and operating a hospital of state-of-the-art quality is quite expensive. Local governmental agencies, religious groups or small investor groups sometimes cannot obtain the capital necessary to provide needed health care services and therefore decide to sell."

(Reilly, 755-56, 1797-99; Schramm, 2351-53; Weisman, 1719-20; RX 5627F, G; *see also* S. Rep. No. 96, 96th Cong., 1st Sess. 87, *reprinted in* 1979 U.S. Code Cong. & Ad. News at 1392)

238. Charles P. Reilly, AMI's Senior Vice President responsible for supervising activities directed toward development of new hospitals and the acquisition of hospitals (Reilly, 1793), testified that he began his position at AMI by submitting a report which indicated AMI was not keeping up with other investor-owned firms in the industry in terms of growth through the acquisition or development of domestic hospitals, and that there were substantial opportunities that AMI was ignoring. (Reilly, 1794-95) He further testified that because of health planning legislation which seeks to limit the expansion of bed capacity and physical plant investment and equipment investment, there are substantially more opportunities to buy hospitals than there are to initiate and charter new ones. (Reilly, 1795) Multi-hospital systems compete to purchase hospitals by offering financial terms and commitments to provide health services and management expertise which meet [113] the community's needs. (Reilly, 1806-08) This competition among multi-hospital systems for acquiring hospitals is intense. (Reilly, 1796; Schramm, 2351; RX 5621; RX 5627)

239. AMI contends that the order sought by complaint counsel is likely to substantially lessen competition among multi-hospital systems for acquisition of hospitals. The bidding and negotiation involved in hospital acquisitions proceed at a rapid pace and effective participation in that process requires the ability to make a firm commitment in a relatively short period. Mr. Reilly, AMI's Vice President, testified that lack of ability to make such a commitment would place AMI at a disadvantage. (Reilly, 1848) Mr. Weisman, AMI's Chief Executive Officer, testified:

These are circumstances where time is almost invariably of the essence. We have situations with frequency where we will receive what the sellers have a tendency to characterize as an RFP, a request for proposal, literally with time dimensions of seven to ten days, two weeks, three weeks, that kind of thing, with an insistence upon the part of the seller that, having made their decision, they want to expedite and arrive at fruition in the shortest possible time.

(Weisman, 1726-27) A pre-approval requirement would undermine AMI's ability to put forth a firm offer in a timely fashion. AMI's offer would necessarily be conditioned on FTC pre-approval. This would be fundamentally different from the Hart-Scott-Rodino filing requirement or a requirement under state law to obtain CON approval because such requirements are equally applicable to all purchasers. Mr. Weisman testified that hospital sellers "don't view Hart-Scott generally as a condition any more than they view, for example, a preparation of a definitive agreement as a condition." (Weisman, 1727) The

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pre-approval remedy, in contrast, would apply only to AMI and would place a unique condition upon AMI's offer. (Weisman, 1727-28) Mr. Reilly also testified that a perception by hospital sellers that AMI is subject to special conditions may cause them not to contact AMI initially, even where the order does not by its terms apply, and thus AMI would not have the opportunity to compete. (Reilly, 1851)

240. In contrast to the testimony of AMI officials in this proceeding, AMI stated in its 1981 Form 10-K, filed with the Securities and Exchange Commission, as follows: [114]

In the opinion of the company's management, divestiture of French Hospital and a reasonable preacquisition screening mechanism would not have a material adverse effect on the Company's business or financial condition.

(CX 18M) The 10-K is signed by AMI's Chairman of the Board of Directors and Chief Operating Officer, as well as other AMI officials. (CX 18Z23-27)

241. Nearly all hospital acquisitions today would fall within the pre-notification requirements of the Hart-Scott-Rodino Act. (Weisman, 1728) Furthermore, in some states, acquisitions of hospitals are subject to the CON laws. In those states hospital acquisitions have to be approved by the local HSA and the state health departments. Extensive evidentiary hearings are required to obtain a CON. (Reilly, 1849, 1861; Johns, 1916; F. 85, 196)

242. The order proposed by complaint counsel would also apply to hospitals leased or managed by AMI, or where AMI attempts to acquire a lease of a hospital or of management control of a hospital. (CB, App., pp. 105-109) AMI currently operates hospitals under long-term leases. (CX 18C-E; RX 5823 at 50-51; *see also* Silvia, 796) A management contract can give the management firm responsibility for running the hospital's day-to-day operations, including decisions as to staffing levels and other personnel policies, and supply and equipment purchases. In at least some cases, key hospital employees (such as the administrator, controller, and director of nursing) are employed by the management firm rather than by the hospital's owners. Even in areas for which the hospital's owners retain responsibility (such as pricing), the management firm may be responsible for making recommendations to the owners, and therefore has some influence over those decisions. (*See, e.g.*, CX 436G-X; CX 439A-N) During the fiscal year ending August 31, 1978, AMI operated five domestic hospitals under management contracts. (CX 11Z8-Z9) Following AMI's acquisition of Hyatt Medical Enterprises and Brookwood Health Services, AMI operated 26 domestic hospitals (including 4 under develop-

ment) under management contracts. (RX 5824 at 18) AMI sold Hyatt's hospital management subsidiary in July 1982. [115]

II. CONCLUSIONS

A. Summary of the Issues

The complaint in this matter issued July 30, 1981, charging respondents American Medical International, Inc. and AMISUB (French Hospital) (collectively "AMI"), Beverly Hills, California, with violations of Section 7 of the Clayton Act, as amended, and Section 5 of the Federal Trade Commission Act, as amended. The complaint challenges the acquisition of the assets and related facilities of the proprietary French Hospital ("French") located in the city of San Luis Obispo, California.

