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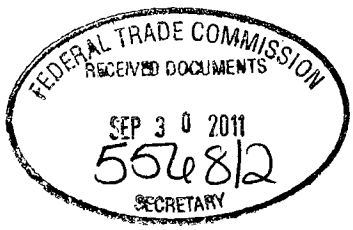

UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

In the Matter of **ProMedica Health System, Inc.** **a corporation**	**PUBLIC** **Docket No. 9346**

COMPLAINT COUNSEL'S REPLY FINDINGS OF FACT AND CONCLUSIONS OF LAW

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Dated: September 30, 2011

RECORD REFERENCES

References to the record are made using the following citation forms and abbreviations:

CCPFF - Complaint Counsel's Proposed Findings of Fact

CCPCL - Complaint Counsel's Proposed Conclusions of Law

RPFF - Respondent's Proposed Findings of Fact

JX - Joint Exhibit

PX - Complaint Counsel Exhibit

RX - Respondent Exhibit

Tr. - Citations to Trial Testimony

(PX00000 at 000 (XX, Dep. at xx)) - Citations to Deposition Testimony

(PX00000 at 000 (XX, Dep. at xx), *in camera*) - Citations to *in camera* Deposition Testimony

(PX00000 at 000 (XX, IHT at xx)) - Citations to Investigational Hearing Testimony

(PX00000 at 000 (XX, IHT at xx), *in camera*) - Citations to *in camera* Investigational Hearing Testimony

Joint Stipulations of Law and Fact, JX00002A ¶ - Citation to Joint Stipulations of Law and Fact

Commission Complaint - Administrative Complaint filed January 6, 2011

Response to RFA at ¶ - Citation to Respondent's Response to Complaint Counsel's Requests for Admission

Response to IROG at ¶ - Citation to Respondent's Response to Complaint Counsel's Interrogatories

Answer at ¶ - Citation to Respondent's Answer to Complaint

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PROPOSED FINDINGS OF FACT

I. Background

A. Hospital Services

1. Hospitals compete on the range of services they offer, the quality of those services, and the level of service they provide to patients. (Pugliese, Tr. 1543-1544).

Response to Finding No. 1

Complaint Counsel does not disagree, and adds that hospitals also compete on the basis of clinical quality, amenities, cost, location, visibility, physical location, and patient experience, among others, to attract patients. (Joint Stipulations of Law and Fact, JX00002A ¶ 11).

1. Inpatient Hospital Services

2. Inpatient services are those that require admission to the hospital for a period of 24 hours or more, while outpatient services either do not require admission to the hospital or require patients stay in a hospital less than a day. (Korducki, Tr. 483-484; Radzialowski, Tr. 638).

Response to Finding No. 2

Complaint Counsel does not disagree.

a. Primary, Secondary, Tertiary, and Quaternary Services

3. There is a continuum of different levels of intensity of inpatient hospital services. This continuum is typically described with reference to various levels or types of services. (Radzialowski, Tr. 637).

Response to Finding No. 3

Complaint Counsel does not disagree.

4. Primary services are those that occur regularly in the community and are of mild to moderate severity, including routine procedures such as hernias, gallbladders, and inpatient pediatrics. (Korducki, Tr. 481-482; Radzialowski, Tr. 637; Gold, Tr. 195).

Response to Finding No. 4

Complaint Counsel does not disagree.

5. Secondary services are more complex than primary services, require some specialization and greater resources, including, for example, complex orthopedic surgery and bariatric services. (Korducki, Tr. 482, 485; Radzialowski, Tr. 637).

Response to Finding No. 5

Complaint Counsel does not disagree.

6. Tertiary services are more complex and specialized than primary or secondary services, and are often more invasive and require different technology and resources. (Korducki, Tr. 482; Radzialowski, Tr. 637; Shook, Tr. 893).

Response to Finding No. 6

Complaint Counsel does not disagree.

7. Tertiary services include complex electrophysiology, burn units, or neurological intensive care. (Gold, Tr. 195; Shook, Tr. 893).

Response to Finding No. 7

Complaint Counsel does not disagree.

8. Hospitals that provide tertiary services typically handle less complex primary and secondary services as well as tertiary services. (Radzialowski, Tr. 737).

Response to Finding No. 8

Complaint Counsel does not disagree.

9. Commercial health plan or managed care organization ("MCO") contracts with tertiary hospitals also cover primary and secondary services at these hospitals. (Radzialowski , Tr. 737).

Response to Finding No. 9

Complaint Counsel does not disagree.

10. Quaternary services are the most complex and include procedures such as transplants and tend to require very specific technologies. (Shook, Tr. 921; Radzialowski, Tr. 637; Guerin-Calvert, Tr. 7185).

Response to Finding No. 10

Complaint Counsel does not disagree.

11. Because higher complexity medical services typically cost more for hospitals to provide than less complex services, hospitals are typically reimbursed at a higher rates for these services than for less complex, primary and secondary services. (Radzialowski, Tr. 766-767; Sandusky, Tr. 1403-1404; Sheridan, Tr. 6655-6656, *in camera*).

Response to Finding No. 11

Complaint Counsel does not disagree.

12. The dividing line between the various levels of service is not precisely defined and may even differ from patient to patient, depending on the patient's health and medical history. What is a primary or secondary level procedure for one person may be a tertiary level procedure for someone else. (Shook, Tr. 892-894; Korducki, 483; PX01917 (Radzialowski Dep. at 9-10, *in camera*)).

Response to Finding No. 12

Complaint Counsel does not disagree.

b. Inpatient Obstetrical Services

13. Some obstetrical ("OB") services are inpatient services and others are outpatient services. (Marlowe, Tr. 2432).

Response to Finding No. 13

Complaint Counsel does not disagree.

14. Childbirth, recovery and some postpartum services are provided on an inpatient basis at a hospital. (Marlowe, Tr. 2431-2433; Read, Tr. 5275).

Response to Finding No. 14

Complaint Counsel does not disagree.

15. LDRP stands for "labor, delivery, recovery, and postpartum." The term refers to a patient room that accommodates a woman from her admission to the hospital when she is in labor through delivery and recovery until she leaves the hospital. (Marlowe, Tr. 2407-2408).

Response to Finding No. 15

Complaint Counsel does not disagree.

16. In an LDR room, patients labor, deliver and recover in one room before being transferred to a postpartum room. (Marlowe, Tr. 2409; Read, Tr. 5280).

Response to Finding No. 16

Complaint Counsel does not disagree.

17. OB services other than actual childbirth, recovery, and immediate postpartum services are generally delivered on an outpatient basis. These services may include office visits and ultrasound or lab tests. (Marlowe, Tr. 2431-2433; Read, Tr. 5276).

Response to Finding No. 17

Complaint Counsel does not disagree.

18. OB care does not include care of the baby after it is delivered. Once a baby is delivered it is cared for by the pediatrician, neonatologist, or family physicians. (Marlowe, Tr. 2431-2432).

Response to Finding No. 18

Complaint Counsel does not disagree.

19. Inpatient OB services can range in complexity from Level I to Level III, with Level III being the most complex, and the difference between Levels II and III being the amount of time for which a baby needs ventilation. (Shook, Tr. 902-903).

Response to Finding No. 19

Complaint Counsel has no specific response.

20. Level I inpatient OB services correspond with uncomplicated, low-risk deliveries. (Shook, Tr. 1044-1045; Marlowe, Tr. 2434-2435; Read, Tr. 5269).

Response to Finding No. 20

Complaint Counsel has no specific response.

21. Level II inpatient OB services correspond with more complicated deliveries and babies needing ventilation for 24 hours or less. (Shook, Tr. 1044).

Response to Finding No. 21

Complaint Counsel has no specific response.

22. A hospital with Level II inpatient OB services can accommodate pregnancy down to approximately 32 weeks gestation. (Read, Tr. 5270).

Response to Finding No. 22

Complaint Counsel has no specific response.

23. Level III inpatient OB services correspond with the most complicated deliveries and babies that require ventilation for an extended period of time. (Shook, Tr. 1044-1045).

Response to Finding No. 23

Complaint Counsel has no specific response.

24. To provide Level III inpatient OB services, a hospital has to have a neonatal intensive care unit and specially trained physicians, nurses, and staff. (Marlowe, Tr. 2435).

Response to Finding No. 24

Complaint Counsel has no specific response.

25. Hospitals that offer Level II or Level III inpatient OB services also offer Level I inpatient OB services. (Marlowe, Tr. 2436).

Response to Finding No. 25

Complaint Counsel has no specific response.

26. Hospitals that do not offer obstetric services will still assist a woman in labor who presents at the hospital and they will deliver the baby. (Read, Tr. 5276-77).

Response to Finding No. 26

Complaint Counsel has no specific response.

27. Signs of complicated or high-risk pregnancies include things like complications from blood pressure, which is called preeclampsia; diabetes; preterm labor; multiple gestation, like twins or triplets; or other medical problems that might be concurrent with the pregnancy. (Read, Tr. 5282).

Response to Finding No. 27

Complaint Counsel has no specific response.

28. If a physician determines during labor that an expectant mother requires more complex care than the hospital can provide, a decision whether to move the mother and child to another facility will be made based on what is safest for the mother and the pregnancy. Sometimes the care will be completed at the hospital and the child will be transported after delivery; sometimes mother and child are transported before delivery. (Read, Tr. 5283; Marlowe, Tr. 2438-2440).

Response to Finding No. 28

Complaint Counsel has no specific response.

29. If a physician can determine prior to labor that an expectant mother presents a risk for a high-risk pregnancy or delivery, the physician typically recommends the mother deliver at a Level III hospital, like The Toledo Hospital or St. Vincent. (Marlowe, Tr. 2437).

Response to Finding No. 29

Complaint Counsel has no specific response.

2. Outpatient Hospital Services

30. Outpatient services are defined as those services that do not require an overnight stay in the hospital. (JX-2 at 001).

Response to Finding No. 30

Complaint Counsel does not disagree.

31. Outpatient services include therapeutic services, like physical therapy or respiratory therapy, and diagnostic services, like lab, radiology, EKG, MRI and CT scanning. (Shook, Tr. 984-985; Beck, Tr. 429-430).

Response to Finding No. 31

Complaint Counsel does not disagree.

32. Outpatient services also include general medical-surgical procedures that do not require a 24-hour admission. (Shook, Tr. 892-893).

Response to Finding No. 32

Complaint Counsel does not disagree.

33. Specialized services like oncology care, wound care, and sleep studies also constitute outpatient services. (Beck, Tr. 429-430; Korducki, Tr. 516-518).

Response to Finding No. 33

Complaint Counsel has no specific response.

34. Gynecological care is an outpatient service. (Gold, Tr. 203).

Response to Finding No. 34

Complaint Counsel has no specific response.

35. Most hospitals treat more patients on an outpatient basis than on an inpatient basis. (Radzialowski, Tr. 738).

Response to Finding No. 35

Complaint Counsel has no specific response.

36. { } (Pirc, Tr. 2305, *in camera*).

Response to Finding No. 36

This proposed finding is unfounded. The cited testimony does not support the proposed finding. Mr. Pirc referenced only MMO's split; he does not mention other MCOs' split. (Pirc, Tr. 2305, *in camera*).

37. Hospitals in Toledo have seen a shift in services from the inpatient setting to outpatient and recognize that an increasing percentage of services are being sought, and rendered, on an outpatient basis. (Shook, Tr. 879, 1022; Gold, Tr. 409; RX-270 at 000004*, in camera*).

Response to Finding No. 37

Complaint Counsel has no specific response.

38. Lucas County hospitals consider outpatient services to be effective substitutes for most medical conditions that currently require hospital admissions. (Shook, Tr. 1139). The services that are shifting to outpatient are typically primary and secondary level services. (Shook, Tr. 1022).

Response to Finding No. 38

This proposed finding is misleading. Mr. Shook did not testify on behalf of and does not represent the views of other Lucas County hospitals. (Shook, Tr. 1139).

39. Some procedures that were treated as inpatient services in the past have become outpatient services. (Gold, Tr. 202).

Response to Finding No. 39

Complaint Counsel has no specific response.

40. Insurance companies have significant influence over whether a patient should be treated as an inpatient or an outpatient. (Shook, Tr. 1139-1140).

Response to Finding No. 40

This proposed finding is misleading and incorrect to the extent that Respondent implies that insurance companies influence whether a patient that presents with a particular medical condition should be admitted to the hospital or not. To the extent that insurance companies have any influence as to whether a patient should be classified as an inpatient or outpatient, Mr. Shook testified that it is not unusual for insurance companies to look at a chart retroactively and change the status of a patient based on certain rules. (Shook, Tr. 1139-1140).

This proposed finding is also incomplete because it fails to mention that physicians have a great influence in deciding whether a patient should be treated as an inpatient or outpatient. (Shook, Tr. 1139-1140).

41. Many medical conditions that currently require hospital admissions could be substituted with outpatient services due to advances in technology. (Shook, Tr. 1139).

Response to Finding No. 41

This proposed finding is unfounded and contrary to the evidence. While the 1990s saw a significant shift of surgical procedures from the inpatient to the outpatient setting, more recent data shows that this trend has been slowing and that the ratio of inpatient surgical procedures to outpatient surgical procedures has remained flat over the past half-decade or so. (Town, Tr. 3671).

42. The inpatient hospital population could experience a decline of about 40 percent over the next decade. (Shook, Tr. 967).

Response to Finding No. 42

This proposed finding is overly broad and misleading. Mr. Shook testified only that it is Mercy's expectation that it will see a decrease in the hospital population over the next decade or so. (Shook, Tr. 967).

3. Factors Patients Consider when Choosing a Hospital

43. Patients consider a variety of factors when choosing a hospital for inpatient services, including whether their physician has admitting privileges at a particular hospital, their doctor's preferences, and insurance coverage. (RX-26 (Riordan, Dep. at 52-54, 56-57, 122); Shook, Tr. 939; Marlowe, Tr. 2444-2445; Town Tr. 3632; Read, Tr. 5283.).

Response to Finding No. 43

Complaint Counsel does not disagree.

44. Patients also consider hospital quality and location as two of many factors when selecting a hospital. (Marlowe, Tr. 2444-2445; Read, Tr. 5283; Town, Tr. 3631). Patients will select a more distant hospital if their insurance does not cover the hospital closest to them or if the closest hospital would not provide them the best care. (Read, Tr. 5284-5285).

Response to Finding No. 44

This proposed finding is incomplete. There is abundant evidence in the record on the importance of a hospital's location to patients, employers, health plans, and hospitals themselves. (*See, e.g.,* CCPFF ¶¶ 216-228, 234-272).

45. Patients also consider factors such as previous personal or family experience with a hospital, how nice the nurses are or what rooms are like when deciding which hospitals to choose. (Read, Tr. 5285; Marlowe, Tr. 2404; Town, Tr. 3631).

Response to Finding No. 45

Complaint Counsel does not disagree.

46. In determining which hospital to choose for inpatient OB and gynecological services, a hospital's status as an in-network provider for their insurance company is a very important factor for patients. (Marlowe, Tr. 2444; Read, Tr. 5283).

Response to Finding No. 46

Complaint Counsel does not disagree.

47. Patients consider whether a hospital has a neonatal intensive care unit when choosing the hospital where they want to deliver. This choice is not dependent upon whether the pregnancy is a high-risk pregnancy. Some mothers prefer the extra level of assurance from knowing that the hospital has facilities to care for unexpected complications. (Marlowe, Tr. 2445-2446; Read, Tr. 5284-5285).

Response to Finding No. 47

Complaint Counsel has no specific response.

48. Patients also consider whether the hospital uses LDRP or LDR rooms for their obstetric patients. (Marlowe, Tr. 2445).

Response to Finding No. 48

Complaint Counsel does not disagree.

49. Similarly, physicians consider various factors when choosing a hospital to admit their patients including their preferences, patient preferences, insurance coverage, and location. (Gold, Tr. 205).

Response to Finding No. 49

Complaint Counsel has no specific response.

50. Location is not as important a factor for complex procedures such as open heart surgery. (RX-26 (Riordan, Dep. at 122-123)).

Response to Finding No. 50

Complaint Counsel has no specific response.

51. Hospitals conduct studies on what patients consider when selecting hospitals. For example, Mercy Health Partners ("Mercy") regularly engages an outside entity, AZG, to conduct public opinion polls to understand how citizens perceive various hospitals located in the Toledo area. (Shook, Tr. 875-878).

Response to Finding No. 51

Complaint Counsel does not disagree.

52. { } (PX02534 at 008-009, *in camera*).

Response to Finding No. 52

Complaint Counsel has no specific response.

53. { } (RX-282 at 000010, *in camera*).

Response to Finding No. 53

Complaint Counsel has no specific response.

54. { } (Shook, Tr. 1085; RX-282 at 000010, *in camera*).

Response to Finding No. 54

Complaint Counsel has no specific response.

55. { } (RX-250 at 000008-000009, *in camera*).

Response to Finding No. 55

This proposed finding is misleading. According to that same survey, location of hospital is still considered as "Somewhat Important" to "Very Important." (RX-250 at 9, *in camera*).

56. { } (RX-249 at 000097, 000114, *in camera*).

Response to Finding No. 56

This proposed finding is inaccurate and misleading. In the survey, respondents did not identify "close to home" as the least important factor in three of the four surveyed time periods for cardiology services. (RX-249 at 97, *in camera*).

B. The Toledo, Ohio Area

1. Demographics

57. The population in the greater Toledo area is stagnant to declining, aging, and not forecast to grow. (Shook, Tr. 1040).

Response to Finding No. 57

This proposed finding is misleading. (*See* Response to RPFF ¶ 1219).

58. Toledo has substantially declining commercially insured hospital admissions. (Guerin-Calvert, Tr. 7274-75). Today, only 29 percent of Lucas County hospital patients have commercial insurance. (Town, Tr. 3609).

Response to Finding No. 58

This proposed finding is misleading. (*See* Response to RPFF ¶ 1219).

59. The obstetric population in the Toledo metropolitan area is projected to decline consistently in the next five to ten years, and the need for obstetrics services will also decrease. (Nolan, Tr. 6304-6305).

Response to Finding No. 59

Complaint Counsel has no specific response.

60. With an aging population in Toledo, the percentage of hospital patients covered by Medicare will increase. (Guerin-Calvert, Tr. 7303).

Response to Finding No. 60

Complaint Counsel has no specific response.

2. Economic Conditions

61. Toledo has high unemployment and has had an exodus of employers, which leads to a decline in patients covered by commercial insurance. (Guerin-Calvert, Tr. 7274-75).

Response to Finding No. 61

Complaint Counsel has no specific response.

62. The unemployment rate in Toledo was between 7 percent and 8 percent from the recession in 2001 to the start of the recession in 2008. (Guerin-Calvert, Tr. 7295-96).

Response to Finding No. 62

Complaint Counsel has no specific response.

63. During the recession of 2008, the unemployment rate peaked at over 13 percent, coming down to only approximately 9.5 percent in 2011. (Guerin-Calvert, Tr. 7295-96).

Response to Finding No. 63

Complaint Counsel has no specific response.

C. The Parties

1. ProMedica Health System, Inc.

64. ProMedica Health System is a nonprofit, mission and community-based, healthcare delivery system in Northwest Ohio and Southeast Michigan. (Oostra, Tr. 5771-5773).

Response to Finding No. 64

Complaint Counsel has no specific response.

65. ProMedica's mission is to improve people's health and well-being. (Oostra, Tr. 5771).

Response to Finding No. 65

Complaint Counsel has no specific response.

66. ProMedica is an integrated delivery health system that includes a physician component, a hospital component, and an insurance company, Paramount Healthcare ("Paramount"). (Oostra, Tr. 5772).

Response to Finding No. 66

Complaint Counsel has no specific response.

67. ProMedica's Board of Trustees is made up of local community leaders, many of whom are employers in Northwest Ohio. (Wachsman, Tr. 4873).

Response to Finding No. 67

Complaint Counsel has no specific response.

a. ProMedica's Hospitals

68. ProMedica has a total of eleven hospitals in Ohio and Michigan. (Oostra, Tr. 5772).

Response to Finding No. 68

Complaint Counsel has no specific response.

69. ProMedica's Michigan hospitals are Bixby Hospital in Adrian, Michigan; Herrick Hospital in Tecumseh, Michigan; and Hillsdale Hospital, a ProMedica affiliate, located in Hillsdale, Michigan. (Oostra, Tr. 5773).

Response to Finding No. 69

Complaint Counsel has no specific response.

70. ProMedica's Ohio hospitals outside of the Lucas County, Ohio area are Defiance Regional Medical Center in Defiance, Ohio; Fostoria Community Hospital in Fostoria, Ohio; and a joint operating company hospital in Lima, Ohio. (Oostra, Tr. 5773).

Response to Finding No. 70

Complaint Counsel has no specific response.

71. ProMedica's legacy hospitals in Lucas County include The Toledo Hospital ("TTH"), Toledo Children's Hospital, Flower Hospital ("Flower") and Bay Park Community Hospital ("Bay Park"). (McGinty, Tr. 1186; Oostra, Tr. 5773).

Response to Finding No. 71

Complaint Counsel has no specific response.

72. TTH provides high-end tertiary level care. (McGinty, Tr. 1186-1187; Pirc, Tr. 2188; Guerin-Calvert, Tr. 7176; Oostra, Tr. 5773-5774). TTH also provides basic general acute care. (Pirc, Tr. 2188; Oostra, Tr. 5774).

Response to Finding No. 72

Complaint Counsel has no specific response.

73. In addition to primary services, ranging from general med-surg to orthopedic care and obstetrics, TTH also houses a Level I trauma center. (Oostra, Tr. 5774).

Response to Finding No. 73

Complaint Counsel has no specific response.

74. TTH is one of the only two Lucas County hospitals that offer Level III inpatient OB services. (Shook, Tr. 1045; Marlowe, Tr. 2436). TTH offers its inpatient OB services in an LDR setting. (Read, Tr. 5281).

Response to Finding No. 74

Complaint Counsel has no specific response.

75. TTH had 769 registered beds, 660 beds in use or staffed beds, 32,000 government, commercially insured and under- and uninsured discharges and $1.3 billion in billed charges in 2009. (Guerin-Calvert, Tr. 7176).

Response to Finding No. 75

This proposed finding overstates the number of staffed beds at TTH and is contrary to the testimony of other Respondent witnesses and Respondent's own document. TTH has about 550 staffed beds. (CCPFF ¶ 13).

76. TTH has earned numerous awards, including approximately 19 HealthGrades awards in 2011. (Oostra, Tr. 5775).

Response to Finding No. 76

This proposed finding is incomplete. There was significant evidence prior to the Acquisition about ProMedica's poor quality, including at TTH, and this concerned St. Luke's.

(CCPFF ¶ 685). For example, TTH ranked last in the Toledo area and below the state average in composite quality scores. (PX01030 at 018 (Affiliation Analysis Update), *in camera*). Barbara Steele, ProMedica's Acute Care President, also noted that TTH struggled to be patient-centered. (PX01904 at 034 (Steele, IHT at 129), *in camera*). Finally, TTH scored in the bottom 6th percentile of all hospitals reviewed by Anthem for its quality scoring program. (PX02453 at 001; Pugliese, Tr. 1446-1447).

77. TTH was the first hospital to become part of what was to become ProMedica Health System. (Oostra, Tr. 5776).

Response to Finding No. 77

Complaint Counsel has no specific response.

78. TTH draws its patients primarily from the Toledo area. (Oostra, Tr. 5777).

Response to Finding No. 78

Complaint Counsel has no specific response.

79. Flower is a full-service community hospital. (McGinty, Tr. 1186; Pirc, Tr. 2188; Oostra, Tr. 5777). Flower became part of ProMedica around 1995. (Oostra, Tr. 5778).

Response to Finding No. 79

Complaint Counsel has no specific response.

80. Flower offers services including general acute care, general med-surg, obstetrics, outpatient radiation and chemotherapy, and post-acute services, such as a rehab center and an Alzheimer's center. (Oostra, Tr. 5777).

Response to Finding No. 80

Complaint Counsel has no specific response.

81. Flower offers Level I inpatient OB services. (Marlowe, Tr. 2435; Read, Tr. 5276). Flower offers inpatient OB services in an LDRP setting. (Marlowe, Tr. 2409; Read, Tr. 5281).

Response to Finding No. 81

Complaint Counsel has no specific response.

82. Flower had 292 registered beds, 257 beds in use, 11,665 government, commercially insured and under- and uninsured discharges, and $315.8 million in billed charges in 2009. (Guerin-Calvert, Tr. 7175-76).

Response to Finding No. 82

Complaint Counsel has no specific response.

83. Flower, which is located in Sylvania, Ohio, draws its patients primarily from Southeast Michigan and the Sylvania area. (Oostra, Tr. 5778). Flower draws patients from Michigan because its location in the northwest quadrant of Sylvania places it very close to the Michigan border. (Oostra, Tr. 5778).

Response to Finding No. 83

Complaint Counsel has no specific response.

84. Bay Park is a full-service community hospital. (McGinty, Tr. 1186; Pirc, Tr. 2188). Bay Park opened around the year 2000. (Oostra, Tr. 5779).

Response to Finding No. 84

Complaint Counsel has no specific response.

85. Bay Park offers Level I inpatient OB services. (Marlowe, Tr. 2435; Read, Tr. 5276). Bay Park offers its Level I inpatient OB services in an LDRP setting. (Marlowe, Tr. 2409; Read, Tr. 5281).

Response to Finding No. 85

Complaint Counsel has no specific response.

86. Bay Park is located in Oregon, Ohio, approximately 40 minutes from Flower and 20 minutes from TTH. (Oostra, Tr. 5779).

Response to Finding No. 86

Complaint Counsel does not disagree.

87. Bay Park had 86 staffed and registered beds, 4,000 government, commercially insured and under- and uninsured discharges, and $113 million in billed charges in 2009. (Guerin-Calvert, Tr. 7177-78).

Response to Finding No. 87

Complaint Counsel has no specific response.

88. Bay Park draws patients from Oregon, Ohio and the suburbs on the east side of Toledo as well as communities east of metropolitan Toledo. (Oostra, Tr. 5779).

Response to Finding No. 88

Complaint Counsel has no specific response.

89. ProMedica recently invested in the construction of an orthopedic satellite hospital, known as Wildwood Medical Center. (Hanley, Tr. 4509). Wildwood will offer dedicated orthopedics and orthopedic surgeons, podiatrists, and spine surgeons and neurosurgeons. (Oostra, Tr. 5780).

Response to Finding No. 89

Complaint Counsel has no specific response.

90. Wildwood is located approximately 15-20 minutes from both Flower and TTH. (Oostra, Tr. 5780).

Response to Finding No. 90

Complaint Counsel has no specific response.

91. ProMedica plans to open Wildwood in October 2011. (Hanley, Tr. 4510; Oostra, Tr. 5779).

Response to Finding No. 91

Complaint Counsel has no specific response.

92. It will cost ProMedica about $28 million to build Wildwood. (Hanley, Tr. 4510). Wildwood's construction will take about two years. (Hanley, Tr. 4510; Oostra, Tr. 5781).

Response to Finding No. 92

Complaint Counsel has no specific response.

b. ProMedica Physicians Group

93. ProMedica Physicians Group ("PPG"), ProMedica's employed physician group employs approximately 330 physicians. (Oostra, Tr. 5795).

Response to Finding No. 93

Complaint Counsel has no specific response except to note that ProMedica is the largest employer of physicians in Lucas County. (Joint Stipulations of Law and Fact, JX00002A ¶ 26).

94. Approximately 25 employed physicians joined PPG from St. Luke's Hospital's ("St. Luke's") employed physician affiliate, WellCare, at the time St. Luke's joined ProMedica. (Oostra, Tr. 5795).

Response to Finding No. 94

Complaint Counsel has no specific response.

95. PPG is a multi-specialty group with about half of its physicians practicing in primary care, which includes family practice, internal medicine and obstetrics, and the other half practicing in specialty care, which includes cardiology, digestive diseases, cancer, and orthopedics, among other specialties. (Oostra, Tr. 5795).

Response to Finding No. 95

Complaint Counsel has no specific response.

96. ProMedica employs physicians because it considers employed physicians to be an important part of a traditional integrated delivery system and to stay competitive with the growing national trend, which indicates that over half of the physicians in the United States are employed either by a hospital or a health system. (Oostra, Tr. 5796-5797).

Response to Finding No. 96

Complaint Counsel has no specific response.

97. ProMedica's employment of PPG physicians is not profitable because ProMedica loses over $10 million each year on its physician practices, in part because young physicians often require time to ramp up their practice and they lose money during that process. (Oostra, Tr. 5800).

Response to Finding No. 97

This proposed finding is incomplete and misleading. Mr. Oostra testified that employing physicians can help a hospital grow its revenue. (Oostra, Tr. 5977-5979). In addition, Mr. Oostra acknowledged that a benefit of employing physicians is that employed physicians largely admit patients to the hospital that employs them. (Oostra, Tr. 5978). This has been ProMedica's experience as well, and in fact, about 95 percent of PPG physicians' patient admissions occur at ProMedica hospitals. (Oostra, Tr. 5978-5979).

98. ProMedica also loses money on employed physicians because some physicians practice in certain specialty areas needed in the community and ProMedica elects to support their practice, despite the fact that they lose money. (Oostra, Tr. 5800).

Response to Finding No. 98

This proposed finding is incorrect and misleading. (Response to RPFF ¶ 97).

99. ProMedica believes that it is worthwhile to employ physicians, even though PPG is not a profitable group, because it is essential to the retention of the medical staff at ProMedica's hospitals. (Oostra, Tr. 5801).

Response to Finding No. 99

This proposed finding is incomplete. In addition, hospital systems – including ProMedica – employ physicians to drive referrals for inpatient and outpatient services, thus increasing total revenues. (*See* CCPFF ¶¶ 928-930).

c. Paramount Healthcare

100. Paramount is a health plan owned by ProMedica. (Randolph, Tr. 6889; Radzialowski, Tr. 627; Pugliese, Tr. 1574).

Response to Finding No. 100

Complaint Counsel does not disagree, and notes that Paramount is a for-profit corporation. (Randolph, Tr. 6902-6903).

101. Paramount was formed in 1988 under parent company Vanguard Health Ventures, as a joint venture between St. Vincent Medical Center and ProMedica. (Randolph, Tr. 6899; Oostra, Tr. 5784). ProMedica's only hospital at that time was the TTH. (PX01910 (Randolph IHT at 54)).

Response to Finding No. 101

Complaint Counsel has no specific response.

102. The joint venture ended when St. Vincent decided that it wanted to be bought out, and ProMedica continued Paramount as the sole owner from that point forward. (Oostra, Tr. 5784).

Response to Finding No. 102

Complaint Counsel has no specific response.

103. Paramount was originally formed in order to provide local, cost-effective health insurance products for employers because ProMedica, St. Vincent, and local employers did not believe they were getting hospital provider discounts passed through to them by the MCOs with whom they contracted. (Randolph, Tr. 6900; Oostra, Tr. 5784).

Response to Finding No. 103

Complaint Counsel has no specific response.

104. ProMedica confirmed that what it had been paying as an employer for health insurance did not reflect the discounts that it had been giving as a provider. (Randolph, Tr. 6901-6902).

Response to Finding No. 104

This proposed finding is incomplete and misleading to the extent that it suggests that health plans are not passing discounts to their customers today. Mr. Randolph admitted that he has no basis for knowing whether health plans unaffiliated with ProMedica are or are not passing lower costs on to their employer customers in today's marketplace, as ProMedica's experience with this was from "20-plus years ago." (Randolph, Tr. 7068).

105. Paramount guarantees that it will pass through 100 percent of its discounts to self-insured employers with an administrative services only ("ASO") contract with Paramount. (Randolph, Tr. 6904).

Response to Finding No. 105

Complaint Counsel has no specific response.

106. Paramount's target operating margin is between 1 and 3 percent. (Randolph, Tr. 6903).

Response to Finding No. 106

Complaint Counsel has no specific response.

107. When Paramount was first formed, it only offered commercial products. (Randolph, Tr. 6948-6949).

Response to Finding No. 107

Complaint Counsel has no specific response.

108. In the last five years, Paramount's commercial insurance products have decreased in membership. (Randolph, Tr. 6948-6949).

Response to Finding No. 108

Complaint Counsel has no specific response.

109. Paramount offers a variety of health insurance products, including: a traditional health maintenance organization ("HMO"), a preferred provider organization ("PPO"), a point-of-service ("POS") product, Medicaid, and a Medicare supplement product, called Paramount Elite. (Randolph, Tr. 6895, 6913; Oostra, Tr. 5786).

Response to Finding No. 109

Complaint Counsel has no specific response.

110. Paramount competes with Medical Mutual of Ohio ("MMO"), Anthem Blue Cross Blue Shield ("Anthem"), UnitedHealth Care ("United"), CIGNA, Aetna, and various other MCOs. (Oostra, Tr. 5791-5792).

Response to Finding No. 110

Complaint Counsel has no specific response.

111. Paramount's products are similar to those available from Anthem and MMO. (Oostra, Tr. 5791-5792).

Response to Finding No. 111

Complaint Counsel has no specific response.

112. Paramount cannot capture enough business to support the financial needs of the entire ProMedica provider system. (Wachsman, Tr. 4887-4888).

Response to Finding No. 112

Complaint Counsel has no specific response.

113. ProMedica treats Paramount as an arm's length MCO and refrains from sharing any information with Paramount regarding ProMedica's relationships with other MCOs, which are Paramount's competitors. (Wachsman, Tr. 4878-4879; Oostra, Tr. 5793-5794).

Response to Finding No. 113

This proposed finding is incorrect. ProMedica does not treat Paramount as an arm's length MCO when the president of Paramount has already admitted that ProMedica will always be included in Paramount's network. (*See* Randolph, Tr. 7070; Response to RPFF ¶ 619). In addition, Mr. Wachsman, ProMedica's Senior Vice President for Managed Care, Reimbursement and Revenue Cycle Management, wrote an email to Mr. Randolph, Paramount's President, stating that "Anthem cannot sigh up st. luke's [sic] until 7/1/09 and will have to pay PHS for the privilege." (PX00380 at 001; CCPFF ¶¶ 1482, 1499).

This proposed finding is also misleading with respect to Paramount, which obtains preferential reimbursement rates from ProMedica because of their common ownership and because Paramount's profitability directly impacts ProMedica's bottom line. (*See* CCPFF ¶¶ 469-470).

d. ProMedica's Obligated Group

114. ProMedica's Obligated Group is the group that guarantees ProMedica's public debt. (Hanley, Tr. 4513).

Response to Finding No. 114

Complaint Counsel has no specific response.

115. ProMedica's Obligated Group includes its hospitals, continuing care services entities, long-term care services, and home health entity. (Hanley, Tr. 4513).

Response to Finding No. 115

Complaint Counsel has no specific response.

116. The Obligated Group does not include PPG, Paramount, or ProMedica's corporate division. (Hanley, Tr. 4513).

Response to Finding No. 116

Complaint Counsel has no specific response.

117. ProMedica's debt associated with its Obligated Group has bond ratings of "Aa3" from Moody's Investor's Service ("Moody's"), with a stable outlook, and "Aa-" from Standard & Poor's with a positive outlook. (Hanley, Tr. 4514).

Response to Finding No. 117

Complaint Counsel has no specific response.

2. St. Luke's Hospital

118. OhioCare Health System, Inc. is made up of St. Luke's Hospital and several other subsidiaries including St. Luke's Hospital Foundation; Care Enterprises, Inc.; Physician Advantage MSO; and OhioCare Physicians, LLC ("WellCare"). (Wakeman, Tr. 2733; RX-1139 at 000032-000033).

Response to Finding No. 118

Complaint Counsel has no specific response.

119. St. Luke's had 315 registered beds, 214 staffed beds, 10,600 government, commercially insured and under- and uninsured discharges, and $200 million in billed charges in 2009. (Guerin-Calvert, Tr. 7178).

Response to Finding No. 119

This proposed finding contains information that is contrary to the evidence. St. Luke's has less than 214 staffed beds. (*See* CCPFF ¶ 25).

120. St. Luke's has ownership interests in two medical office buildings in Perrysburg, Wood County, Ohio. It also operates three outpatient radiology imaging centers: one is located in Sylvania, Ohio; one in Toledo proper, and one in Oregon, Ohio. (Wakeman, Tr. 2752-2753).

Response to Finding No. 120

Complaint Counsel has no specific response.

121. St. Luke's offers a range of outpatient and inpatient services, including: emergency services, medical/surgical services, OB services, intensive care services, imaging services, and limited oncology, neurosurgery, and pediatric services. (Wakeman, Tr. 2753-2754).

Response to Finding No. 121

Complaint Counsel has no specific response.

122. St. Luke's offers Level I inpatient OB services. (Shook, Tr. 1045; Marlowe, Tr. 2435; Read, Tr. 5276; Wakeman, Tr. 2755). St. Luke's does not offer more complex obstetrical services. (Wakeman, Tr. 2755-2756). St. Luke's offers its inpatient OB services in an LDRP setting. (Marlowe, Tr. 2408-2409; Read, Tr. 5281).

Response to Finding No. 122

Complaint Counsel has no specific response.

123. St. Luke's has about 1900 employees, including part-time employees. It has about 1500 full-time equivalent employees. (Wakeman, Tr. 2752).

Response to Finding No. 123

Complaint Counsel has no specific response.

124. St. Luke's Board of Directors included 23 members that made up a broad cross section of the community including business leaders, doctors, and attorneys, and other community members. (Wakeman, Tr. 2748-2749, 2772-2773).

Response to Finding No. 124

Complaint Counsel has no specific response.