AMI is engaged primarily in the owning, operation and management of general acute care hospitals in the United States and in foreign countries; more than 85 percent of its revenues are derived from its operation of such institutions. AMI also provides health care services through subsidiaries to hospitals and physicians, which include medical-technical support services, financial and management services, and health care development services. In AMI's fiscal year 1982, it had total operating revenues of approximately \$1.4 billion and net income of \$78.8 million. It owns, operates, or has under construction 72 hospitals in the United States and 24 hospitals abroad. AMI is the nation's third largest proprietary hospital chain in terms of domestic hospitals owned. AMI currently owns and operates three hospitals in San Luis Obispo County, California; they are Sierra Vista Hospital ("Sierra Vista") and French located in the city of San Luis Obispo, and Arroyo Grande Community Hospital ("Arroyo Grande") located in Arroyo Grande, California.

AMISUB (French Hospital) is a wholly-owned subsidiary corporation of AMI, and was established by AMI in connection with the acquisition and operation of French.

On July 18, 1979, AMI acquired from Central Coast Hospital Company all of the common stock of French Hospital Corporation. Central Coast Hospital Company at the time of the acquisition was a limited partnership consisting of both general and limited partners, all but two of whom were physicians. The partnership owned the land, buildings, and other improvements relating to French Hospital. Central Coast Hospital Company's wholly-owned subsidiary, French Hospital Corporation, operated French Hospital, owned or leased the hospital's equipment, and held the license necessary to operate the hospital prior to the acquisition. Central Coast Hospital Company leased to

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French Hospital Corporation on a long-term basis the property on which [116] French Hospital is located and the improvements on that property, including the buildings housing the hospital's facilities. In the year ending June 30, 1978, Central Coast Hospital Company and its subsidiary, French Hospital Corporation, had total revenues of \$8,171,482 and a combined net income of \$745,160.

In the same transaction AMI also acquired from Central Coast Hospital Company certain other assets, including the Company's ownership interest in the French Hospital premises leased to French Hospital Corporation. AMI also purchased from French Medical Clinic, Inc.¹ a CAT scanner and other x-ray and laboratory equipment. (CX 70D-F, W, X-Z; CX 78) While the purchase contract designated AMISUB (French Clinic) as the purchaser, AMI paid the entire consideration for the purchase from its own funds. AMISUB (French Clinic) also that day subleased from French Medical Clinic, Inc. space for use as a CAT scanning and x-ray facility and a clinical laboratory. (CX 71A, F)

The total cost to AMI of the transactions described above was \$10,970,000. AMI issued to Central Coast Hospital Company 220,225 shares of stock, with a fair market value of approximately \$6.5 million, and assumed approximately \$3.9 million in long-term debt of Central Coast Hospital Company. Finally, AMI paid \$570,000 in cash for the CAT scanner, x-ray, and laboratory equipment (CX 70E, G) purchased from French Medical Clinic, Inc.

At the time of the acquisition there were five general acute care hospitals in San Luis Obispo County: Sierra Vista, French, and San Luis Obispo General Hospital ("SLO General"), all located in the city of San Luis Obispo near the center of the county; Arroyo Grande Community Hospital ("Arroyo Grande") located in Arroyo Grande in the south area of the county; and Twin Cities Community Hospital ("Twin Cities") located in Templeton in the north area of the county.

Sierra Vista, purchased by AMI in 1968, was the largest hospital in the county with 172 acute care hospital beds. Arroyo Grande, which had 79 acute care hospital beds, was [117] acquired by AMI in 1972. SLO General, owned by the county, had 78 acute care hospital beds.² Twin Cities, owned by National Medical Enterprises, had 84 acute care hospital beds. French, acquired by AMI in July 1979 from partnership composed primarily of physicians practicing in the city of San Luis Obispo, was the second largest hospital in the county with 38 acute care hospital beds. With the acquisition of French, AMI

¹ French Medical Clinic, Inc. was a professional corporation which owned or leased the equipment used at French Hospital. It was a wholly-owned subsidiary of Central Coast Clinic Company, a partnership composed of many other partners in Central Coast Hospital Company which owned French Hospital.

² SLO General also had 14 psychiatric beds, which are separately licensed and differ from acute care hospital

controlled 310 hospital beds in the city of San Luis Obispo out of a total of 388 acute care hospital beds (over 79%), and 389 acute care hospital beds out of a county total of 551 beds (over 70%). In terms of 1979 inpatient hospital days, AMI hospitals in the city of San Luis Obispo had a market share of 87.2%, and a county market share of 75.5%. In terms of 1980 gross hospital revenues, AMI hospitals had a market share in the city of San Luis Obispo of 82.4%, and a county market share of 71.3%. (See Appendix D)

The complaint alleges, and complaint counsel contends, that the effects of the acquisition of French may be to lessen competition substantially or tend to create a monopoly in the general acute care hospital market in San Luis Obispo County, California, and/or parts thereof in violation of Section 7 of the Clayton Act, as amended, and Section 5 of the Federal Trade Commission Act, as amended. It is further alleged that AMI, through its wholly-owned subsidiaries, has, with specific intent to exclude competitors and maintain the power to control delivery of hospital services, attempted to monopolize and has otherwise engaged in unfair methods of competition in the market for general acute care hospital services in San Luis Obispo County, or parts thereof. This course of conduct and effects are alleged to violate Section 5 of the Federal Trade Commission Act, as amended.