125. St. Luke's draws most of its patients from the zip codes closest to the hospital. (Wakeman, Tr. 2756-2757).

Response to Finding No. 125

Complaint Counsel does not disagree.

126. St. Luke's primary service area is the combination of about fourteen zip codes from where St. Luke's draws 80 percent of its patients. (Wakeman, Tr. 2756-2757).

Response to Finding No. 126

Complaint Counsel has no specific response.

127. St. Luke's core service area is the combination of about seven zip codes from where St. Luke's draws about 55 percent of its patients. (Wakeman, Tr. 2756-2757).

Response to Finding No. 127

Complaint Counsel has no specific response except to note that St. Luke's core service area includes eight zip codes. (CCPFF ¶ 268).

128. St. Luke's draws patients from outside of Lucas County including Wood County, Fulton County and Henry County. (Wakeman, Tr. 2757). Wood County is the county from which St. Luke's draws the most patients outside Lucas County. (Wakeman, Tr. 2757).

Response to Finding No. 128

Complaint Counsel has no specific response.

129. { }

(Nolan, Tr. 6311, *in camera*; PX00479 at 033, *in camera*).

Response to Finding No. 129

Complaint Counsel has no specific response.

130. { }

(Nolan, Tr. 6311, *in camera*; PX00479 at 033, *in camera*).

Response to Finding No. 130

Complaint Counsel has no specific response.

131. St. Luke's has delivered approximately 600 babies a year over the past ten years. (Marlowe, Tr. 2443).

Response to Finding No. 131

Complaint Counsel has no specific response.

132. St. Luke's pre-joinder competitors included UTMC, Mercy Health Partners ("Mercy"), ProMedica, WCH, Fulton County Health Center ("FCHC"), and Blanchard Valley Hospital. (Wakeman, Tr. 2758).

Response to Finding No. 132

This proposed finding is misleading. ProMedica and St. Luke's were significant competitors prior to the Acquisitions. (CCPFF ¶¶ 315-398). St. Luke's ordinary course documents did not show WCH, FCHC, or Blanchard Valley as competitors; rather the only meaningful competitors that St. Luke's considered were those in Lucas County. (*See, e.g.* PX01352 at 006 (showing market shares that only include Lucus County hospitals)).

133. WellCare is a multispecialty physician group under the umbrella of St. Luke's Hospital. (Read, Tr. 5264).

Response to Finding No. 133

Complaint Counsel does not disagree.

134. St. Luke's also has a 50 percent ownership in SurgiCare, an outpatient center located on St. Luke's campus. (Wakeman, Tr. 2873).

Response to Finding No. 134

Complaint Counsel does not disagree.

135. SurgiCare offers some of the same outpatient services provided by St. Luke's hospital, but SurgiCare does not provide any inpatient general acute care services. (Wakeman, Tr. 2873-2875).

Response to Finding No. 135

Complaint Counsel has no specific response.

136. SurgiCare contracts separately from St. Luke's Hospital with MCOs. (Wakeman, Tr. 2875).

Response to Finding No. 136

Complaint Counsel has no specific response.

137. SurgiCare's cost for treating a case is significantly lower than that of St. Luke's, because SurgiCare is a freestanding outpatient surgery facility only. (Wakeman, Tr. 2876).

Response to Finding No. 137

Complaint Counsel has no specific response.

D. Competitor Hospitals

1. Mercy Health Partners

138. Mercy is a not-for-profit hospital system that is part of Catholic Health Partners ("CHP"). (Shook, Tr. 889-890).

Response to Finding No. 138

Complaint Counsel has no specific response.

139. CHP has hospitals in five states and is headquartered in Cincinnati, Ohio. (Shook, Tr. 889-890). CHP is broken down by divisions and then regions. (Shook, Tr. 890).

Response to Finding No. 139

Complaint Counsel has no specific response.

140. Mercy is within CHP's northern division and, more narrowly, located in CHP's northern, Toledo-centered region. (Shook, Tr. 890).

Response to Finding No. 140

Complaint Counsel has no specific response.

141. Mercy shares a bond rating with CHP. (Shook, Tr. 1029). CHP's bond rating is "A1" from Moody's and "AA-" from Standard and Poor's. (RX-206 (Shook, Dep. at 45); Shook, Tr. 1029).

Response to Finding No. 141

Complaint Counsel has no specific response.

142. Mercy operates six hospitals in CHP's northern region; three of which are located in Lucas County, near Toledo. (Shook, Tr. 887).

Response to Finding No. 142

Complaint Counsel has no specific response.

143. Mercy's three hospitals in Lucas County are St. Vincent, Mercy St. Anne Hospital ("St. Anne"), and Mercy St. Charles Hospital ("St. Charles"). (Shook, Tr. 892).

Response to Finding No. 143

Complaint Counsel has no specific response.

144. Mercy's three Lucas County hospitals line up "literally side by side" with ProMedica's Lucas County hospitals. (Sheridan, Tr. 6617).

Response to Finding No. 144

This proposed finding is misleading because Ms. Sheridan was only describing the locations of the Mercy hospitals in relation to the ProMedica hospitals. (Sheridan, Tr. 6617).

145. St. Vincent is a large, tertiary teaching facility with eight intensive care units, a Level I trauma center, a Level III OB unit, and a large cardiology service known as the Regional Heart and Vascular Center. (Shook, Tr. 887-888, 895-896, 1045).

Response to Finding No. 145

Complaint Counsel has no specific response.

146. St. Vincent is the only other Lucas County hospital besides TTH that offers Level III inpatient OB services. (Shook, Tr. 1045; Marlowe, Tr. 2436). St. Vincent offers its inpatient OB services in an LDR setting. (Read, Tr. 5281).

Response to Finding No. 146

Complaint Counsel has no specific response.

147. St. Vincent also has the only burn unit in Northwest Ohio. (Shook, Tr. 1029; Wakeman, Tr. 2759).

Response to Finding No. 147

Complaint Counsel has no specific response.

148. St. Vincent had 568 registered beds, 445 staffed beds, 22,000 government, commercially insured and under- and uninsured discharges, and $969.8 million in billed charges in 2009. (PX02136 at 022-023, *in camera* ; Guerin-Calvert, Tr. 7176-7177).

Response to Finding No. 148

Complaint Counsel has no specific response.

149. St. Vincent is partially unionized. (Shook, Tr. 1105-1106).

Response to Finding No. 149

Complaint Counsel has no specific response.

150. St. Vincent is located in downtown Toledo and is the largest provider to Medicaid patients in the state of Ohio. (Shook, Tr. 887-889).

Response to Finding No. 150

Complaint Counsel has no specific response.

151. St. Vincent attracts a significant number of patients from outside Lucas County, including some patients from communities in Michigan. (Shook, Tr. 897).

Response to Finding No. 151

Complaint Counsel has no specific response.

152. The hospital located closest to St. Vincent is ProMedica's TTH. (Shook, Tr. 899).

Response to Finding No. 152

Complaint Counsel has no specific response.

153. Mercy's Children's Hospital is on the campus of St. Vincent, but operates as a separate entity. (Shook, Tr. 1030).

Response to Finding No. 153

Complaint Counsel has no specific response.

154. St. Anne, which opened in 2002 and is located in west Toledo, is a general medical-surgical hospital with operating rooms and performs both inpatient and outpatient surgeries. St. Anne does not offer tertiary services, obstetrics, psychiatric services, or serious emergency services. (Shook, Tr. 899-900, 903).

Response to Finding No. 154

Complaint Counsel has no specific response.

155. St. Anne had 128 registered beds, 96 staffed beds, 5,200 government, commercially insured and under- and uninsured discharges, and $207 million in billed charges in 2009. (Guerin-Calvert, Tr. 7178).

Response to Finding No. 155

Complaint Counsel has no specific response.

156. St. Anne offered inpatient OB services when it opened, but Mercy discontinued those services at St. Anne in early 2008, because St. Anne experienced a significant decrease in deliveries and no longer performed enough deliveries to maintain quality standards or break even financially. (Shook, Tr. 901, 958, 1047).

Response to Finding No. 156

Complaint Counsel has no specific response.

157. Prior to closing, St. Anne delivered about 400 babies a year, but Mercy estimated that a hospital needed to deliver 800 or 900 a year in order to break-even financially. (Shook, Tr. 1047).

Response to Finding No. 157

Complaint Counsel does not disagree, and notes that Mercy has no plans to resume offering obstetrics at St. Anne. (CCPFF ¶ 772).

158. By comparison, St. Vincent delivered 1180 babies in 2010. (Marlowe, Tr. 2444).

Response to Finding No. 158

Complaint Counsel has no specific response.

159. { } (PX02068 at 5-6, *in camera*).

Response to Finding No. 159

Complaint Counsel has no specific response.

160. Flower is the closest hospital to St. Anne. (Shook, Tr. 917).

Response to Finding No. 160

Complaint Counsel has no specific response.

161. St. Charles, located in Oregon, Ohio, is on the east-side of the Maumee River from downtown Toledo, located less than one mile away from ProMedica's Bay Park. (Shook, Tr. 902, 917, 1036).

Response to Finding No. 161

Complaint Counsel has no specific response.

162. St. Charles is a general medical-surgical hospital that also offers Level II OB services. (Shook, Tr. 902). St. Charles is the only Lucas County, Ohio hospital that offers Level II inpatient OB services. (Shook, Tr. 1045). St. Charles offers its inpatient OB services in an LDRP setting. (Read, Tr. 5281).

Response to Finding No. 162

Complaint Counsel has no specific response.

163. In 2009, St. Charles had 390 registered beds, 264 staffed beds, approximately 11,000 government, commercially insured and under- and uninsured discharges, and $292.2 million in billed charges. (Guerin-Calvert, Tr. 7177).

Response to Finding No. 163

Complaint Counsel has no specific response.

164. None of Mercy's Lucas County hospitals offer all private beds; of the three, St. Charles has the largest percentage of private beds. (Shook, Tr. 903).

Response to Finding No. 164

Complaint Counsel does not disagree, and notes that ProMedica's The Toledo Hospital and Flower Hospital do not offer all private beds. In fact, Respondent's own consultant, Navigant, found that there are "significant shortages of private rooms in the [ProMedica] system" with the exception of Bay Park. (Nolan, Tr. 6287, *in camera*; PX01946 at 021 (Nolan, Dep. at 75); PX00479 at 008, *in camera* ("most of the PHS metro facilities appear to have a combination of issues related to private bed availability")).

165. Mercy is making extensive renovations at St. Vincent to add more private beds. (Shook, Tr. 904).

Response to Finding No. 165

Complaint Counsel has no specific response.

166. Mercy's Toledo-area hospitals overlap with ProMedica's Toledo-area hospitals in terms of service lines offered and geographic area served. (PX02136 at 015-016, *in camera*; Oostra, Tr. 5802-5804).

Response to Finding No. 166

Complaint Counsel has no specific response, except to note the significant fact that Mercy St. Anne does not offer obstetrical services. (RPFF ¶ 154).

167. {

} (PX02136 at 010, *in camera*; RX-261 at 000003, *in camera*).

Response to Finding No. 167

This proposed finding is incomplete. (*See* Response to RPFF ¶ 166).

168. Commercial health plans note the overlap and substitution of services between Mercy hospitals and ProMedica hospitals. (Sheridan, Tr. 6616-6618).

Response to Finding No. 168

Complaint Counsel has no specific response, except to note that Respondent cites only one source for support of this proposed finding.

169. { } (Shook, Tr. 1081-1082, *in camera*; RX-261 at 000006, *in camera*). { } (RX-261 at 000006, *in camera*).

Response to Finding No. 169

Complaint Counsel has no specific response.

170. { } (Shook, Tr. 1015, *in camera*).

Response to Finding No. 170

Complaint Counsel has no specific response.

171. { } (PX02136 at 035, *in camera*).

Response to Finding No. 171

Complaint Counsel has no specific response.

172. { } (Shook, Tr. 1116, *in camera*).

Response to Finding No. 172

Complaint Counsel has no specific response.

173. Mercy employs roughly 125 to 130 physicians in the Toledo area. (Shook, Tr. 905-906).

Response to Finding No. 173

Complaint Counsel has no specific response.

174. In the past, Mercy had an HMO health plan that it marketed to the Toledo community, known as the Family Health Plan. (Shook, Tr. 1024). Family Health Plan did not include ProMedica in its network of providers. (Shook, Tr. 1025).

Response to Finding No. 174

Complaint Counsel has no specific response.

175. Mercy discontinued Family Health Plan about ten years ago. (Shook, Tr. 1025).

Response to Finding No. 175

Complaint Counsel has no specific response.

2. University of Toledo Medical Center

176. UTMC is part of the University of Toledo and is an instrumentality of the State of Ohio. (Gold, Tr. 295).

Response to Finding No. 176

Complaint Counsel does not disagree.

177. As such, UTMC's financial statement is incorporated into that of the University of Toledo at the end of every year. (Gold, Tr. 298).

Response to Finding No. 177

Complaint Counsel has no specific response.

178. UTMC is considered a research and teaching hospital. (Radzialowski, Tr. 737; McGinty, Tr. 1188). UTMC's mission is to support the academic needs of the University of Toledo, to deliver high-quality healthcare, and to serve the tertiary and quaternary needs of the community. (Gold, Tr. 192-193; Radzialowski, Tr. 743).

Response to Finding No. 178

Complaint Counsel has no specific response.

179. UTMC is the only academic medical center in the Toledo-area and its academic mission differentiates it from other hospitals in Lucas County, including ProMedica, Mercy, and St. Luke's. (Gold, Tr. 252-253; PX02064 at 2).

Response to Finding No. 179

Complaint Counsel has no specific response.

180. UTMC offers specialty care in cardiology, neurology, orthopedics, cancer, surgery, has a Level I trauma center, and is the only hospital in Lucas County that performs organ transplants. (Shook, Tr. 921; PX02136 at 024, *in camera*; PX02064 at 1).

Response to Finding No. 180

Complaint Counsel has no specific response.

181. UTMC had 319 registered beds, 226 staffed beds, 12,000 government, commercially insured and under- and uninsured discharges and $472 million in billed charges in 2009. (Guerin-Calvert, Tr. 7178).

Response to Finding No. 181

Complaint Counsel has no specific response.

182. { } (PX02136 at 035, *in camera*).

Response to Finding No. 182

Complaint Counsel has no specific response.

183. UTMC does not offer, and has no plans to offer, inpatient OB services. (Gold, Tr. 203; Guerin-Calvert, Tr. 7669). However, UTMC does offer outpatient OB and gynecology services, as well as inpatient pediatrics. (Gold, Tr. 203).

Response to Finding No. 183

Complaint Counsel does not disagree, except to note that UTMC does not have an inpatient acute pediatrics unit for medical-surgical problems. (Gold, Tr. 203).

184. If UTMC were to offer inpatient OB services, it would choose to be a full-service provider and offer high-risk OB services and a neonatal intensive care unit, because it is an academic institution, and, therefore, its students would need instruction on high-risk procedures in addition to low-risk, routine procedures. (Gold, Tr. 222-223).

Response to Finding No. 184

Complaint Counsel has no specific response, except to note it would cost tens of millions of dollars to offer inpatient OB services, which would include, among other things, a facility renovation, hiring specialists, and building the nursing capacities. (Gold, Tr. 222).

185. UTMC recognizes, however, that it would be far less expensive to offer OB services limited to routine deliveries, like those offered at St. Luke's, rather than full-service OB services with high-risk deliveries. (Gold, Tr. 336-337).

Response to Finding No. 185

This proposed finding mischaracterizes Dr. Gold's testimony. Not only did Dr. Gold testify that he has "certainly not studied the economics or costs of the [] services that St. Luke's provides," but also that he would "guess" that it would be far less expensive to offer limited OB services compared to full-service OB services. (Gold, Tr. 336-337).

186. UTMC students and residents are taught OB through partnerships at TTH, St. Vincent, Blanchard Valley, and Henry County Hospital. (Gold, Tr. 335).

Response to Finding No. 186

The citation does not support this proposed finding. Dr. Gold did not mention Henry County Hospital. (Gold, Tr. 335).

187. UTMC has a medical education agreement with Mercy through which the hospitals share residency programs. (Shook, Tr. 921-923).

Response to Finding No. 187

Complaint Counsel has no specific response.

188. UTMC has an affiliation with ProMedica by which UTMC manages the academic, teaching, and research activities of ProMedica. (Gold, Tr. 192).

Response to Finding No. 188

Complaint Counsel has no specific response.

189. {

} (PX02136 at 010, *in camera*).

Response to Finding No. 189

Complaint Counsel has no specific response.

190. UTMC considers ProMedica hospitals, Mercy hospitals, St. Luke's, Blanchard Valley, and WCH to be its competitors for inpatient primary care services. (Gold, Tr. 214).

Response to Finding No. 190

Complaint Counsel has no specific response.

191. UTMC competes for patients from Bowling Green, Ohio in addition to Lucas County, Ohio. (Gold, Tr. 214-215).

Response to Finding No. 191

Complaint Counsel has no specific response.

192. WCH is a source of referrals to UTMC for various services including tertiary and cardiac services, as well as orthopedics. (Gold, Tr. 216).

Response to Finding No. 192

Complaint Counsel has no specific response.

193. UTMC also considers the University of Michigan Health System, The Ohio State University Medical Center, The Cleveland Clinic, and other hospitals across the United States to be its competitors for tertiary and quaternary services. (Gold, Tr. 216).

Response to Finding No. 193

Complaint Counsel has no specific response.

194. UTMC employs about 175 physicians in its University of Toledo Physicians group. (Gold, Tr. 203-204).

Response to Finding No. 194

Complaint Counsel has no specific response.

195. Many of UTMC's employees are unionized with AFSCME Local 2415 which represents approximately 1,800 of UTMC's hourly employees. (Gold, Tr. 294-295).

Response to Finding No. 195

Complaint Counsel has no specific response.

3. Wood County Hospital

196. WCH, located in Bowling Green, in Wood County, Ohio, is the only hospital in Wood County. (Korducki, Tr. 475). Bowling Green is 25 miles from downtown Toledo and only 15 miles from St. Luke's. (Shook, Tr. 938; PX02136 at 013, 026 *in camera*).

Response to Finding No. 196

Complaint Counsel has no specific response.

197. WCH is a not-for-profit hospital offering primary and secondary general acute care services, including general medical, inpatient and outpatient surgery, sleep lab, strokes,

pneumonia, pain management, orthopedics, OB, intensive care, bariatric surgery, emergency services, and neurology. (Korducki, Tr. 475, 484, 538).

Response to Finding No. 197

Complaint Counsel has no specific response.

198. WCH has 179 registered beds, but operates only 85. (Korducki, Tr. 475-478).

Response to Finding No. 198

Complaint Counsel has no specific response.

199. WCH admits approximately 3,600 or 3,700 patients each year. (Korducki, Tr. 511).

Response to Finding No. 199

Complaint Counsel has no specific response.

200. { } (PX02136 at 035, *in camera*).

Response to Finding No. 200

Complaint Counsel has no specific response.

201. WCH has nine private birthing suites, but does not offer high-risk OB services. (Korducki, Tr. 566-567).

Response to Finding No. 201

Complaint Counsel does not disagree.

202. WCH opened an outpatient wound care service line in 2009 at a cost of approximately a million dollars. (Korducki, Tr. 516-518, 559).

Response to Finding No. 202

Complaint Counsel has no specific response.

203. WCH estimates that approximately 100 patients each year travel from Lucas County to Wood County for hospital services. (Korducki, Tr. 510-511). About a dozen of these are OB patients. (Korducki, Tr. 513).

Response to Finding No. 203

Complaint Counsel has no specific response.

204. Conversely, some patients from Wood County seek hospital services in Lucas County. (Korducki, Tr. 554-555).

Response to Finding No. 204

Complaint Counsel has no specific response.

205. WCH estimates that patients residing in its primary service area that choose not seek hospital services from providers other than WCH, seek services primarily from St. Luke's, TTH, St. Vincent, UTMC, and Blanchard Valley. (Korducki, Tr. 556).

Response to Finding No. 205

Complaint Counsel has no specific response.

206. WCH recently completed a hundred-thousand square foot expansion in February 2010 including a new perioperative area, new surgical area, a new women's center with new mammography and women's diagnostic area, and two new medical surgical units. (Korducki, Tr. 521, 566).

Response to Finding No. 206

Complaint Counsel has no specific response.

207. The expansion also converted 56 beds from semi-private to private, so that all of its beds are now private and have telemetry capability. (Korducki, Tr. 521, 524, 566).

Response to Finding No. 207

Complaint Counsel has no specific response.

208. WCH's expansion is part of a larger renovation project that WCH anticipates will cost about $42 million and will take at least four years to complete. (Korducki, Tr. 522, 561, 566).

Response to Finding No. 208

Complaint Counsel has no specific response.

209. Included in this larger project is renovating and enlarging the emergency department, and support departments, such as purchasing and pharmacy. (Korducki, Tr. 522-523).

Response to Finding No. 209

Complaint Counsel has no specific response.

210. WCH also has plans to open new outpatient service lines. (Korducki, Tr. 561).

Response to Finding No. 210

Complaint Counsel has no specific response.

4. Fulton County Health Center

211. Fulton County Health Center ("FCHC") is a non-profit general acute care hospital and a critical access hospital. (Beck, Tr. 376, 382).

Response to Finding No. 211

Complaint Counsel has no specific response.

212. A critical access hospital can only have a maximum of 25 inpatient beds. (Beck, Tr. 376).

Response to Finding No. 212

Complaint Counsel has no specific response.

213. FCHC's 25 inpatient beds are all in private rooms. (Beck, Tr. 377). Of the 25 beds, seven are designated for critical care, five for obstetrics, and the remaining 13 for general medical-surgical needs. (Beck, Tr. 378).

Response to Finding No. 213

Complaint Counsel has no specific response.

214. FCHC provides a range of inpatient services including surgery, orthopedics, and low-risk obstetrics. (Beck, Tr. 379). FCHC does not offer tertiary services or high-risk obstetrics. (Beck, Tr. 380, 423).

Response to Finding No. 214

Complaint Counsel does not disagree.

215. FCHC's daily census fluctuates between 17-18 patients, on average. (Beck, Tr. 381).

Response to Finding No. 215

Complaint Counsel does not disagree.

216. FCHC is located approximately 30 miles from St. Luke's. (Beck, Tr. 384).

Response to Finding No. 216

Complaint Counsel does not disagree.

5. Others

217. Toledo-area hospitals also experience competition from the University of Michigan Health System and The Cleveland Clinic for certain services, such as complex cardiovascular services or oncology services. (RX-26 (Riordan, Dep. at 29-32, 52)).

Response to Finding No. 217

Complaint Counsel does not disagree.

6. Distance Between Competing Hospitals

218. Some patients drive past St. Luke's to seek services at hospitals located further away from their homes. (RX-21 (Peron, Dep. at 90-91)).

Response to Finding No. 218

This proposed finding is incomplete and misleading. Some patients travel past other hospitals to receive care at St. Luke's. (Read, Tr. 5286, 5297-5298).

219. A drive-time analysis shows that driving times from a given set of zip codes are not materially different for one hospital than for another competing hospital. (Guerin-Calvert, Tr. 7333-7335).

Response to Finding No. 219

Complaint Counsel has no specific response.

220. Out of one hundred admissions at St. Luke's, 75 of those admissions travel less than 14 minutes to get to St. Luke's; 95 travel less than 20 minutes. (Guerin-Calvert, Tr. 7336-7337).

Response to Finding No. 220

Complaint Counsel does not disagree that St. Luke's patients want to receive healthcare services close to home and therefore do not travel long distances to receive care at St. Luke's Hospital. (*See, e.g.* CCPFF ¶¶ 216-228, 234-247, 264-265).

221. The average drive time for St. Luke's patients is approximately 12 minutes. (Guerin-Calvert, Tr. 7336-7337).

Response to Finding No. 221

Complaint Counsel does not disagree that St. Luke's patients want to receive healthcare services close to home and therefore do not travel long distances to receive care at St. Luke's hospital. (*See, e.g.* CCPFF ¶¶ 216-228, 234-247, 264-265).

222. Looking at the incremental drive time for patients located in each of St. Luke's top 10 zip codes from which it admits patients shows that there are very short distances between St. Luke's and other competing hospitals. (Guerin-Calvert, Tr. 7335-7337).

Response to Finding No. 222

This proposed finding is incomplete and unfounded. Ms. Guerin-Calvert testified that on average the incremental drive time for a St. Luke's patient to go to a different hospital is 18 additional minutes. (Guerin-Calvert, Tr. 7336). Ms. Guerin-Calvert gives no criteria for determining that 18 additional minutes is a "very short" distance nor does she attempt to measure the impact of additional travel time on consumer welfare. (*See* Response to RPFF ¶ 1210). Patients do not want to travel far to receive healthcare services. (*See* CCPFF ¶¶ 216-222). In fact, Respondent states that the average St. Luke's patient drives only 12 minutes and that 75 percent drive less than 14 minutes to reach St. Luke's. (RPFF ¶ 220, 221).

223. A resident of zip code 43537, where St. Luke's is located, would need only five more minutes to drive to UTMC than to St. Luke's, ten additional minutes to drive to Flower or St. Anne and 16 additional minutes to drive to Bay Park or St. Charles. (Guerin-Calvert, Tr. 7339-40).

Response to Finding No. 223

This proposed finding is incomplete and misleading. Ms. Guerin-Calvert testified that for this zip code, there is a five minute drive time to St. Luke's. Therefore, it takes twice as long to get to UTMC, three times as long to reach Flower, and more than three times as long to drive to Bay Park or Flower. (Guerin-Calvert, Tr. 7339-7340). In addition, Respondent's expert did not measure the impact of additional travel time on consumer welfare. (*See* Response to RPFF ¶ 1210).

224. St. Luke's is unable to attract a majority of patients from within its own zip code who seek general acute care inpatient services. (Town, Tr. 3944).

Response to Finding No. 224

This proposed finding is incomplete and misleading. Professor Town testified that it is not uncommon for a hospital to attract less than a majority of patients in its core service area. (Town, Tr. 4439). Professor Town also noted that market shares in this case were created using pre-Acquisition data when St. Luke's did not have access to Paramount. He noted that St. Luke's inclusion in Paramount would increase its market share in the core service area. (Town, Tr. 4439).

225. Complaint Counsel's economic expert, Prof. Town, showed that for zip code 43537 two out of three patients went to a hospital other than St. Luke's. (Town, Tr. 3943).

Response to Finding No. 225

This proposed finding overstates the cited testimony. Professor Town stated that less than two out of three patients went to a hospital other than St. Luke's. (Town, Tr. 3943). Additionally, the finding is incomplete and misleading. (*See* Response to RPFF ¶ 224).

226. From zip code 43528, it would take a resident one additional minute to drive to Flower or UTMC than it would to drive to St. Luke's and 12 additional minutes to drive to Bay Park or St. Charles, three additional minutes to drive to St. Anne, and five additional minutes to drive to TTH than it would to drive to St. Luke's. (Guerin-Calvert, Tr. 7340-7341; RX-71(A) at 000185, *in camera*).

Response to Finding No. 226

Complaint Counsel does not disagree that patients choose to receive high-quality care at St. Luke's in spite of the fact that several other hospitals may be located within a similar driving distance to a resident. In fact, zip code 43528 is St. Luke's fourth-highest zip code by the number of discharges according to the drive time analysis created by Respondent. (RX-71(A) at 185, *in camera*). In addition, Respondent's expert did not measure the impact of additional travel time on consumer welfare. (*See* Response to RPFF ¶ 1210).

227. Prof. Town's analysis showed that 77.1 percent of residents from zip code 43528 went to a hospital other than St. Luke's. (Town, Tr. 3943-3944).

Response to Finding No. 227

This proposed finding is incomplete and misleading. (*See* Response to RPFF ¶ 224).

228. From zip code 43542, it would take18 additional minutes to drive to St. Charles, or Bay Park than it would to drive to St. Luke's, the two furthest Lucas County Hospitals from St. Luke's. (Guerin-Calvert, Tr. 7340-41; RX-71(A) at 000185, *in camera*).

Response to Finding No. 228

This proposed finding is incomplete, misleading, and unsupported by part of the cited evidence. For zip code 43542, neither St. Charles nor Bay Park is listed with drive times on RX-71(A) at 185. Further, patients do not like to travel far for healthcare services, and the average person at St. Luke's drives only 12 minutes. (*See* Response to RPFF ¶ 222). To get to Bay Park or St. Charles, it would take a patient 18 additional minutes on top of the 11 minutes it already takes them to travel to St. Luke's. (Guerin-Calvert, Tr. 7340-7341; RX-71(A) at 185, *in camera*). In addition, Respondent's expert did not measure the impact of additional travel time on consumer welfare. (*See* Response to RPFF ¶ 1210).

229. From zip code 43551, which is in Wood County but in St. Luke's core service area, it would take less than fifteen additional minutes to drive to all Lucas County hospitals than it would to drive to St. Luke's. (Guerin-Calvert, Tr. 7341; RX-71(A) at 000185, *in camera*).

Response to Finding No. 229

This proposed finding is misleading and unsupported by the cited evidence. Ms. Guerin-Calvert testified that it would be less than 16 additional minutes, not 15 additional minutes. (Guerin-Calvert, Tr. 7341). Additionally, zip code 43551 is not in RX-71(A) at 185, which would indicate that St. Luke's discharged one or less patients from that zip code during the time period used by Respondent to create the drive time analysis. (RX-71(A) at 185, *in camera*). In

addition, Respondent's expert did not measure the impact of additional travel time on consumer welfare. (*See* Response to RPFF ¶ 1210).

230. Even in Prof. Town's general acute care inpatient services market, 65 percent of patients in zip code 43551 drove past St. Luke's to go to another hospital. (Town, Tr. 3939-3940).

Response to Finding No. 230

This proposed finding is incomplete and misleading. (*See* Response to RPFF ¶ 224).

231. From zip code 43558, the longest additional time to drive to another hospital from St. Luke's is sixteen additional minutes to St. Charles. Driving to all the other hospitals would require less than 16 additional minutes of driving time. (Guerin-Calvert, Tr. 7341-42; RX-71(A) at 000185, *in camera*).

Response to Finding No. 231

This proposed finding is incomplete, misleading, and unsupported by some of the cited evidence. Zip code 43558 is not in RX-71(A) at 185, which would indicate that St. Luke's discharged one or less patients from that zip code during the time period used by Respondent to create the drive time analysis. (RX-71(A) at 185, *in camera*). Further, Ms. Guerin-Calvert testified that it already takes patients 21 minutes to drive to St. Luke's from zip code 43558. An additional 16 minutes would give a total drive time of 37 minutes. (Guerin-Calvert, Tr. 7341-7342). Patients do not like to travel far to receive healthcare services; in fact, the average patient only drives 12 minutes to receive care at St. Luke's. (*See* Response to RPFF ¶ 222). In addition, Respondent's expert did not measure the impact of additional travel time on consumer welfare. (*See* Response to RPFF ¶ 1210).

232. From zip code 43566, it would take about 17 additional minutes to drive to the furthest other hospital than it would to drive to St. Luke's. (Guerin-Calvert, Tr. 7342; RX-71(A) at 000185, *in camera*).

Response to Finding No. 232

This proposed finding is incomplete, misleading, and unsupported by some of the cited evidence. RX-71(A) at 185 does not give the drive time for the hospitals furthest away from the zip code. (RX-71(A) at 185, *in camera*). The average drive time to St. Luke's from zip code 43566 is 10 minutes. (RX-71(A) at 185, *in camera*). The average patient who receives care at St. Luke's travels only 12 minutes and 75 percent of patients drive less than 14 minutes. (*See* RPFF ¶¶ 220-221). Therefore, patients traveling to the furthest hospital from zip code 43566 would have to drive 27 minutes. (Guerin-Calvert, Tr. 7342). In addition, Respondent's expert did not measure the impact of additional travel time on consumer welfare. (*See* Response to RPFF ¶ 1210).

233. From zip code 43571, it would take an additional 18 minutes to drive to the furthest other hospital than it would to drive to St. Luke's. (Guerin-Calvert, Tr. 7342; RX-71(A) at 000185, *in camera*).

Response to Finding No. 233

This proposed finding is incomplete, misleading, and unsupported by some of the cited evidence. RX-71(A) at 185 does not give the drive time for the hospitals furthest away from zip code 43571. (RX-71(A) at 185, *in camera*). The average drive time to St. Luke's from zip code 43571 is 16.4 minutes. (RX-71(A) at 185, *in camera*). The average patient who receives care at St. Luke's travels only 12 minutes and 75 percent of patients drive less than 14 minutes. (*See* RPFF ¶¶ 220-221). Therefore, patients traveling to the furthest hospital from zip code 43571 would have to drive 34 minutes. (Guerin-Calvert, Tr. 7342). In addition, Respondent's expert did not measure the impact of additional travel time on consumer welfare. (*See* Response to RPFF ¶ 1210).

234. From zip code 43614, the closest hospital is UTMC so it would take five fewer minutes to drive to UTMC than it would to drive to St. Luke's, and driving to the furthest hospital from St. Luke's would only require six additional minutes. (Guerin-Calvert, Tr. 7342-7343; RX-71(A) at 000185, *in camera*).

Response to Finding No. 234

This proposed finding misleading and incomplete. While Complaint Counsel does not disagree that some patients are willing to travel further to receive high-quality care at St. Luke's, Complaint Counsel notes that patients driving to UTMC from zip code 43614 travel only five minutes. Therefore, the drive to St. Luke's is less than 10 minutes. Additionally, zip code 43614 has the second highest amount of discharges from St. Luke's according to the analysis created by Respondent. (RX-71(A) at 185, *in camera*). So the 10 minute drive from zip code 43614 is *less* than the average drive time of a patient seeking inpatient care at St. Luke's. (*See* RPFF ¶ 221). In addition, Respondent's expert did not measure the impact of additional travel time on consumer welfare. (*See* Response to RPFF ¶ 1210).

235. Even in Prof. Town's general acute care inpatient services market, seven out of ten patients in zip code 43614 went to a hospital other than St. Luke's. (Town, Tr. 3940-3943).

Response to Finding No. 235

This proposed finding is incomplete and misleading. (*See* Response to RPFF ¶ 224).

236. From zip code 43402, which is located in Wood County but from which St. Luke's draws a large number of patients, driving to the furthest Lucas County hospital would take approximately twelve additional minutes than driving to St. Luke's. (Guerin-Calvert, Tr. 7343; RX-71(A) at 000185, *in camera*).

Response to Finding No. 236

This proposed finding is incomplete, misleading, and unsupported by some of the cited evidence. Zip code 43402 is not in RX-71(A) at 000185, which would indicate that St. Luke's discharged one or less patients from that zip code during the time period used by Respondent to create the drive time analysis. (RX-71(A) at 000185, *in camera*). Further, Ms. Guerin-Calvert testified that it already takes patients 24 minutes to drive to St. Luke's from zip code 43402. An additional 12 minutes to drive to Flower would give a total drive time of 36 minutes. (Guerin-

Calvert, Tr. 7343). Patients do not like to travel; in fact, the average patient only drives 12 minutes to receive care at St. Luke's. (*See* Response to RPFF ¶ 222). In addition, Respondent's expert did not measure the impact of additional travel time on consumer welfare. (*See* Response to RPFF ¶ 1210).

237. From zip code 43567, which is located in Fulton County but from which St. Luke's draws patients, the drive time to St. Luke's is 38 minutes and it would only take 13 additional minutes to get to the furthest other hospital in Lucas County than it would to drive to St. Luke's. (Guerin-Calvert, Tr. 7343-7344; RX-71(A) at 000185, *in camera*).

Response to Finding No. 237

This proposed finding is incomplete, misleading, and unsupported by some of the cited evidence. Zip code 43567 is not in RX-71(A) at 185, which would indicate that St. Luke's discharged one or less patients from that zip code during the time period used by Respondent to create the drive time analysis. (RX-71(A) at 185, *in camera*). This is likely because patients do not like to travel for healthcare services. (*See* CCPFF ¶¶ 216-222). In addition, Respondent's expert did not measure the impact of additional travel time on consumer welfare. (*See* Response to RPFF ¶ 1210).

238. From zip code 43504, Flower is the closest hospital, closer than St. Luke's. And to drive to the furthest Lucas County hospital from St. Luke's would take only 19 more minutes. (Guerin-Calvert, Tr. 7344; RX-71(A) at 000185, *in camera*).

Response to Finding No. 238

This proposed finding is incomplete and misleading. St. Luke's only had three discharges from this zip code during the time period used by Respondent to create its drive time analysis. This is likely because patients do not like to travel for healthcare services. (*See* CCPFF ¶¶ 216-222). Patients from zip code 43504 already drive over 15 minutes to receive care at Flower Hospital, and would have to drive an additional 8 minutes to arrive at St. Luke's. (RX-

71(A) at 185, *in camera*). In addition, Respondent's expert did not measure the impact of additional travel time on consumer welfare. (*See* Response to RPFF ¶ 1210).

239. Across all services, approximately half of the patients discharged from St. Luke's had a hospital that was closer than St. Luke's. (Guerin-Calvert, Tr. 7347).

Response to Finding No. 239

Complaint Counsel does not disagree that some patients are willing to drive further to receive high quality care at St. Luke's.

240. For the other half of the patients discharged from St. Luke's, St. Luke's was the closest hospital, but the next closest hospital was from one to seventeen additional minutes farther away. (Guerin-Calvert, Tr. 7347).

Response to Finding No. 240

Complaint Counsel does not disagree that Lucas County patients want to receive healthcare services close to home and therefore choose the closest hospital to where they live. In addition, Respondent's expert did not measure the impact of additional travel time on consumer welfare. (*See* Response to RPFF ¶ 1210).

241. For general acute care patients, as defined by Prof. Town, discharged from St. Luke's, approximately 49 percent would have had a shorter drive time had they gone to a hospital other than St. Luke's; the other 51 percent would have only had to travel an additional one to 10 minutes to another hospital. (Guerin-Calvert, Tr. 7349-50).

Response to Finding No. 241

Complaint Counsel does not disagree that while many Lucas County patients want to receive healthcare services close to home and therefore choose the closest hospital to where they live, other patients are willing to travel farther to receive high-quality care at St. Luke's instead of at their closest hospital option. So, St. Luke's was the closest hospital for 51 percent of patients. In addition, Respondent's expert did not measure the impact of additional travel time on consumer welfare. (*See* Response to RPFF ¶ 1210).

242. For OB patients discharged from St. Luke's, 37 percent have a hospital that is closer than St. Luke's; the remaining 63 percent would have had an additional one to seventeen minutes to another hospital. (Guerin-Calvert, Tr. 7350-7351).

Response to Finding No. 242

Complaint Counsel does not disagree that while most Lucas County patients needing OB services want to receive healthcare services close to home and therefore choose the closest hospital to where they live, other patients are willing to travel farther to receive high-quality care at St. Luke's instead of at their closest hospital option. So, St. Luke's was the closest hospital for 63 percent of patients. In addition, Respondent's expert did not measure the impact of additional travel time on consumer welfare. (*See* Response to RPFF ¶ 1210).

243. Even Prof. Town calculated that 82.4 percent of expectant mothers who resided in St. Luke's core service area went to hospitals other than St. Luke's. (Town, Tr. 3944).

Response to Finding No. 243

This proposed finding is incomplete and misleading. (*See* Response to RPFF ¶ 224).

E. Health Insurers

244. Hospitals receive reimbursement for their services from various sources. Patients can be classified according to their primary means of payment: government insurance (Medicare and Medicaid), private commercial insurance, self-pay, and charity or indigent care. (RX-1264 at 000007, *in camera*; Oostra, Tr. 5783).

Response to Finding No. 244

Complaint Counsel does not disagree.

1. Government Health Insurers

245. Medicare is a health insurance program administered by the federal government, and Medicaid is a health insurance program administered by state governments. (Wachsman, Tr. 4848).

Response to Finding No. 245

Complaint Counsel does not disagree.

246. To be eligible for Medicare, patients must generally be aged 65 or older. (Pugliese, Tr. 1435).

Response to Finding No. 246

Complaint Counsel does not disagree.

247. Toledo has an aging population, which means there are an increasing number of residents covered by Medicare. (Guerin-Calvert, Tr. 7303).

Response to Finding No. 247

Complaint Counsel has no specific response.

248. Hospitals are obligated to accept Medicaid admissions. (Guerin-Calvert, Tr. 7296.)

Response to Finding No. 248

Complaint Counsel has no specific response.

249. Providers cannot negotiate Medicare and Medicaid reimbursement rates. (Wachsman, Tr. 4848). CMS establishes the reimbursement rates for hospitals and physicians, and the provider community simply agrees to accept that level of reimbursement. (McGinty, Tr. 1169; Den Uyl, Tr. 6512).

Response to Finding No. 249

Complaint Counsel has no specific response.

250. Medicare and Medicaid reimbursements do not cover the costs of providing the hospital services to those patients. (Wachsman, Tr. 4848; Guerin-Calvert, Tr. 7299; RX-71(A) at 000128, 000133, *in camera*).

Response to Finding No. 250

Complaint Counsel does not disagree.

251. Medicare reimbursed hospitals on average 89 to 90 percent of the hospital's cost of treating Medicare patients in 2009. (Guerin-Calvert, Tr. 7302-7303; RX-71(A) at 000133, *in camera*).

Response to Finding No. 251

Complaint Counsel has no specific response.

252. Because Medicare and Medicaid reimbursement rates cover less than the provider's costs, providers must subsidize the difference between the government reimbursement rates and the provider's costs. (Wachsman, Tr. 4848).

Response to Finding No. 252

Complaint Counsel does not disagree.

253. Compensation from private MCOs not only covers their costs but provides some contribution toward covering the insufficient funding for Medicare and Medicaid. (Guerin-Calvert, Tr. 7304).

Response to Finding No. 253

Complaint Counsel has no specific response.

254. { } (Shook, Tr. 1101, *in camera*).

Response to Finding No. 254

Complaint Counsel has no specific response.

255. { } (Shook, Tr. 1102, *in camera*).

Response to Finding No. 255

Complaint Counsel does not disagree.

2. Managed Care Organizations

256. MCO stands for "Managed Care Organization." Managed care organizations include companies like Aetna and MMO that negotiate provider networks with hospitals and offer health insurance products to employers. (Rupley, Tr. 1968; Radzialowski, Tr. 731-733; Pirc, Tr. 2175-2176, 2274-2275). MCOs may also act as a third party administrator or TPA; the TPA provides claims-handling services as part of an "administrative services only" (ASO) contract with self-insured employers. (Neal, Tr. 2096-2097; Radzialowski, Tr. 731-733; Pirc, Tr. 2175-2176, 2274-2275). MCOs may be variously referred to as "payors," "health insurance plans," or "health insurance companies." The terms are used interchangeably. (Pirc, Tr. 2175; Wachsman, Tr. 4712, 4833-4834).

Response to Finding No. 256

Complaint Counsel has no specific response.

257. MCOs operating in Lucas County, Ohio include MMO, Anthem, Paramount, United, Aetna, United, CIGNA, FrontPath, and some smaller companies. (Pugliese, Tr. 1574; Pirc, Tr. 2178).

Response to Finding No. 257

Complaint Counsel does not disagree.

a. Medical Mutual of Ohio

(i) Company Background and Products Offered

258. MMO is a mutual company, which means that it is owned by its policyholders. (Pirc, Tr. 2172-2173).

Response to Finding No. 258

Complaint Counsel does not disagree.

259. MMO operates statewide networks in Ohio, Indiana, Georgia, and South Carolina and operates in 17 counties of Kentucky. (Pirc, Tr. 2174).

Response to Finding No. 259

Complaint Counsel does not disagree.

260. MMO offers health insurance plans, dental plans, and term life insurance. (Pirc, Tr. 2273).

Response to Finding No. 260

Complaint Counsel does not disagree.

261. MMO offers PPO, HMO and point-of-service commercial health insurance products. (Pirc, Tr. 2174-2175). MMO exited the Medicare Advantage market beginning January 1, 2011. (Pirc, Tr. 2273).

Response to Finding No. 261

Complaint Counsel has no specific response.

262. MMO also provides third party administration services to employers who self-insure their employees' health insurance. (Pirc, Tr. 2273-2274; Neal, Tr. 2096).

Response to Finding No. 262

Complaint Counsel does not disagree.

263. MMO has approximately 1.4 million covered lives in Ohio, and is the largest health plan in Lucas County with approximately 100,000 covered lives in Lucas County. (Pirc, Tr. 2177-2178, 2273).

Response to Finding No. 263

Complaint Counsel does not disagree.

264. MMO has a market share of approximately 25 percent in Lucas County. (Pirc, Tr. 2178).

Response to Finding No. 264

Complaint Counsel does not disagree.

265. Approximately 60 percent of MMO's commercial business comes from administrative services it provides to self-insured employers; the remaining 40 percent is for fully insured products. (Pirc, Tr. 2274).

Response to Finding No. 265

Complaint Counsel does not disagree.

266. MMO's self-insured employers pay an administrative fee to MMO for the administrative services MMO performs. (Pirc, Tr. 2273-2274).

Response to Finding No. 266

Complaint Counsel does not disagree.

(ii) Network in Lucas County

267. MMO's ultimate goal is to be able to offer products to employer groups at a lower premium than other MCOs in a given market. (Pirc, Tr. 2208-2209, 2211-2212, 2284).

Response to Finding No. 267

Complaint Counsel has no specific response.

268. MMO currently has all of the Lucas County hospitals in all of its networks. (Pirc, Tr. 2203).

Response to Finding No. 268

Complaint Counsel does not disagree.

269. ProMedica's hospitals have participated in the MMO network since January 1, 2008. (Pirc, Tr. 2204; 2275).

Response to Finding No. 269

Complaint Counsel does not disagree.

270. Mercy has participated in the MMO network for more than 10 years. (Pirc, Tr. 2275).

Response to Finding No. 270

Complaint Counsel does not disagree.

271. UTMC has participated in MMO's network for more than 10 years. (Pirc, Tr. 2275).

Response to Finding No. 271

Complaint Counsel does not disagree.

272. St. Luke's has participated in MMO's network for more than 10 years. (Pirc, Tr. 2275).

Response to Finding No. 272

Complaint Counsel does not disagree.

273. St. Luke's does not offer the high level services MMO requires to meet the needs of its members, and MMO requires hospitals other than St. Luke's to meet those needs. (Pirc, Tr. 2280).

Response to Finding No. 273

Complaint Counsel has no specific response.

b. Anthem Blue Cross Blue Shield

(i) Company Background and Services Offered

274. WellPoint is a publicly traded, for-profit national health insurer, offering health insurance products in Ohio and many other states, including California, Colorado, Connecticut, Indiana, Kentucky, New York, Virginia, Wisconsin. (Pugliese, Tr. 1420, 1427, 1528).

Response to Finding No. 274

Complaint Counsel does not disagree.

275. WellPoint is an independent licensee of the Blue Cross and Blue Shield Association and markets its health insurance products under the Blue Cross Blue Shield brand. (Pugliese, Tr. 1427, 1528).

Response to Finding No. 275

Complaint Counsel does not disagree.

276. WellPoint has over 33.3 million insured members in its health plans and is the largest health benefits company in terms of medical membership in the United States. (Pugliese, Tr. 1529-1530).

Response to Finding No. 276

Complaint Counsel has no specific response.

277. WellPoint reported $57 billion in revenue in 2010. (Pugliese, Tr. 1530).

Response to Finding No. 277

Complaint Counsel has no specific response.

278. In Ohio, WellPoint does business as Community Insurance Company and is also referred to as Anthem Blue Cross Blue Shield ("Anthem"). (Pugliese, Tr. 1530-1531).

Response to Finding No. 278

Complaint Counsel does not disagree.

279. Anthem offers health, dental, vision, behavioral health, life and disability insurance plans. (Pugliese, Tr. 1534-1535).

Response to Finding No. 279

Complaint Counsel does not disagree.

280. Anthem offers a broad spectrum of managed-care plans in Ohio, including PPO plans, HMO plans, POS plans and traditional indemnity plans. (Pugliese, Tr. 1531-1532).

Response to Finding No. 280

Complaint Counsel does not disagree.

281. In Lucas County, Anthem markets a broad-access PPO network for its commercial customers. (Pugliese, Tr. 1434-1435).

Response to Finding No. 281

Complaint Counsel does not disagree.

282. For its commercial health insurance plans, Anthem offers a fully-insured product and a self-insured product, called its Administrative Services Only ("ASO") product. (Pugliese, Tr. 1430).

Response to Finding No. 282

Complaint Counsel does not disagree.

283. Anthem is one of the top two or three MCOs in Lucas County. (Pugliese, Tr. 1436).

Response to Finding No. 283

Complaint Counsel does not disagree.

284. Anthem has approximately 30,000 commercially insured members in Lucas County. (RX-204 (Pugliese, Dep. at 9)).

Response to Finding No. 284

Complaint Counsel has no specific response.

285. Anthem primarily markets its commercial health insurance products to employers. (Pugliese, Tr. 1429-1430).

Response to Finding No. 285

Complaint Counsel does not disagree.

286. Anthem serves a wide variety of employers, ranging from large employers with more than 1000 employees to small companies with less than 50 employees. (Pugliese, Tr. 1429-1430)

Response to Finding No. 286

Complaint Counsel has no specific response.

287. Anthem's self-insured product comprises approximately 55 percent of its commercial business in Lucas County. (Pugliese, Tr. 1432).

Response to Finding No. 287

Complaint Counsel does not disagree.

288. Anthem's self-insured employers pay an administrative fee to Anthem for managing the benefit design and handling claim administration. (Pugliese, Tr. 1431).

Response to Finding No. 288

Complaint Counsel does not disagree.

289. Anthem's fee for providing administrative services is a "per-head" price. The level of the fee varies according to the types of administrative services provided. (Pugliese, Tr. 1570-1571).

Response to Finding No. 289

Complaint Counsel has no specific response.

290. In addition to claim processing and benefit design services, Anthem also offers stop-loss insurance to self-employed insurers. (Pugliese, Tr. 1533).

Response to Finding No. 290

Complaint Counsel has no specific response.

(ii) Network in Lucas County

291. Anthem currently has all Lucas County hospitals in its commercial PPO network and includes hospitals outside of Lucas County. (Pugliese, Tr. 1450).

Response to Finding No. 291

Complaint Counsel has no specific response.

292. ProMedica has participated in Anthem's network for at least 20 years. (Pugliese, Tr. 1538).

Response to Finding No. 292

Complaint Counsel does not disagree.

293. Mercy began participating in Anthem's commercial PPO network as of January 1, 2008. (Pugliese, Tr. 1539).

Response to Finding No. 293

Complaint Counsel does not disagree.

294. UTMC has participated in Anthem's network since 2003 or 2004. (Pugliese, Tr. 1476, *in camera*; Pugliese, Tr. 1538).

Response to Finding No. 294

Complaint Counsel has no specific response.

295. St. Luke's participated in Anthem's network prior to 2005. (Pugliese, Tr. 1538-1539).

Response to Finding No. 295

Complaint Counsel does not disagree.

296. Anthem terminated St. Luke's PPO contract effective January 31, 2005. (Pugliese, Tr. 1539; RX-1026 at 000001).

Response to Finding No. 296

Complaint Counsel has no specific response.

297. St. Luke's began participating in Anthem's network again in July 2009. **(**Pugliese, Tr. 1477, *in camera*; Wakeman, Tr. 2530-2531).

Response to Finding No. 297

Complaint Counsel does not disagree.

298. Blue Cross Blue Shield's "BlueCard" program allows travelers to access the networks of other Blue Cross Blue Shield licensees throughout the United States and benefit from negotiated network discounts. (Pugliese, Tr. 1536-1537).

Response to Finding No. 298

Complaint Counsel has no specific response.

299. Anthem's ability to offer its insureds access to the Blue Cross Blue Shield network wherever they may require care is a competitive advantage that Anthem markets to both providers and employers in Lucas County. (Pugliese, Tr. 1531).

Response to Finding No. 299

Complaint Counsel has no specific response.

(iii) National Brand Recognition

300. Blue Cross Blue Shield is the most recognized brand in the healthcare industry. (Pugliese, Tr. 1528).

Response to Finding No. 300

Complaint Counsel has no specific response.

301. Anthem's position as the exclusive licensee of Blue Cross Blue Shield in Ohio gives it national name recognition that other health insurance providers do not have. (Pugliese, Tr. 1531).

Response to Finding No. 301

Complaint Counsel has no specific response.

302. Anthem affirmatively markets this national name recognition to healthcare providers when trying to contract with them to become part of the Anthem provider network. (Pugliese, Tr. 1531).

Response to Finding No. 302

Complaint Counsel has no specific response.

303. Anthem also affirmatively markets its national name recognition to employers and members. (Pugliese, Tr. 1531).

Response to Finding No. 303

Complaint Counsel has no specific response.

c. Paramount Healthcare

(i) Company Background and Products Offered

304. Paramount Healthcare is the trade name for Paramount's commercial HMO product. (Randolph, Tr. 6907).

Response to Finding No. 304

Complaint Counsel has no specific response.

305. Paramount's HMO product is its largest product, and is offered in both a fully insured and a self-funded environment. (Randolph, Tr. 6907-6708).

Response to Finding No. 305

Complaint Counsel does not disagree.

306. There are approximately 85,000 to 90,000 covered lives in Paramount's commercially insured products. (Randolph, Tr. 6906).

Response to Finding No. 306

Complaint Counsel has no specific response.

307. Approximately 50 percent of Paramount's commercially insured membership are fully-insured, and approximately 50 percent are self-insured. (Randolph, Tr. 6929).

Response to Finding No. 307

Complaint Counsel has no specific response.

308. In Paramount's commercial market, a larger share of hospital payments are for outpatient services than for inpatient services. (Randolph, Tr. 6970).

Response to Finding No. 308

Complaint Counsel has no specific response.

309. Paramount's health insurance products are marketed in two counties in the southeastern part of Michigan, and 22 to 24 counties in northwest Ohio, including Lucas County. (Randolph, Tr. 6895- 6896).

Response to Finding No. 309

Complaint Counsel has no specific response.

310. Paramount is licensed for its Medicare, Medicaid, and commercial insurance products in Ohio, and is licensed for its commercial and Medicare products in Michigan. (Randolph, Tr. 6905).

Response to Finding No. 310

Complaint Counsel has no specific response.

311. Paramount focuses its marketing efforts to employers and providers by noting its low cost and local service. (Randolph, Tr. 6915-6916, 6942).

Response to Finding No. 311

Complaint Counsel has no specific response.

312. In the small group arena (50-employee-and-under), Paramount uses insurance brokers and agents, and their distribution channels, as its primary conduit to connect with employers. (Randolph, Tr. 6926).

Response to Finding No. 312

Complaint Counsel has no specific response.

(ii) Network in Lucas County

313. Paramount's provider network is low cost, meaning Paramount's aggregate premium cost is low compared to its competitors in Northwest Ohio. (Randolph, Tr. 6940).

Response to Finding No. 313

Complaint Counsel has no specific response.

314. Paramount has a closed or limited network of hospitals; the Mercy hospitals do not participate in Paramount's network. (Radzialowski, Tr. 627; Pugliese Tr. 1574-1575).

Response to Finding No. 314

Complaint Counsel does not disagree.

315. Paramount's hospital provider network is the smallest in Lucas County compared to its competitors. (Randolph, Tr. 6934).

Response to Finding No. 315

Complaint Counsel has no specific response.

316. Paramount's hospital provider network in Lucas County includes: Flower, TTH, Toledo Children's Hospital, Bay Park, UTMC, and now St. Luke's. (Randolph, Tr. 6936).

Response to Finding No. 316

Complaint Counsel does not disagree.

317. St. Luke's rejoined Paramount's hospital provider network as part of the Joinder agreement with ProMedica in September 2010 at rates comparable to the average metro rate that Paramount pays to ProMedica hospitals in the Toledo area. (Randolph, Tr. 7004).

Response to Finding No. 317

Complaint Counsel does not disagree with this proposed finding, except to note that nothing prevented Paramount from allowing St. Luke's to join its hospital provider network prior to the Acquisition. In fact, St. Luke's was interested in joining Paramount, but it was ProMedica's decision to not allow Paramount to accept St. Luke's into its hospital provider network because of fear that Paramount members would begin to use St. Luke's Hospital instead of ProMedica's hospitals. (CCPFF ¶¶ 381-386).

318. Paramount's provider network does not include Mercy because ProMedica believes that it can keep costs lower by keeping the provider panel limited. (Oostra, Tr. 5788-5789).

Response to Finding No. 318

Complaint Counsel has no specific response.

319. Adding the Mercy hospitals to Paramount's provider network would be a significant cost increase for Paramount compared to its contracts with the ProMedica hospitals and UTMC. (Randolph, Tr. 6937-6938).

Response to Finding No. 319

Complaint Counsel has no specific response.

320. For physician providers, Paramount's network is comparable to the networks of its competitors in Lucas County. (Randolph, Tr. 6934).

Response to Finding No. 320

Complaint Counsel has no specific response.

321. Paramount contracts with the following physician groups: PPG, the Toledo Clinic, and the University of Toledo Physicians, among others. (Randolph, Tr. 6938-6939).

Response to Finding No. 321

Complaint Counsel has no specific response.

322. Approximately 80 percent of the physician providers in Paramount's network are independent of a hospital or health system. (Randolph, Tr. 6938-6939).

Response to Finding No. 322

Complaint Counsel has no specific response.

323. Paramount contracts with hospital employers of physicians with whom Paramount does not contract to provide hospital services on an in-network basis. (Randolph, Tr. 6933).

Response to Finding No. 323

Complaint Counsel has no specific response.

324. Paramount contracts with approximately 40 of the Mercy employed physicians. (Randolph, Tr. 6933).

Response to Finding No. 324

Complaint Counsel has no specific response.

325. Paramount contracted with St. Luke's employed physicians when St. Luke's was not in Paramount's provider network. (Randolph, Tr. 6933).

Response to Finding No. 325

Complaint Counsel has no specific response.

326. Paramount does not have any exclusive contracts with physician groups that would prevent them from contracting with any of Paramount's competitors. (Randolph, Tr. 6940).

Response to Finding No. 326

Complaint Counsel has no specific response.

327. Paramount does not have any exclusive contracts with hospital providers that would prevent them from contracting with any of Paramount's competitors. (Randolph, Tr. 6940).

Response to Finding No. 327

Complaint Counsel has no specific response.

d. FrontPath

(i) Company Background and Services Offered

328. FrontPath is a business coalition for health. It is a membership organization governed and managed by its 125-130 "sponsors," who include corporations, labor organizations, and public entities. (Sandusky, Tr. 1283, 1299).

Response to Finding No. 328

Complaint Counsel has no specific response.

329. FrontPath began operations in 1988 as the Western Lake Erie Employers' Coalition. (Sandusky, Tr. 1293).

Response to Finding No. 329

Complaint Counsel does not disagree.

330. FrontPath does business in northwest Ohio, southeast Michigan, and northeast Indiana. (Sandusky, Tr. 1298).

Response to Finding No. 330

Complaint Counsel does not disagree.

331. FrontPath's sponsors are predominantly self-insured, large employers. (Sandusky, Tr. 1293, 1299).

Response to Finding No. 331

Complaint Counsel does not disagree.

332. FrontPath's corporate sponsors include businesses in the community like Libbey Glass or Owens-Illinois, ranging in size from 200-300 to 10,000 employees or participants. (Sandusky, Tr. 1285-1286).

Response to Finding No. 332

Complaint Counsel does not disagree.

333. FrontPath's labor organization sponsors include union funds that provide health benefits to trades likes the plumbers, carpenters, or pipefitters. (Sandusky, Tr. 1285).

Response to Finding No. 333

Complaint Counsel does not disagree.

334. FrontPath's public entity sponsors include the City of Toledo, Lucas County, Wood County, other municipalities in the area, fire departments, and school districts. (Sandusky, Tr. 1284).

Response to Finding No. 334

Complaint Counsel does not disagree.

335. { } (Sandusky, Tr.1356, *in camera*).

Response to Finding No. 335

Complaint Counsel has no specific response.

336. FrontPath is one of the top three or four MCOs in Lucas County, with approximately 125,000 total covered lives, of which approximately 80,000 are in Lucas County. (Sandusky, Tr. 1299, 1300).

Response to Finding No. 336

Complaint Counsel has no specific response.

337. FrontPath offers both a self-insured product and a fully-insured product, and has the "lion's share" of the market for self-insured employers. (Sandusky, Tr. 1300, 1397)

Response to Finding No. 337

Complaint Counsel has no specific response.

338. For its self-insured sponsors, FrontPath charges a flat $4 per employee per month fee for access to its network. (Sandusky, Tr. 1394-1395).

Response to Finding No. 338

Complaint Counsel has no specific response.

339. FrontPath does not design the employee health benefits plans for its sponsors or decide upon the specific elements of the plans they offer, such as their deductibles, coverage breadth and limits, out-of-pocket limits. (Sandusky, Tr. 1390, 1395).

Response to Finding No. 339

Complaint Counsel has no specific response.

340. FrontPath's fully-insured product only has approximately 2,000 covered lives and represents a very small portion of FrontPath's overall preferred provider network business. (Sandusky, Tr. 1399).

Response to Finding No. 340

Complaint Counsel has no specific response.

(ii) Network in Lucas County

341. FrontPath seeks to create provider networks that offer a full complement of services, including primary, secondary, tertiary and quaternary care services. (Sandusky, Tr. 1400-1401).

Response to Finding No. 341

Complaint Counsel does not disagree.

342. FrontPath has always maintained an open-access platform that includes all Lucas County hospitals and tries to include as many healthcare providers as possible. Its goal is to have the broadest access while achieving the greatest cost savings for members and their plan participants. (Sandusky, Tr. 1287-1288).

Response to Finding No. 342

Complaint Counsel has no specific response.

343. All Lucas County hospitals participate in the FrontPath network. (Sandusky, Tr. 1315).

Response to Finding No. 343

Complaint Counsel does not disagree.

344. Not every Lucas County hospital offers all the services FrontPath seeks when building its provider network. (Sandusky, Tr. 1400-1401).

Response to Finding No. 344

Complaint Counsel does not disagree.

345. In order for FrontPath to offer a full complement of healthcare services it is essential for it to include a least one hospital that offers advanced services. (Sandusky, Tr. 1401).

Response to Finding No. 345

Complaint Counsel has no specific response.

346. St. Luke's does not offer the high level secondary, tertiary or quaternary services FrontPath requires in its network. (Sandusky, Tr. 1401).

Response to Finding No. 346

Complaint Counsel has no specific response.

347. St. Luke's does not offer neonatal intensive care that FrontPath requires in its network. (Sandusky, Tr. 1402).

Response to Finding No. 347

Complaint Counsel has no specific response.

348. FrontPath requires other hospitals in addition to St. Luke's in order to meet all the needs of its sponsors. (Sandusky, Tr. 1402).

Response to Finding No. 348

Complaint Counsel does not disagree.

e. UnitedHealthcare

(i) Company Background and Services Offered

349. {

} (PX01902 (Sheridan, IHT at 9, *in camera*)).

Response to Finding No. 349

Complaint Counsel has no specific response.

350. United offers various health insurance products throughout the United States. (Sheridan, Tr. 6613).

Response to Finding No. 350

Complaint Counsel does not disagree.

351. In Lucas County, United offers predominantly PPO plans. (Sheridan, Tr. 6613).

Response to Finding No. 351

Complaint Counsel has no specific response.

352. United has approximately 1 million commercial members in Ohio. (Sheridan, Tr. 6614).

Response to Finding No. 352

Complaint Counsel has no specific response.

353. Within Lucas County, United has approximately 15,000 commercially insured members. (Sheridan, Tr. 6615).

Response to Finding No. 353

Complaint Counsel has no specific response.

354. United's customers in Lucas County included the Catholic Diocese of Toledo and national accounts like Best Buy that have a presence in Toledo. (Sheridan, Tr. 6615; PX01902 (Sheridan, IHT at 17, *in camera*)).

Response to Finding No. 354

Complaint Counsel does not disagree.

355. { } (PX01902 (Sheridan, IHT at 17), *in camera*).

Response to Finding No. 355

Complaint Counsel has no specific response.

(ii) Network in Lucas County

356. When building its hospital provider network, United considers access, hospital quality, physician privileges, and the types of services offered. (Sheridan, Tr. 6622).

Response to Finding No. 356

Complaint Counsel has no specific response.

357. {

} (PX01902 (Sheridan, IHT at 39-40, *in camera*)).

Response to Finding No. 357

Complaint Counsel has no specific response.

358. All hospitals in Lucas County currently participate in United's provider network, but United did not always have all Lucas County hospitals in its network. (Sheridan, Tr. 6620).

Response to Finding No. 358

Complaint Counsel has no specific response.

359. ProMedica participated with United until 2005. ProMedica then left the network and Mercy became a participating provider as of January 1, 2006. (Sheridan, Tr. 6620).

Response to Finding No. 359

Complaint Counsel has no specific response.

360. ProMedica rejoined United's network in the fall of 2010. (Sheridan, Tr. 6621).

Response to Finding No. 360

Complaint Counsel does not disagree.

361. UTMC was also not always a participating provider in United's network. (Sheridan, Tr. 6620).

Response to Finding No. 361

Complaint Counsel does not disagree.

362. { } (PX01902 (Sheridan, IHT at 49, *in camera*)).

Response to Finding No. 362

Complaint Counsel has no specific response.

363. Over the past six years, United's overall membership within Lucas County remained consistent. (Sheridan, Tr. 6621).

Response to Finding No. 363

Complaint Counsel has no specific response.

364. United's membership totals did not change when ProMedica left its network and, first, Mercy and then, later, UTMC were added to its network. (Sheridan, Tr. 6621-6622, 6710-6711, *in camera*).

Response to Finding No. 364

Complaint Counsel has no specific response.

365. {

} (RX-27 (Sheridan, Dep. at 16, *in camera*)).

Response to Finding No. 365

This proposed finding is misleading to the extent it implies that St. Luke's is not important to United's network after the Acquisition. United cannot market a network in Lucas County if it were unable to reach agreement with St. Luke's because United would necessarily also not have an agreement with ProMedica's legacy hospitals after the Acquisition. To the extent ProMedica contracts with all or none of its Lucas County hospitals, and St. Luke's is now part of ProMedica, United or any other health plan would have to do without ProMedica's legacy hospitals and St. Luke's if it failed to reach an agreement with St. Luke's. And no health plan in the last 20 years has offered a product with a hospital network consisting only of UTMC and Mercy (CCPFF ¶¶ 510-513), and no health plan believes that such a network would be marketable and viable. (CCPFF ¶¶ 514-533). And as Ms. Sheridan testified, United would face even greater difficulty serving its membership without ProMedica and St. Luke's than without ProMedica's pre-Acquisition hospital network in Lucas County. (Sheridan, Tr. 6687, *in camera*).

(iii) National Brand Recognition

366. United's national presence and the national accounts it had in Lucas County was a particular strength in its negotiations with Lucas County hospitals. (Sheridan, Tr. 6624).

Response to Finding No. 366

Complaint Counsel has no specific response.

367. United acknowledges that it was not handicapped or limited in bargaining power in its negotiations with any Lucas County hospital or hospital system. (Sheridan, Tr. 6625).

Response to Finding No. 367

Complaint Counsel has no specific response.

368. { } (RX-47 (Sheridan, IHT at 42, *in camera*)).

Response to Finding No. 368

Complaint Counsel has no specific response.

369. { } (PX01902 (Sheridan, IHT at 41, *in camera*)).

Response to Finding No. 369

Complaint Counsel has no specific response.

f. Aetna

(i) Company Background and Services Offered

370. Aetna is a national, for-profit, publicly traded health insurance company that operates individual subsidiaries in each state. (Radzialowski, Tr. 608, 611, 740, 827).

Response to Finding No. 370

Complaint Counsel has no specific response.

371. { } (Radzialowski, Tr. 827, *in camera*).

Response to Finding No. 371

Complaint Counsel has no specific response.

372. Aetna has millions of members nationwide. (Radzialowski, Tr. 744).

Response to Finding No. 372

Complaint Counsel does not disagree.

373. Aetna offers three types of commercial health insurance products: HMO plans, a Managed Choice plan, and a PPO plan. (Radzialowski, Tr. 601-602).

Response to Finding No. 373

Complaint Counsel does not disagree.

374. Aetna offers a standard HMO and an Open Access HMO which has fewer restrictions for patients. (Radzialowski, Tr. 610).

Response to Finding No. 374

Complaint Counsel does not disagree.

375. Aetna's Managed Choice plan is a POS plan that is less restrictive than its HMO plans and more restrictive than its PPO plan. (Radzialowski, Tr. 612).

Response to Finding No. 375

Complaint Counsel has no specific response.

376. In Ohio, Aetna has between seven hundred fifty thousand and one million commercial members. (Radzialowski, Tr. 744).

Response to Finding No. 376

Complaint Counsel has no specific response.

377. In Lucas County, Aetna has approximately 30,000 members for its commercial insurance products and 4,000 members for its government product. (Radzialowski, Tr. 618).

Response to Finding No. 377

Complaint Counsel has no specific response.

378. Aetna's largest customers are large national corporations that have sites throughout the United States. (Radzialowski, Tr. 608).

Response to Finding No. 378

Complaint Counsel does not disagree.

379. Aetna's customers in Lucas County include large employers like the State of Ohio, IBM, and Microsoft. (Radzialowski, Tr. 620).

Response to Finding No. 379

Complaint Counsel does not disagree.

380. Aetna estimates that, nationally and in Lucas County, its HMO product represents 50 percent of its commercial healthcare insurance business; its point-of-service product represents 20 percent of its business; and its PPO product represents 30 percent of its business. (Radzialowski, Tr. 613, 617).

Response to Finding No. 380

Complaint Counsel has no specific response.

381. Of its 30,000 commercially insured members, approximately 10,000 are fully insured and 20,000 are self-insured. (Radzialowski, Tr. 626).

Response to Finding No. 381

Complaint Counsel has no specific response.

382. For Aetna's self-insured employers, Aetna designs their policy, provides identification cards for employees, provides access to the network of providers that it has created, and administers member claims. (Radzialowski, Tr. 630).

Response to Finding No. 382

Complaint Counsel has no specific response.

383. Aetna's self-insured customers pay an administrative fee to Aetna for the services that Aetna provides. (Radzialowski, Tr. 629).

Response to Finding No. 383

Complaint Counsel does not disagree.

384. Nationally, for Aetna's self-insured employers, medical costs comprise about 85 percent of their total healthcare expenditures; administrative costs account for the remaining 15 percent of the total. (Radzialowski, Tr. 629, 734-735).

Response to Finding No. 384

Complaint Counsel has no specific response.

(ii) Network in Lucas County

385. Aetna seeks to provide members a full complement of services when building its networks. (Radzialowski, Tr. 655-656).

Response to Finding No. 385

Complaint Counsel does not disagree.

386. The level and type of service a hospital can provide and the quality of the service provided are some of the more important factors Aetna considers when building its provider network. (Radzialowski, Tr. 600).

Response to Finding No. 386

Complaint Counsel has no specific response.

387. Individual providers do not need to provide the full spectrum of care as long as the whole network contains all the options needed for individual pieces of care. (Radzialowski, Tr. 656).

Response to Finding No. 387

Complaint Counsel does not disagree.

388. Aetna considers it essential to have at least one tertiary hospital in its network, but Aetna does not require more than one Lucas County hospital that provides tertiary or higher-level services in its network. (Radzialowski, Tr. 599-600, 657, 743).

Response to Finding No. 388

Complaint Counsel has no specific response.

389. Aetna would be unable to provide an adequate network in Lucas County with St. Luke's alone if it did not also have either TTH or St. Vincent in its network. (Radzialowski, Tr. 743).

Response to Finding No. 389

Complaint Counsel has no specific response.

390. Aetna has contracted with all hospitals in Lucas County since 2006. (Radzialowski, Tr. 670).

Response to Finding No. 390

Complaint Counsel does not disagree.

391. Prior to 2006, Aetna did not contract with UTMC. (Radzialowski, Tr. 670-671).

Response to Finding No. 391

Complaint Counsel has no specific response.

392. Between 2006 and 2008, when Aetna had a broad network and competitors MMO and Anthem only offered narrow networks, membership did not change substantially. (Radzialowski, Tr. 741-742).

Response to Finding No. 392

Complaint Counsel has no specific response.

393. Aetna has not experienced any significant shift in its market share in early 2011. (Radzialowski, Tr. 646).

Response to Finding No. 393

This proposed finding is incorrect. Mr. Radzialowski was testifying that *hospital* market shares in Toledo had not been shifting; he was not discussing Aetna's market share. (Radzialowski, Tr. 645-646).

(iii) National Brand Recognition

394. In contract negotiations with hospitals, Aetna seeks to leverage its national brand image. (Radzialowski, Tr. 659, 744).

Response to Finding No. 394

Complaint Counsel has no specific response.

395. According to Aetna, hospitals like to be able to say "We are an Aetna provider." (Radzialowski, Tr. 659).

Response to Finding No. 395

Complaint Counsel has no specific response.

g. Humana

(i) Company Background and Services Offered

396. Humana is a large, publicly-traded, national healthcare company that offers a diverse range of products and services. (McGinty, Tr. 1224).

Response to Finding No. 396

Complaint Counsel does not disagree.

397. Humana reported revenues from premiums and administrative service fees of $33.2 billion in 2010. (McGinty, Tr. 1224).

Response to Finding No. 397

Complaint Counsel has no specific response.

398. Humana operates in all 50 states, and has approximately 10.2 million covered lives in its government and commercial insurance programs. (McGinty, Tr. 1154-1155, 1225).

Response to Finding No. 398

Complaint Counsel has no specific response.

399. Humana entered the Ohio market in 1997 after its acquisition of the ChoiceCare health plan. (McGinty, Tr. 1155).

Response to Finding No. 399

Complaint Counsel has no specific response.

400. Prior to the ChoiceCare acquisition, Humana offered products to large, self-insured ASO clients and contracted with hospitals and physicians in Ohio to provide access to services for these clients. (McGinty, Tr. 1155).

Response to Finding No. 400

Complaint Counsel has no specific response.

401. Humana has approximately 470,000 members in Ohio covered by its government and commercial programs. (McGinty, Tr. 1225).

Response to Finding No. 401

Complaint Counsel has no specific response.

402. Of the 470,000 persons covered by Humana's commercial and government products in Ohio, approximately 9,000 reside in Lucas County. (McGinty, Tr. 1226)

Response to Finding No. 402

Complaint Counsel has no specific response.

403. Humana offers both a fully insured and a self-insured, ASO, product in Lucas County. (McGinty, Tr. 1228).

Response to Finding No. 403

Complaint Counsel does not disagree.

404. The only health plan product that Humana offers to employers in Lucas County is its ChoiceCare PPO network. (McGinty, Tr. 1228).

Response to Finding No. 404

Complaint Counsel has no specific response.

405. Humana has approximately 2,000 commercially insured members in Lucas County. (McGinty, Tr. 1226). For its commercially insured members, between 2007 and March 2011, Humana had fewer than 100 discharges annually at St. Luke's. (McGinty, Tr. 1228-1229).