Complaint counsel requests an order requiring complete divestiture of all assets, tangible and intangible, that AMI acquired from Central Coast Hospital Company, French Hospital Corporation of San Luis Obispo, and French Medical Clinic, Inc., together with any subsequent improvements. The divestiture shall be subject to the prior approval of the Federal Trade Commission; pending divestiture, AMI must take all measures necessary to maintain French Hospital in its present condition and to prevent any deterioration, except for normal wear and tear, of any of the assets to be divested. [118]

Complaint counsel also seeks an order that, for a period of ten (10) years, AMI shall not, without the prior approval of the Federal Trade Commission, directly or indirectly acquire any general acute care hospital located in the states of Oregon, California, Texas, Oklahoma, Missouri, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, South Carolina, or North Carolina, if AMI already operates such a hospital within the same SMSA, or within the same county, or within a specified area of such a hospital. (See CB, App. 105-109)

Respondents' principal contentions are that the National Health Planning and Resources Development Act, 42 U.S.C. 300k-300s (1976 & Supp. IV 1980), depends for its effectiveness on voluntary actions by providers to reduce excess hospital capacity. The local implementing agency, the Mid-Coast Health Systems Agency, had advocated mergers of hospitals to alleviate over-capacity and duplicative hospi-

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tal services in San Luis Obispo. AMI's acquisition of French and its plans to merge that facility with Sierra Vista were intended and reasonably calculated to advance that goal. Thus, an antitrust exemption in this case is necessary to make the Planning Act work.

Respondents also contend that the antitrust laws, if applied, have not been violated. Because nearly all hospital bills are covered by insurance, neither patients nor physicians are price-sensitive and, as a result, there is not price competition in the hospital industry. This is particularly true in San Luis Obispo where French and Sierra Vista have never competed on price. Moreover, because of physician politics and animosities in San Luis Obispo there was scant non-price competition between the hospitals. Hence, competition could not be substantially lessened, nor market power enhanced by the acquisition. One future effect of the acquisition, according to respondents, is the increased efficiency leading to cost savings and quality enhancement which would result from the merger of French and Sierra Vista, a benefit that Congress sought to promote in the Planning Act.

Finally, respondents submit that the divestiture relief requested by complaint counsel is inappropriate because separate ownership of French and Sierra Vista is not likely to enhance competition in view of the unique economics of the hospital industry. The ten-year prior approval provision is also inappropriate since the record reflects no likelihood that AMI, without such restraint, will engage in illegal conduct. The prior approval provision will dramatically reduce, if not eliminate, AMI's ability to participate effectively in the competitive market for the purchase of hospitals, to the substantial detriment of the communities involved. [119]

B. Jurisdiction

1. Section 7 of the Clayton Act

In 1979, when AMI acquired French Hospital, Section 7 of the Clayton Act applied only to the direct or indirect acquisition by a corporation of the stock of another corporation, or the direct or indirect acquisition by a corporation of the assets of another corporation.³

On July 18, 1979, AMI acquired the assets of Central Coast Hospital Company, a partnership, which included all the common stock of

³ Section 7 of the Clayton Act reads, in pertinent part, as follows:

That no corporation engaged in commerce shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no corporation subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another corporation engaged also in commerce, where in any line of commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly. 15 U.S.C. 18 (1976)

³⁸⁰ The Clayton Act was amended to cover noncorporate acquisitions. Antitrust Procedural Improvements Act 1980, Pub. L. No. 96-349, Section 6(a), 94 Stat. 1154, 1157-58 (1980).

French Hospital Corporation. Through acquisition of this corporate stock, AMI acquired the corporation operating French Hospital, the state license necessary to operate the hospital, a long-term lease of the hospital building, a substantial amount of equipment, and the corporation's receivables. French Hospital Corporation held a lease from Central Coast Hospital Company under which the corporation had the right to occupy the French Hospital premises until 1991, with an option to renew until 2006. The only assets that AMI purchased from Central Coast Hospital Company, aside from the common stock of French Hospital Corporation, were the French Hospital building, and a vacant lot.⁴ Acquisition of the [120] French Hospital Corporation stock gave AMI control of the hospital.⁵ The fact that AMI acquired the corporation's stock from a partnership, and not from a corporation does not affect the result.⁶ Section 7 does not require that "stock or other share capital" be acquired from a corporation; it prohibits the direct or indirect acquisition by a corporation (AMI) of the stock of another corporation (stock of French Hospital Corporation) where the effect of such acquisition may be substantially to lessen competition or tend to create a monopoly. Thus, AMI's acquisition of the common stock of French Hospital Corporation from the Central Coast Hospital Company, a partnership, satisfies the terms of Section 7 of the Clayton Act in effect in 1979 since it was a "direct or indirect" acquisition of the stock of a corporation.

The critical point in the above analysis is not who had the ultimate control over all the assets, but the fact that French Hospital Corporation, *at the time of the acquisition*, owned or had under lease all the principal assets necessary to the operation of the hospital, and also operated the hospital. AMI acquired the stock of that corporation. Other arrangements could have been worked out to avoid Section 7's proscriptions, such as having the partnership dissolve the corporation and take over the operation of the hospital sometime prior to its acquisition. However, these measures were not undertaken, corporate stock was acquired by another corporation, and Section 7 applies to the acquisition. [121]

AMI's acquisition of French Hospital also included the purchase from French Medical Clinic, Inc. of some equipment, including a CAT scanner and other x-ray and laboratory equipment, used in the opera-

⁴ The record is not clear as to equipment owned by the partnership and equipment owned by the corporation. (See Resp. Reply Brief, p. 190 n.; CX 535; CX 70; CX 60; CX 49B-I; CX 35Z5) However, a precise determination of the equipment owned—or leased—by each entity is not necessary to a resolution of the jurisdictional issue.