Response to Finding No. 405

Complaint Counsel has no specific response.

406. Employers offering Humana's commercial product to their employees in Lucas County include large national companies, like Proctor & Gamble, which have a presence in all 50 states. (McGinty, Tr. 1227-1228).

Response to Finding No. 406

Complaint Counsel has no specific response.

407. { } (PX02073 at 1, *in camera*.)

Response to Finding No. 407

Complaint Counsel does not disagree.

408. Humana considers its commercial volume to define it as a second-tier, or possibly even third-tier, competitor among all MCOs operating in Lucas County. (McGinty, Tr. 1176).

Response to Finding No. 408

Complaint Counsel has no specific response.

409. Humana has approximately 7,000 members in its government Medicare Advantage product in Lucas County. (McGinty, Tr. 1226).

Response to Finding No. 409

Complaint Counsel does not disagree.

410. Humana's Medicare Advantage network is a limited network product that has never included all Lucas County hospitals. (McGinty, Tr. 1199-1200).

Response to Finding No. 410

Complaint Counsel has no specific response.

411. Humana's Medicare Advantage reimbursement rates for both ProMedica and St. Luke's are the same and are consistent with the rates paid by Medicare. (McGinty, Tr. 1220-1221).

Response to Finding No. 411

Complaint Counsel has no specific response.

(ii) Network in Lucas County

412. In constructing its hospital networks, Humana considers price, geographic access, quality, and scope of service. (McGinty, Tr. 1172-1173).

Response to Finding No. 412

Complaint Counsel does not disagree.

413. Humana's strategic vision indicates that in the future it will focus on narrower networks of high-quality, very efficient hospitals. (McGinty, Tr. 1191).

Response to Finding No. 413

Complaint Counsel has no specific response.

414. Humana considers hospitals offering high-end tertiary services to be an essential network component. (McGinty, Tr. 1173).

Response to Finding No. 414

Complaint Counsel has no specific response.

415. Humana currently includes all Lucas County hospitals in its commercial PPO network. (McGinty, Tr. 1234).

Response to Finding No. 415

Complaint Counsel does not disagree.

416. Humana did not experience any active growth of its membership during the period when it offered a broad provider network and MMO and Anthem offered more limited networks. (McGinty, Tr. 1198-99).

Response to Finding No. 416

Complaint Counsel has no specific response.

F. Employers

1. Employers Provide Health Insurance Benefits to Employees

417. Employers may offer multiple health plan products to their employees. (Radzialowski, Tr. 619-620).

Response to Finding No. 417

Complaint Counsel does not disagree.

418. Larger employers typically can offer more health plan options to their employees. (Radzialowski, Tr. 620-621).

Response to Finding No. 418

Complaint Counsel does not disagree.

419. Some employers have exclusive relationships with a particular MCO, meaning that those employers agree only to use that MCO's provider network for their health services. (Sandusky, Tr. 1399-1400)

Response to Finding No. 419

Complaint Counsel does not disagree.

420. Employers may also offer health plan products from more than one insurance company. (Radzialowski, Tr. 619-620; Sandusky, Tr. 1400).

Response to Finding No. 420

Complaint Counsel has no specific response.

421. When an employer offers multiple plans or networks, the employer may price the offerings at different premium levels. (Sandusky, Tr. 1400).

Response to Finding No. 421

Complaint Counsel has no specific response.

2. Fully-Insured vs. Self-Insured Employers

422. For fully-insured health insurance products, health plans charge a fixed premium for a set period of time. (Randolph, Tr. 6920).

Response to Finding No. 422

Complaint Counsel has no specific response.

423. For fully-insured health insurance products, the risk that expenses for healthcare may exceed the premiums collected is typically borne by the health insurer and not the employer. (Radzialowski, Tr. 624; Sandusky, Tr. 1390; Pugliese, Tr. 1430-1431; Pirc, Tr. 2175-2176; Randolph, Tr. 6916-6917).

Response to Finding No. 423

Complaint Counsel has no specific response.

424. Premiums charged to employers for fully insured products are affected by the employer's benefit design and vary by size of employer and age of workforce, among other things. (Randolph, Tr. 6921-6922).

Response to Finding No. 424

Complaint Counsel has no specific response.

425. The premiums charged by the MCO cover various administrative and medical services. (Randolph, Tr. 6917).

Response to Finding No. 425

Complaint Counsel has no specific response.

426. Approximately 90 percent of the premiums that Paramount collects goes towards paying provider medical claims. (Randolph, Tr. 6917).

Response to Finding No. 426

Complaint Counsel has no specific response.

427. Of provider medical claims in both the fully-insured product arena and the self-insured product arena, approximately 30 percent of those expenses are for physician services, 30 percent for outpatient services, approximately 25 percent are for inpatient hospital services, and 15 percent for prescription drug expenses. (Randolph, Tr. 6917-6920).

Response to Finding No. 427

Complaint Counsel has no specific response.

428. Self-insured employers bear the risk that expenses for healthcare may exceed the premiums collected. (Radzialowski, Tr. 624-625; Sandusky, Tr. 1293-1296, 1390; Pugliese, Tr. 1430-1431; Pirc, Tr. 2175-2176; Randolph, Tr. 6917-6919).

Response to Finding No. 428

Complaint Counsel does not disagree.

429. "Self-funded" is another term for self-insured. (Radzialowski, Tr. 628).

Response to Finding No. 429

Complaint Counsel does not disagree.

430. For self-insured products, the employer typically funds an account that the insurer draws upon to pay healthcare expenses. (Pugliese, Tr. 1431).

Response to Finding No. 430

Complaint Counsel does not disagree.

431. An employer who is "partially self-insured" bears the financial risk for employee health benefit claims up to a specified maximum amount; the employer purchases a layer of insurance, reinsurance, or stop-loss insurance to cover any claims that exceed that maximum. (Sandusky, Tr. 1294-1296).

Response to Finding No. 431

Complaint Counsel does not disagree

432. Self-insured employers gain access to the provider network and discounted prices negotiated by health insurance companies. (Pugliese, Tr. 1533-1534; Sandusky, Tr. 1297).

Response to Finding No. 432

Complaint Counsel does not disagree

433. Self-insured employers can design their own benefit plans in accordance with their own requirements and objectives. (Pugliese, Tr. 1534; Sandusky, Tr. 1390, 1395; Randolph, Tr. 6922-6923).

Response to Finding No. 433

Complaint Counsel does not disagree.

434. Some self-insured employers will administer claims themselves; others pay a fee to a third party administrator or to the MCO to handle claims and other administrative functions. (Sandusky, Tr. 1297; Radzialowski, Tr. 630; Pugliese, Tr. 1431; Pirc, Tr. 2273-2274)

Response to Finding No. 434

Complaint Counsel does not disagree.

3. Factors Employers Consider When Choosing a Health Plan

435. For customers, the cost and benefits of the health plan are the most important factors when choosing the health plan. (Randolph, Tr. 6980-6981).

Response to Finding No. 435

Complaint Counsel has no specific response.

436. At the employer level, cost means the premium or medical expense. (Randolph, Tr. 6980-6981).

Response to Finding No. 436

Complaint Counsel has no specific response.

437. At the consumer level, cost refers to the employee contribution, if any. (Randolph, Tr. 6980-6981).

Response to Finding No. 437

Complaint Counsel has no specific response.

438. At the employer level, benefit means the benefit design. (Randolph, Tr. 6981).

Response to Finding No. 438

Complaint Counsel has no specific response.

439. The physician network is the second-most important consideration for customers choosing a health plan. (Randolph, Tr. 6980-6981).

Response to Finding No. 439

Complaint Counsel has no specific response.

440. The health plan service levels and reputation are the next-most important considerations. (Randolph, Tr. 6980-6982).

Response to Finding No. 440

Complaint Counsel has no specific response.

441. Hospital participation is not a primary consideration for customers when choosing their MCO because customers tend not to use hospitals very frequently. For example,

typically only about 6 percent of the commercially-insured go to a hospital in any given year. (Randolph, Tr. 6982-6983).

Response to Finding No. 441

This proposed finding is incomplete, inaccurate, and misleading. In fact, employers testified that they have a strong preference for a broad provider network, including all of the Toledo area hospitals. (*See* CCPFF ¶¶ 634-638). Further, the fact that a relatively small percentage of health plan members go to a hospital in a given year does not mean that access to convenient, high quality hospitals is not important to a much larger percentage of members.

442. Hospital location is not a high magnitude factor for selecting an MCO in Toledo where all hospitals are within 25 minutes of each other. (Randolph, Tr. 6983).

Response to Finding No. 442

This proposed finding is inaccurate and misleading for two reasons. First, Respondent cites to a ProMedica employee's testimony for employer preferences. Second, both employers and health plans universally testified to the importance of hospital location within Lucas County. (CCPFF ¶¶ 216-220, 238, 243, 264-267).

4. Employers Do Not Immediately Face a Change in Healthcare Provider Rates

443. A fully-insured employer may have a contract with a MCO whose duration is anywhere from one to three years. (Pirc, Tr. 2290).

Response to Finding No. 443

Complaint Counsel has no specific response.

a. Fully-Insured Member Rates/Premiums Do Not Change until the Next Contract Renewal with MCO

444. An increase in hospital rates is not immediately felt by fully-insured employers; any such increase can only become effective at the time of a policy renewal. (McGinty, Tr. 1242-1243; Randolph, Tr. 6920).

Response to Finding No. 444

Complaint Counsel has no specific response.

445. A fully-insured employer may have a contract with a MCO whose duration is anywhere from one to three years. (Pirc, Tr. 2290).

Response to Finding No. 445

Complaint Counsel has no specific response.

446. The premiums for fully-insured health insurance products are calculated by a MCO's actuaries and are set for a particular employer or individual member for a specified period of time. (Pugliese, Tr. 1555-1558).

Response to Finding No. 446

Complaint Counsel has no specific response.

447. The premium for fully-insured health insurance product remains the same for the entire term of the contract, even if a provider's reimbursement rates change during the course of the contract. (Pugliese, Tr. 1557-, 1558; Pirc, Tr. 2291; Radzialowski, Tr. 780-781; McGinty, Tr. 1242-1243).

Response to Finding No. 447

This proposed finding is misleading to the extent it suggests that health plans will not ultimately pass along the cost of a provider rate increase to employers. When a health plan incurs a rate increase from a hospital, it will pass down the increased costs to employers in the form of higher premiums. (Radzialowski, Tr. 625-626, 779; PX01938 at 030 (Radzialowski, Dep. at 114), *in camera* ("{

}"); Pugliese, Tr. 1558, 1560; PX01942 at 025 (Pugliese, Dep. at 94), *in camera*; McGinty, Tr. 1210-1211, 1242-1243; Pirc, Tr. 2174; PX01944 at 020 (Pirc, Dep. at 76), *in camera*; Sheridan, Tr. 6701-6702, *in camera*; Town, Tr. 3614; PX02148 at 011- 013 (¶ 18) (Town Expert Report), *in camera*).

448. MCOs pass through increases in provider reimbursement rates, because they do not want to pay out more money in claims than they collect in premiums. (McGinty, Tr. 1245; Pugliese, Tr. 1560; Pirc, Tr. 2291).

Response to Finding No. 448

Complaint Counsel does not disagree

449. MCOs do not always pass through *decreases* in reimbursement rates to members in the form of lower premiums. (Radzialowski, Tr. 785-786; Pugliese, Tr. 1603-1604, *in camera*).

Response to Finding No. 449

This proposed finding is irrelevant because Respondent has not argued that it plans to decrease reimbursement rates to MCOs. Instead, the record overwhelmingly supports the conclusion that ProMedica will have the power to increase reimbursement rates at both St. Luke's and its legacy hospitals. (*See* CCPFF ¶¶ 399-628). In addition, ProMedica has admitted to renegotiating contracts on behalf of St. Luke's that have resulted in rate increases already. (CCPFF ¶ 409).

450. If an MCO anticipates a rate increase, it may build the rate increase into its premium even before it receives any increase from the provider. (Radzialowski, Tr. 780-781). If that anticipated rate increase does not occur, however, Aetna, at least, does not make any adjustments to the premiums it calculated to reduce the cost of the premium. (Radzialowski, Tr. 785-786).

Response to Finding No. 450

This proposed finding is irrelevant, but it is further evidence of the pass through of an increase in hospital reimbursement rates to fully-insured employers in the form of higher premiums.

b. Employers May Decide Not To Pass on Rate Increases to Employees

451. Employers determine the amount of their employees' healthcare costs to pass through to their non-union employees. (Buehrer, Tr. 3086; Pugliese, Tr. 1558-1560; McGinty, Tr. 1245).

Response to Finding No. 451

Complaint Counsel does not disagree.

452. Employers have various options in the face of any premium increase and they may opt not to pass along a price increase to their employees. (Pugliese, Tr. 1559-1560; McGinty, Tr. 1245).

Response to Finding No. 452

This proposed finding is misleading and incomplete. Employers may be forced to account for the increased cost of health care in other ways, such as by reducing wages, laying off employees, or discontining offering health insurance to their employees. (Town, Tr. 3614).

c. Unions Constrain Employers' Ability To Pass through Rates

453. The United Auto Workers' ("UAW") collective bargaining agreements are typically three years in duration. (Lortz, Tr. 1694-1695).

Response to Finding No. 453

Complaint Counsel does not disagree.

454. For the duration of the contract between the UAW and the employer, union members' out-of-pocket healthcare costs cannot change absent an additional or subsequent agreement between the employer and the UAW. (Neal, Tr. 2143-2144).

Response to Finding No. 454

Complaint Counsel has no specific response.

455. Thus, if a healthcare provider like a hospital increased the rates it charged to a health insurance company, UAW employees would not see the effect of that increase until the UAW and the company negotiated a new collective bargaining agreement. (Neal, Tr. 2144).

Response to Finding No. 455

This proposed finding is incomplete and misleading. A collective bargaining agreement may build increases into out-of-pocket healthcare costs during the term of the contract with an additional or subsequent agreement. (RPFF ¶ 454). Alternatively, when the new collective bargaining agreement is negotiated, an employer will shift that increase in cost over the previous contract to the employees. (Lortz, Tr. 1713).

456. The UAW negotiates the level of healthcare benefits with the employer, then the employer negotiates with the health plan. (Lortz, Tr. 1720; Caumartin, Tr. 1867-1868).

Response to Finding No. 456

Complaint Counsel does not disagree.

457. The UAW must agree to any benefit program that an employer implements on behalf of UAW members. (Neal, Tr. 2105).

Response to Finding No. 457

Complaint Counsel does not disagree.

458. The UAW can encourage the employer to use certain healthcare providers. (Lortz, Tr. 1736).

Response to Finding No. 458

This proposed finding is misleading to the extent it suggests that employers or unions are creating networks of healthcare providers for their employees to use. Health plans contract with healthcare providers to create a provider network and then the employer contracts with a health plan to provide benefits to employees. (CCPFF ¶¶ 76-80). The UAW does not select the health plan with whom the employer contracts and so, as a result, can not choose which healthcare providers are in- or out-of-network. (Lortz, Tr. 1703-1704).

5. Employers Do Not Negotiate Directly with Hospitals

459. Employers do not negotiate directly with hospitals; they rely on health insurance companies to do that. (Neal, Tr. 2106, 2145; Caumartin, Tr. 1838-1839, 1872; Buehrer, Tr. 3062; Radzialowski, Tr. 623-624; McGinty, Tr. 1239; Pugliese, Tr. 1547; Pirc, Tr. 2282-2283).

Response to Finding No. 459

Complaint Counsel does not disagree.

460. Employers rely on MCOs to develop the network of providers that members can access. (Neal, Tr. 2144; Buehrer, Tr. 3066-3067; Town, Tr. 3955).

Response to Finding No. 460

Complaint Counsel does not disagree.

6. Employers May Not Negotiate Directly with MCOs

461. Employers use consultants to solicit and evaluate health plans which MCOs offer. (Neal, Tr. 2092).

Response to Finding No. 461

Complaint Counsel does not disagree.

462. Consultants assist employers in selecting and negotiating with MCOs to create a benefit design that meets the employer's needs for network access and cost. (Caumartin, Tr. 1836, 1839, 1842-1843, 1848, 1853, 1855-1856, 1867-1868, 1873; Randolph, Tr. 6925-6926).

Response to Finding No. 462

Complaint Counsel does not disagree.

G. Physicians

463. Physicians play a key role in determining where a patient receives general acute care inpatient services. (Pirc, Tr. 2281-2282; Andreshak, Tr. 1772-1773).

Response to Finding No. 463

This proposed finding is misleading. Patient preference plays a central role in where a patient receives general acute-care inpatient services. (CCPFF ¶¶ 599-608).

464. Multiple factors determine where a physician chooses to admit his patients. (Gbur, Tr. 3107-3108; Andreshak, Tr. 1771-1774).

Response to Finding No. 464

Complaint Counsel does not disagree, but notes that patient preference is one of the key factors in this decision. (CCPFF ¶¶ 599-608).

465. Physicians are mindful of the expenses patients face . (Guerin-Calvert, Tr. 7357). They will consider whether a hospital is in-network for the patient's insurance when deciding which hospital to select for the patient's treatment. (Read, Tr. 5293). Physicians also have access to various tools that permit them to compare relative hospital costs. (Guerin-Calvert, Tr. 7357-7358).

Response to Finding No. 465

This proposed finding is misleading. Physicians are mindful of the expenses patients face, but do not know the rate hospitals charge health plans for services and do not have the ability to steer patients to defeat a rate increase by a hospital. (CCPFF ¶¶ 612-628).

466. Patients typically seek services from the hospital their physician suggests. (Gbur, Tr. 3123; Town, Tr. 3632).

Response to Finding No. 466

Complaint Counsel has no specific response.

467. Over 1,000 physicians in the Toledo area admit patients to Lucas County hospitals. (Town, Tr. 4094; RX-71(A) at 000022, *in camera*).

Response to Finding No. 467

Complaint Counsel has no specific response.

H. Competitive Landscape

468. Hospitals in Lucas County compete on the basis of the range of services offered, clinical quality, amenities, cost, location, visibility, physician location, and patient experience, among others, to attract patients. (JX-2 at 002.).

Response to Finding No. 468

Complaint Counsel does not disagree.

1. Provider/MCO Contracting

a. Medicare and Medicaid Reimburse Hospitals below Their Total Cost of Care

469. Medicare and Medicaid comprise over 41 percent of ProMedica's payor mix. (PX00009 at 044).

Response to Finding No. 469

Complaint Counsel has no specific response.

470. {

} (Wachsman, Tr. 4943-4944, *in camera*).

Response to Finding No. 470

Complaint Counsel has no specific response.

471. {

(Wachsman, Tr. 4943, *in camera*).

Response to Finding No. 471

Complaint Counsel has no specific response.

472. {

} (Wachsman, Tr. 4944, *in camera*).

Response to Finding No. 472

Complaint Counsel has no specific response.

473. {

} (Wachsman, Tr. 4944-4945, *in camera*).

Response to Finding No. 473

Complaint Counsel has no specific response.

474. In fact, the State of Ohio plans to institute increases in the Medicaid franchise fees paid by hospitals and to reduce the Medicaid payments to Ohio hospitals. The Ohio Hospital Association recently estimated the net fiscal impact of the increased franchise fees and reductions in Medicaid reimbursements to St. Luke's. The estimated impact on St. Luke's over the next two years is an additional loss of approximately $3 million. (RX-56 at 000014-000015; RX-1279 at 000001-000002).

Response to Finding No. 474

Complaint Counsel has no specific response.

b. Shortfalls in Medicare and Medicaid Reimbursement Require Cost-Shifting to MCOs

475. Hospitals must make up the shortfall from Medicare and Medicaid reimbursements with payments from MCOs. (Guerin-Calvert, Tr. 7304, 7936).

Response to Finding No. 475

Complaint Counsel has no specific response.

476. The cost and cost structure of hospitals affect negotiations between hospitals and MCOs, because hospitals with higher fixed costs will seek higher rates from MCOs. (Guerin-Calvert, Tr. 7180-7181).

Response to Finding No. 476

Complaint Counsel has no specific response.

477. Hospitals for whom Medicare and Medicaid patients represent a substantial portion of admissions will also seek higher rates from MCOs. (Guerin-Calvert, Tr. 7302-7305, 7352).

Response to Finding No. 477

This proposed finding is misleading. While ProMedica's rates are the highest in Lucas County, ProMedica treats the lowest share of Medicare patients among the hospitals in Lucas County, and while St. Luke's rates are the lowest in Lucas County, St. Luke's treats the highest share of Medicare patients among the hospitals in Lucas County. (PX01850 at 045 (¶ 68) (Town Rebuttal Report), *in camera*). Also, the evidence indicates that ProMedica bargains aggressively to obtain the highest rates it can from third-party health plans. (*See* CCPFF ¶¶ 445-456)

478. Medicare and Medicaid reimbursement to hospitals as a percentage of the hospitals'' cost of treating Medicare and Medicaid patients has declined since 2000. (Guerin-Calvert, Tr. 7302-7303).

Response to Finding No. 478

Complaint Counsel has no specific response.

479. In addition, Medicare cuts have already been implemented under new healthcare laws. (Guerin-Calvert, Tr. 7307-7308).

Response to Finding No. 479

Complaint Counsel has no specific response.

c. All Hospitals, For Profit and Not-for-Profit, Must Earn a Margin above Their Direct and Indirect Costs To Stay in Business.

480. There is no difference in the way that for-profit and not-for-profit hospitals negotiate with MCOs. (Radzialowski, Tr. 670; Sandusky, Tr. 1330; McGinty, Tr. 1239; Pugliese, Tr. 1462-1463; Pirc, Tr. 2212-2213; Sheridan, Tr. 6684).

Response to Finding No. 480

Complaint Counsel has no specific response.

481. Non-profit and for-profit hospitals both have a margin of revenue that they need and aim to achieve. (Radzialowski, Tr. 670).

Response to Finding No. 481

Complaint Counsel has no specific response.

482. Hospitals in and around Lucas County seek to maximize the reimbursement they receive from MCOs in order to cover their total cost of caring for their patients, which tends to increase over time, and yield an operating margin to fund capital expenditures, expansion, and maintain a strong balance sheet. (Gold, Tr. 209-210, 265-266, 268; Korducki, Tr. 539, 547-549, 554; Beck, Tr. 432, 434; Shook, Tr. 950, 1050).

Response to Finding No. 482

Complaint Counsel has no specific response.

(i) ProMedica

483. ProMedica's costs of providing care have increased in recent years for expenses such as construction costs, equipment costs, pharmaceutical costs, physician salaries, employee health costs and employee salaries. (Oostra, Tr. 5834-5835).

Response to Finding No. 483

Complaint Counsel has no specific response.

484. With reductions in government reimbursement and the increasing pressure of rising expenses, ProMedica is faced with the challenge of covering its costs. (Oostra, Tr. 5835).

Response to Finding No. 484

Complaint Counsel has no specific response.

485. {

} (Wachsman, Tr. 4945-4946, *in camera*).

Response to Finding No. 485

Complaint Counsel has no specific response.

486. {

} (Wachsman, Tr. 4946, *in camera*).

Response to Finding No. 486

Complaint Counsel has no specific response.

487. { }

(RX-1854 at 000005, *in camera*).

Response to Finding No. 487

Complaint Counsel has no specific response.

488. {

}

(Wachsman, Tr. 4947-4948, *in camera*).

Response to Finding No. 488

Complaint Counsel has no specific response.

489. {

} (Wachsman, Tr. 4948, *in camera*).

Response to Finding No. 489

Complaint Counsel has no specific response.

490. {

} (Wachsman, Tr. 4949, *in camera*).

Response to Finding No. 490

Complaint Counsel has no specific response.

491. {

} (RX-1854 at 000005, *in camera*; Wachsman, Tr. 4949-4950, *in camera*).

Response to Finding No. 491

This proposed finding is misleading. ProMedica does not restrain itself from exceeding these cost-coverage targets with respect to third-party MCOs. For example, ProMedica's average cost-coverage ratio for third-party commercial health plans exceeded { } in June of 2010. (*See* CCPFF ¶¶ 445-451).

492. {
} (RX-18 (Marcus, Dep. at 172-173, *in camera*)).

Response to Finding No. 492

Complaint Counsel has no specific response.

493. {
}(Wachsman, Tr. 4950-4951, *in camera*; PX00233 at 001, *in camera*).

Response to Finding No. 493

This proposed finding is misleading with respect to Paramount, which obtains preferential reimbursement rates from ProMedica because of their common ownership and because Paramount's profitability directly impacts ProMedica's bottom line. (*See* CCPFF ¶¶ 14, 468-470).

494. {
} (RX-18 (Marcus, Dep. at 172, *in camera*)).

Response to Finding No. 494

This proposed finding is contradicted by the evidence. ProMedica contracted with Anthem to have St. Luke's excluded from Anthem's network while allowing UTMC to remain in

Anthem's network. (CCPFF ¶¶ 117, 366-376; Pugliese, Tr. 1538-1539). While conceding to Anthem's addition of Mercy at the beginning of 2008, ProMedica bargained vigorously to delay St. Luke's entry into Anthem's provider network until July 2009, deeming the issue to be the "main deal breaker" in its negotiations with Anthem. (CCPFF ¶ 372).

495. { } (Wachsman, Tr. 4952-4953, *in camera*).

Response to Finding No. 495

Complaint Counsel has no specific response.

496. ProMedica believes these target cost coverage ratio levels are necessary so that on average for all patients, the ProMedica hospitals can recover their full operating expenses, including unfunded charity and government insurance shortfalls, and achieve a small positive operating margin of about 3 to 4 percent or an overall cost coverage ratio of 103-104 percent. (RX-1854 at 000006, *in camera*; Guerin-Calvert, Tr. 7936; Hanley, Tr. 4505-4506).

Response to Finding No. 496

This proposed finding is misleading. ProMedica's operating margin through September 10, 2010 was over 6 percent, a fact significant enough to be presented by ProMedica to investors in January 2011. (CCPFF at ¶ 453).

(ii) Mercy

497. Mercy tries to obtain the most favorable rates possible when negotiating with MCOs. (Shook, Tr. 950, 1050).

Response to Finding No. 497

Complaint Counsel has no specific response.

498. Mercy does this so it can cover its direct and indirect costs of delivering care, as well as the costs of providing indigent and charity care consistent with its religious mission. (Shook, Tr. 950, 1050).

Response to Finding No. 498

Complaint Counsel has no specific response.

(iii) UTMC

499. UTMC also seeks to maximize the reimbursement rates it receives from MCOs so that UTMC can cover its direct and indirect costs, including its indigent and charity care costs, and to have access to capital for expansion and to maintain a strong balance sheet. (Gold, Tr. 209, 210, 265-266, 268).

Response to Finding No. 499

Complaint Counsel has no specific response.

500. Another reason UTMC seeks to maximize its reimbursement is because it financially supports the University of Toledo's academic mission. (Gold, Tr. 266-267).

Response to Finding No. 500

Complaint Counsel has no specific response.

501. UTMC aims to earn a profit and perform with a positive operating margin each year. (Gold, Tr. 207).

Response to Finding No. 501

Complaint Counsel has no specific response.

502. UTMC has met its goal and has had positive operating margins for each of the years from 2007 to 2010. (Gold, Tr. 269).

Response to Finding No. 502

Complaint Counsel has no specific response.

503. Notwithstanding a positive bottom line for the past four years, UTMC has certain service lines that are not profitable. (Gold, Tr. 270).

Response to Finding No. 503

Complaint Counsel has no specific response.

504. As UTMC's costs have risen over time, UTMC has also raised the rates that it charged to MCOs. (Gold, Tr. 271).

Response to Finding No. 504

Complaint Counsel has no specific response.

d. Common MCO-Provider Contracting Terminology and Provisions

505. "Member" or "insured" is the term used to refer to the person who is covered by a particular payor's insurance plan. (Radzialowski, Tr. 616-617).

Response to Finding No. 505

Complaint Counsel has no specific response.

506. The member may choose the insurance plan or, in some cases, the choice of a plan may be made by an employer for all of its employees. (Radzialowski, Tr. 617)

Response to Finding No. 506

Complaint Counsel has no specific response.

507. "HMO" stands for Health Maintenance Organization. (Radzialowski, Tr. 609).

Response to Finding No. 507

Complaint Counsel has no specific response.

508. An HMO is a collaborative product where a member is supposed to work through a primary care physician ("PCP"), who is the gatekeeper for his or her care and ensures coordination among all healthcare providers. (Radzialowski, Tr. 609; Randolph, Tr. 6895).

Response to Finding No. 508

Complaint Counsel has no specific response.

509. HMOs traditionally required members to obtain referrals from their PCPs, before they could obtain care from specialists. (Radzialowski, Tr. 610).

Response to Finding No. 509

Complaint Counsel has no specific response.

510. HMOs have evolved over the years and some HMOs today have fewer restrictions than the traditional HMOs did. (Radzialowski, Tr. 610).

Response to Finding No. 510

Complaint Counsel has no specific response.

511. In a pure HMO product, if a member goes to a non-preferred provider, they receive no benefits. (Radzialowski, Tr. 614).

Response to Finding No. 511

Complaint Counsel has no specific response.

512. "PPO" stands for Preferred Provider Organization. (Radzialowski, Tr. 612).

Response to Finding No. 512

Complaint Counsel has no specific response.

513. In a PPO plan, members receive a list of preferred or "in-network" providers. If they obtain care from one of the listed providers, their out-of-pocket costs are lower than if they see a provider that is not on the list (e.g., an "out-of-network" provider). (Radzialowski, Tr. 612).

Response to Finding No. 513

Complaint Counsel has no specific response.

514. MCOs also offer POS plans. These plans vary from MCO to MCO, but are generally less restrictive than an HMO and more restrictive than a PPO. (Radzialowski, Tr. 613).

Response to Finding No. 514

Complaint Counsel has no specific response.

515. In a POS plan, some out-of-network providers are available to the member, at a higher coinsurance level. (Randolph, Tr. 6895).

Response to Finding No. 515

Complaint Counsel has no specific response.

516. In a point-of-service plan, a member is encouraged to have a primary care physician as gatekeeper, but this is not a requirement. (Radzialowski, Tr. 614).

Response to Finding No. 516

Complaint Counsel has no specific response.

517. "CDHP" stands for Consumer Driven Health Plan, or Consumer Directed Health Plan. (Randolph, Tr. 6910).

Response to Finding No. 517

Complaint Counsel has no specific response.

518. A CDHP is characterized by more consumer involvement in their healthcare and wellness. (Randolph, Tr. 6910).

Response to Finding No. 518

Complaint Counsel has no specific response.

519. A CDHP is often coupled with a health savings account, to set aside funds for various health-related expenditures. (Randolph, Tr. 6911).

Response to Finding No. 519

Complaint Counsel has no specific response.

520. In a traditional indemnity plan, there are no restrictions on the medical care that is received. The MCO will pay whatever the hospital bills. (Radzialowski, Tr. 615-161).

Response to Finding No. 520

Complaint Counsel has no specific response.

521. A hospital chargemaster is a list of the prices for the hospital's services. (Radzialowski, Tr. 761; Randolph, Tr. 6959).

Response to Finding No. 521

Complaint Counsel has no specific response.

522. Provider contracts may include a negotiated annual inflation escalator. (Radzialowski, Tr. 761; Sandusky, Tr. 1320; Wachsman, Tr. 4905).

Response to Finding No. 522

Complaint Counsel has no specific response.

523. The negotiated escalators may be based on an index like one of the U.S. Department of Labor's official Consumer Price Indexes. (Sandusky, Tr. 1320).

Response to Finding No. 523

Complaint Counsel has no specific response.

524. { } (Sandusky, Tr. 1354, *in camera*; Sheridan, Tr. 6663-64, *in camera*).

Response to Finding No. 524

Complaint Counsel has no specific response.

525. {

} (Sandusky, Tr. 1354, *in camera*).

Response to Finding No. 525

Complaint Counsel has no specific response.

526. Coordination of benefits provisions determine what happens when a patient is covered by more than one insurance policy or MCO. The provisions determine how much each MCO will reimburse. (Radzialowski, Tr. 762-63).

Response to Finding No. 526

Complaint Counsel has no specific response.

527. {

} (Radzialowski, Tr. 801, *in camera*).

Response to Finding No. 527

Complaint Counsel has no specific response.

528. {

} (Radzialowski, Tr. 801, *in camera*).

Response to Finding No. 528

Complaint Counsel has no specific response.

529. A carve-out is a clustering of services within the contract that are paid differently than the majority of services in the contract. (Town, Tr. 3637-3638).

Response to Finding No. 529

Complaint Counsel has no specific response.

530. Antidiscrimination contract language may provide that a MCO cannot market or promote one provider over another, or that a MCO cannot establish new products that are not covered by the current contract. (Wachsman, Tr. 4874).

Response to Finding No. 530

Complaint Counsel has no specific response.

531. MCO definition contract provisions identify the official members of the health plan, which determine who can benefit from the discount ProMedica provides to the MCO. (Wachsman, Tr. 4882-4883).

Response to Finding No. 531

Complaint Counsel has no specific response.

532. "Medical necessity" contract provisions relate to when an MCO can or cannot deny payment for a claim based upon certain authorization criteria. (Wachsman, Tr. 4883-4884).

Response to Finding No. 532

Complaint Counsel has no specific response.

533. Contracts include clauses indicating circumstances that may cause technical denial of payment. (Wachsman, Tr. 4885).

Response to Finding No. 533

Complaint Counsel has no specific response.

534. Contracts contain billing provisions, which state the timeframe in which ProMedica must bill the MCO for a claim in order to receive reimbursement. (Wachsman, Tr. 4885).

Response to Finding No. 534

Complaint Counsel has no specific response.

535. Contract terms related to access to records determine the extent to which a MCO may access medical records from the provider. (Wachsman, Tr. 4898).

Response to Finding No. 535

Complaint Counsel has no specific response.

536. The contract term identifies the length of time in which the contract is in force, such as one-year or multiyear terms. (Wachsman, Tr. 4899).

Response to Finding No. 536

Complaint Counsel has no specific response.

537. Audit provisions in contracts set forth the MCO's ability to go back in time and readjudicate a claim after it has been paid. (Wachsman, Tr. 4899).

Response to Finding No. 537

Complaint Counsel has no specific response.

538. Reimbursement methodology is a term that is discussed in contract negotiations. (Wachsman, Tr. 4899).

Response to Finding No. 538

Complaint Counsel has no specific response.

539. "DRG" stands for Diagnosis Related Group. It is a billing methodology that was implemented by Medicare in the 1970s and 1980s and is commonly used today by MCOs. (Radzialowski, Tr. 673; Pugliese, Tr. 1473).

Response to Finding No. 539

Complaint Counsel has no specific response.

540. A DRG code is assigned to a patient based on the event or services that the patient obtained. (Guerin-Calvert, Tr. 7161)

Response to Finding No. 540

Complaint Counsel has no specific response.

541. A patient and their physician do not necessarily know, in advance, which DRG the patient will be coded. (Guerin-Calvert, Tr. 7162).

Response to Finding No. 541

Complaint Counsel has no specific response.

542. The DRG reimbursement methodology is geared toward cases that have a lower level of charges than cases that fall into outlier categories. (Wachsman, Tr. 4904).

Response to Finding No. 542

Complaint Counsel has no specific response.

543. There are some 400 to 500 individual DRG codes. (Radzialowski, Tr. 674).

Response to Finding No. 543

This proposed finding is incorrect. There are approximately 747 individual DRG codes.

(PX02148 at 022-023 (n. 53) (Town Expert Report), *in camera*).

544. Sets of DRGs can be grouped together into service lines (e.g., MS-DRGs). (Guerin-Calvert, Tr. 7162).

Response to Finding No. 544

This proposed finding is incorrect. DRGs are grouped by medical diagnosis category ("MDC"), with each MDC generally corresponding to an organ system. (Town, Tr. 4011-4012).

545. MCOs and hospitals may negotiate a fixed price list that is based on the DRG codes. (Sandusky, Tr. 1319-1320).

Response to Finding No. 545

Complaint Counsel has no specific response.

546. Outlier threshold contract provisions protect providers against catastrophic cases that incur charges outside the range of services covered by a DRG rate by providing reimbursement for those cases that reach outlier status. (Wachsman, Tr. 4901-4902).

Response to Finding No. 546

Complaint Counsel has no specific response.

547. The DRG rate alone does not fully represent a contract's reimbursement level because a high outlier methodology may cause cases that exceed the DRG rate, but fall short of the outlier threshold, to go unpaid. (Wachsman, Tr. 4903-4904).

Response to Finding No. 547

Complaint Counsel has no specific response.

548. In general, ProMedica's MCO contracts cover inpatient rates and outpatient rates. (Wachsman, Tr. 4906).

Response to Finding No. 548

Complaint Counsel has no specific response.

549. ProMedica's MCO contracts typically include separate sections covering access to ancillary services, which are providers that are not part of the traditional hospital unit. (Wachsman, Tr. 4906).

Response to Finding No. 549

Complaint Counsel has no specific response.

550. Ancillary services include physician services and facility services that are not part of the hospital, including long-term care facilities, home health services, durable medical equipment, pharmacy services, and outpatient surgery centers. (Wachsman, Tr. 4906).

Response to Finding No. 550

Complaint Counsel has no specific response.

551. Rates for ancillary services are separate from the inpatient and outpatient rates in a contract, and there is a rate attached to each ancillary service. (Wachsman, Tr. 4906).