⁵ Complaint counsel places emphasis on the long-term lease which French Hospital Corporation held on the hospital building. (CB, p. 4; Complaint counsel Reply Brief, p. 61) As respondents point out, if the partnership had desired to amend or change the lease (CX 534Z1), or cancel the lease for that matter, it could have done so at will since the partnership (lessor) wholly-owned and controlled the corporation (lessee). (Resp. Reply Brief, p. 191)

⁶ Numerous acquisitions are accomplished through tender offers where the stock is acquired from individuals. No one has suggested, to my knowledge, that such acquisitions are not subject to Section 7 of the Clayton Act.

tions of French Hospital. This acquisition of corporate assets was an integral part of the transaction which gave AMI control of French Hospital. Section 7 reaches this direct purchase of the corporate assets of French Medical Clinic, Inc., which completed AMI's acquisition of the French Hospital operation.

2. Section 5 of the Federal Trade Commission Act

Section 5 of the Federal Trade Commission Act provides that "[u]nfair methods of competition in or affecting commerce . . . are hereby declared unlawful." 15 U.S.C. 45 (1976). The Commission has applied Section 5 to reach transactions which violate the standards of the Clayton Act, though technically not subject to the Act. For example, in *Beatrice Foods Co.*, 67 F.T.C. 473 (1965), the Commission held that Section 5 could be used to challenge noncorporate acquisitions even though the Clayton Act is inapplicable to such transactions. As the Commission stated in *Beatrice*:

It is well established that Section 5 reaches transactions which violate the standards of the Clayton Act though for technical reasons are not subject to that Act, unless such application of Section 5 would be an attempt to "supply what Congress has studiously omitted" . . . or to "circumvent the essential criteria of illegality prescribed by the express prohibitions of the Clayton Act" . . . Applying Section 5 to noncorporate acquisitions effectuates, rather than circumvents or conflicts with, Congress' policy with respect to the prevention of anticompetitive acquisitions.

Id. at 726; see also, *Grand Union Co. v. FTC*, 300 F.2d 92, 98-99 (1962).

Section 5 of the Federal Trade Commission Act applies to the entire acquisition transaction which gave AMI control of French Hospital. Because the acquisition of partnership as well as corporate assets can be challenged under Section 5, it is not necessary to predicate Section 5 liability on satisfaction of the technical requirements of Section 7 of the Clayton Act. "[T]he Commission's power to challenge noncorporate acquisitions under Section 5 is well-settled." *Ash Grove Cement Co.*, 85 F.T.C. 1123, 1167 n. 61 (1975). [122]

3. Interstate Commerce

a. Section 7 of the Clayton Act

At the time of the French acquisition, Section 7 of the Clayton Act applied to mergers only if both the acquiring and the acquired firms were "engaged in commerce."⁷ A firm is engaged "in commerce" within the meaning of Section 7 of the Clayton Act if it is "directly engaged in the production, distribution, or acquisition of goods or services in interstate commerce." *United States v. American Building*

⁷ 15 U.S.C. 18 (1976). The Clayton Act was amended in 1980 to extend jurisdiction to firms "affecting commerce." Antitrust Procedural Improvements Act of 1980, Pub. L. No. 96-349, Section 6(a), 94 Stat. 1154, 1157-58 (1980).

Maintenance Industries, 422 U.S. 271, 283 (1975) Participation in the flow of interstate commerce need not be substantial, it need only be more than *de minimis*. *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 785 (1975); *United States v. M.P.M., Inc.*, 397 F.Supp. 78, 84-86 (D. Colo. 1975).

AMI has admitted doing business in a number of states. For example, at the time of the French acquisition, AMI owned or leased 44 general acute care hospitals that were located in nine states. It coordinated their activities from its Beverly Hills, California, headquarters. In the year before the acquisition, AMI acquired four domestic hospitals, a design and architectural firm, and a prepaid health care firm, all of which were located in states other than California. AMI also provided cardiopulmonary, diagnostic, and therapeutic services under contracts with hospitals in 40 states. These interstate transactions place AMI in the flow of interstate commerce. Furthermore, AMI was engaged in interstate commerce by virtue of its ownership of Sierra Vista and many other hospitals that purchase substantial amounts of goods from sources in other states, and receive substantial revenues from out-of-state sources, including payments from Medicare and private third-party payor insurance plans. See *United States v. Hospital Affiliates International, Inc.*, 1980-81 Trade Cas. (CCH) ¶ 63,721 at 77,853 (E.D. La. 1980).

At the time of the acquisition, French Hospital Corporation was making payments of over \$200,000 per year on equipment leases, which payments were sent to locations outside the State [123] of California. (F. 8, n. 4) French Hospital Corporation received millions of dollars in payments that originated outside of the State of California from Medicare and private third-party payors. French Hospital Corporation made substantial purchases of supplies and equipment from out-of-state sources. Finally, French Hospital Corporation occasionally treated patients that did not reside in the State of California. The payment of funds to locations outside the State of California, the receipt of funds from interstate sources, and treatment of patients from other states placed French Hospital Corporation in the flow of interstate commerce. *Goldfarb v. Virginia State Bar*, 421 U.S. at 783-84; *McLain v. Real Estate Bd. of New Orleans*, 444 U.S. 232, 245 (1980); *United States v. Hospital Affiliates International, Inc.*, *supra*. See also *Hospital Building Co. v. Trustees of Rex Hospital*, 425 U.S. 738, 744 (1976); *Crane v. Intermountain Health Care, Inc.*, 637 F.2d 715, 725 (10th Cir. 1981) (en banc).