Response to Finding No. 551

Complaint Counsel has no specific response.

e. Description/Implications of In-Network v. Out-of-Network Status

552. MCOs contract with physicians, hospitals and ancillary providers to create a network. Their members receive the highest level of benefits when using this network of healthcare providers. (Radzialowski, Tr. 584; Pirc, Tr. 2176-2177).

Response to Finding No. 552

Complaint Counsel has no specific response.

553. A hospital provider network is comprised of those hospitals with which an MCO has reimbursement contracts. The MCO's members may select these hospitals for medical care. (Radzialowski, Tr. 583).

Response to Finding No. 553

Complaint Counsel has no specific response.

554. A physician provider network is the group of physicians with which an MCO has contracts to provide care to its members. (Radzialowski, Tr. 584).

Response to Finding No. 554

Complaint Counsel has no specific response.

555. When MCOs build a physician provider network, they approach physician groups with a proposed fee schedule and contract. (Randolph, Tr. 6930).

Response to Finding No. 555

Complaint Counsel has no specific response.

556. "In-network" refers to physicians and hospitals that are part of an MCO's network and hold contracts with the MCO. (Radzialowski, Tr. 584; Randolph, Tr. 6933).

Response to Finding No. 556

Complaint Counsel has no specific response.

557. Ancillary providers include skilled nursing facilities, durable medical equipment companies, and others. (Randolph, Tr. 6931).

Response to Finding No. 557

Complaint Counsel has no specific response.

558. MCOs also contract with providers for pharmaceutical benefits for their members, though some MCOs subcontract with pharmacy benefit managers to provide pharmacy services to their members. (Randolph, Tr. 6931).

Response to Finding No. 558

Complaint Counsel has no specific response.

559. MCOs seek to negotiate the lowest reimbursement rates that they can achieve. (Radzialowski, Tr. 750; McGinty, Tr. 1240; Pugliese, Tr. 1553; Pirc, Tr. 2211-2112).

Response to Finding No. 559

Complaint Counsel has no specific response.

560. MCOs ensure that their plans contain financial incentives that encourage employees to use in-network providers instead of out-of-network providers. (Sandusky, Tr. 1395-1396).

Response to Finding No. 560

Complaint Counsel has no specific response.

561. Providing financial incentives for in-network providers drives more patient volume to these providers and increases an MCO's bargaining leverage with in-network providers. (Sandusky, Tr. 1395-1397).

Response to Finding No. 561

Complaint Counsel has no specific response.

562. Hospital networks that include all hospitals in a given area may be more costly than narrower networks. (Radzialowski, Tr. 657-658; McGinty, Tr. 1262).

Response to Finding No. 562

Complaint Counsel has no specific response.

563. Narrower networks drive more volume to the in-network hospitals and those hospitals will agree to more favorable reimbursement terms in exchange for that increased volume. (Radzialowski, Tr. 657-58).

Response to Finding No. 563

Complaint Counsel has no specific response.

564. Patients prefer to have access to a broad network of hospitals and physicians. (Pugliese, Tr. 1544; Pirc, Tr. 2281).

Response to Finding No. 564

Complaint Counsel has no specific response.

565. Insureds are willing to pay a higher premium for plans that have broad provider networks than they are for plans that have narrower provider networks. (Pirc, Tr. 2282).

Response to Finding No. 565

Complaint Counsel has no specific response.

566. Employers have different preferences for plan networks that balance broad access and lower cost. (Radzialowski, Tr. 665; McGinty, Tr. 1262, 1263; Pirc, Tr. 2214-2215; Randolph, Tr. 6943).

Response to Finding No. 566

Complaint Counsel has no specific response.

567. Smaller, local businesses tend to be more open to a restricted network due to the cost savings associated with smaller networks. (Radzialowski, Tr. 772).

Response to Finding No. 567

Complaint Counsel has no specific response.

f. Reimbursement Methodologies

568. Contracts with Lucas County hospitals may contain many different reimbursement methods. (Radzialowski, Tr. 672; Randolph, Tr. 6955-6956).

Response to Finding No. 568

Complaint Counsel has no specific response.

(i) Per Diems

569. One reimbursement method is a per diem, where the MCO pays a daily rate for all care the hospital provides to a member on that day. (Radzialowski, Tr. 672; Town, Tr. 3639; Randolph, Tr. 6955; Wachsman, Tr. 4900).

Response to Finding No. 569

Complaint Counsel has no specific response.

570. Per diem rates at tertiary hospitals apply to both the tertiary and less complex services that the hospital offers and can be higher than per diems at other non-tertiary hospitals as a result. (Radzialowski, Tr. 767).

Response to Finding No. 570

Complaint Counsel has no specific response.

(ii) DRG Case Rates

571. Contracts also may use DRG case rates, which is an all inclusive rate that the hospital is paid for that patient admission, regardless of the number of days the patient stays in the hospital or the amount of resources the hospital uses for the patient's care. (Radzialowski, Tr. 673; Randolph, Tr. 6955).

Response to Finding No. 571

Complaint Counsel has no specific response.

572. {

}(Pirc, Tr. 2218-2219, *in camera*).

Response to Finding No. 572

Complaint Counsel has no specific response.

573. {

}(Pirc, Tr. 2219, *in camera*).

Response to Finding No. 573

Complaint Counsel has no specific response.

574. The higher the DRG case weight, the higher on average are the resources and costs to treat a patient in that DRG. (Town, Tr. 3989).

Response to Finding No. 574

Complaint Counsel has no specific response.

575. Some contracts that utilize DRG case rates also have stop-loss clauses that protect the hospital in cases where more services are required and the cost for care exceeds the DRG amount. In contracts with such clauses, where charges exceed a negotiated threshold, the MCO makes additional reimbursements pursuant to negotiated terms. (Radzialowski, Tr. 677-678).

Response to Finding No. 575

Complaint Counsel has no specific response.

576. {

}(Sheridan, Tr. 6638, *in camera*).

Response to Finding No. 576

Complaint Counsel has no specific response.

(iii) Percent-of-Charge

577. Percent-of-charge is another reimbursement method. (McGinty, Tr. 1195; Randolph, Tr. 6955).

Response to Finding No. 577

Complaint Counsel has no specific response.

578. For the percent-of-charge method, MCOs and providers negotiate a percentage rate. Hospitals then bill from their chargemaster and MCOs reimburse the negotiated percentage rate of that price. (McGinty, Tr. 1195; Town, Tr. 3639).

Response to Finding No. 578

Complaint Counsel has no specific response.

579. The reimbursement that is negotiated for outlier cases is typically a percentage of charge. (Wachsman, Tr. 4902).

Response to Finding No. 579

Complaint Counsel has no specific response.

(iv) Fee-for-Service

580. Another reimbursement methodology is fee-for-service, where for every service rendered by the provider, the MCO pays a fee associated with that service. (Radzialowski, Tr. 673).

Response to Finding No. 580

Complaint Counsel has no specific response.

581. The fee-for-service methodology is more common for outpatient services than for inpatient services that hospitals provide. (Radzialowski, Tr. 673).

Response to Finding No. 581

Complaint Counsel has no specific response.

(v) MCO and Provider Preferences

582. MCOs believe that the providers prefer percent-of-charge contracts while MCOs prefer fixed-price contracts. (PX01902 (Sheridan, IHT at 41, *in camera*); McGinty, Tr. 1195-1196).

Response to Finding No. 582

Complaint Counsel has no specific response.

583. { } (RX-47 (Sheridan, IHT at 41), *in camera*).

Response to Finding No. 583

Complaint Counsel has no specific response.

584. ProMedica's current contracts typically provide for a mix of fixed pricing and percent of charge reimbursements across all services. (PX00091 at 008, *in camera*; PX00093 at 008, *in camera*; PX00095 at 008, *in camera*; PX02533 at 034, in camera; RX-1665 at 000005, *in camera*; RX-1886 at 000003, *in camera*; RX-1882 at 000003, *in camera*; RX-1890 at 000003, *in camera*; PX00365 at 030, *in camera*; Wachsman, Tr. 4916-4917; PX02118 at 001, *in camera*).

Response to Finding No. 584

Complaint Counsel has no specific response.

g. Dynamics of Negotiations

585. MCOs approach contract negotiations with a view toward the overall cost for inpatient, outpatient and all other services for their entire patient base at a particular hospital or hospital system. (Radzialowski, Tr. 759-760; Sheridan, Tr. 6627-6628).

Response to Finding No. 585

This proposed finding is incomplete. Inpatient hospital rates are easily one of the most important components of the total amount of reimbursement that health plans pay to hospitals. (Pirc, Tr. 2292; Pugliese, Tr. 1560-1561; Radzialowski, Tr. 782-783).

586. In addition to rates, MCOs negotiate other contract terms with hospital providers, such as the length of contract, operational parameters such as claims payment, medical necessity reviews, and appeal mechanisms. (Randolph, Tr. 6950-6951).

Response to Finding No. 586

This proposed finding is incomplete. Notwithstanding these other contract terms, reimbursement rates are the most important point of negotiation between health plans and hospitals. (CCPFF ¶ 124).

587. In negotiations with providers, MCOs will accept higher rates in one particular service if they can offset that cost with lower rates for a different service. (Randolph, Tr. 6954; Pirc, Tr. 2287-2288; Radzialowski, Tr. 758; Sheridan, Tr. 6627-6628).

Response to Finding No. 587

This proposed finding is incomplete. The fact that inpatient rates and outpatient rates are negotiated at the same time does not give health plans greater bargaining leverage against hospitals. (Radzialowski, Tr. 661). ProMedica's persistently high inpatient rates have not been offset by lower outpatient rates, or vice versa. (RX-216 (Comparison of 2008-2009 Discount Rates), *in camera*; Sandusky, Tr. 1338-1348, *in camera*). Moreover, the Acquisition has { } with respect to both inpatient and outpatient rates. (PX01944 at 013-014 (Pirc, Dep. at 49-50), *in camera*).

(i) MCOs Have Access to Hospital Costs and Billed Amounts

588. Medicare requires every hospital to file a cost report annually. (Radzialowski, Tr. 598).

Response to Finding No. 588

Complaint Counsel has no specific response.

589. MCOs review the publicly available Medicare cost-to-charge ratios to assess the actual cost of care at individual hospitals. (Radzialowski, Tr. 598).

Response to Finding No. 589

Complaint Counsel has no specific response.

590. MCOs also review their own claims data, Ingenix data, and data from pricing partners to assess the market. (Sheridan, Tr. 6623).

Response to Finding No. 590

Complaint Counsel has no specific response.

591. Ingenix is a claims warehouse organization that stores claims data and provides MCOs access to the data. (Sheridan, Tr. 6623).

Response to Finding No. 591

Complaint Counsel has no specific response.

592. All MCOs have access to their own claims paid data that they can review to determine whether they are paying competitive rates in a given area. (Sheridan, Tr. 6625-6626).

Response to Finding No. 592

Complaint Counsel has no specific response.

(ii) Competitor Rates and Network Configurations Can Be Estimated By MCOs

593. MCOs can roughly assess how the rates they negotiate with a provider compare to their competitor's rates by analyzing coordination of benefits data. (Pirc, Tr. 2285).

Response to Finding No. 593

Complaint Counsel has no specific response.

594. MCOs compare their competitor's provider networks by using publicly available directory information on competitor websites. (Radzialowski, Tr. 599; Randolph, Tr. 6985).

Response to Finding No. 594

Complaint Counsel has no specific response.

595. Employers and insurance agents and brokers inform MCOs as to how their rates roughly compare to competitors' rates. (Randolph, Tr. 6924).

Response to Finding No. 595

Complaint Counsel has no specific response.

(iii) The "Most Favored Nation" Clauses Demanded by MCOs Constrain Rate Negotiations

596. A most-favored nation ("MFN") clause is a contractual provision that prohibits a hospital provider who has agreed to rates with one MCO from agreeing to lower rates with competing MCOs unless they also extend the same rates to the first MCO. (Pugliese, Tr. 1549, 1580).

Response to Finding No. 596

Complaint Counsel has no specific response.

597. MFN clauses give the MCO the ability to perform an audit to ensure that competing MCOs are not receiving a lower rate. (Wachsman, Tr. 4907-4908).

Response to Finding No. 597

Complaint Counsel has no specific response.

598. MFN clauses affect rates because the contract with the MCO that has the MFN clause may result in lower rates from the provider in that contract, but it can also result in higher rates in the contract of other MCOs. (Guerin-Calvert, Tr. 7458-7459).

Response to Finding No. 598

Complaint Counsel has no specific response.

599. MFN clauses are also referred to as "modified rate clauses" or "equally favored rate" clauses. (Pugliese, Tr. 1578).

Response to Finding No. 599

Complaint Counsel has no specific response.

600. Several Lucas County provider contracts contain MFN clauses. (Pugliese, Tr. 1549).

Response to Finding No. 600

Complaint Counsel has no specific response.

601. Anthem has MFN clauses in its contracts with ProMedica and St. Luke's. (Pugliese, Tr. 1579; PX00091 at 005, *in camera*; PX00093 at 005, *in camera*; PX00095 at 004-005, *in camera*; PX02237 at 010, *in camera*).

Response to Finding No. 601

Complaint Counsel has no specific response.

602. { } (Pirc, Tr. 2330-2331, *in camera*; RX-327 at 000005, *in camera*; RX-321 at 000005, *in camera*; RX-315 at 000005*, in camera*).

Response to Finding No. 602

Complaint Counsel has no specific response.

603. {

}(Pirc, Tr. 2337-2338, *in camera*; PX02282 at 005, *in camera*).

Response to Finding No. 603

Complaint Counsel has no specific response.

604. {

}

(Radzialowski, Tr. 801, 803, *in camera*; RX-125, *in camera*; RX-131, *in camera*).

Response to Finding No. 604

Complaint Counsel has no specific response.

605. ProMedica considers MFN clauses to be disadvantageous to hospitals. (Wachsman, Tr. 4907-4908).

Response to Finding No. 605

Complaint Counsel has no specific response.

606. The State of Ohio has enacted a moratorium on the use of MFN clauses. (Pugliese, Tr. 1580).

Response to Finding No. 606

Complaint Counsel has no specific response.

(iv) Expired Contracts Favor MCOs

607. { }(Pugliese, Tr. 1476-1477*, in camera*).

Response to Finding No. 607

This proposed finding is misleading. When contracted rates expire before an agreement on new rates is reached, the old rates do not continue in place indefinitely. Rather, each party to the contract may terminate agreement without notice, usually subject to some notification requirements. (*See*, *e.g.*, PX00091 at 005 (Amendment to Anthem Hospital Provider Agreement for The Toledo Hospital), *in camera*; PX00093 at 005 (Amendment to Anthem Hospital Provider Agreement For Flower Hospital), *in camera*; PX00095 at 005 (Amendment to Anthem Hospital Provider Agreement for Bay Park Community Hospital), *in camera*).

608. { }(Pugliese, Tr. 1644*, in camera*).

Response to Finding No. 608

This proposed finding is incomplete. Hospitals also benefit from this because they can continue to treat a significantly larger portion of a health plan's members than they would if they were out-of-network, due to higher out-of-pocket costs for members using out-of-network hospitals. (*See* CCPFF ¶¶ 108-109, 113).

h. Paramount's Approach to Provider Contracting

609. Paramount builds and maintains a provider network to provide healthcare services to its members. (Randolph, Tr. 6929-6930).

Response to Finding No. 609

Complaint Counsel has no specific response.

610. Paramount contracts with physicians, hospitals, skilled nursing facilities, durable medical equipment companies, and other ancillary providers to provide services to its members. (Randolph, Tr. 6930-6931).

Response to Finding No. 610

Complaint Counsel has no specific response.

611. Paramount subcontracts with a pharmacy benefits manager, Express Scripts, to provide a pharmacy network to its insureds. (Randolph, Tr. 6931).

Response to Finding No. 611

Complaint Counsel has no specific response.

612. These provider contracts all include reimbursement rates that Paramount pays the providers in return for services provided to Paramount's members. (Randolph, Tr. 6932).

Response to Finding No. 612

Complaint Counsel has no specific response.

613. Paramount believes it needs to be lower cost in order to compete with its competitors with broader networks. (Randolph, Tr. 6942-6943).

Response to Finding No. 613

Complaint Counsel has no specific response.

614. When Paramount negotiates with providers, its goals are to reach a good cost framework, while ensuring good cooperation on care coordination. (Randolph, Tr. 6944).

Response to Finding No. 614

Complaint Counsel has no specific response.

615. When Paramount negotiates with providers, it emphasizes its history of administration and client service, as well as its reimbursement levels. (Randolph, Tr. 6945).

Response to Finding No. 615

Complaint Counsel has no specific response.

616. Paramount tries to contract hospital providers to participate in all of Paramount's products. (Randolph, Tr.6945-6946).

Response to Finding No. 616

Complaint Counsel has no specific response.

617. Paramount tries to negotiate for the provision of all services, both inpatient and outpatient, with every provider. (Randolph, Tr. 6960-6962).

Response to Finding No. 617

Complaint Counsel has no specific response.

618. When Paramount negotiates payment methodologies with hospital providers, it reviews volume of business, variability of services, and the general charge level of the provider. (Randolph, Tr. 6956-6957).

Response to Finding No. 618

Complaint Counsel has no specific response.

(i) Paramount's Negotiations with ProMedica

619. Paramount negotiates with ProMedica hospitals on an annual basis for inclusion of the ProMedica hospitals in Paramount's provider network. (Randolph, Tr. 6971).

Response to Finding No. 619

This proposed finding is misleading. Paramount and ProMedica do not negotiate in a traditional sense for ProMedica's inclusion in Paramount's network because "it's not realistic that Paramount and ProMedica would ever fail to reach agreement on a contract[.]" (Randolph, Tr. 7070). Rather, representatives from Paramount and ProMedica meet annually to adjust reimbursement rates and other terms in the contract between Paramount and ProMedica. (Randolph, Tr. 7069-7070).

620. Paramount gets a pricing advantage from ProMedica, as opposed to other providers. (Randolph, Tr. 6971).

Response to Finding No. 620

Complaint Counsel does not disagree.

621. Paramount's profits are retained within the ProMedica system to further Paramount's business objectives. (Randolph, Tr. 6975).

Response to Finding No. 621

Complaint Counsel does not disagree.

622. ProMedica's cost coverage ratio target for negotiations between ProMedica and Paramount is 115 percent. (Randolph, Tr. 6975).

Response to Finding No. 622

Complaint Counsel has no specific response.

623. Paramount does not share the rates it negotiates with other providers with ProMedica, nor does Paramount share the rates it negotiates with other physicians with PPG. (Randolph, Tr. 6976).

Response to Finding No. 623

This proposed finding is misleading to the extent it suggests that ProMedica and Paramount do not discuss ProMedica's contractual arrangements with other health plans. For example, Mr. Wachsman, ProMedica's Senior Vice President for Managed Care, Reimbursement and Revenue Cycle Management, wrote an email to Mr. Randolph, Paramount's President, stating that "Anthem cannot sign up st. luke's [sic] until 7/1/09 and will have to pay PHS for the privilege." (PX00380 at 001 (Wachsman (ProMedica) email, 5/7/08), CCPFF ¶¶ 1481-1482, 1499).

i. ProMedica's Approach to MCO Contracting

624. ProMedica has general financial objectives that it attempts to achieve in contract negotiations with MCOs. (Wachsman, Tr. 4870).

Response to Finding No. 624

Complaint Counsel has no specific response.

625. In addition to its general financial objectives, ProMedica also develops a set of specific recommendations for each MCO based on ProMedica's knowledge of and relationship with each MCO. (Wachsman, Tr. 4870).

Response to Finding No. 625

Complaint Counsel has no specific response.

626. One of ProMedica's objectives in contract negotiations is to achieve reimbursement rates that cover ProMedica's costs. (Wachsman, Tr. 4871). {
} (Wachsman, Tr. 4947, *in camera*).

Response to Finding No. 626

Complaint Counsel has no specific response.

627. ProMedica seeks to achieve working relationships with MCOs that are sustainable on a long-term basis. (Wachsman, Tr. 4871).

Response to Finding No. 627

Complaint Counsel has no specific response.

628. ProMedica aims to address all operational matters with MCOs to ensure proper claims processing and proper contract performance. (Wachsman, Tr. 4871).

Response to Finding No. 628

Complaint Counsel has no specific response.

629. When ProMedica negotiates with MCOs on behalf of its hospitals, it negotiates with respect to all providers that it represents, including physicians and other entities that are part of ProMedica. (Wachsman, Tr. 4872).

Response to Finding No. 629

Complaint Counsel has no specific response.

630. One of ProMedica's objectives is to have mutually beneficial relationships with MCOs and establish reimbursement rates that do not create any competitive advantage or disadvantage to ProMedica or the MCOs. (Wachsman, Tr. 4872).

Response to Finding No. 630

This proposed finding is contradicted by testimony and documents, which show that ProMedica bargains aggressively to maximize its revenues and reimbursement rates from commercial health plans. (*See* CCPFF ¶¶ 445-456).

631. ProMedica aims to create relationships with MCOs that will allow ProMedica to support all of the MCOs and employers in market. (Wachsman, Tr. 4872).

Response to Finding No. 631

Complaint Counsel has no specific response.

632. ProMedica's MCO contracts vary as to the different terms included in each contract, because the results of ProMedica's contract negotiations with each MCO are different. (Wachsman, Tr. 4888).

Response to Finding No. 632

Complaint Counsel has no specific response.

633. ProMedica discusses various contract terms with an MCO during the course of a contract negotiation, and each of the terms has a different value. (Wachsman, Tr. 4909).

Response to Finding No. 633

Complaint Counsel has no specific response.

634. If, for example, ProMedica is negotiating twenty different contract terms with an MCO, ProMedica may compromise with the MCO on one term in exchange for a compromise from the MCO on another term. (Wachsman, Tr. 4910)

Response to Finding No. 634

Complaint Counsel has no specific response. .

635. ProMedica negotiates the extent to which an MCO's network is limited, and a more limited network generally allows ProMedica to receive a higher volume of business from the MCO. (Wachsman, Tr. 4907).

Response to Finding No. 635

Complaint Counsel has no specific response.

636. ProMedica negotiates as to the products for which it will provide service, such as PPO and HMO products, and the rates that will be paid for each product. (Wachsman, Tr. 4908).

Response to Finding No. 636

Complaint Counsel has no specific response.

637. ProMedica typically negotiates for all of the products a MCO offers as part of one contract. (Wachsman, Tr. 4908-4909).

Response to Finding No. 637

Complaint Counsel has no specific response.

638. The reimbursement rates that each ProMedica hospital receives may vary from one hospital to another, and this variation is based on different factors, including historical reasons or other considerations that arise during negotiations. (Wachsman, Tr. 4913).

Response to Finding No. 638

Complaint Counsel has no specific response.

639. In some instances, one ProMedica hospital may require a higher rate increase than another hospital, and MCOs will sometimes agree to increase reimbursement rates at one hospital in exchange for a lower the rate at another ProMedica hospital. (Wachsman, Tr. 4913-4914).

Response to Finding No. 639

Complaint Counsel has no specific response.

640. {

} (Wachsman, Tr. 4957-4958, *in camera*).

Response to Finding No. 640

Complaint Counsel has no specific response.

641. {

} (Wachsman, Tr. 4954, *in camera*).

Response to Finding No. 641

Complaint Counsel has no specific response.

642. {

} (Wachsman, Tr. 4954, *in camera*).

Response to Finding No. 642

This proposed finding is contradicted by testimony and documents, which show that ProMedica bargains aggressively to maximize its revenues and reimbursement rates from commercial health plans. (*See* CCPFF ¶¶ 445-456).

643. {

} (Wachsman, Tr. 4957, *in camera*).

Response to Finding No. 643

Complaint Counsel has no specific response.

644. {

} (RX-18 (Marcus, Dep. at 164-165, *in camera*)).

Response to Finding No. 644

This proposed finding is misleading. Reimbursement rates are the most important aspects of contract negotiations – including renewal negotiations – between hospitals and health plans. (*See* CCPFF ¶ 124).

645. {

} (RX-18 (Marcus, Dep. at 164-165, *in camera*))

Response to Finding No. 645

Complaint Counsel has no specific response.

646. {

} (RX-18 (Marcus, Dep. at 167, *in camera*)).

Response to Finding No. 646

Complaint Counsel has no specific response.

647. {

} (RX-1854 at 000006, *in camera*).

Response to Finding No. 647

Complaint Counsel has no specific response.

648. {

} (RX-1854 at 000006, *in camera*).

Response to Finding No. 648

Complaint Counsel has no specific response.

649. {

} (RX-1854 at 000006, *in camera*).

Response to Finding No. 649

Complaint Counsel has no specific response.

650. {

} (RX-1854 at 000006, *in camera*).

Response to Finding No. 650

This proposed finding is misleading. Audits do not always discover improper increases immediately, and resolution of the audit process can be drawn-out and contentious. For example, MMO entered into a dispute with ProMedica after its auditors discovered that it had been overpaying ProMedica throughout the past 10 years. (Pirc, Tr. 2226-2227, *in camera*; PX01944 at 015 (Pirc, Dep. at 54-55), *in camera*).

651. {

} (Wachsman, Tr. 4947, *in camera*).

Response to Finding No. 651

This proposed finding is incomplete. ProMedica's bargaining leverage enabled it to charge substantially higher prices than Mercy or any other Lucas County hospital. (*See* PX02148 at 037-038 (¶¶ 68-69) (Town Expert Report), *in camera*). Also, ProMedica's actual {

} exceed ProMedica's internal targets. (CCPFF ¶¶ 448-453).

652. { }

(Wachsman, Tr. 4947, *in camera*).

Response to Finding No. 652

Complaint Counsel has no specific response.

j. Rates/Premiums Paid by Employees/Insureds Involve More than Just Inpatient Hospital Rates

653. The cost of services for an employer's employees at a hospital are only one component of the total cost of healthcare. (Lortz, Tr. 1733; Pugliese, Tr. 1560-1561; McGinty, Tr. 1246).

Response to Finding No. 653

Complaint Counsel has no specific response.

654. There are many factors that affect or influence the cost of medical coverage such as outpatient services, ancillary services, the number of employees and family members covered, the benefit design offering, the demographic mix and health history of covered members, prescription drug usage trend, and employees' utilization rate. (Lortz, Tr. 1733-1735; Neal, Tr. 2121-2122, 2140-2142; Caumartin, Tr. 1867, 1872; Buehrer, Tr. 3084-3086; Pugliese, Tr. 1561-1562; McGinty, Tr. 1246-1247; Pirc, Tr. 2292-2294; Town, Tr. 3949-3952).

Response to Finding No. 654

Complaint Counsel has no specific response.

655. The price an employer compensates a third party administrator also affects the amount an employer spends on healthcare. (Lortz, Tr. 1735; Neal, Tr. 2096- 2097, 2142; Caumartin, Tr. 1871-1872).

Response to Finding No. 655

Complaint Counsel has no specific response.

656. MMO estimates that the cost of general acute care inpatient services accounts for only about 20 to 25 percent of its members' health insurance premiums. (Pirc, Tr. 2292).

Response to Finding No. 656

This proposed finding is incomplete and use of the word "only" in this proposed finding is misleading. Mr. Pirc testified that the reimbursement rates that MMO pays for hospital

services are "the primary cost" among all the costs that influence health insurance premiums. (Pirc, Tr. 2291-2292). Mr. Pirc also testified that the cost of outpatient services accounts for 15 to 20 percent of the total cost that influences health insurance premiums, that physician costs account for 25 to 30 percent, and that pharmacy costs account for about 10 percent. (Pirc, Tr. 2292).

657. Health insurance premiums set by national MCOs servicing national clients also may be calculated with reference to many different providers in many different geographies (that is, not just those providers located in Lucas County). (Radzialowski, Tr. 785-786)

Response to Finding No. 657

This proposed finding is misleading. The weight of the evidence shows that any reimbursement rate increases which result from the Acquisition will be passed on to self-insured and fully-insured employers and, ultimately, on to individual consumers of commercial health insurance. (*See* CCPFF ¶¶ 643-661).

658. Ultimately, the terms and rates in a contract between a provider and an MCO are mutually agreed upon. (Town, Tr. 4110).

Response to Finding No. 658

Complaint Counsel has no specific response.

2. Hospital Capacity and Utilization

659. There is excess inpatient bed capacity in Lucas County. (RX-21 (Peron, Dep. at 161); Guerin-Calvert, Tr. 7276-7281).

Response to Finding No. 659

This proposed finding is misleading. Aetna's Senior Network Manager for northern Ohio testified that there are not an unusually high number of hospitals or beds in the Toledo area, as compared to other cities of similar size. (Radzialowski, Tr. 651-652). Moreover, analysis conducted by Respondent's economic expert, Ms. Guerin-Calvert, shows that the Toledo area is not an outlier regarding the number of beds it has relative to its population, but that the Toledo

area does have fewer hospital competitors than other urban areas of similar size. (CCPFF ¶¶ 1156-1157).

660. {

}

(Nolan, Tr. 6313, *in camera*).

Response to Finding No. 660

Complaint Counsel has no specific response.

661. Mercy is currently operating about 470 to 500 beds between its three Lucas County hospitals, with about 265 at St. Vincent, 130 at St. Charles, and 70 at St. Anne. (Shook, Tr. 1031-1032).

Response to Finding No. 661

Complaint Counsel has no specific response.

662. Mercy believes that there is excess capacity, in the form of excess inpatient beds, for inpatient hospital services in Toledo. (Shook, Tr. 1032, 1037, 1041; PX02288 at 003, *in camera*).

Response to Finding No. 662

Complaint Counsel has no specific response.

663. Mercy has the capacity to accommodate an additional ten patients a day at its Toledo-area hospitals. (Shook, Tr. 1042).

Response to Finding No. 663

Complaint Counsel has no specific response.

664. Similarly, St. Charles and St. Vincent have the capacity to accommodate an additional expectant mother each day. (Shook, Tr. 1042).

Response to Finding No. 664

Complaint Counsel has no specific response.

665. Mercy also believes that Toledo has more than enough obstetricians to meet the community's needs. (Shook, Tr. 1046).

Response to Finding No. 665

Complaint Counsel has no specific response.

666. If Mercy needed to use additional beds, it could staff beds that are currently not in use, and doing so would be faster, easier, and less costly than building a new hospital or expanding one of its facilities. (Shook, Tr. 1043).

Response to Finding No. 666

This proposed finding is incomplete. It ignores the fact that marshaling additional beds would require some effort, particularly with respect to locating space and assembling additional nursing staff for the added beds. (Shook, Tr. 1042-1043).

667. UTMC has over 300 licensed beds and operates 225. (Gold, Tr. 198).

Response to Finding No. 667

Complaint Counsel has no specific response.

668. UTMC typically operates with an occupancy rates of roughly 80 percent, and UTMC acknowledged that it has excess capacity to treat additional patients. (Gold, Tr. 199, 255).

Response to Finding No. 668

Complaint Counsel has no specific response.

669. UTMC also believes that the community of Northwestern Ohio has more inpatient acute care beds than needed. (Gold, Tr. 257; PX02206 at 001).

Response to Finding No. 669

Complaint Counsel has no specific response.

670. UTMC has referred to the Toledo area as "overbedded" and believes that there is a high degree of duplication of services in the community. (Gold, Tr. 340; PX02206 at 001).

Response to Finding No. 670

Complaint Counsel has no specific response.

671. Most days, UTMC could provide general acute care inpatient services to additional patients, if needed, by utilizing more of its staffed beds. (Gold, Tr. 283).

Response to Finding No. 671

Complaint Counsel has no specific response.

672. UTMC could also treat additional patients by staffing more of its registered beds that are currently unstaffed. (Gold, Tr. 256).

Response to Finding No. 672

This proposed finding is incomplete. If UTMC expanded its number of staffed inpatient beds, it would have to find additional space for the services it would displace to make room for the additional beds. (Gold, Tr. 199-200). UTMC does not currently have additional space in which to locate inpatient beds. (Gold, Tr. 199). During periods when UTMC has an occupancy rate of 80 percent, UTMC does not necessarily have beds available for additional patients, because the occupancy rate does not take into account beds that cannot be used due to infectious isolation reasons or gender mismatches. (Gold, Tr. 199, 350-351). UTMC has no plans to increase its capacity in response to the Acquisition. (Gold, Tr. 224).

673. In the past, UTMC converted 15 geriatric psychiatry beds to inpatient patient care beds as needed. (Gold, Tr. 202).

Response to Finding No. 673

Complaint Counsel has no specific response.

3. Physician Privileges

a. Physicians in Lucas County Maintain Privileges at Multiple Hospitals

674. Most physicians have privileges at multiple hospitals in Lucas County. (Gbur, Tr. 3105; RX-35 (Hammerling, IHT at 16-18)).

Response to Finding No. 674

Complaint Counsel does not disagree.

675. Most obstetricians have privileges at several different hospitals. (Read, Tr. 5274).

Response to Finding No. 675

Complaint Counsel does not disagree.

676. Anthem acknowledges that Lucas County physicians tend to have admitting privileges in more than one hospital. (Pugliese, Tr. 1466, 1573-1574).

Response to Finding No. 676

Complaint Counsel has no specific response.

677. Anthem recognizes that employed physicians also maintain privileges at hospitals other than the hospital employing them. (Pugliese, Tr. 1467).

Response to Finding No. 677

Complaint Counsel has no specific response.

678. Anthem acknowledges that physicians employed by PPG have privileges at hospitals other than the ProMedica hospitals. (Pugliese, Tr. 1574).

Response to Finding No. 678

Complaint Counsel has no specific response.

b. Physicians Choose To Maintain Privileges at Multiple Hospitals for Personal and Patient-Care Related Reasons

679. Physicians obtain privileges at multiple hospitals for various reasons, including personal preference and convenience, access to adequate medical and surgical facilities to treat their patients, and for business reasons, such as the ability to cover for partners in their practice. (Andreshak, Tr. 1754-1755; Marlowe, Tr. 2428-2429).

Response to Finding No. 679

Complaint Counsel does not disagree.

680. Physicians also obtain privileges at multiple hospitals in order to respond to patient preferences and to serve patients whose health insurance plans or MCOs may not have certain hospitals in their networks. (Andreshak, Tr. 1754-1755, 1807; Marlowe, Tr. 2398; Read, Tr. 5268).

Response to Finding No. 680

Complaint Counsel does not disagree.

c. Having Privileges at Multiple Hospitals Benefits Patients

681. Admitting privileges allow a physician to admit and see patients, prescribe medications and perform procedures at the hospital. (Andreshak, Tr. 1752).

Response to Finding No. 681

Complaint Counsel does not disagree.

682. Having privileges at multiple hospitals allows a physician to direct a patient to an in-network hospital for treatment so the patient may minimize out-of-pocket expenses. (Andreshak, Tr. 1805-1806).

Response to Finding No. 682

Complaint Counsel does not disagree.

683. Having privileges at multiple hospitals also enables a physician to continue caring for patients if an insurer eliminates one of the hospitals or systems from its network The patient will not experience any disruption in care or have to seek a new physician, because their existing physician can direct the patient to another in-network hospital where he has privileges. (Marlowe, Tr. 2430; Read, Tr. 5271).

Response to Finding No. 683

This proposed finding is incomplete. Disruption of care could result from being admitted into a new hospital. (*Cf.* CCPFF ¶ 639).

684. Anthem believes that having privileges at more than one hospital allows a physician to serve more customers in the community. (Pugliese, Tr. 1467).

Response to Finding No. 684

Complaint Counsel has no specific response.

685. Anthem believes that having a doctor with privileges at more than one hospital enables a patient to influence the choice of the hospital to which they are admitted for care. (Pugliese, Tr. 1467).

Response to Finding No. 685

Complaint Counsel has no specific response.

d. Hospital Employed Physicians May Hold Privileges at and Admit Patients to Other Hospitals

686. PPG physicians have admitting privileges at non-ProMedica hospitals because ProMedica wants to allow its physicians to honor patient preference if the patient wants to receive service at a non-ProMedica facility. (Oostra, Tr. 5798).

Response to Finding No. 686

The proposed finding is incomplete and directly contradicted by testimony. Physicians employed by a hospital system generally admit to that hospital system. Dr. Riordan, a ProMedica physician, testified that he would not be able to admit patients to either UTMC or Mercy hospitals due to exclusive contracting arrangements. (*See* CCPFF ¶ 614; *see also* CCPFF ¶ 615-617).

687. A PPG physician may admit a patient to a non-ProMedica facility if the physician thinks a particular service would be better delivered at another hospital or if the physician thinks there is a better specialist at another hospital. (Oostra, Tr. 5798).

Response to Finding No. 687

The proposed finding is incomplete and directly contradicted by testimony. (*See* Response to RPFF ¶ 686).

688. PPG physicians' freedom to refer patients to other physicians or hospitals is memorialized in the "Use of Facilities" clause in every physician contract. (Oostra, Tr. 5799; RX-1908 at 000005, *in camera*).

Response to Finding No. 688

The proposed finding is incomplete and directly contradicted by testimony. (*See* Response to RPFF ¶ 686).

689. St. Luke's WellCare employed physician group also imposes no restrictions of physicians regarding where they admit their patients. (Read, Tr. 5297). WellCare physicians receive no financial incentives to admit patients to particular hospitals. (Read, Tr. 5297).

Response to Finding No. 689

The proposed finding is incomplete. Despite the lack of restrictions on St. Luke's WellCare employed physician group, Dr. Read testified she admits the majority of her patients to ProMedica facilities, 60 percent to St. Luke's alone. (Read, 5291; *see also* CCPFF ¶ 598).

690. Physicians employed by Mercy are not required to refer their patients to Mercy's hospitals; instead they may take into consideration other factors such as patient preference, insurance, and physician opinion. (Shook, Tr. 1057).