French Medical Clinic, Inc. leased substantial medical equipment from an out-of-state concern, and made payments therefor approximating \$200,000 per year. (F. 6) Most of the payments for rental of this equipment were made in interstate commerce. The CAT scanner

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owned by French Medical Clinic, Inc. was used both in the Clinic and for inpatients at French Hospital. (F. 167, n. 18) It is inferred that the Clinic purchased supplies and equipment in interstate commerce, and received substantial funds in interstate commerce as payment for health care services. Thus, French Medical Clinic, Inc. was substantially involved in the flow of interstate commerce at the time of the French acquisition. As the court in *McLain* explained, its earlier holding in *Goldfarb* that the activities of the attorneys were within the stream of interstate commerce "in no way restricted it to those challenged activities that have an integral relationship to an activity in interstate commerce." *McLain v. Real Estate Bd. of New Orleans*, 444 U.S. at 244.

Respondents, French Medical Clinic, Inc., and French Hospital Corporation, prior to the acquisition, could not have furnished hospital services to patients without the purchasing of supplies from interstate sources, leasing of equipment from interstate sources, and receiving substantial funds in payment for services from interstate sources. The actual furnishing of the hospital services to patients [*e.g.*, anesthesiology], which respondents seek to isolate as being a local activity (RB, pp. 151-52; Resp. Reply Brief, p. 186), is "an integral part" of the total hospital operation which is substantially involved in interstate commerce. See *Goldfarb v. Virginia State Bar*, 421 U.S. at 784-85. Thus, for jurisdictional purposes, all necessary parties to the French acquisition were "directly engaged in the production, distribution, or acquisition of goods [124] or services in interstate commerce." *United States v. American Building Maintenance Industries*, 422 U.S. at 283.

b. *Section 5 of the FTC Act*

Section 5 of the Federal Trade Commission Act declares unfair methods of competition "in or affecting commerce" to be unlawful. 15 U.S.C. 45 (1976). The activities which place AMI, French Hospital Corporation, and French Medical Clinic, Inc. in interstate commerce for purposes of Section 7 of the Clayton Act are also activities which meet the "in commerce" requirements of Section 5. This showing is sufficient to establish jurisdiction under Section 5.

The "affecting commerce" requirement of Section 5 is satisfied if some nexus exists between the acts or practices at issue and interstate commerce. Purely intrastate activities are deemed to "affect commerce" if the activity, local in nature, "has an effect on some other appreciable activity demonstrably in interstate commerce." *McLain v. Real Estate Bd. of New Orleans, Inc.*, 444 U.S. at 242 (1980); see also *Hospital Building Co. v. Trustees of Rex Hospital*, *supra*. To establish the jurisdictional element of a Section 5 violation, "it would be sufficient [for complaint counsel] to demonstrate a substantial effect on

interstate commerce" generated by AMI's and French Hospital Corporation's total hospital operation; a more particularized showing is not required. *McLain v. Real Estate Bd. of New Orleans*, 444 U.S. at 242.

The record in this proceeding demonstrates that AMI's acquisition of French Hospital and AMI's attempt to monopolize "affect" interstate commerce in a variety of ways, including the following:

(1) French Hospital receives substantial interstate payments from private third-party payors. Many of these private third-party payors reimburse on the basis of charges rather than costs. The French acquisition may tend to impair price competition which will necessarily mean that interstate payments from such charge-based payors will be affected. AMI is in the process of standardizing the charges of its three hospitals in San Luis Obispo County. Any standardization of charges will affect these interstate payments. In addition, AMI will seek a return on its investment in French Hospital, which investment substantially exceeds the investment of French's previous owners. This will affect charges.

(2) French Hospital also receives payments from Medi-Cal, a portion of which is interstate in nature (*i.e.*, the federal share). AMI's acquisition of French Hospital will [125] substantially affect these revenues to the extent that AMI's conduct eliminates price competition for Medi-Cal business.

(3) Medicare payments, which are interstate in nature, are also affected by AMI's acquisition of French Hospital. Medicare paid AMI's San Luis Obispo County hospitals on the basis of costs, and AMI's acquisition of French Hospital affected the cost basis upon which its Medicare revenues were predicated. A substantial portion of the almost \$11 million purchase price for French Hospital was amortized by AMI and passed on to Medicare each year, and also passed on to Medi-Cal in essentially the same way. Since the cost-based reimbursement formulas used by Medicare and Medi-Cal included a reasonable return on equity (profit), AMI's return on equity on this stepped-up investment basis resulted in higher reimbursement to AMI than to the previous owners of French. These changes in French Hospital's cost basis affected interstate payments to the hospital.

(4) French Hospital purchased a substantial amount of drugs, medical devices, and other supplies from sources outside of California. AMI's acquisition of French affects these interstate purchases to the extent that reduced competition among hospitals resulting from the acquisition will affect the nature and quantity of supplies that AMI purchases.

These links with interstate commerce are sufficient to satisfy the "affecting commerce" requirement of Section 5. See *Hospital Building Co. v. Trustees of Rex Hospital*, *supra*; *Indiana Federation of Dentists*, Dkt. 9118, 101 F.T.C. 57 (1983); *American Medical Ass'n.*, 94 F.T.C. 701, 993-996, *aff'd as modified*, 638 F. 2d 443 (2d Cir. 1980); *aff'd per curiam by an equally divided court*, 455 U.S. 676 (1982) Nor is it necessary to show a "direct" connection between the challenged act or practice and an effect on interstate commerce, *Hospital Building Co.*, 425 U.S. at 744-45; nor the magnitude of the effect; or even that an effect has already occurred. *McLain*, 444 U.S. at 243; *Goldfarb*, 421 U.S. at 785. This is particularly true for violations of the Clayton and Federal Trade Commission Acts, which can be based on probabilities of anticompetitive effects and not necessarily actualities. *FTC v. Motion Picture Adv. Service Co.*, 344 U.S. 392, 394-395 (1953). Further, it is not necessary to show that there will be a reduction, rather than an increase, in the flow of commerce through interstate channels. *Harold Friedman Inc. v. Thorofare Markets Inc.*, 587 F.2d 127, 132, 137 (3d Cir. 1978)