Response to Finding No. 690

Complaint Counsel has no specific response.

691. Mercy believes that many physicians who admit patients to Mercy's hospitals also practice at and admit patients to ProMedica's hospitals. (Shook, Tr. 1033).

Response to Finding No. 691

Complaint Counsel has no specific response.

692. Mercy recognizes that some members of its medical staff serve on ProMedica's medical staff, and some also serve on the medical staff at St. Luke's. (Shook, Tr. 1057-1058).

Response to Finding No. 692

Complaint Counsel has no specific response.

693. UTMC faculty physicians can admit and treat patients at hospitals other than UTMC and may refer their patients to other Toledo-area hospitals for services that UTMC offers. (Gold, Tr. 260-262).

Response to Finding No. 693

Complaint Counsel has no specific response.

e. Expert Review of Physician Referral Patterns Confirms that Lucas County Physicians Maintain Privileges at Multiple Hospitals and Refer Patients to Multiple Hospitals

694. { }

(Guerin-Calvert, Tr. 7359-7360, *in camera*)

Response to Finding No. 694

Complaint Counsel has no specific response.

695. { } (Guerin-Calvert, Tr. 7360-7361, *in camera*).

Response to Finding No. 695

Complaint Counsel has no specific response.

696. {

} (Guerin-Calvert, Tr. 7360-7361, *in camera*).

Response to Finding No. 696

Complaint Counsel has no specific response.

697. {

} (Guerin-Calvert, Tr. 7360-7361, *in camera*).

Response to Finding No. 697

Complaint Counsel has no specific response.

698. Of the physicians who admit to ProMedica, more of them admit to Mercy than to St. Luke's. (Town, Tr. 4337; Guerin-Calvert, Tr. 7366-7367, *in camera*).

Response to Finding No. 698

The proposed finding is misleading and incomplete. If physician admitting privileges overlap is a measure of substitutability between hospitals, then one should examine the degree in overlap in physician privileges between the merging parties. (PX01850 at 16 (¶ 23-24) (Town Expert Report), *in camera*). Professor Town's analysis demonstrates that, for the physicians who admit to St. Luke's, the greatest overlap in admitting privileges is with ProMedica. (PX01850 at 16 (¶ 23-24) (Town Expert Report), *in camera*); *see generally* CCPFF ¶ 593-628).

699. {

} (Guerin-Calvert, Tr. 7362-7363, *in camera*; RX-71(A) at 000141-000144, *in camera*).

Response to Finding No. 699

Complaint Counsel has no specific response.

700. {

} (Guerin-Calvert, Tr. 7362-63, *in camera*; RX-71(A) at 000141-000144, *in camera*).

Response to Finding No. 700

Complaint Counsel has no specific response.

701. Twice as many of the physicians who have privileges at ProMedica admit to Mercy as well than to St. Luke's. (Town, Tr. 4338; Guerin-Calvert, Tr. 7366-7368, *in camera*).

Response to Finding No. 701

The proposed finding is misleading and incomplete. *See* Response to RPFF ¶ 698.

702. {

} (Guerin-Calvert, Tr. 7365-7366, *in camera*; RX-71(A) at 000141-000144, *in camera*).

Response to Finding No. 702

Complaint Counsel has no specific response.

703. Even Prof. Town calculates that only 30 percent of the physicians in all of Lucas County admit to St. Luke's. (Town, Tr. 4095).

Response to Finding No. 703

Complaint Counsel has no specific response.

704. {

} (Guerin-Calvert, Tr. 7366, *in camera*; RX-71(A) at 000141-000144, *in camera*).

Response to Finding No. 704

Complaint Counsel has no specific response.

705. {

} (Guerin-Calvert, Tr. 7367-7368, *in camera*; RX-71(A) at 000141-000144, *in camera*).

Response to Finding No. 705

Complaint Counsel has no specific response.

706. {

} (Guerin-Calvert, Tr. 7369-7370, *in camera*; RX-71(A) at 000141-000144, *in camera*).

Response to Finding No. 706

Complaint Counsel has no specific response.

707. {

} (Guerin-Calvert, Tr. 7367-7371, *in camera*; RX-71(A) at 000142, *in camera*).

Response to Finding No. 707

Complaint Counsel has no specific response.

708. {

} (Guerin-Calvert, Tr. 7364-7367, *in camera*).

Response to Finding No. 708

The proposed finding is incorrect. The examination of physician admitting privileges, by itself, ignores the role of patient preference in selecting a hospital for inpatient care. Patients' preferences play a major role in where the patient is ultimately admitted for inpatient care. Physicians maintain privileges at multiple hospitals to accommodate these patient preferences. (*See* CCPFF ¶ 599-607; *see also* Response to RPFF ¶ 698). Moreover, Professor Town's analysis demonstrates that, for the physicians who admit to St. Luke's, the greatest overlap in admitting privileges is with ProMedica. (PX01850 at 17 (¶ 24, table 1) (Town Expert Report), *in camera*) (62.5 percent of physicians who had privileges at St. Luke's prior to the acquisition also had privileges at ProMedica, compared to 53.8 percent who also had privileges at Mercy).

4. History of Closed Provider Network Contracting

709. In 2000, ProMedica was the only Lucas County hospital system not in MMO's network; Mercy was the only hospital system not in Paramount's or United's network; UTMC was the only hospital not in Cigna's network. Anthem, Aetna, FrontPath and Humana had all Toledo area hospitals in their networks. (Guerin-Calvert, Tr. 7324-7330).

Response to Finding No. 709

Complaint Counsel has no specific response.

710. In 2001, St. Luke's was dropped from Paramount's network and Mercy was still out of network; ProMedica remained out of network for MMO; UTMC remained out of network for Cigna and Mercy remained out of network for United. (Guerin-Calvert, Tr. 7326).

Response to Finding No. 710

Complaint Counsel has no specific response.

711. In 2002, the only change to the network configurations in the Toledo area was that UTMC was dropped from United's network. (Guerin-Calvert, Tr. 7326).

Response to Finding No. 711

Complaint Counsel has no specific response.

712. There were no changes again until 2005 when Anthem dropped Mercy and St. Luke's from its network, keeping only ProMedica and UTMC; Paramount still also had only ProMedica and UTMC; MMO was still without ProMedica in its network; Cigna was without UTMC and United was without Mercy and UTMC. (Guerin-Calvert, Tr. 7326-7327).

Response to Finding No. 712

Complaint Counsel has no specific response.

713. In 2006, United was the only managed care organization to change its network; it added Mercy and UTMC but dropped ProMedica. (Guerin-Calvert, Tr. 7327).

Response to Finding No. 713

Complaint Counsel has no specific response.

714. The next change came in 2008 when Anthem added Mercy and MMO added ProMedica; Anthem still did not have St. Luke's in its network at this time. (Guerin-Calvert, Tr. 7327; Radzialowski, Tr. 791, *in camera*; PX02212, *in camera*).

Response to Finding No. 714

This proposed finding is incomplete. Anthem did not have St. Luke's in its network in 2008 because ProMedica contracted with Anthem to have St. Luke's excluded from Anthem's network, in exchange for lower reimbursement rates at ProMedica's hospitals. (CCPFF ¶¶ 117, 366-376). Although Anthem expressed to ProMedica its desire to add St. Luke's to its provider

network, a "huge effort" by ProMedica resulted in a deal to delay St. Luke's re-entry until July 2009. (CCPFF ¶¶ 117, 367-373).

715. In 2009, Cigna added UTMC and Anthem added St. Luke's to their respective networks. (Guerin-Calvert, Tr. 7327).

Response to Finding No. 715

Complaint Counsel has no specific response.

716. In 2010, Paramount added St. Luke's to its network. (Guerin-Calvert, Tr. 7327).

Response to Finding No. 716

Complaint Counsel has no specific response.

717. Finally in 2011, United added ProMedica to its network. (Guerin-Calvert, Tr. 7328).

Response to Finding No. 717

Complaint Counsel has no specific response.

a. Lucas County's Closed Provider Networks Were Marketable and Met Patient Needs

718. The history of MCO networks in Toledo shows that major networks such as MMO and Anthem, using various narrow network configurations, and 50-55 percent of the Toledo area's bed capacity in-network competed successfully with open networks like Aetna. (Guerin-Calvert, Tr. 7328-7330).

Response to Finding No. 718

This proposed finding is incomplete and misleading. In the past 10-20 years, no health plan has marketed in Lucas County a network consisting of only Mercy's Lucas County hospitals and UTMC. (CCPFF ¶ 510-511). Health plans would face great difficulty in marketing such a network. (CCPFF ¶¶ 514-533). Health plans would find it much harder to market such a network than to market a network of Mercy's Lucas County hospitals, UTMC, and St. Luke's. (CCPFF ¶¶ 517, 419(d)-(e)). In recent years, consumer preferences in Lucas County have shifted towards open-access hospital networks. (Pugliese, Tr. 1544; PX02072 at 003-004 (¶13)

(Firmstone, Decl.), *in camera*). During the period in which MMO excluded ProMedica from its provider network, MMO's main competitors, Anthem and Paramount, excluded Mercy from their provider networks. (PX01944 at 024 (Pirc, Dep. at. 92-93), *in camera*; PX01942 at 009 (Pugliese, Dep. at 32), *in camera*; PX02068 at 003-004 (¶¶ 15-16) (Shook, Decl.), *in camera*). ProMedica entered MMO's network at the same time that Mercy entered Anthem's provider network. (Pirc, Tr. 2276; Pugliese, Tr. 1539). The degree of harm to the marketability of an MCO's provider network from the exclusion of a hospital will depend on whether that MCO's main competitors offer broad or restricted hospital networks. (*See* PX01944 at 025 (Pirc, Dep. at 94-95), *in camera*). The marketability of the MCO's product will suffer more from the exclusion of a hospital if the MCO's competitors market broad hospital networks than if they market restricted hospital networks. (*See* PX01944 at 025 (Pirc, Dep. at 94-95), *in camera*).

(i) MMO Was Able Successfully To Market a Network that Did Not Include ProMedica

719. During the time that ProMedica was not in MMO's network, MMO's membership remained fairly stable. (Pirc, Tr. 2275).

Response to Finding No. 719

This proposed finding is incomplete. During this time period, MMO's network contained Mercy, UTMC, *and* St. Luke's. (Pirc, Tr. 2275).

720. MMO was able to compete with other MCOs and have a successful PPO product in the period prior to January 1, 2008 when ProMedica's hospitals were not in its network. (Pirc, Tr. 2204-2205, 2275-2276).

Response to Finding No. 720

This proposed finding is incomplete. (*See* Response to RPFF ¶ 719).

721. After ProMedica entered MMO's network, MMO's membership remained stable. (Pirc, Tr. 2276).

Response to Finding No. 721

This proposed finding is incomplete and misleading. At the time ProMedica entered MMO's network, Mercy became an in-network provider with Anthem, one of MMO's main competitors in Lucas County. (Pirc, Tr. 2275-2276; Pugliese, Tr. 1539).

722. The reconfigurations of the networks that resulted in ProMedica participating with MMO and Mercy participating with Anthem did not cause a discernable change in MMO's market share relative to Anthem. (Pirc, Tr. 2276).

Response to Finding No. 722

This proposed finding is incomplete and misleading. ProMedica entered MMO's network at the same time that Mercy entered Anthem's provider network. (Pirc, Tr. 2276; Pugliese, Tr. 1539).

(ii) When ProMedica Was Not in MMO's network, Those Members with MMO as Their Health Insurance Provider Were Well-Served

723. When ProMedica was not in MMO's network, the Wood County Schools Health Consortium did not switch to a plan that had ProMedica as an in-network provider. (Caumartin, Tr. 1881-1882)

Response to Finding No. 723

Complaint Counsel has no specific response.

724. Members were well-served by MMO's network, despite ProMedica not being an in-network provider for a period of time. (Caumartin, Tr. 1878).

Response to Finding No. 724

Complaint Counsel has no specific response.

(iii) Anthem Successfully Marketed a Network that Did Not Include Mercy or St. Luke's

725. From 2005 until January 1, 2008, Anthem had only ProMedica and UTMC in its provider network. (Pugliese, Tr. 1539).

Response to Finding No. 725

Complaint Counsel has no specific response.

726. During the period when Anthem had only ProMedica and UTMC in its network, it still competed with other health insurance providers in Lucas County. (Pugliese, Tr. 1539-1540).

Response to Finding No. 726

This proposed finding is incomplete and misleading. At this time, Anthem's main competitors, Paramount and MMO, had limited networks. (Pirc, Tr. 2204; Randolph, Tr. 6934; Shook, Tr. 951). Like Anthem, Paramount had only ProMedica and UTMC in its network, while MMO had Mercy, UTMC, and St. Luke's in its network. (Randolph, Tr. 7065-7066; Pirc, Tr. 2203-2204).

727. During this same period when Anthem had only ProMedica and UTMC in its network, the other MCOs operating in Lucas County, except for Paramount, had the Mercy hospitals in their networks. (Pugliese, Tr. 1540).

Response to Finding No. 727

This proposed finding is incomplete and misleading. *See* Response to RPFF ¶ 726.

728. During the period between 2005 and 2008 when Anthem had only a limited number of hospital providers in its network, which did not include St. Luke's, Anthem's membership remained steady, indicating that Anthem was not at a competitive disadvantage. (Pugliese, Tr. 1540; Guerin-Calvert, Tr. 7941).

Response to Finding No. 728

This proposed finding is misleading. When Anthem opened its network to include Mercy, it wanted to add St. Luke's as well, because it feared being at a competitive disadvantage without that hospital in its network. (CCPFF ¶¶ 350-351). ProMedica negotiated the continued exclusion of St. Luke's from Anthem's network for an additional 18 months. (*See* CCPFF ¶¶ 117, 366-376).

729. After Anthem opened its network to include Mercy and St. Luke's hospitals, its insureds continued to want to go to ProMedica's hospitals. (Pugliese, Tr. 1544-1545).

Response to Finding No. 729

Complaint Counsel has no specific response.

b. The Move to Open Networks Led to Reduced Volume Discounting

730. { } (Radzialowski, Tr. 791, *in camera*; PX02212, *in camera*).

Response to Finding No. 730

Complaint Counsel has no specific response.

731. { } (Radzialowski, Tr. 791-792, *in camera*; PX02212, *in camera*).

Response to Finding No. 731

Complaint Counsel has no specific response.

732. { } (Radzialowski, Tr. 791**,** *in camera*; PX02212, *in camera*).

Response to Finding No. 732

Complaint Counsel has no specific response.

(i) MMO Paid Mercy Significant Sums To Add PHS to Its Network

733. When MMO and Mercy had an exclusive network, MMO was contractually obligated to pay Mercy additional reimbursement for the right to negotiate with ProMedica to become an in-network provider for MMO. (Shook, Tr. 1062; RX-265 at 000002, *in camera*; RX-267 at 000002, *in camera*).

Response to Finding No. 733

Complaint Counsel has no specific response.

734. Later, when ProMedica actually joined MMO's network, MMO paid additional reimbursement to Mercy. (Shook, Tr. 1063; Pirc, Tr. 2328, *in camera*; RX-290 at 000006, *in camera*; RX-266 at 000002, *in camera*).

Response to Finding No. 734

Complaint Counsel has no specific response.

735. {

} (Pirc, Tr. 2328-2329, *in camera*; RX-265 at 000002, *in camera*).

Response to Finding No. 735

Complaint Counsel has no specific response.

736. {

} (Pirc, Tr. 2329-2330, *in camera*).

Response to Finding No. 736

Complaint Counsel has no specific response.

737. Mercy and MMO negotiated the additional reimbursement because the value of MMO's narrow network to Mercy decreased when MMO broadened its network by adding ProMedica because the volume of MMO members going to Mercy was expected to decrease. (Town, Tr. 4127-4128).

Response to Finding No. 737

Complaint Counsel has no specific response.

738. Additionally, Mercy and MMO had a provision in their contract by which Mercy was obligated to give MMO the lowest reimbursement rates as compared to Mercy's contracts with other commercial health plans. (Shook, Tr. 1074; Pirc, Tr. 2330-2331, *in camera*; RX-265 at 000002, *in camera*).

Response to Finding No. 738

This proposed finding is incomplete. MMO and Mercy agreed that Mercy would charge MMO lower reimbursement rates as compared to Mercy's contracts with other commercial health plans that included *both* ProMedica and Mercy in their provider networks. (Pirc, Tr. 2330; RX-265 at 2, *in camera*).

(ii) Anthem "Paid" ProMedica To Add Mercy to Its Network

739. {

} (Pugliese, Tr. 1593, *in camera*).

Response to Finding No. 739

Complaint Counsel has no specific response.

740. {

} (RX 208 (Wachsman, Dep. at 41, *in camera*)).

Response to Finding No. 740

Complaint Counsel has no specific response.

741. {

} (Pugliese, Tr. 1593-1594, *in camera*; Guerin-Calvert, Tr. 7815, *in camera*).

Response to Finding No. 741

Complaint Counsel has no specific response.

742. {

} (Pugliese, Tr. 1598, *in camera*).

Response to Finding No. 742

Complaint Counsel has no specific response.

743. {

} (Pugliese, Tr. 1599, *in camera*; Guerin-Calvert, Tr. 7816, *in camera*).

Response to Finding No. 743

Complaint Counsel has no specific response.

744. Prior to Mercy's return to Anthem's network in 2008, Anthem paid Mercy over $37 million in out-of-network payments as a non-participating provider. (Pugliese, Tr. 1598, *in camera*; PX02443 at 002).

Response to Finding No. 744

Complaint Counsel has no specific response.

745. {

} (Pugliese, Tr. 1599, *in camera*).

Response to Finding No. 745

Complaint Counsel has no specific response.

746. {

} (Pugliese, Tr. 1600, *in camera*).

Response to Finding No. 746

This proposed finding is incomplete. Another factor that caused Anthem to want to bring Mercy into its network was Anthem's realization that the Lucas County market was shifting to open-access networks. (CCPFF ¶ 539).

747. { } (Pugliese, Tr. 1600-1601, *in camera*; PX02443 at 002; RX-1792 at 000005, *in camera*; RX-1796 at 000005, *in camera*).

Response to Finding No. 747

Complaint Counsel has no specific response.

748. Anthem's five-year contract with Mercy achieved "aggressive network rates" that resulted in savings to Anthem of 32 percent and over $12 million in the first year alone. (Pugliese, Tr. 1600, *in camera*; PX02443 at 002).

Response to Finding No. 748

Complaint Counsel has no specific response.

749. {

}

(Pugliese, Tr. 1601, *in camera*; RX-1792 at 000003, *in camera*).

Response to Finding No. 749

Complaint Counsel has no specific response.

750. Anthem's agreement with Mercy triggered a renegotiation of Anthem's contract with ProMedica due to the exclusivity provisions in the existing Anthem-ProMedica contract. (Pugliese, Tr. 1601, *in camera*; PX02443 at 002).

Response to Finding No. 750

Complaint Counsel has no specific response.

751. Following the entry of Mercy into Anthem's network, Anthem and ProMedica reached agreement on a new four-year contract. (Pugliese, Tr. 1602, *in camera*; PX02443 at 002; PX00091 at 005, *in camera*; PX00093 at 005, *in camera*; PX00095 at 005, *in camera*).

Response to Finding No. 751

Complaint Counsel has no specific response.

752. Anthem's new contract with ProMedica increased ProMedica's rates to adjust for the end of exclusivity and the entry of Mercy's hospitals to the Anthem provider network. (Pugliese, Tr. 1502**,** *in camera*; PX02443 at 002).

Response to Finding No. 752

Complaint Counsel has no specific response.

753. {

}

(Wachsman, Tr. 4976-4977, *in camera*; RX-208 (Wachsman, Dep. at 41-42, *in camera*)).

Response to Finding No. 753

Complaint Counsel has no specific response.

754. Anthem's new contract with ProMedica also included an MFN clause to ensure Anthem remained competitive with any MCO who may contract with ProMedica. (Pugliese, Tr. 1602, *in camera*; PX02443 at 002; PX00091 at 005, *in camera*; PX00093 at 005, *in camera*; PX00095 at 004, *in camera*).

Response to Finding No. 754

Complaint Counsel has no specific response.

755. { } (Pugliese, Tr. 1602, *in camera*).

Response to Finding No. 755

Complaint Counsel has no specific response.

756. The new contracts with Mercy and ProMedica allowed Anthem to reduce its overall costs and save over $5 million in Toledo alone, including $2 million on its fully-insured plans. (Pugliese, Tr. 1603, *in camera*; PX02443 at 002).

Response to Finding No. 756

Complaint Counsel has no specific response.

757. { } (Pugliese, Tr. 1603-1604, *in camera*).

Response to Finding No. 757

This finding is incomplete and misleading. Mr. Pugliese testified that Anthem did not reduce premiums for its fully-insured employees as of the day the agreement was made but that Anthem did apply that amount towards its cost-of-care-savings target for that year. The weight of the evidence shows that any reimbursement rate increases which result from the Acquisition will be passed on to self-insured and fully-insured employers and, ultimately, on to individual consumers of commercial health insurance. (*See* CCPFF ¶¶ 643-661).

758. { } (Pugliese, Tr. 1604, *in camera*).

Response to Finding No. 758

Complaint Counsel has no specific response.

(iii) Anthem Paid Significantly Less To Add St. Luke's to Its Network than It Paid To Add Mercy

759. In July 2004, Anthem provided St. Luke's with notice that it was terminating its contract, effective on February 1, 2005. (RX-11 (Oppenlander, Dep. at 57)).

Response to Finding No. 759

Complaint Counsel has no specific response.

760. { } (Pugliese, Tr. 1586-1587, *in camera*).

Response to Finding No. 760

This proposed finding is incomplete. This arrangement provided a higher volume of patients to ProMedica by excluding St. Luke's from Anthem's network and thereby eliminating

in-network competition from St. Luke's. (CCPFF ¶¶ 116-117, 368). In fact, ProMedica exerted a "huge effort" to prolong St. Luke's exclusion from Anthem's network, labeling this issue the "main deal breaker" for ProMedica in its negotiations with Anthem. (CCPFF ¶ 372).

761. { } (Pugliese, Tr. 1587, *in camera*).

Response to Finding No. 761

This proposed finding is incomplete. *See* Response to RPFF ¶ 760.

762. { } (Pugliese, Tr. 1591, *in camera*; PX02215 at 004-005, *in camera*).

Response to Finding No. 762

Complaint Counsel has no specific response.

763. { } (Pugliese, Tr. 1592, *in camera*; PX02215 at 006, *in camera)*.

Response to Finding No. 763

Complaint Counsel has no specific response.

764. { } (Pugliese, Tr. 1593, *in camera*).

Response to Finding No. 764

This proposed finding is misleading. Steering, in the context of this proposed finding, refers to the financial incentive for members to use in-network hospitals over out-of-network hospitals. (*See* RPFF ¶ 760; Response to RPFF ¶ 760; CCPFF ¶ 113). This reduction in reimbursement rates was the result of direct competition from St. Luke's to ProMedica, which incentivized ProMedica to lower its reimbursement rates to Anthem in exchange for the exclusion of St. Luke's. (*See* RPFF ¶¶ 760-761; Response to RPFF ¶ 760).

765. After Anthem terminated its contract with St. Luke's in 2005, St. Luke's waived out-of-network fees for Anthem's insureds who continued receiving care at St. Luke's, which succeeded in limiting St. Luke's patient decline to 2.5 percent of St. Luke's overall volume. (PX01519 at 003, *in camera*; RX-11 (Oppenlander, Dep. at 96-98)).

Response to Finding No. 765

Complaint Counsel has no specific response.

766. Despite threatening to take legal action against St. Luke's practice of waiving out-of-network fees for Anthem's members after Anthem had terminated its contract with St. Luke's, it never initiated a breach of contract suit against St. Luke's; St. Luke's continued the practice of waiving out-of-network fees for Anthem's insureds while it remained out of Anthem's network until July 2009. (RX-11 (Oppenlander, Dep. at 98-100)).

Response to Finding No. 766

Complaint Counsel has no specific response.

767. { } (Pugliese, Tr. 1478-1479, 1482-1483, *in camera*).

Response to Finding No. 767

Complaint Counsel has no specific response.

768. { } (Pugliese, Tr. 1483, *in camera*).

Response to Finding No. 768

Complaint Counsel has no specific response.

769. { }
(Wachsman, Tr. 5004-5005, 5240-5241, *in camera*; PX00333 at 002, *in camera*).

Response to Finding No. 769

Complaint Counsel has no specific response.

770. { } (Wachsman, Tr. 5005, 5240-5241, *in camera*; PX00333 at 002, *in camera*).

Response to Finding No. 770

Complaint Counsel has no specific response.

771. {
} (Pugliese, Tr. 1498, *in camera*).

Response to Finding No. 771

Complaint Counsel has no specific response.

772. {
} (Pugliese, Tr. 1605, *in camera*).

Response to Finding No. 772

This proposed finding is incomplete. Mr. Wachsman, ProMedica's executive responsible for managed care contracting, stated at the time that Anthem would "have to pay PHS for the privilege" of adding St. Luke's to its network. (CCPFF ¶ 371).

773. {
} (Pugliese, Tr. 1498-1499, *in camera*).

Response to Finding No. 773

Complaint Counsel has no specific response.

774. Once Anthem broadened its network to include St. Luke's, that contract no longer provided a benefit to ProMedica, because of the possibility that some of Anthem's members would choose St. Luke's instead of ProMedica for treatment. (Town, Tr. 4124)

Response to Finding No. 774

Complaint Counsel has no specific response.

775. Therefore, it was in ProMedica's interest, given the potential decline in volume and corresponding decline in the value of Anthem's network, to negotiate the removal of the discount to Anthem for a narrower network once Anthem added St. Luke's as an in-network hospital. (Town, Tr. 4125)

Response to Finding No. 775

Complaint Counsel has no specific response.

776. {

}

(Wachsman, Tr. 4977, *in camera*; Pugliese, Tr. 1605-1606, *in camera*).

Response to Finding No. 776

This proposed finding is unfounded to the extent that the cited portion of Mr. Pugliese's testimony does not contain any statements about the amount of ProMedica's rate increase in response to Mercy's re-entry into Anthem's network. (Pugliese, Tr. 1605-1606, *in camera*).

777. {

} (Pugliese, Tr. 1608-1609, *in camera*).

Response to Finding No. 777

Complaint Counsel has no specific response.

778. {

} (Pugliese, Tr. 1610, *in camera*).

Response to Finding No. 778

Complaint Counsel has no specific response.

c. Paramount Has Always and Continues To Operate a Closed Provider Network, and Yet Is Successful in the Market

779. Paramount is the only health insurance plan in Lucas County that does not have an open or broad hospital provider network. (Pirc, Tr. 2204).

Response to Finding No. 779

Complaint Counsel does not disagree.

780. Paramount's hospital provider network is the smallest in Lucas County compared to its competitors. (Randolph, Tr. 6934).

Response to Finding No. 780

Complaint Counsel has no specific response.

781. Paramount has been one of the largest health plans in Lucas County for a long time. (Pirc, Tr. 2178).

Response to Finding No. 781

Complaint Counsel does not disagree.

782. Paramount's network did not broaden to include Mercy even when MMO expanded to include ProMedica and Anthem expanded to include Mercy. (Town, Tr. 4328; Guerin-Calvert, Tr. 7327).

Response to Finding No. 782

Complaint Counsel has no specific response.

783. Prof. Town agrees that Paramount was successful in marketing a narrower network against the broader networks of MMO and Anthem. (Town, Tr. 4328-4329; Guerin-Calvert, Tr. 7332).

Response to Finding No. 783

The proposed finding is incomplete. Professor Town testified that a narrow network could generate market share, depending on the cost of the network. (Town, Tr. 4328). Paramount was able to offer a narrow network at a lower price point than its competitors that offered broad networks. (Randolph, Tr. 6966). Paramount gets better rates than it would otherwise because it is part of ProMedica Health System and its margin contributes to the ProMedica Health System bottom line. (Randolph, Tr. 7070-7071). Compared to any other health plan, Paramount gets the best pricing from ProMedica. (Randolph, Tr. 7071). In fact, Paramount gets better rates from ProMedica than even another health plan that was primarily aligned with ProMedica and had the same network composition. (Randolph, Tr. 7071-7072). Jack Randolph, President of Paramount, has had concerns about Paramount's ability to compete with broader networks. (PX00405 at 001). In fact, in 2008, Mr. Randolph wanted to add St.

Luke's to Paramount's network because he felt Paramount would be at a competitive disadvantage to Anthem. However, ProMedica senior executives, including Mr. Oostra, were concerned about the impact of adding St. Luke's on Flower Hospital and TTH. Mr. Randoplh ultimately was not allowed to add St. Luke's to its network in 2008. (*See* CCPFF ¶ 383-385).

784. St. Luke's was included in the Paramount network until January 1, 2001. (PX01022 at 002; Rupley, Tr. 1938; Randolph, Tr. 6997).

Response to Finding No. 784

Complaint Counsel has no specific response.

785. St. Luke's and Paramount negotiated about a potential new contract in 2000, but did not come to an agreement. (Rupley, Tr. 1938-1940; Randolph, Tr. 6997-6999).

Response to Finding No. 785

Complaint Counsel has no specific response.

786. ProMedica owns property in Arrowhead, a business development park in South Toledo, near St. Luke's. (Randolph, Tr. 7000).

Response to Finding No. 786

Complaint Counsel has no specific response.

787. In 2000, then St. Luke's CEO Jack Bartell was concerned that ProMedica might build a hospital close to St. Luke's and then transfer its Paramount patients away from St. Luke's when the new hospital opened. (Rupley, Tr. 1938-1939).

Response to Finding No. 787

Complaint Counsel has no specific response.

788. ProMedica had built Bay Park close to St. Charles. As soon as Bay Park opened, Paramount cancelled its contract with St. Charles. St. Luke's did not want to suffer the same fate if ProMedica built a hospital near St. Luke's. (PX01022 at 002; Rupley, Tr. 1938-1939).

Response to Finding No. 788

Complaint Counsel has no specific response.

789. In 2000, St. Luke's was concerned that Paramount was "using St. Luke's as an engine of growth" in the Southwest Toledo area. (PX01022 at 002).

Response to Finding No. 789

Complaint Counsel has no specific response.

790. In addition, in 2000, St. Luke's did not agree with a proposed Paramount contract term that required St. Luke's to offer Paramount as a health insurance plan for its own employees if Paramount became more than 20 percent of St. Luke's MCO mix. (PX01022 at 002; Rupley, Tr. 1939).

Response to Finding No. 790

Complaint Counsel has no specific response.

791. A few years before the end of the St. Luke's-Paramount contract in 2001, Paramount purchased a small health plan called Medical Value Plan. (Randolph, Tr. 6998).

Response to Finding No. 791

Complaint Counsel has no specific response.

792. Paramount discovered through that merger that St. Luke's had been offering a greater level of discount to Medical Value Plan than it had to Paramount, despite Paramount being much larger. (Randolph, Tr. 6997-6999).

Response to Finding No. 792

The proposed finding is incomplete. Paramount discovered at this time that it had unutilized bargaining leverage against St. Luke's. (*See generally* CCPFF ¶ 121-170, 185-188).

793. During contract renewal negotiations with St. Luke's in 2000, Paramount wanted the Medical Value Plan pricing to apply to the Paramount business. (Randolph, Tr. 6998).

Response to Finding No. 793

Complaint Counsel has no specific response.

794. St. Luke's asked for the old Paramount pricing to apply to the Medical Value Plan business. (Randolph, Tr. 6998).

Response to Finding No. 794

Complaint Counsel has no specific response.

795. St. Luke's then deemed that the reimbursement rates that Paramount offered St. Luke's at that time to be too low. (Rupley, Tr. 1939-1940).

Response to Finding No. 795

Complaint Counsel has no specific response.

796. St. Luke's and Paramount mutually parted ways in 2001 subsequent to these negotiations, after which St. Luke's was no longer in the Paramount network. (PX01022 at 002; Rupley, Tr. 1938-1940).

Response to Finding No. 796

Complaint Counsel has no specific response.

797. The loss of St. Luke's as a hospital provider in Paramount's network in 2001 had a minimal effect on Paramount's membership. (Randolph, Tr. 7003).

Response to Finding No. 797

The proposed finding is incomplete. Mr. Randolph believed that a failure to add St. Luke's to Paramount's network in 2008 would put Paramount at a competitive disadvantage to Anthem. (PX00405 at 001; CCPFF ¶ 381, 384). ProMedica estimated that adding St. Luke's would increase Paramount's membership by up to 15,000. (CCPFF ¶ 363). Further, the loss of Paramount patients to St. Luke's impacted St. Luke's ability to access to managed care patients. (*See* PX01144 at 002). St. Luke's wanted to rejoin Paramount from 2001 to 2010. (*See* CCPFF ¶ 382). One objective of Mr. Wakeman's three-year plan for St. Luke's was to increase St. Luke's access to managed care patients, which involved gaining access to Paramount insured patients. (PX01026 at 001 (St. Luke's Three-Year Plan). Mr. Wakeman was unable to achieve this objective, due to Paramount's unwillingness to contract with St. Luke's. (Wakeman, Tr. 2584-2585; *see also* CCPFF ¶¶ 361-362, 381-382)

798. In 2008, St. Luke's new CEO, Mr. Dan Wakeman, contacted Paramount after he joined St. Luke's to discuss the Paramount-St. Luke's relationship. (Randolph, Tr. 7016).

Response to Finding No. 798

Complaint Counsel has no specific response.

799. St. Luke's submitted proposals to Paramount regarding rejoining the network, but they were not acceptable to Paramount. (Randolph, Tr. 7017).

Response to Finding No. 799

This finding is incomplete and misleading. Paramount wanted to add St. Luke's from 2001 to 2010, *see* Response to RPFF ¶ 783, but Mr. Oostra and ProMedica Hospital Presidents were concerned that adding St. Luke's to Paramount's network would result in a loss of volume at Flower and TTH. (*See* CCPFF ¶ 362, 381-386).

d. MCOs with All Hospitals in Their Networks Did Not Gain Any Significant Advantage over MCOs with More Limited Networks

800. Between 2006 and 2008, Aetna had all hospitals in its hospital provider network while MMO and Anthem offered more limited networks. (Radzialowski, Tr. 741).

Response to Finding No. 800

Complaint Counsel has no specific response.

801. Aetna's broad network configuration at this time was a factor playing to its advantage compared to Anthem and MMO. (Radzialowski, Tr. 741-742).

Response to Finding No. 801

This proposed finding is incomplete. Anthem and MMO had the advantage of offering narrower network configurations than Aetna at lower prices. (*See generally* Town, Tr. 4328).

802. In spite of this apparent competitive advantage, Aetna did not grow its business significantly during the period when it was the only open network in Lucas County. (Radzialowski, Tr. 742).

Response to Finding No. 802

This proposed finding mischaracterizes Mr. Radzialowski's testimony. Mr. Radzialowski testified that Aetna's business grew in a small way and further growth was hindered by Aetna's internal issues. (Radzialowski, Tr. 741-742).

803. Aetna's commercial membership in Lucas County has not changed dramatically since 2004. (Radzialowski, Tr. 742).

Response to Finding No. 803

Complaint Counsel has no specific response.

804. After the other MCOs shifted to broad and open networks, Aetna was still able to compete successfully with those MCOs in Lucas County. (Radzialowski, Tr. 742-743).

Response to Finding No. 804

Complaint Counsel has no specific response.

805. Humana also maintained a broad network while MMO and Anthem were offering limited networks. (McGinty, Tr. 1198-1199).

Response to Finding No. 805

Complaint Counsel has no specific response.

806. Humana's commercial membership in Lucas County has declined over the years. (McGinty, Tr. 1168).

Response to Finding No. 806

This proposed finding is misleading and incomplete. Humana's Medicare advantage product has increased membership over the years. (McGinty, Tr. 1168).

807. FrontPath has always maintained a broad network in Lucas County. (Sandusky, Tr. 1287-1288).

Response to Finding No. 807

Complaint Counsel has no specific response.

808. FrontPath experienced no gain or loss in membership during the period when other payors maintained limited networks. (Sandusky, Tr. 1299; PX01352 at 008).

Response to Finding No. 808

This proposed finding is unfounded. The transcript cited does not support RPFF ¶ 808.

5. Industry Trends

809. A trend among physicians is seeking employment from hospitals in lieu of opening their own practices, because they are interested in practicing medicine and not in running their own businesses. (Korducki, Tr. 459, 497; Oostra, Tr. 5796; Pugliese, Tr. 1573).

Response to Finding No. 809

Complaint Counsel has no specific response.

810. Physicians increasingly seek to be employed by hospital systems because of the many challenges to running a successful independent practice. These challenges include the difficulty of negotiating with powerful MCOs like Anthem and MMO. (Pugliese, Tr. 1573).

Response to Finding No. 810

Complaint Counsel has no specific response.

811. Many younger medical school graduates are opting for employment because of the lifestyle it allows them to lead and the ability it gives them to practice medicine in an environment that may not require a productivity level as high as is required in private practice. (Oostra, Tr. 5797).

Response to Finding No. 811

Complaint Counsel has no specific response.

812. Even if a hospital does not recruit or employ a particular physician, it may provide an "income guarantee" to the physician or the physician's group to cover costs and expenses of starting a new practice. (Andreshak, Tr. 1801-1802).

Response to Finding No. 812

Complaint Counsel has no specific response.

813. Every year more and more hospital price information is available to commercially insured patients. (RX-18 (Marcus, Dep. at 136-137)).

Response to Finding No. 813

This proposed finding is misleading. ProMedica has negotiated into its contracts with MMO language that prevents MMO from sharing with its members the rates it pays to ProMedica's hospitals, thus preventing MMO's members from comparing the cost of care at

ProMedica with the cost of care at other hospitals. (CCPFF ¶ 563). Aetna's efforts to steer members to lower-cost hospitals by disclosing rate information have not been effective, because such measures "don't have teeth, they haven't had [an] impact." (CCPFF ¶ 572). ProMedica { }—defined as the use of "some type of incentive or information that would cause patients or physicians to use one provider more than another"—that would lower ProMedica's patient volume. (PX01945 at 013 (Wachsman, Dep. at 42-43), *in camera*).

814. {

(Wachsman, Tr. 5167, *in camera*).

Response to Finding No. 814

Complaint Counsel has no specific response.

815. The standard of care has changed from semi-private to private rooms because (1) inpatients tend to be sicker today than in the past because outpatient care has improved; (2) there is more technology and equipment in hospital rooms than in the past and private rooms provide the space for that equipment; (3) private rooms improve infection control; and (4) private rooms ensure greater patient privacy as mandated by HIPAA regulations. (Nolan, Tr. 6277-6278, *in camera*; Johnston, Tr. 5376; Guerin-Calvert, Tr. 7288-7289; Black, Tr. 5585).

Response to Finding No. 815

This proposed finding is incomplete. A conservative, pro forma projection of St. Luke's operating performance into the future – based on trial testimony, historical performance, and ordinary course documents – shows that St. Luke's would continue to be able to convert semi-private rooms to private rooms, in addition to implementing electronic medical records, eliminating its outstanding bond debt, and continuing to make growth-minded investments. (CCPFF ¶¶ 1082-1083).

816. Private rooms are more efficient operationally and also help improve patient satisfaction. (Johnston, Tr. 5375-5376; Black, Tr. 5585).

Response to Finding No. 816

Complaint Counsel has no specific response.

817. Because patients of different sexes cannot share a room, the use of semi-private forces St. Luke's to move patients around from room to room in order to maximize the use of its rooms. (Johnston, Tr. 5376).

Response to Finding No. 817

Complaint Counsel has no specific response.

818. Many patients also dislike being in semi-private rooms. (Johnston, Tr. 5376).

Response to Finding No. 818

Complaint Counsel has no specific response.

I. The ProMedica/St. Luke's Joinder

1. St. Luke's Considered Several Potential Partners before Seeking an Affiliation with ProMedica

a. Criteria St. Luke's Used To Evaluate Potential Partners

819. { } (PX01030 at 002, *in camera*).

Response to Finding No. 819

Complaint Counsel has no specific response.

820. { } (PX01030 at 007, *in camera*; Wakeman, Tr. 2959-2960, *in camera*; Black, Tr. 5634-5635, *in camera*).

Response to Finding No. 820

Complaint Counsel has no specific response.

821. {

} (Wakeman, Tr. 2961*, in camera*; Black, Tr. 5636, *in camera*).

Response to Finding No. 821

This proposed finding is incomplete and against the weight of the evidence. In addition to the factors listed in this proposed finding, the record is littered with documents and testimony speaking to the importance of higher reimbursement rates from health plans in St. Luke's evaluation of potential affiliation partners. (CCPFF ¶¶ 400-416). Some examples include:

- A St. Luke's planning document, dated August 10, 2009, and reflecting a brainstorming session by St. Luke's senior leaders, notes that an option for St. Luke's would be to "enter[] into an affiliation/partnership with a local health system with the express purpose to raise reimbursement rates to the level of our competitors." (PX01390 at 002 (Framing the St. Luke's Strategy Discussion for Dan Wakeman and the Board), *in camera*; Wakeman, Tr. 2640, 2643, *in camera*).
- Mr. Wakeman testified that he hoped that an affiliation with ProMedica would allow St. Luke's to obtain the higher reimbursement rates that ProMedica was receiving. (Wakeman, Tr. 2685-2686, *in camera*).
- Mr. Black, St. Luke's Board of Directors Chairman, testified that he was under the understanding that "we [St. Luke's] would receive higher reimbursements through our affiliation with ProMedica." (Black, Tr. 5738-5740, *in camera* (discussing PX01030)). Mr. Black also testified that he viewed the potential for "[r]evenue/ reimbursement enhancement" as an important factor in the evaluation of potential affiliation partners by St. Luke's board. (Black, Tr. 5634-5635; *in camera* (discussing PX01030 at 007); PX01030 at 007 (Affiliation Analysis Update, Oct. 30, 2009), *in camera*).

822. {

} (Wakeman, Tr. 2888-2889, *in camera*).

Response to Finding No. 822

Complaint Counsel has no specific response.

823. {

} (Wakeman, Tr. 2961, *in camera*; Black, Tr. 5642, *in camera*).

Response to Finding No. 823

This proposed finding is misleading and incorrect. Obtaining higher reimbursement rates in an affiliation was of paramount importance to St. Luke's leadership. (*See* Response to RPFF ¶ 821).

824. {

} (Wakeman, Tr. 3001-3002, *in camera*).

Response to Finding No. 824

This proposed finding is misleading and incomplete. Not only was St. Luke's board focused on maintaining and improving St. Luke's quality, but it was also specifically concerned about the impact of ProMedica's poor quality on St. Luke's. St. Luke's identified TTH as a "High Cost, Low Quality" option and noted ProMedica's poor quality measures in its planning documents. (PX01016 at 006, 023 (St. Luke's Board Meeting Affiliation Update Dec. 2009), *in camera*; PX01018 at 012, 014 (Options for St. Luke's), *in camera*; CCPFF ¶¶ 669-682).

825. {

} (Wakeman, Tr. 2941-2942, *in camera*).

Response to Finding No. 825

This proposed finding is incorrect. UTMC's Dr. Jeffrey Gold testified that UTMC does not have any current plans to build a new hospital in or near Lucas County. (Gold, Tr. 223). Dr. Gold also testified that UTMC has no current plans to increase capacity for general acute-care inpatient services, either in general or in response to ProMedica's acquisition of St. Luke's. (Gold, Tr. 223-224).

826. {

} (PX01283 at 002, *in camera*; Wakeman, Tr. 2950-2951, *in camera*).

Response to Finding No. 826

Complaint Counsel has no specific response.

b. Potential Non-Lucas County, Ohio Affiliation Partners

(i) The Cleveland Clinic

827. In late 2008, St. Luke's discussions with The Cleveland Clinic about a potential affiliation. (Wakeman, Tr. 2541-2542; PX01911 (Wakeman, IHT at 194-195)).

Response to Finding No. 827

Complaint Counsel has no specific response.

828. The Cleveland Clinic requested a fee in excess of $300,000 to evaluate a potential partnership with St. Luke's, which St. Luke's did not think was acceptable. (PX01911 (Wakeman, IHT at 194); Black, Tr. 5604).

Response to Finding No. 828

Complaint Counsel has no specific response.

829. The Cleveland Clinic informed St. Luke's that they were not interested in an affiliation, because they did not want to threaten their referrals from other Toledo Hospitals. (PX01911 (Wakeman, IHT at 194)).

Response to Finding No. 829

Complaint Counsel has no specific response.

(ii) University of Michigan Health System

830. In late 2008 or early 2009, St. Luke's had discussions with the University of Michigan Health System ("UMHS") about a potential affiliation. (Wakeman, Tr. 2542-2544; PX01911 (Wakeman, IHT at 195-196); Black, Tr. 5603).

Response to Finding No. 830

Complaint Counsel has no specific response.

831. During its discussions with UMHS, St. Luke's outlined its major capital needs, to which UMHS responded that it was not interested in making the significant influx of capital that St. Luke's required. (PX01911 (Wakeman, IHT at 195-196)).

Response to Finding No. 831

This proposed finding is unfounded and mischaracterizes Mr. Wakeman's testimony. St. Luke's did not require a significant influx of capital. Mr. Wakeman testified, "*if* we had required significant influx of capital," not that such an influx actually was needed or required. (PX01911 at 050 (Wakeman, IHT at 195), *in camera* (emphasis added)).

832. UMHS also informed St. Luke's that they were not interested in an affiliation because UMHS did not want to jeopardize their referrals from the two large systems in Toledo. (PX01911 (Wakeman, IHT at 195)).

Response to Finding No. 832

Complaint Counsel has no specific response.

(iii) McLaren Health Care Corporation

833. In late 2008, St. Luke's had discussions with McLaren Health Care Corporation ("McLaren") about a potential affiliation. (PX01911 (Wakeman, IHT at 196)).

Response to Finding No. 833

Complaint Counsel has no specific response.

834. McLaren informed St. Luke's that it was not interested in an affiliation because it did not fit with McLaren's strategic plan. (PX01911 (Wakeman, IHT at 197)).

Response to Finding No. 834

Complaint Counsel has no specific response.

835. St. Luke's did not reinitiate discussions with any of the potential joinder partners from outside of Toledo, The Cleveland Clinic, UMHS, or McLaren, after those discussions initially ended because St. Luke's Board was more interested in joining with an organization that would have more local governance ties. (Wakeman, Tr. 2547-2548).

Response to Finding No. 835

Complaint Counsel has no specific response.

(iv) White House Group

836. The "White House Group" was a group of community hospitals located close to St. Luke's, including WCH, FCHC, Henry County Hospital, Blanchard Valley Hospital, and St. Luke's, that met on a regular basis, about once a month. (Wakeman, Tr. 2548- 2549).

Response to Finding No. 836

Complaint Counsel does not disagree.

837. In mid- to late 2008, St. Luke's and the other White House Group members began discussions about a potential affiliation among the White House Group members. (Wakeman, Tr. 2548-2549).

Response to Finding No. 837

This proposed finding is misleading. Mr. Wakeman testified that the White House Group did not exchange due diligence materials or even discuss a structure or governance model. (Wakeman, Tr. 2549). Mr. Wakeman did not categorize any discussions with the White House Group as "detailed." (Wakeman, Tr. 2549).

838. Affiliation discussions at the White House Group included a presentation by an attorney about developments in federal healthcare reform including potential Accountable Care Organizations. (Wakeman, Tr. 2549-2550).

Response to Finding No. 838

Complaint Counsel does not disagree.

839. St. Luke's believed that getting this diverse group of hospitals to agree on governance and risk sharing provisions would be very complex and challenging. (Wakeman, Tr. 2551).

Response to Finding No. 839

Complaint Counsel has no specific response.

840. In 2009, St. Luke's decided not to pursue an affiliation among the White House Group members because "the time frame of putting something together…would far exceed our ability to survive long-term given our losses." (Wakeman, Tr. 2551).

Response to Finding No. 840

This proposed finding is misleading. No detailed discussions occurred regarding the affiliation. (*See* Response to RPFF ¶ 837).

c. UTMC

841. UTMC began exploring an affiliation with St. Luke's in late 2008. (Gold, Tr. 225).

Response to Finding No. 841

Complaint Counsel has no specific response.

842. UTMC and St. Luke's signed a non-exclusive Memorandum of Understanding in April 2009. (PX02203 at 001; Wakeman, Tr. 2857; Gold, Tr. 239).

Response to Finding No. 842

Complaint Counsel does not disagree.

843. The Memorandum of Understanding between St. Luke's and UTMC was not a binding agreement to affiliate, had a term of 180 days, and could be terminated by either party with 30 days notice. (PX02203 at 001, 004; Wakeman, Tr. 2857).

Response to Finding No. 843

Complaint Counsel does not disagree.

844. St. Luke's CEO, Mr. Wakeman, described the Memorandum of Understanding between UTMC and St. Luke's in internal communications as "just an agreement to talk and explore." (PX01460; Wakeman, Tr. 2858).

Response to Finding No. 844

This proposed finding is incorrect and misleading. UTMC's Dr. Gold testified that this Memorandum of Understanding was "the first formal document that we exchanged that was

intended to lay out the framework for the basis of an affiliation and a due diligence process[.]" (Gold, Tr. 233).

845. Affiliation discussions between UTMC and St. Luke's stretched approximately eight months in 2009. (Gold, Tr. 364).

Response to Finding No. 845

Complaint Counsel does not disagree.

846. UTMC felt that an affiliation with St. Luke's would have to result in one surviving entity with the term "University," central in the surviving brand and that a teaching hospital ethos had to prevail. (Gold, Tr. 326; RX-944 at 000002).

Response to Finding No. 846

This proposed finding is misleading. Dr. Gold did not discuss the corporate structure in the cited testimony; he simply discussed the "corporate branding" of an affiliation. (Gold, Tr. 326). This branding concept was, in fact, agreed to by St. Luke's and did not stand in the way of a potential affiliation with UTMC. (Gold Tr., 326).

847. During the eight months that UTMC was exploring an affiliation with St. Luke's, there was no discussion regarding the feasibility of such an affiliation. (Gold, Tr. 291).

Response to Finding No. 847

This proposed finding is misleading. According to Dr. Gold, the feasibility analysis of a UTMC-St. Luke's affiliation was on hold pending completion of the due diligence process. (Gold, Tr. 291). In fact, the due diligence process was ongoing, but information was never exchanged because the President and CEO of St. Luke's informed Dr. Gold that St. Luke's was discontinuing talks with UTMC in favor of proceeding with the Acquisition. (Gold, Tr. 360-361).

848. During the eight months that UTMC was exploring an affiliation with St. Luke's, UTMC did not conduct a formal analysis of St. Luke's quality. (Gold, Tr. 226, 287).

Response to Finding No. 848

This proposed finding is misleading. It was UTMC's intention to conduct a formal analysis of St. Luke's quality, along with many other parts of the due diligence process, but ultimately it could not do so because St. Luke's informed Dr. Gold that St. Luke's was not going to pursue a relationship with UTMC. (Gold, Tr. 226-227, 360-361).

849. During the eight months that UTMC was exploring an affiliation with St. Luke's, UTMC did not conduct formal due diligence of St. Luke's. (Gold, Tr. 248, 291). Their information exchange was limited to publicly accessible information. (Wakeman, Tr. 2866-2867).

Response to Finding No. 849

This proposed finding is misleading. In fact, the due diligence process was ongoing, but information was never exchanged because the President and CEO of St. Luke's informed Dr. Gold that St. Luke's was not going to go forward with a relationship with UTMC. (Gold, Tr. 360-361).

850. St. Luke's affiliation discussions with UTMC did not proceed to the due diligence stage where any potential efficiencies could have been identified or quantified in any detail. (RX-1860 at 000008; Gold, Tr. 322-323).

Response to Finding No. 850

This proposed finding is inaccurate and misleading. UTMC officials believed that a St. Luke's/UTMC affiliation could have led to substantial efficiencies, including many of the same types of efficiencies Respondent claims may result from the Acquisition. (Gold, Tr. 245-246 (including "back-of-the house functions: finance, information technology, human resources services, and many others that are typically used to run hospitals" and "consolidation of clinical services [which] would allow us to deliver higher volume, higher quality services, and be more efficient."); PX01406 at 001 (Wakeman Jul. 2009 Email) (benefits to UTMC partnership are "endless"); PX01407 at 001 (Wakeman (St. Luke's) Oct. 2009 Email to Dr. Gold (UTMC)) (a

UTMC affiliation "would provide just as much [expense reduction] as the two systems [Mercy and ProMedica]."); Response to RFA at ¶ 11).

UTMC was not able to formally quantify efficiencies from a UTMC-St. Luke's affiliation because UTMC was "informed of the decision of the board of St. Luke's to not continue the efforts to bring St. Luke's and the University of Toledo together." (Gold, Tr. 361).

851. During the eight months that UTMC was exploring an affiliation with St. Luke's, UTMC did not receive any of the information it requested from St. Luke's in its draft due diligence request. (Gold, Tr. 312).

Response to Finding No. 851

Complaint Counsel has no specific response.

852. During the eight months that UTMC was exploring an affiliation with St. Luke's, UTMC neither learned about St. Luke's capital needs, nor evaluated St. Luke's financial health. (Gold, Tr. 318).

Response to Finding No. 852

Complaint Counsel has no specific response.

853. UTMC also did not offer to make a capital contribution to St. Luke's in the context of the affiliation discussions. (Gold, Tr. 320).

Response to Finding No. 853

Complaint Counsel has no specific response.

854. During the time that UTMC was exploring an affiliation with St. Luke's, UTMC was aware that St. Luke's was also discussing possible affiliations with other hospitals. (Gold, Tr. 293).

Response to Finding No. 854

Complaint Counsel does not disagree.

855. During the time that UTMC was exploring an affiliation with St. Luke's, UTMC identified several challenges to a potential affiliation, including: combining a small community hospital with a large, academic medical center; merging two different cultures; and dealing with the union status at UTMC and the non-union status at St. Luke's. (Gold, Tr. 294).

Response to Finding No. 855

This proposed finding is misleading. Dr. Gold specifically testified that none of these issues were insurmountable. (Gold, Tr. 352-353).

856. During the time that UTMC was exploring an affiliation with St. Luke's, the parties never finalized a business plan. (Gold, Tr. 316-317).

Response to Finding No. 856

This proposed finding is misleading and incomplete. Dr. Gold believed that UTMC and St. Luke's were close to finalizing a structure for the affiliation, but they were not able to complete the process because St. Luke's cut off talks with UTMC. (Gold, Tr. 363-364).

857. During the time that UTMC was exploring an affiliation with St. Luke's, the parties never converted the Memorandum of Understanding to a merger agreement. (Gold, Tr. 317).

Response to Finding No. 857

This proposed finding is misleading and incomplete. St. Luke's and UTMC never converted the Memorandum of Understanding to a merger agreement because St. Luke's cut off talks with UTMC regarding an affiliation before the process could be completed. (*See* Responses to RPFF ¶¶ 847-850, 856).

858. St. Luke's management believed that a weakness of UTMC was that its board was responsible for the entire University and would give relatively little attention to the potential combined St. Luke's-UTMC hospital. (PX01352 at 020; Wakeman, Tr. 2807-2808).

Response to Finding No. 858

This proposed finding is unfounded. The cited document and testimony state that the University of Toledo Board of Regents has responsibility for the hospital, but does not specifically call that "a weakness." (PX01352 at 020 (St. Luke's Board and Medical Staff Planning Retreat Apr. 2008); Wakeman, Tr. 2807-2808).

859. In 2009 partnering discussions with St. Luke's, UTMC proposed an eight person board for the combined organization where the President of the University would have final say

over all decisions if there was a tie vote. This proposed governance model was not acceptable to St. Luke's CEO or its board. (Wakeman, Tr. 2852-2853).

Response to Finding No. 859

Complaint Counsel has no specific response.

860. During its discussions with UTMC, St. Luke's was concerned that UTMC faced possible cuts in their state funding and reduced enrollment due to the economic downturn. (Wakeman, Tr. 2853-2854, 2867-2868).

Response to Finding No. 860

Complaint Counsel has no specific response.

861. St. Luke's management and board also had concerns about UTMC's unionized workforce and hierarchical structure in contrast to St. Luke's non-union, flat structure. (Wakeman, Tr. 2868).

Response to Finding No. 861

This proposed finding is misleading. Dr. Gold specifically testified that this issue was not insurmountable. (Gold, Tr. 352).

862. { } (PX01030 at 008, *in camera*).

Response to Finding No. 862

Complaint Counsel has no specific response.

863. In the summer of 2009, partnering talks between St. Luke's and UTMC were not making progress as the senior management and boards of directors of each of the organizations could not come to agreement on the structure of the potential partnership. UTMC's proposed structures were not acceptable to St. Luke's board leadership group. (Wakeman, Tr. 2866-2867).

Response to Finding No. 863

This proposed finding is incorrect and misleading. Dr. Gold testified that UTMC intended to move forward with efforts to finalize a structure for an affiliation with St. Luke's –

and in fact, UTMC was very close. (Gold, Tr. 363). The only reason this was not completed was because of St. Luke's decision to terminate discussions with UTMC. (Gold, Tr. 363-364).

864. St. Luke's and UTMC did not engage a third party consultant to evaluate the potential partnership (as St. Luke's would do when exploring a potential affiliation with Mercy). (Wakeman, Tr. 2866).

Response to Finding No. 864

Complaint Counsel has no specific response.

865. During partnering discussions with UTMC, St. Luke's board believed that the complexity of a relationship of St. Luke's, a private non-profit, with UTMC, a state entity, would be "onerous" and would have "a lot of challenges." (Wakeman, Tr. 2867-2868).

Response to Finding No. 865

Complaint Counsel has no specific response.

866. During partnering discussions with UTMC, St. Luke's perceived that UTMC was struggling with some core quality measures. (Wakeman, Tr. 2869).

Response to Finding No. 866

This proposed finding is incomplete and misleading. In fact, the potential affiliation partner whose quality St. Luke's was most concerned about was not UTMC, but *ProMedica*. (*See* Response to RPFF ¶ 824).

867. St. Luke's board was concerned that UTMC's quality of care was not as good as St. Luke's and that was a negative consideration for an affiliation between UTMC and St. Luke's. (RX-16 (Bazeley, Dep. at 67-68)).

Response to Finding No. 867

This proposed finding is incomplete and misleading. In fact, the potential affiliation partner whose quality St. Luke's was most concerned about was not UTMC, but *ProMedica*. (*See* Response to RPFF ¶ 824).

868. {

} (PX01030 at 018, *in camera*).

Response to Finding No. 868

This proposed finding is incomplete and misleading. Respondent failed to note that the hospital with the lowest quality ranking was ProMedica's TTH. (PX01030 at 018 (St. Luke's Affiliation Analysis Update Oct. 2009), *in camera*).

869. { }
(PX01018 at 013, *in camera*).

Response to Finding No. 869

This proposed finding is irrelevant and misleading. As Professor Town testified, UTMC is an academic medical center, so its costs may be different. (Town, Tr. 4101). UTMC also serves the tertiary and quaternary needs of the Toledo community, and may have higher costs as a result of providing these high level services. (Gold, Tr. 193).

870. { }
(PX01018 at 013, *in camera*).

Response to Finding No. 870

This proposed finding is misleading. Because UTMC is an academic medical center and serves the tertiary and quaternary needs of Toledo, its cost structure is different than the other hospitals in the Toledo area. (*See* Response to RPFF ¶ 869). In addition, since UTMC focuses on higher complexity services than the other hospitals in Toledo, it is understandable its revenue per discharge would be higher. (RPFF ¶ 11).

871. St. Luke's board was also concerned that UTMC's status as a state institution and the fact that it received state subsidies meant that it was not as financially savvy as a truly independent institution, like St. Luke's. (RX-16 (Bazeley, Dep. at 68-69)).

Response to Finding No. 871

Complaint Counsel has no specific response.

872. St. Luke's management believed that UTMC had { } (PX01018 at 016, *in camera*).

Response to Finding No. 872

Complaint Counsel has no specific response.

873. By October 2009, St. Luke's and UTMC had not resolved many of the fundamental questions needed to proceed with full due diligence, including what the functional structure of the partnership would be, what the "service line focus" would be, and how incentives would be set up to meet certain quality goals. (PX01407; Wakeman, Tr. 2956-2958*, in camera*).

Response to Finding No. 873

This proposed finding is misleading. Dr. Gold testified that UTMC intended to move forward with efforts to finalize a structure for an affiliation with St. Luke's – and in fact, UTMC was very close. (Gold, Tr. 363). In addition, the due diligence process was ongoing, but information was never exchanged. (Gold, Tr. 360-361). The only reason these things were not completed was because of St. Luke's decision to terminate discussions with UTMC. (Gold, Tr. 360-361, 363-364).

874. {

} (PX01583 at 001, *in camera*; Wakeman, Tr. 2977-2978, in *camera*).

Response to Finding No. 874

Complaint Counsel has no specific response.

875. In late November 2009, St. Luke's Board of Directors determined that joining with UTMC was not in the best interest of the hospital or the community and terminated affiliation discussions with UTMC because: (1) UTMC's proposed board structure was not acceptable to St. Luke's because the UT leadership wanted to maintain full veto power over the combined board and any decision made by that board; (2) UTMC was "a totally unionized organization" and St. Luke's board was very concerned about the UTMC's union culture moving into St. Luke's non-union culture; and (3) the general hierarchy and culture at UTMC was not deemed to be compatible with St. Luke's culture. (Wakeman, Tr. 2556-2557; Black, Tr. 5648, *in camera*; RX-1860 at 000008-000009).

Response to Finding No. 875

This proposed finding is incomplete and misleading. St. Luke's also rejected UTMC because its leadership questioned UTMC's ability to "give [St. Luke's] enough managed care clout? Would we become 'too important to be ignored' with this partnership?" (PX01018 at 017, *in camera*). Instead, St. Luke's picked ProMedica because of ProMedica's higher reimbursement rates. (*See* Response to RPFF ¶ 821).

876. {

} (Wakeman, Tr. 3003*, in camera*; PX01457, *in camera*).

Response to Finding No. 876

Complaint Counsel has no specific response.

d. Mercy

877. St. Luke's originally approached Mercy in 2008 with a the idea of a joint venture involving heart and maternal/child services. These were two areas where St. Luke's was losing money and there appeared to be overcapacity in the community. (Wakeman, Tr. 2823-2825; Black, Tr. 5589; Shook, Tr. 988-989, *in camera*).

Response to Finding No. 877

This proposed finding is unfounded. There is no discussion of "overcapacity" in the cited testimony. (Wakeman, Tr. 2823-2825; Black, Tr. 5589; Shook, Tr. 988-989, *in camera*).

878. {

}

(Shook, Tr. 1103-1104, *in camera*).

Response to Finding No. 878

Complaint Counsel has no specific response.

879. St. Luke's and Mercy hired Health Care Futures, an outside consultant, to assist them in evaluating information about the potential joint ventures in heart and vascular and maternal/child services. (Wakeman, Tr. 2825; Shook, Tr. 990, *in camera*).

Response to Finding No. 879

Complaint Counsel has no specific response.

880. {
} (Shook, Tr. 1097, *in camera*).

Response to Finding No. 880

Complaint Counsel has no specific response.

881. {

} (Shook, Tr. 1097-1098, *in camera*).

Response to Finding No. 881

Complaint Counsel has no specific response.

882. { } (Shook, Tr. 1107, *in camera*).

Response to Finding No. 882

This proposed finding is misleading and unfounded. Mr. Shook testified that "I'm not quite sure we had that information." (Shook, Tr. 1107, *in camera*).

883. {
} (PX02307 at 002, *in camera*).

Response to Finding No. 883

Complaint Counsel has no specific response.

884. {

} (Wakeman, Tr. 2882-2883, 2887, *in camera*; Shook, Tr. 1099, *in camera*; PX02307 at 002, *in camera*; PX01232 at 002-003, *in camera*).

Response to Finding No. 884

Complaint Counsel has no specific response.

885. {

} (Shook, Tr. 1100, *in camera*; PX02307 at 002, *in camera*).

Response to Finding No. 885

Complaint Counsel has no specific response.

886. {
}

(Shook, Tr. 1103, *in camera*; PX02307 at 002, *in camera*).

Response to Finding No. 886

Complaint Counsel has no specific response.

887. {
}

(Shook, Tr. 991, 994, *in camera*).

Response to Finding No. 887

Complaint Counsel has no specific response.

888. {
} (Shook, Tr. 994, *in camera*).

Response to Finding No. 888

Complaint Counsel has no specific response.

889. {
}

(Shook, Tr. 1105, *in camera*; PX02307 at 009, *in camera*).

Response to Finding No. 889

Complaint Counsel has no specific response.

890. {
} (Shook, Tr. 1105-1106, *in camera*; PX02307 at 009, *in camera*).

Response to Finding No. 890

Complaint Counsel has no specific response.

891. {

} (Shook, Tr.1106, *in camera*).

Response to Finding No. 891

This proposed finding is misleading. Mercy did not commit to contribute capital to St. Luke's because St. Luke's ended discussions prematurely while Mercy remained interested in an affiliation. (Wakeman, Tr. 2559; PX01922 at 021, 023 (Shook, Dep. at 80, 89), *in camera*). Like UTMC, Mercy was surprised and disappointed by St. Luke's decision to end affiliation discussions. (Shook, Tr. 1002, *in camera*).

892. {

} (Shook, Tr. 1106-1107 *in camera*).

Response to Finding No. 892

This proposed finding is misleading. Mercy and St. Luke's did not come to an agreement on governing or managing structure because St. Luke's cut off talks before discussions could progress that far. (*See* Response to RPFF ¶ 891).

893. {

} (Shook, Tr. 1107, *in camera*).

Response to Finding No. 893

This proposed finding is misleading. Mercy and St. Luke's did not conduct formal due diligence because St. Luke's cut off talks before this could happen. (*See* Response to RPFF ¶ 891).

894. {

} (Shook, Tr. 1108-1109, *in camera*).

Response to Finding No. 894

This proposed finding is misleading. Mercy and St. Luke's did not enter into a formal partnering agreement or a signed memorandum of understanding, letter of intent, or final agreement because St. Luke's cut off talks before this could happen. (*See* Response to RPFF ¶ 891).

895. {

} (Shook, Tr. 1009, 1111, 1118, *in camera*).

Response to Finding No. 895

Complaint Counsel has no specific response.

896. {

} (Shook, Tr. 1009, *in camera*).

Response to Finding No. 896

Complaint Counsel has no specific response.

897. {

} (PX01583 at 001-002, *in camera*).

Response to Finding No. 897

Complaint Counsel has no specific response.

898. {

} (PX01583 at 002, *in camera*; Wakeman, Tr. 2560-2561, 2980-2982, *in camera*; Black, Tr. 5647, *in camera*; Shook, Tr. 1000-1001, *in camera*; RX-16 (Bazeley, Dep. at 91-94)).

Response to Finding No. 898

Complaint Counsel has no specific response.

899. {

}

(PX01583 at 002, *in camera*; Wakeman, Tr. 2980-2982*, in camera*). "It appeared to our board that much of the key decision-making … was coming from Catholic Health Partners in Cincinnati and not locally." (Wakeman, Tr. 2560-2561).

Response to Finding No. 899

Complaint Counsel has no specific response.

900. {

} (Wakeman, Tr. 2888-2889, 2894, *in camera*; PX01018 at 015, *in camera*).

Response to Finding No. 900

Complaint Counsel has no specific response.

901. {

} (PX01232 at 002, *in camera*).

Response to Finding No. 901

Complaint Counsel has no specific response.

902. {

} (Wakeman, Tr. 3003, *in camera*).

Response to Finding No. 902

Complaint Counsel has no specific response.

2. ProMedica

a. Information Technology and Service Line Joint Ventures Discussions Lead to Joinder Negotiations

903. {

} (PX1232 at 003, *in camera*; Wakeman, Tr. 2892, *in camera*).

Response to Finding No. 903

This proposed finding is misleading. ProMedica's CEO testified that ProMedica has been interested in acquiring or affiliating with St. Luke's for at least fifteen years. (Oostra, Tr. 6116-6117).

904. ProMedica and St. Luke's first discussed a possible heart and vascular service line joint venture. (Hanley, Tr. 4528).

Response to Finding No. 904

Complaint Counsel has no specific response.

905. At the same time that ProMedica and St. Luke's discussed a possible heart and vascular service line joint venture, they also discussed a potential information technology joint venture. (Oostra, Tr. 5840).

Response to Finding No. 905

Complaint Counsel has no specific response.

906. The joint venture discussions did not materialize, in part, due to the complexity of that type of integration, and because resolution of the major issues confronting St. Luke's would require a more extensive relationship, like a joinder. (Hanley, Tr. 4531; Oostra, Tr. 5841).

Response to Finding No. 906

This proposed finding is misleading. The St. Luke's Hospital Board voted to pursue a joint venture option with ProMedica. However, ProMedica pushed St. Luke's into full joinder discussions and used Paramount as leverage. St. Luke's was told that they would not get full access to Paramount without a joinder agreement. (PX01516 at 001, *in camera*). It was Mr. Oostra that pushed St. Luke's for a full Acquisition. (PX01906 at 033-034 (Oostra, IHT at 128-129), *in camera* ("Every time that I talked to Dan, I – I drove the issue.")).

907. Next, the parties began discussing a full joinder in fall of 2009. (Hanley, Tr. 4531).

Response to Finding No. 907

Complaint Counsel has no specific response.

908. A joinder is a member substitution structure in which ProMedica functions as the parent entity and holds reserve powers over the "joined" party, which retains its own board and independent governance. (Hanley, Tr. 4531-4532).

Response to Finding No. 908

This proposed finding is misleading. The St. Luke's Board still exists but St. Luke's does not have independent governance. Under the joinder agreement, ProMedica reserves the power to approve all nominees to the St. Luke's Board and to remove any board member with or without cause. ProMedica also has the power to authorize, adopt, and/or approve all of St. Luke's strategic plans, annual operating budget, and capital budgets. Additionally, ProMedica can appoint and remove the president, secretary, and treasurer of St. Luke's, and authorize and/or approve any amendments to the articles of incorporation, code of regulations, by-laws, operating agreements or analogous governing documents of St. Luke's. (PX00058 at 016-018 (Joinder Agreement, Article 4 – Reserve Powers); *see also* CCPFF ¶ 47).

909. ProMedica's board and finance committee discussed the potential joinder with St. Luke's at its regular meetings from late 2009 through 2010. (Oostra, Tr. 5843-5845; RX-507 at 000004; RX-508 at 000003; RX-509 at 000002; RX-510 at 000001; RX-511 at 000002; RX-512 at 000001).

Response to Finding No. 909

Complaint Counsel has no specific response.

910. ProMedica's board members had a detailed discussion about the wisdom of bringing St. Luke's into ProMedica Health System, given St. Luke's financial condition. (Oostra, Tr. 5850).

Response to Finding No. 910

Complaint Counsel has no specific response.

911. {
} (PX01232 at 002, *in camera*; Wakeman, Tr. 2894-2897, *in camera*).

Response to Finding No. 911

This proposed finding is misleading and incomplete. St. Luke's acknowledged that an affiliation with ProMedica had many negative consequences for the Toledo community. In an email on October 11, 2009, to St. Luke's Board members and managers tasked with searching for possible affiliation partners, Mr. Wakeman wrote that "incredible access to outstanding pricing on managed care agreements" is among the important "things Pro[M]edica brings to the table" as an affiliation partner, and that "[t]aking advantage" of this strength "may not be the best thing for the community in the long run" but that it "[s]ure would make life much easier right now though." (PX01125 at 002, *in camera*; Wakeman, Tr. 2682-2683, *in camera*; *see also* PX01130 at 004 (Notes from Due Diligence Meetings, Aug. 26, 2009), *in camera* ("Concern that U.T.[M.C.] does/ may not have as high of [sic] reimbursement rates as ProMedica and/ or Mercy.")). Mr. Wakeman wrote this statement under the assumption that "if our [St. Luke's] rates would have went up to the insurers, the insurers would have then passed those rates off to the employers and the community." (Wakeman, Tr. 2682, *in camera*, 2687, *in camera* (discussing PX01125 at 002)).

912. {

} (PX01390 at 003, *in camera*; Wakeman, Tr. 2901*, in camera*).

Response to Finding No. 912

Complaint Counsel has no specific response.

913. {

} (Wakeman, Tr. 2902, *in camera*).

Response to Finding No. 913

Complaint Counsel has no specific response.

914. {

}

(Wakeman, Tr. 2902, *in camera*).

Response to Finding No. 914

Complaint Counsel has no specific response.

915. {

} (PX01018 at 014, *in camera*).

Response to Finding No. 915

This proposed finding is incomplete. In addition to the items listed, the record is littered with documents and testimony speaking to the importance of higher reimbursement rates from health plans in St. Luke's decision to proceed with the Acquisition. (Response to RPFF ¶ 821).

916. {

} (Wakeman, Tr. 2914, *in camera*).

Response to Finding No. 916

This proposed finding is misleading. ProMedica could have given St. Luke's access to the Paramount network at any time absent the Acquisition. (Dagen, Tr. 3289-3290, *in camera*; PX02147 at 080-081 (¶ 158) (Dagen Expert Report)). St. Luke's executives expressed interest in participating in Paramount's provider network prior to the Acquisition. (Wakeman, Tr. 2584-2585; PX01911 at 035 (Wakeman, IHT at 134-135), *in camera* ("we'd really like to get back in")). Mr. Wachsman, ProMedica's Director of Managed Care Contracting, testified that it was ProMedica's reluctance that prevented St. Luke's from being a part of the Paramount provider

network prior to the Acquisition. (PX01905 at 052 (Wachsman, IHT at 203), *in camera*). In particular, ProMedica did not add St. Luke's to Paramount's network prior to the Acquisition due to concerns about the patient volume that ProMedica's hospitals would lose to St. Luke's. (Wachsman, Tr. 5193, *in camera*).

Mr. Wakeman testified in court that St. Luke's might have been able to gain access to Paramount's provider network through an affiliation with UTMC, as well. (Wakeman, Tr. 2692, *in camera*; PX01030 at 002 (Affiliation Analysis Update), *in camera*).

917. {

} (PX01018 at 014, *in camera*; Wakeman, Tr. 2916, *in camera*).

Response to Finding No. 917

Complaint Counsel has no specific response.

918. {

} (PX01018 at 014, *in camera*; Wakeman, Tr. 2916-2917, *in camera*).

Response to Finding No. 918

This proposed finding is misleading. The fact that many physicians in Lucas County had admitting privileges at both ProMedica and St. Luke's before the Acquisition supports the conclusion that these firms directly competed with one another before the Acquisition. (PX01850 at 011-016 (¶¶ 14-23) (Town Rebuttal Report), *in camera*); *see* PX02136 at 043 (¶ 42) (Guerin-Calvert Supp. Decl.), *in camera*).

919. {

} (PX01283 at 002, *in camera*; Wakeman, Tr. 2950-2951, *in camera*).