The record establishes that the Federal Trade Commission has jurisdiction over the acquisition of French Hospital both under Section 7 of the Clayton Act and Section 5 of the FTC Act. [126]

Finally, respondents place reliance upon *Cardio-Medical Associates v. Crozer-Chester Medical Center*, 552 F.Supp. 1170 (E.D. Pa. 1982), as establishing that the provision of health services is essentially local in nature, and that the interstate transfer of funds, the interstate purchase of drugs and supplies, and the treatment of some out-of-state patients do not satisfy "in commerce" or "affecting commerce" jurisdiction. That proceeding involved allegations of denial of certain specialized privileges in cardiology at a medical center to four local physicians. The court stressed that the plaintiffs' case related "only to a limited number of cardiology procedures. . . ." *Id.* at 1203. There was no allegation that plaintiffs had been foreclosed from practicing cardiology at the defendant medical center, or from pursuing their practices in their offices, or anywhere else. *Ibid.* The court pointed out that the interstate commerce involved, if any, was "miniscule," *Ibid.*, that "[i]f antitrust jurisdiction can be invoked on the basis of these plaintiffs' allegations, virtually all activities, even if purely local, and including our hypothetical house painter, would be subject to federal antitrust scrutiny." *Id.* at 1205.

In this present proceeding the antitrust challenge is directed to the acquisition of an entire hospital operation, not some limited aspect of patient services such as was involved in *Cardio-Medical*. Thus, even if the holding in *Cardio-Medical* is correct on its facts, it is inapplicable to this proceeding.

C. *The Relevant Markets*

Section 7 of the Clayton Act prohibits acquisitions where the effect thereof may be "substantially to lessen competition, or to tend to create a monopoly" in any "line of commerce" in any "section of the country." 15 U.S.C. 18 (1976). Therefore, determination of the relevant product market and the relevant geographic market is a necessary predicate to the examination of the legality of a merger under the Clayton Act, *United States v. Marine Bancorporation*, 418 U.S. 602, 618 (1974), because measurement of the substantiality of impact may be made only in terms of the market affected. *United States v. E.I. du Pont de Nemours & Co.*, 353 U.S. 586, 593 (1957); *Brown Shoe Co. v. United States*, 370 U.S. 294, 324 (1962). "[T]he problem of defining a market turns on discovering [127] patterns of trade which are followed in practice." *United States v. United Shoe Machinery Co.*, 110 F.Supp. 295, 303 (D. Mass. 1953), *aff'd per curiam*, 347 U.S. 521 (1954).⁸

1. The Relevant Product Market

The relevant product market alleged in the complaint for the purpose of evaluating the anticompetitive effect of AMI's acquisition of French Hospital is "general acute care hospitals." It is clear, however, that it is the patient services furnished by general acute care hospitals that is the product market intended by the complaint. (Complaint, ¶ 6)

The outer boundaries of a market are set by the "reasonable interchangeability of use" or "cross-elasticity of demand" between the product and proposed potential substitutes. *Brown Shoe*, 370 U.S. at 325. However, the relevant market cannot include the infinite range of possibilities that may in some aspects be interchangeable, and yet still retain any meaning as a concept and provide any guidance in fashioning a rule. The circle must be drawn narrowly to exclude any other product to which, within reasonable variations in price, only a limited number of buyers will turn; in technical terms, products whose cross-elasticities of demand are small.⁹ (See, *Times-Picayune Publishing Co. v. United States*, 345 U.S. 594, 612, n. 31 (1953)) It is

⁸ Market definition is also an element of an attempt to monopolize claim. The process of market definition in monopolization cases is similar to that used in Section 7 cases. *United States v. Grinnell Corp.*, 384 U.S. 563, 573 (1966).

⁹ The Commission, in its statement concerning horizontal mergers, stated: "The purpose of product market analysis is to ascertain what grouping of products or services should be included in a single relevant market. Where the cross-elasticity of demand for separate products or services is high, they normally will be within the same product market. Similarly, a high cross-elasticity of supply tends to suggest the existence of a common product market. Therefore, the issue of whether related products or services place a significant constraint on the ability of merging firms to raise prices, limit supply or lower quality is central to evaluating the competitive effects of a horizontal merger." Statement of Federal Trade Commission Concerning Horizontal Mergers, June 14, 1982, at 12.

now established that within a broad product market well-defined submarkets may exist which constitute product markets for antitrust purposes. *Brown Shoe* outlines the [128] criteria by which such product markets are to be established. These are:

[I]ndustry or public recognition of the submarket as a separate economic identity, the product's peculiar characteristics and uses, unique production facilities, distinct customers, distinct prices, sensitivity to price changes, and specialized vendors.

370 U.S. at 325.

In establishing these guidelines, the Court noted that absolute precision in definition of the market is not what is required; the definition of the relevant market must merely reflect the market realities. 370 U.S. at 336, 342, n. 69. In addition, it is not necessary that the market chosen fulfill *all* of the criteria. *United States v. Aluminum Co. of America*, 377 U.S. 271, 276-77 (1964); *Reynolds Metals Co. v. FTC*, 309 F.2d 223, 227 (D.C. Cir. 1962).

Courts have held in a variety of different industries that when firms offer a group of services that are, as a matter of trade reality, considered economically distinctive when viewed collectively, the "cluster" of products or services can and should be treated as a product market for purposes of antitrust analysis. *United States v. Phillipsburg National Bank & Trust Co.*, 399 U.S. 350, 360-361 (1970) (commercial banking services); *United States v. Philadelphia National Bank*, 374 U.S. 321, 356 (1963) (commercial banking services); *United States v. Grinnell Corp.*, 384 U.S. 563, 571 (1966) (central station protective services); *Crown Zellerbach Corp. v. FTC*, 296 F.2d 800, 811 (9th Cir. 1961), *cert denied*, 370 U.S. 937 (1962) (paper products); *American Medicorp v. Humana, Inc.*, 445 F. Supp. 589, 605 (E.D. Pa. 1977) (short-term acute care hospital services). This principle of a "cluster of services" provided by general acute care hospitals is the most appropriate product market for purposes of analyzing the effects of the French Hospital acquisition.¹⁰ [129]

General acute care hospitals offer a cluster of services not available from any other type of health facility. General acute care hospitals in California are required to offer the following services on a 24-hour basis: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. *Cal. Health & Safety Code* Section 1250(a) (Deering 1982). There are no reasonable substitutes in consumption or supply for this cluster of services. The cluster of services

¹⁰ Complaint counsel proposes that the product market can be characterized in two ways: general acute care hospital services (hospital services) or general acute care hospital inpatient services (inpatient services). The narrower market of inpatient services is inconsistent with the "cluster of services" product market since it attempts to carve out all outpatient services rendered by general acute care hospitals. In addition, the record supports a conclusion that substantially all outpatient services rendered by general acute care hospitals simply were not *practically* available to consumers from other sources. (See, e.g., F. 45-46)

offered by general acute care hospitals provides for the complete treatment of patients with a broad range of conditions. Thus, the hospital offers a variety of facilities to help diagnose disease; it offers facilities for surgery; it provides round-the-clock nursing services. Most importantly, hospitals provide the equipment and personnel to deal with unexpected, but potentially life-threatening, situations. While a particular service may be available at some other institution, general acute care hospitals are unique in that they alone offer this whole cluster of services in a single setting. (F. 35)

It is critically important for doctors to have access to general acute care hospitals. Surgeons, for example, require hospitals not only for the surgery itself, but also for the other support staff and services necessary to care for the patient before and after the surgery. Only hospitals have the necessary equipment to perform major surgery. Likewise, hospitals are often the only facilities able to perform certain sophisticated tests which doctors require.

A number of physical ailments can be treated safely only by admitting a patient to the hospital. These situations include, among others, patients in need of certain kinds of surgery, patients requiring certain diagnostic procedures, and patients in need of observation or around-the-clock monitoring. Almost any patient with acute cardiovascular disease must be admitted to the hospital for treatment. Patients in need of intravenous medication, and those in need of intensive care services, must be admitted to the hospital. Also, patients having procedures which require general anesthesia usually will be admitted to the hospital. [130]

There are some other situations where it is possible to treat a patient without admission to a hospital, but a number of factors make this option unattractive. In those instances where nursing care is required, a patient could be treated at home only if private duty nurses were employed at great expense. Even if nurses were hired, it still might be necessary to admit a patient if complications arose. (Boyd, 335) Unexpected complications, or patients with certain "pre-disposing conditions" creating the risk of complications, makes treating many conditions in a nonhospital setting extremely risky.

Some ancillary services, such as x-rays and laboratory tests, which are rendered to inpatients also are available in doctors' offices and clinics and private labs. However, these nonhospital facilities are not used to treat individuals in need of inpatient care. When people needing inpatient care require such services, they use the facilities present in the hospital.

The most important outpatient service provided by a hospital is the hospital's emergency room. All hospitals in San Luis Obispo County offered full-time emergency room services. In some case, emergency

rooms may treat relatively minor problems that probably could be treated in a doctor's office or a clinic. But patients often come to emergency rooms unaware of what is wrong with them, but aware that the full gamut of care is available to them at an emergency room. Doctors' offices, which are not open 24 hours a day and cannot provide as broad a range of services as emergency rooms, are therefore not a substitute for a patient who believes he needs emergency care. A patient seeking emergency care may use the emergency room because he does not have a regular doctor or is not readily knowledgeable about an available doctor.

The cluster of services offered by general acute care hospitals is distinct from that available from other sources in at least two ways. First, hospitals offer a collection of complementary services that are most efficiently supplied together. These services are needed by patients and doctors alike; indeed, the services are essential to seriously ill patients needing sophisticated back-up services, and patients whose general health status or medical condition poses a risk of complications. Second, the cluster of hospital services are not available outside the hospital. Patients needing full-time nursing care or observation, emergency support services, many kinds of surgery, intensive care, or certain sophisticated equipment, have no reasonable alternative to hospital care. Other types of health care facilities and services, such as doctors' offices, outpatient laboratories, long-term care [131] facilities and home health services, simply are not reasonably interchangeable with hospital services, for they do not and cannot offer the range and combination of services found in hospitals.

Moreover, cross-elasticity of supply for hospital services is also low. Legal requirements and other considerations indicate that other firms cannot easily begin to offer hospital services if existing hospitals raise prices, restrict output, or lower quality. While AMI asserts that nationwide, more medical and surgical procedures are being performed in doctors' offices or in freestanding surgical centers and more diagnostic tests are being performed on an outpatient basis, the evidence adduced at trial showed that these factors are not likely to have any significant effect on San Luis Obispo County hospitals in the foreseeable future.

In addition to the lack of reasonable substitutes for hospital services, other factors reinforce the conclusion that general acute care hospital services constitute a distinct product market. General acute care hospitals are recognized by government agencies and industry participants as a distinct class of health care provider. There is a well-accepted definition of acute care hospitals used by groups such as health planning organizations, hospital associations, accrediting bodies, and government agencies that does not include long-term care

facilities, psychiatric hospitals, or doctors' offices or clinics. In addition, California law treats general acute care hospitals separately from other types of facilities that offer inpatient care, such as psychiatric and specialty hospitals and skilled nursing and intermediate care facilities. *Cal. Health & Safety Code* Section 1250 (Deering 1982). AMI documents introduced into evidence listed only other general acute care hospitals as competitors of its hospitals in San Luis Obispo County. Hospital administrators, when asked about their competitors, mentioned only other general acute care hospitals and not outpatient facilities.

In sum, general acute care hospital services are clusters of services for which patients have no reasonable substitutes outside hospitals. Nor do other facilities exist that could be expected to offer interchangeable services if existing hospitals exercise market power to the detriment of consumers. Thus, there are no alternatives that can significantly constrain pricing and other behavior of general acute care hospitals. As a consequence, general acute care hospital services is the appropriate product market in which to evaluate the competitive effects of AMI's acquisition of French Hospital. [132]

2. The Relevant Geographic Markets

a. *Legal Criteria*

The complaint alleges that the relevant geographic market is San Luis Obispo County and/or parts thereof. (Complaint, ¶ 7) Complaint counsel asserts that the city of San Luis Obispo is a relevant geographic market, in addition to San Luis Obispo County. More than one relevant market may exist in an antitrust case. *United States v. Marine Bancorporation*, 418 U.S. 602, 621 (1974); *United States v. Pabst Brewing Co.*, 384 U.S. 546, 551-552 (1966).

The purpose of defining a geographic market¹¹ is to delineate the geographic area within which market power could be successfully exercised. Thus, the relevant geographic market is the territory within which a firm could exercise market power because sellers outside this area lack the ability to compete on substantial parity with those in the market.¹²

In determining the relevant geographic market, the courts seek to identify the market area where the effect of the merger will be direct and immediate. The "area of effective competition in the known line

¹¹ The terms "section of the county," as used in Section 7 of the Clayton Act, and "relevant geographic market" are equivalent. *United States v. Marine Bancorporation*, 418 U.S. 602, 620-21 (1974).

¹² As the Commission has noted in discussing geographic market definition, "[t]he issue is whether producers of the merged firm's product in other geographic areas place a significant constraint on the ability of the merged firm to raise price or restrict output. As a general proposition, an area is a separate geographic market if a change in the price of the product in the area does not, within a relevant period of time, induce substantial changes in the quantity of the product sold in other areas."

of commerce" is determined by delineating "the market area in which the seller operates, and to which the purchaser can practicably turn for supplies." *United States v. Philadelphia National Bank*, 374 U.S. 321, 359 (1963) (quoting *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320, 327 (1961)).

One commentator has defined the relevant market as follows:

The area of effective competition may be any commercially significant geographic area which can [133] reasonably be said to confine the relevant commercial activities. If sellers within the area are making price and output decisions protected from the need to take account of sellers outside the area, there is a distinct market. If sellers within the market must take account of sellers outside it, either because these sellers are mobile and can easily come into the area to sell, or because buyers are mobile and can easily go outside of the area to buy, the market is being defined too narrowly.

L. Sullivan, *Handbook of the Law of Antitrust* 68 (1977).

The exact size of the market need not be established. *British Oxygen Co. Ltd.*, 86 F.T.C. 1241, 1371 (1975), *rev'd sub nom. on other grounds, BOC International Limited v. FTC*, 557 F.2d 24 (2d Cir. 1977); *Paper-craft Corp.*, 78 F.T.C. 1352, 1405-06 (1971), *aff'd*, 472 F.2d 927 (7th Cir. 1973). "[P]recision of detail is less important than the accuracy of the broad picture presented." *Brown Shoe Co. v. United States*, 370 U.S. 294, 342, n. 69 (1962). The geographic market, like the product market, must correspond to commercial realities and be economically significant. *Id.* at 336-37. The physical dimensions of the geographic market need not be set out in metes and bounds, *Pabst Brewing Co.*, 384 U.S. at 549, but must constitute a rough approximation of the relevant market. In *Philadelphia National Bank*, the Supreme Court stated that the relevant geographic markets in service industries are generally local, because "convenience of location is essential to effective competition." 374 U.S. at 358.

In defining the geographic market for hospital services, the Commission and the Justice Department have stated that the factfinder should use "the 'traditional' method of economic analysis" to identify "the area of effective competition that the [hospital] encounters when it offers the designated product for sale." Brief for United States as Amicus Curiae at 13-14, *Jefferson Parish Hospital District No. 2 v. Hyde*, *cert. granted*, 51 U.S.L.W. 3649 (U.S. Mar. 7, 1983) (No. 82-1031).¹³ In a case involving hospital services, patient flow [134] statis-

¹³ Courts have found local geographic markets of varying sizes in antitrust cases involving hospitals, depending on the particular product market at issue and the economic factors affecting the local area. See, e.g., *Robinson v. Magovern*, 521 F.Supp. 842, 885-86 (W.D. Pa. 1981), *aff'd mem.*, 688 F.2d 824 (3d Cir. 1982), *cert. denied*, 103 S.Ct. 302 (1982) (market for adult open heart surgery was 16-county area surrounding Pittsburgh, Pennsylvania); *United States v. Hospital Affiliates International, Inc.*, 1980-81 Trade Cas. (CCH) ¶ 63,721 at 77,853 (E.D. La. 1980) (market for inpatient psychiatric care was New Orleans and surrounding area constituting the local health systems area ("HSA")); *American Medicorp v. Humana, Inc.*, 445 F.Supp. 589, 604, 605 (E.D. Pa. 1977) (market for development of new hospitals was the HSA; market for delivery of short term acute care community hospital services was town of Bluefield, West Virginia).