Response to Finding No. 919

This proposed finding is misleading. Any efficiencies occurring as a result of the consolidation of back-room activities could have been achieved through an affiliation with Mercy, UTMC, or another partner. (*See* CCPFF ¶¶ 845-854).

920. {

} (Wakeman, Tr. 3000-3001, *in camera*).

Response to Finding No. 920

Complaint Counsel has no specific response.

921. {

} (Wakeman, Tr. 3002, *in camera*).

Response to Finding No. 921

This proposed finding is incomplete and misleading. In fact, St. Luke's was concerned about low quality at ProMedica's legacy hospitals and the potential negative impact on St. Luke's quality that could result from an acquisition by ProMedica. (*See* Response to RPFF ¶ 824). ProMedica's TTH's quality scores ranked last out of all Toledo hospitals. (PX01030 at 018 (Affiliation Analysis Update), *in camera*).

b. Memorandum of Understanding

922. ProMedica and St. Luke's signed a Memorandum of Understanding ("MOU") on January 15, 2010 to "provide a framework for their discussions" for a proposed transaction in which OhioCare and its subsidiaries including St. Luke's "would become an integral part of ProMedica." (Hanley, Tr. 4545; RX-1912 at 000001, *in camera*; Oostra, Tr. 5849).

Response to Finding No. 922

Complaint Counsel has no specific response.

923. {

(Wakeman, Tr. 3010-3011, *in camera*).

Response to Finding No. 923

Complaint Counsel has no specific response.

924. {

} (Wakeman, Tr. 3010-3011, *in camera*).

Response to Finding No. 924

This proposed finding is misleading and incomplete. As of December 31, 2010, St. Luke's held a total of at least $70 million in cash and investment balances. (Joint Stipulations of Law and Fact, JX00002A ¶ 35). St. Luke's reserves have been, and can continue to be, used for appropriate capital projects. (PX01006 at 010 (OhioCare Consolidated Financial Report Dec. 31, 2009) ("Assets limited as to use include assets designated by the board of directors for future capital improvements . . . over which the board retains control, and may, at its discretion, subsequently use for other purposes.")). St. Luke's "established its investment policy to provide a financial reserve for long-term replacement, modernization and expansion of hospital facilities." (PX01275 at 047 (St. Luke's Credit Presentation)).

St. Luke's had sufficient funds to complete its high priority capital projects, including EMR implementation and private room conversions. (Black, Tr. 5695 5696; Dagen, Tr. 3213; PX02147 at 015-018 (¶¶ 29-34) (Dagen Expert Report); *see also* PX01908 at 056 (Deacon, IHT at 216), *in camera*). Even Mr. Den Uyl testified that, absent the Acquisition, St. Luke's "fully intended" to implement EMR starting in 2010. (PX01951 at 044 (Den Uyl, Dep. at 170-171), *in camera*; *see also* Johnston, Tr. 5481-5484, *in camera*).

925. In the context of negotiating and drafting the MOU, ProMedica perceived that there were three conceptual topics of particular importance to St. Luke's: (1) St. Luke's maintaining its identity, (2) St. Luke's keeping its board in place, and (3) St. Luke's receiving a capital contribution from ProMedica. (Hanley, Tr. 4547-4548).

Response to Finding No. 925

Complaint Counsel has no specific response.

926. ProMedica understood that St. Luke's had significant capital needs for IT, EMR, outpatient surgery, private rooms, and investing in its OB program. (Hanley, Tr. 4548; Oostra, Tr. 5854-5855).

Response to Finding No. 926

Complaint Counsel has no specific response.

927. ProMedica believed that St. Luke's was not capable of making investments into its facility on its own. (Hanley, Tr. 4549).

Response to Finding No. 927

This proposed finding is misleading, incomplete, and incorrect. St. Luke's large cash and investment reserve balance would have enabled it to make investments in its facility on its own, without the Acquisition. (*See* Response to RPFF ¶ 924).

928. During the MOU and joinder discussions with St. Luke's, ProMedica agreed to contribute $5 million to St. Luke's Foundation at closing and $30 million over three years to St. Luke's to be dedicated to capital projects. (Hanley, Tr. 4555; Oostra, Tr. 5852).

Response to Finding No. 928

Complaint Counsel has no specific response.

929. ProMedica has made a capital contribution in all of its joinders; therefore ProMedica arrived at the $35 million sum by evaluating the size and timing of its other joinders to assign a capital contribution to St. Luke's that would be in line with its contributions to other hospitals. (Oostra, Tr. 5852-5853).

Response to Finding No. 929

Complaint Counsel has no specific response.

930. The MOU provided that following the joinder with ProMedica, St. Luke's board and the St. Luke's Foundation board would remain intact and composed of representatives of the community. (Hanley, Tr. 4556; RX-1912 at 000003, *in camera*).

Response to Finding No. 930

This proposed finding is incomplete, misleading, and irrelevant to the extent that the joinder agreement and not the MOU now controls. While the joinder agreement did leave St. Luke's with a hospital and a foundation board, ProMedica has the right to approve all nominees to the board and the right to remove any board member with or without cause. (PX00058 at 016-017 (Joinder Agreement, Article 4.1 (a-c)); *see also* CCPFF ¶ 47).

931. The MOU provided that St. Luke's would be governed by its own board, subject to ProMedica's reserve powers. (Hanley, Tr. 4557; RX-1912 at 000003, *in camera*).

Response to Finding No. 931

This proposed finding is incomplete, misleading, and irrelevant to the extent that the joinder agreement and not the MOU now controls. The reserve powers that ProMedica retained give it almost full control of the St. Luke's board. Under the joinder agreement, ProMedica reserves the power to approve all nominees to the St. Luke's board and to remove any board member with or without cause. ProMedica also has the power to authorize, adopt, and/or approve all of St. Luke's strategic plans, annual operating budgets, and capital budgets. Additionally, ProMedica can appoint and remove the president, secretary, and treasurer of St. Luke's, and authorize and/or approve any amendments to the articles of incorporation, code of regulations, by-laws, operating agreements or analogous governing documents of St. Luke's. (PX00058 at 016-018 (Joinder Agreement, Article 4 – Reserve Powers); *see also* CCPFF ¶ 47). This includes being able to amend the joinder agreement itself without the approval of St. Luke's board. (PX01929 at 049 (Black, Dep. at 186-187), *in camera*).

932. The MOU provided that St. Luke's would maintain its name and brand. (Hanley, Tr. 4558; RX-1912 at 000004, *in camera*).

Response to Finding No. 932

This finding is irrelevant because the joinder agreement now controls, not the MOU.

933. The MOU provided that upon closing the joinder, St. Luke's would become a participating provider in Paramount's network with rates comparable to other ProMedica hospitals. (Hanley, Tr. 4558; RX-1912 at 000005, *in camera*).

Response to Finding No. 933

This finding is misleading and irrelevant because the joinder agreement now controls, not the MOU. Additionally, the proposed finding is irrelevant to the extent it suggests that this is a merger specific benefit. ProMedica could have permitted St. Luke's to be added to the Paramount provider network without the Acquisition. St. Luke's had been interested in St. Luke's joining Paramount prior to the Acquisition. However, ProMedica would not allow St. Luke's to join Paramount due to concerns about St. Luke's drawing patients (and profits) away from ProMedica's hospitals. (*See* CCPFF ¶¶ 865-866).

934. The MOU provided that ProMedica would keep St. Luke's open as an acute care hospital and maintain certain service lines for an agreed upon period of time. (Hanley, Tr. 4559; RX-1912 at 000005, *in camera*).

Response to Finding No. 934

This proposed finding is misleading, incomplete, and also irrelevant to the extent that the joinder agreement and not the MOU now controls. The joinder agreement only requires ProMedica to maintain specific enumerated services: emergency room, ambulatory surgery, inpatient surgery, obstetrics, inpatient nursing and a CLIA certified laboratory. (PX00058 at 023 (Joinder Agreement, Article 7.1)). Many of St. Luke's services are not protected, such as oncology, heart and vascular services, neurology, orthopedics, pediatrics, and diabetes. (Oostra, Tr. 6136-6138).

935. The Executive Committee of ProMedica's Board of Trustees unanimously approved the MOU following a discussion regarding the entities' commonality of missions, visions, and values. (Hanley, Tr. 4561-4562).

Response to Finding No. 935

Complaint Counsel has no specific response.

936. ProMedica estimated that the financial impact of bringing St. Luke's into its system would be an additional $50 million over and above the $35 million it pledged to St. Luke's in capital contributions. (Hanley, Tr. 4561).

Response to Finding No. 936

Complaint Counsel has no specific response.

c. Rationale

(i) St. Luke's Rationale for the Joinder

937. {

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- { } (Wakeman, Tr. 2996–2997, *in camera*).

Response to Finding No. 937

This proposed finding is incomplete. In addition to the reasons listed in the proposed finding, Mr. Wakeman recommended St. Luke's move forward with an affiliation with ProMedica due to the likelihood of increasing reimbursement rates with health plans. (CCPFF ¶¶ 399-417). Both Mr. Wakeman, and St. Luke's Director of Marketing and Strategy, Scott Rupley, testified that, at the time St. Luke's was considering its affiliation options, ProMedica was believed to enjoy the highest reimbursement rates in the area. (Wakeman, Tr. 2681-2682, *in camera*; *see* Rupley, Tr. 1998, *in camera*). Mr. Wakeman hoped that an affiliation with ProMedica would allow St. Luke's to obtain the higher reimbursement rates that ProMedica was receiving. (Wakeman, Tr. 2685-2686, *in camera*).

A presentation regarding potential affiliation partners, made to St. Luke's Board of Directors by Mr. Wakeman and other members of St. Luke's leadership team, states: "An SLH affiliation with ProMedica has the greatest potential for higher hospital rates. A ProMedica-SLH partnership would have a lot of negotiating clout." (PX01030 at 020 (Affiliation Analysis Update, Oct. 30, 2009), *in camera*; Wakeman, Tr. 2689-2690, *in camera*; Black, Tr. 5634, *in camera*). This statement conveyed the belief that "ProMedica had a significant leverage on negotiations with some of the [health plans]," that this leverage would allow St. Luke's to obtain higher reimbursement rates, and that an affiliation with ProMedica could "[h]arm the community by forcing higher hospital rates on them." (Wakeman, Tr. 2698-2700, *in camera*; Rupley, Tr. 2003, *in camera* (discussing PX01124 at 009, which contains the contents of PX01030 at 020)).

938. {

}

(PX01457 at 004, *in camera*).

Response to Finding No. 938

Complaint Counsel has no specific response.

939. {

} (PX01457 at 004, *in camera*; Black, Tr. 5646, *in camera*).

Response to Finding No. 939

Complaint Counsel has no specific response.

940. ProMedica and St. Luke's never discussed what MCO reimbursement rates would be at St. Luke's after the Joinder. (RX-43 (Wagner, IHT at 125)).

Response to Finding No. 940

This proposed finding is misleading and incomplete. ProMedica's higher reimbursement rates and the opportunity to obtain higher reimbursement rates were central to St. Luke's motivation for the Acquisition. (*See* Response to RPFF ¶ 937).

(ii) ProMedica's Rationale for the Joinder

941. When ProMedica considers entering into an affiliation with another entity, it looks at the likely effect of that affiliation on the system as a whole, on ProMedica's financial capacity in terms of cash on hand and its balance sheet, and on the greater community. (Hanley, Tr. 4518-4519).

Response to Finding No. 941

Complaint Counsel has no specific response.

942. {

} (Oostra, Tr. 5876-5877, *in camera*).

Response to Finding No. 942

This proposed finding is incomplete and misleading. In fact, ProMedica decided to pursue the Acquisition with St. Luke's, in part, because of recent market share losses to St. Luke's. The 2010 ProMedica Environmental Assessment concluded that "[m]arket share continued to wane early in 2009" and that "[a]dding St. Luke's would 'recapture' a substantial portion of recent losses." (PX00159 at 005, *in camera*). The same report noted, "[I]n metro Toledo, ProMedica's share of the inpatient market declined 1% through nine months of 2009, with St. Luke's Hospital picking up half of that share[.]" (PX00159 at 012, *in camera*). One percent of ProMedica's 2009 gross revenue represents tens of millions of dollars. (PX00322 at 001 (ProMedica Gross Revenues 1Q2009)).

943. {

} (Oostra, Tr. 5878-5879, *in camera*).

Response to Finding No. 943

Complaint Counsel has no specific response.

944. ProMedica sought a joinder with St. Luke's because it believed that the clinical integration would result in an increase in quality, service, and access, and create a more economical model. (Hanley, Tr. 4536).

Response to Finding No. 944

This proposed finding is incomplete and misleading. (*See* Response to RPFF ¶ 942).

945. ProMedica also believed that a joinder was needed to gain sufficient volumes in certain programs to ensure better quality and outcomes. (Hanley, Tr. 4536).

Response to Finding No. 945

Complaint Counsel has no specific response.

946. ProMedica felt St. Luke's was an attractive partner because of its location and the commonality of services offered by both entities. (Hanley, Tr. 4537).

Response to Finding No. 946

Complaint Counsel does not disagree. In fact, witnesses universally testified to St. Luke's optimal location. (*See* CCPFF ¶¶ 269-270). In addition, the commonality of services offered by St. Luke's and ProMedica are one indication of the two being close competitors to one another. Testimony, documents, and data demonstrate that St. Luke's and ProMedica hospitals were considered close substitutes by patients seeking inpatient hospital services, especially those residing in southwest Lucas County. (*See, e.g.,* PX01235 at 003, 005; PX02148 at 042-046 (¶¶ 79-87) (Town Expert Report), *in camera*; PX01077 at 009-015 (St. Luke's Market Report 2008); Wakeman, Tr. 2511, 2523-2525, 2527; Rupley, Tr. 1945; CCPFF ¶¶ 315-364).

947. { } (Oostra, Tr. 5881, *in camera*).

Response to Finding No. 947

This proposed finding is misleading. ProMedica acknowledged the benefits of combining systems in terms of greater leverage in health plan negotiations and advertised this strength to entice potential affiliation partners. (PX00226 at 008 (ProMedica Health Network ProMedica Partnerships) ("Why ProMedica? . . . Payer System Leverage")).

948. Similarly, during the course of the joinder discussions with St. Luke's, ProMedica did not discuss the potential for increasing MCO rates at St. Luke's, TTH, Flower, or Bay Park. (Hanley, Tr. 4544-4545).

Response to Finding No. 948

Complaint Counsel has no specific response.

949. { } (Oostra, Tr. 5881, *in camera*).

Response to Finding No. 949

This proposed finding is irrelevant. Section 7 of the Clayton Act does not require an element of intent. (15 U.S.C. § 18 (2006)). Further, the proposed finding is incomplete and misleading. (*See* Response to RPFF ¶ 942).

950. {

} (Oostra, Tr. 5881, *in camera*).

Response to Finding No. 950

This proposed finding is irrelevant. Section 7 of the Clayton Act does not require an element of intent. (15 U.S.C. § 18 (2006)). Further, the proposed finding is incomplete and misleading. (*See* Response to RPFF ¶ 942).

d. Due Diligence

951. During its initial joinder discussions with St. Luke's, ProMedica reviewed St. Luke's public financial data in the form of audited reports and agency ratings. (Hanley, Tr. 4534).

Response to Finding No. 951

Complaint Counsel has no specific response.

952. ProMedica learned that St. Luke's financial strength had deteriorated during the last few years, it had a negative financial trend, it had an underfunded pension liability, and it had operational losses. (Hanley, Tr. 4535).

Response to Finding No. 952

This proposed finding is incomplete and misleading. Specifically, this proposed finding ignores many of the positive trends in financial metrics at St. Luke's in 2010. By the time of the Acquisition, St. Luke's already was seeing the benefits of Mr. Wakeman's three-year plan: its inpatient and outpatient volumes were increasing, its profitability and cash flow had improved, and it was well-positioned for health care reform and the foreseeable future. (*See* CCPFF ¶¶ 885-992). In addition, St. Luke's so-called "underfunded pension liability" is misleading and actually put St. Luke's in the same category as many large corporations. (CCPFF ¶¶ 993-1012).

953. ProMedica also learned that the volume of patients St. Luke's treated had been increasing, but St. Luke's still had operational losses reflecting that the growth in volume was unprofitable. (Hanley, Tr. 4536).

Response to Finding No. 953

This proposed finding is incorrect and misleading. In fact, St. Luke's volume growth in 2010 caused its losses to decrease and its operating cash flow to improve. (Dagen, Tr. 3191-3193; PX01925 at 054-055 (Guerin-Calvert, Dep. at 209-210); PX02129 at 002 (Ex. 1) (Hanley, Decl.)). This is due to the fact that St. Luke's did not, contrary to Respondent's claims, lose money on the commercial patients who received services at St. Luke's. (Dagen, Tr. 3190-3193).

Mr. Den Uyl, Respondent's financial expert, testified that St. Luke's was profitable in the treatment of { } members during the first eight months of 2010. (Den Uyl, Tr. 6597-6598, *in camera*; PX01951 at 039-040 (Den Uyl, Dep. at 150-153)*, in camera*; *see also* PX02136 at 056 (Table 11) (Guerin-Calvert, Supp. Decl.), *in camera*; Dagen, Tr. 3239-3240, *in camera*). Even before the Acquisition, St. Luke's covered its direct costs when treating { }. (PX01951 at 039-040 (Den Uyl, Dep. at 150-154), *in camera*; Dagen, Tr. 3239-3240, *in camera*; PX00513 at 001 (spreadsheet of St. Luke's Aug. 31, 2010 year-to-date payor cost coverage ratios), *in camera*).

954. ProMedica believed, therefore, that St. Luke's increase in patient volume was not profitable because that increase was not reflected in St. Luke's operating margin or cash flow percentage. (Hanley, Tr. 4611).

Response to Finding No. 954

This proposed finding is inaccurate. (*See* Response to RPFF ¶ 953).

955. Following approval of the MOU, ProMedica began a due diligence review of St. Luke's. (Hanley, Tr. 4563).

Response to Finding No. 955

Complaint Counsel has no specific response.

956. ProMedica hired Deloitte & Touche to review St. Luke's financial position, actuaries to understand St. Luke's pension status, and bond counsel to understand St. Luke's debt issues. (Hanley, Tr. 4565).

Response to Finding No. 956

Complaint Counsel has no specific response.

957. Due diligence took place from January of 2010 until the joinder was consummated on September 1, 2010. (Hanley, Tr. 4563-4564).

Response to Finding No. 957

Complaint Counsel has no specific response.

958. Through Deloitte and due diligence, ProMedica learned that St. Luke's financial trend was negative over many years. (Hanley, Tr. 4566).

Response to Finding No. 958

This proposed finding is incorrect and misleading. In fact, St. Luke's had generated positive operating cash flow in nine of the eleven years prior to the Acquisition. (PX02147 at 010 (¶ 21) (Dagen Expert Report)). In addition, by the time of the Acquisition, St. Luke's had rebounded from financial difficulties in 2008 and 2009 with improvements in numerous metrics, including net patient service revenue, operating income, operating cash flow, and volume. (*See* CCPFF ¶¶ 964-986).

959. During due diligence of St. Luke's, ProMedica prepared a summary report containing St. Luke's financial data in the form of statistics, summaries, and ratios from 1999 to August 31, 2010. (Hanley, Tr. 4570-4571; RX-191 at 000007).

Response to Finding No. 959

Complaint Counsel has no specific response.

960. Statistics reflecting patient volume informed ProMedica that St. Luke's generally saw an increase in volume between 1999 and August, 2010. (Hanley, Tr. 4574; RX-191 at 000007).

Response to Finding No. 960

Complaint Counsel has no specific response.

961. Financial summary data informed ProMedica that St. Luke's operating income declined from 2000 to August 2010. (Hanley, Tr. 4576; RX-191 at 000007).

Response to Finding No. 961

Complaint Counsel has no specific response.

962. Specifically, ProMedica learned that St. Luke's had operating losses in seven years between 2000 and August 2010. (Hanley, Tr. 4576; Johnston, Tr. 5316; RX-191 at 000007).

Response to Finding No. 962

Complaint Counsel has no specific response.

963. ProMedica learned that on August 31, 2010, St. Luke's had an operating income loss of $2.7 million for the year. (Hanley, Tr. 4576; RX-191 at 000007).

Response to Finding No. 963

This proposed finding is incomplete and misleading. From 2009 to August 31, 2010, St. Luke's operating income was *improving* – and would have continued to improve for an independent St. Luke's absent the Acquisition. (Joint Stipulations of Law and Fact, JX00002A ¶ 29; CCPFF ¶¶ 982-986).

964. ProMedica learned that St. Luke's excess revenue over expenses declined from 2000 to 2010, and St. Luke's had negative excess revenues over expenses in the amount of $3 million on August 31, 2010. (Hanley, Tr. 4577; RX-191 at 000007).

Response to Finding No. 964

Complaint Counsel has no specific response.

965. ProMedica learned that St. Luke's unrestricted net assets had declined by over $100 million, from $178 million in 2000 to $74 million in August of 2010. (Hanley, Tr. 4579; RX-191 at 000007).

Response to Finding No. 965

Complaint Counsel has no specific response.

966. ProMedica learned that St. Luke's operating margin through August of 2010 was negative 2.6 percent. (Hanley, Tr. 4580; RX-191 at 000007).

Response to Finding No. 966

This proposed finding is misleading. In fact, St. Luke's was profitable in its treatment of patients from virtually all commercial health plans, and covering its costs for all commercial patients prior to the Acquisition. (*See* Response to ¶ RPFF 953).

967. By contrast, ProMedica aims for an operating margin of about positive 3 to 4 percent. (Hanley, Tr. 4582).

Response to Finding No. 967

Complaint Counsel has no specific response.

968. ProMedica learned that St. Luke's operating cash flow margin percentage had declined since 2000 and was 3.8 percent through August of 2010. (Hanley, Tr. 4582; RX-191 at 000007).

Response to Finding No. 968

Complaint Counsel has no specific response.

969. By contrast, ProMedica aims for an operating cash flow margin percentage of 9.5 to 10 percent. (Hanley, Tr. 4582).

Response to Finding No. 969

Complaint Counsel has no specific response.

970. ProMedica learned that St. Luke's excess margin percentage had declined from 2000 and was negative 0.2 percent through August of 2010. (Hanley, Tr. 4583; RX-191 at 000007).

Response to Finding No. 970

Complaint Counsel has no specific response.

971. ProMedica learned that St. Luke's days cash on hand had declined from 358.5 in 2000 to 104 as of August of 2010. (Hanley, Tr. 4584).

Response to Finding No. 971

This proposed finding is misleading. Respondent's own expert witness, Ms. Guerin-Calvert, described St. Luke's "days of cash on hand" as of August 31, 2010 as "above its comparables." (*See* CCPFF ¶ 979). St. Luke's cash-to-debt ratio was 412 percent, compared to 102 percent for all Moody's rated hospitals, putting St. Luke's cash situation in a much more favorable position when compared to many other hospitals. (*See* CCPFF ¶ 980).

972. ProMedica learned that St. Luke's net property and equipment assets decreased from $81 million in 2000 to $50 million in 2010, reflecting that St. Luke's was depreciating assets faster than they were adding new assets to the hospital. (Hanley, Tr. 4588-4589; RX-191 at 000008).

Response to Finding No. 972

Complaint Counsel has no specific response.

973. During the time that ProMedica was conducting due diligence on St. Luke's, it learned that Moody's downgraded St. Luke's bond rating from a Baa1 to a Baa2 with a negative outlook. (Hanley, Tr. 4590, 4593; PX00053 at 001).

Response to Finding No. 973

Complaint Counsel has no specific response.

974. ProMedica believed that the downgrade would have a negative impact on St. Luke's ability to access capital. (Hanley, Tr. 4595).

Response to Finding No. 974

This proposed finding is incorrect and misleading. Ms. Hanley went on to testify that Moody's rating had no "practical effect" on St. Luke's in early 2010 because St. Luke's had no intention to borrow money. (Hanley, Tr. 4706-4707).

In addition, according to Complaint Counsel's unrebutted bond rating expert, Mr. Brick, St. Luke's would have been able to access capital from the tax-exempt debt markets even with its Baa2 rating from Moody's. (*See* CCPFF ¶¶ 1019-1020).

975. Moody's downgraded St. Luke's following several years of operating losses and indicated that its outlook would remain negative, reflecting "continued operating losses expected

through fiscal year 2010, and ongoing challenges to negotiate favorable commercial contracts as competitive pressures continue." (Hanley, Tr. 4596; PX00053 at 003).

Response to Finding No. 975

Complaint Counsel has no specific response.

976. During due diligence, ProMedica learned that St. Luke's rates with commercial health plans were, on average, 125 percent of Medicare, which is less than ProMedica targets for its own contracts. (Hanley, Tr. 4598).

Response to Finding No. 976

Complaint Counsel does not disagree that St. Luke's rates with commercial health plans are lower than ProMedica's rates with commercial health plans.

977. During due diligence, ProMedica learned that St. Luke's was not in compliance with its bond covenants that were insured by AMBAC. (Hanley, Tr. 4600).

Response to Finding No. 977

This proposed finding is misleading. In fact, St. Luke's had only a "technical default" on its AMBAC insured bonds – not a payment default. (*See* CCPFF ¶ 1039). As a result, holders of St. Luke's bonds received every one of their regularly scheduled principal and interest payments in full and on time. (*See* CCPFF ¶ 1039). Such technical defaults were extremely common during this time period. (*See* CCPFF ¶ 1041).

978. { } (Hanley, Tr. 4600; RX-906 at 000001-000002).

Response to Finding No. 978

This proposed finding is misleading. By the time of the Acquisition, St. Luke's debt service coverage ratio was 3.7, well above the 1.3 required by the bond indenture. (*See* CCPFF ¶ 1040).

979. AMBAC required St. Luke's to retain an independent consultant, but St. Luke's did not do so and, subsequently, AMBAC notified St. Luke's that it was in default on March, 11 2010. (Hanley, Tr. 4602).

Response to Finding No. 979

Complaint Counsel has no specific response.

980. St. Luke's bonds with AMBAC were not callable or refundable, and they had a million dollar negative arbitrage if paid off early. (Hanley, Tr. 4603, 4605).

Response to Finding No. 980

This proposed finding is irrelevant. St. Luke's was not required to pay off its bonds early; AMBAC's only remedy likely would have been to require St. Luke's to hire an independent consultant to assist with improving its debt service coverage ratio. (CCPFF ¶ 1042). Mr. Gordon testified that {

} (Gordon, Tr. 6860, *in camera*). Furthermore, St. Luke's large cash reserves gave it the ability to pay off not just its AMBAC-insured bonds if required to, but all of its outstanding debt. (Response to RFA at ¶ 48).

981. During due diligence, ProMedica learned that St. Luke's pension was underfunded by about $34 million. (Hanley, Tr. 4606-4607).

Response to Finding No. 981

This proposed finding is misleading. (*See* CCPFF ¶¶ 993-1012). The pension liability that appears on St. Luke's financial statements – and which is used by Respondent to calculate the "funded status" of St. Luke's pension fund – is calculated under a separate set of rules than the AFTAP and does not determine the actual cash contributions that St. Luke's must make into its pension fund per ERISA. (Arjani, Tr. 6767-6768, *in camera*; Response to RFA at ¶ 45 ("St. Luke's 'pension liability'. . . is not the [AFTAP])). The pension liability does not reflect an actual cash obligation. (Arjani, Tr. 6768, *in camera*; Dagen, Tr. 3167; PX001951 at 043 (Den Uyl, Dep. at 168), *in camera*).

It is not uncommon for firms to have an underfunded pension fund. (Dagen, Tr. 3168). At the end of 2009, St. Luke's pension had a funded status of 71 percent, on par with large companies such as ExxonMobil (73.5 percent), CBS (71.1 percent), Disney (69.1 percent), and Motorola (67.0 percent). (PX02147 at 023-024 (¶ 45) (Dagen Expert Report); PX01060 at 015 (Feb. 2010 St. Luke's Retirement Plan Actuarial Valuation Report), *in camera*; *see also* PX01287 at 017 (St. Luke's Aug. 2010 Our Mission Presentation), *in camera*; Dagen, Tr. 3168-3171).

St. Luke's pension fund assets have increased in value from their 2008 levels. (Black, Tr. 5699-5700). In 2008, the fair market value of the plan assets was $69 million. (PX02147 at 022-023 (¶ 43) (Dagen Expert Report); PX01060 at 015 (Feb. 2010 St. Luke's Retirement Plan Actuarial Valuation Report), *in camera*). As of September 2010, the fair market value of the assets had increased to $90 million. (PX01288 at 018 (St. Luke's Sep. 2010 interim financial statements), *in camera*). The fair market value of the pension assets further increased to $101.9 million by the end of 2010. (Dagen, Tr. 3165).

982. During due diligence, ProMedica learned that St. Luke's average age of plant was 13.6 years at the end of 2009, as compared to industry norms of about 10 or 11 years. (Hanley, Tr. 4608).

Response to Finding No. 982

Complaint Counsel has no specific response.

983. ProMedica also learned during due diligence that St. Luke's parent, OhioCare, was losing money. (Hanley, Tr. 4615).

Response to Finding No. 983

Complaint Counsel has no specific response.

984. { } (Hanley, Tr. 4623, 4655, *in camera*).

Response to Finding No. 984

Complaint Counsel has no specific response.

985. {

} (Hanley, Tr. 4654-4655, *in camera*).

Response to Finding No. 985

Complaint Counsel has no specific response.

986. {

} (Hanley, Tr. 4655, *in camera*).

Response to Finding No. 986

Complaint Counsel has no specific response.

987. {

} (Hanley, Tr. 4655-4656, *in camera*).

Response to Finding No. 987

Complaint Counsel has no specific response.

988. {

} (Hanley, Tr. 4658-4659, *in camera*).

Response to Finding No. 988

Complaint Counsel has no specific response.

989. {

}

(Hanley, Tr. 4656, 4663, *in camera*).

Response to Finding No. 989

Complaint Counsel has no specific response.

990. {

} (Hanley, Tr. 4666-4667, *in camera*).

Response to Finding No. 990

This proposed finding is misleading. A hospital's reimbursement rates reflect a hospital's relative bargaining leverage against health plans. (*See* CCPFF ¶¶ 185-188). In addition, the Acquisition will enable ProMedica to raise rates for St. Luke's. (*See* CCPFF ¶¶ 399-439).

e. Terms of the Joinder Agreement

991. ProMedica and St. Luke's signed the Joinder Agreement on May 25, 2010. (PX00058 at 001; Hanley, Tr. 4628, *in camera*).

Response to Finding No. 991

Complaint Counsel does not disagree.

992. { } (Black, Tr. 5660, *in camera*; RX-1235 at 004, *in camera*).

Response to Finding No. 992

Complaint Counsel does not disagree.

993. The Joinder Agreement commits ProMedica to "maintain [St. Luke's] using its current name and identity and at its current location for a minimum of ten (10) years . . . as a fully operational acute care hospital providing for the following services: emergency room, ambulatory surgery, inpatient surgery, obstetrics, inpatient nursing and a CLIA certified laboratory." (PX00058 at 023, 045-046; Hanley, Tr. 4631-4632, *in camera*; Oostra, Tr. 5856).

Response to Finding No. 993

This proposed finding is misleading and incomplete to the extent it suggests that the Joinder Agreement prohibits ProMedica from eliminating services at St. Luke's. (*See* Response to RPFF ¶ 934).

994. { } (Hanley, Tr. 4630, *in camera*; Oostra, Tr. 5857; PX00058 at 007, 009).

Response to Finding No. 994

This proposed finding is incomplete and misleading. While the St. Luke's governing board would still exist, ProMedica would have control over it. Under the Joinder Agreement, ProMedica reserved the right to approve all nominees to the St. Luke's board. ProMedica also reserved the right to remove any individual from the board with or without cause. (PX00058 at 016-017 (Joinder Agreement, Article 4 – Reserve Powers).

995. Specifically, the Joinder Agreement maintains St. Luke's independent board and gives it the authority to challenge ProMedica for any breaches of the Joinder Agreement, including its commitment to maintain services at St. Luke's. (PX00058 at 007, 051; PX00141 at 002) ("PHS and OHS acknowledge that SLH, acting by the affirmative vote of at least ten (10) of the SLH Hospital Appointees serving on the SLH board, will have the right to seek specific performance or injunctive or other equitable relief to enforce the terms and conditions of Articles 6, 7, and 13 of this Agreement after the Closing Date.").

Response to Finding No. 995

This proposed finding is incomplete and misleading. St. Luke's board is not independent. ProMedica reserved for itself the right to approve all nominees to the board, and the right to remove any member with or without cause. (PX00058 at 016-017 (Joinder Agreement, Article 4.1 (a-c)). Additionally, ProMedica reserved the right to authorize and approve amendments to St. Luke's articles of incorporation, code of regulations, bylaws, operating agreements or analogous governing documents. (PX00058 at 018 (Article 4.1(n)). In fact, ProMedica has the ability to amend the Joinder Agreement itself without the approval of St. Luke's board. (PX01929 at 049 (Black, Dep. at 186-187), *in camera*).

996. In the Joinder Agreement, ProMedica agreed to provide St. Luke's with $35 million in capital to fund capital projects that St. Luke's had deferred because it lacked the funds needed to pay for them. (Hanley, Tr. 4628, *in camera*; PX00058 at 021, 056; Johnston, Tr. 5351-5352, 5372).

Response to Finding No. 996

This proposed finding is misleading. In fact, St. Luke's substantial cash and investment balances would have enabled it to complete all of its planned, high priority capital projects. (CCPFF ¶ 1074-1079)

997. {

} (Hanley, Tr. 4628, *in camera*; PX00058 at 056).

Response to Finding No. 997

Complaint Counsel has no specific response.

998. The Joinder Agreement maintains St. Luke's existing medical staff bylaws, rules, and regulations. (PX00058 at 046).

Response to Finding No. 998

Complaint Counsel has no specific response.

999. In a draft of the Joinder Agreement, ProMedica had included an "out clause," giving St. Luke's board the authority to step away from the affiliation within a certain time frame, but it was removed from the Joinder Agreement at the St. Luke's board's request because they wanted to join and stay in the system. (Black, Tr. 5658-5659, *in camera*; Oostra, Tr. 5859-5860).

Response to Finding No. 999

This proposed finding is incorrect and unfounded. Mr. Black testified that this clause was removed because he "found it to be a distraction," not what the proposed finding suggests. (Black, Tr. 5659, *in camera*). Mr. Black explained that, "[t]here were members of the leadership group who focused solely on how that was going to work, that we were losing sight of what was occurring." (Black, Tr. 5659, *in camera*).

1000. The Joinder Agreement provided that St. Luke's would become a participating provider in Paramount upon closing. (Hanley, Tr. 4631, *in camera*; PX00058 at 022- 023).

Response to Finding No. 1000

Complaint Counsel has no specific response.

II. THE RELEVANT MARKET AND MARKET CONCENTRATION

A. The Relevant Product Market Is General Acute Care Inpatient Services Available to Commercially Insured Patients

1001. The relevant product market is general acute care inpatient services available to commercially insured patients. (Guerin-Calvert, Tr. 7155, 7200-7201).

Response to Finding No. 1001

Complaint Counsel does not disagree that this is one of the relevant product markets in which to analyze the competitive effects of the Acquisition.

1002. Demand side substitution must be analyzed to define the relevant product market for hospitals. (Guerin-Calvert, Tr. 7186).

Response to Finding No. 1002

Complaint Counsel does not disagree that demand-side substitution is one factor that must be analyzed to define the relevant product market for hospitals.

1003. Specifically in the Toledo healthcare marketplace, one must look at what MCOs demand in their negotiations with hospitals, what the ultimate consumers (patients) are demanding and what physician are demanding. (Guerin-Calvert, Tr. 7186).

Response to Finding No. 1003

This proposed finding is confusing. The finding is confusing because it does not explain for what purpose one must "look at" what MCOs, patients, and physicians are demanding. Nor does it explain why this inquiry would be specific to the Toledo healthcare marketplace, as opposed to the need to inquire about these demands in any other healthcare marketplace.

1004. A cluster market approach is appropriate for defining the relevant product market in this situation. (Guerin-Calvert, Tr. 7189; Town, Tr. 3665).

Response to Finding No. 1004

Complaint Counsel does not disagree.

1005. A cluster market is a method of grouping a set of services that are complements to each other in that the services included involve demands for the same kinds of services and facilities. (Guerin-Calvert, Tr. 7187).

Response to Finding No. 1005

Complaint Counsel does not disagree.

1006. A cluster market provides the ability to assess all services at once in the context of one market. (Guerin-Calvert, Tr. 7188).

Response to Finding No. 1006

Complaint Counsel does not disagree.

1007. The demand that is analyzed using a cluster market is the demand for a set of services and skills. (Guerin-Calvert, Tr. 7190).

Response to Finding No. 1007

Complaint Counsel has no specific response.

1008. Relevant product market definition entails evaluation of the products and services that are provided, and are interchangeable. (Guerin-Calvert, Tr. 7193).

Response to Finding No. 1008

This proposed finding is misleading to the extent that it ignores the fact that the services grouped together within the general acute-care cluster market are not interchangeable, but rather are combined for analytical convenience because they are offered and consumed under similar competitive conditions. (Guerin-Calvert, Tr. 7631-7633; CCPFF ¶ 191).

1009. When defining the relevant product market for hospital services, all services available to any patient seeking medical care must be considered because product market definition consists of determining what services are demanded in the marketplace and are available from potential suppliers. (Guerin-Calvert, Tr. 7200-7201).

Response to Finding No. 1009

This proposed finding is misleading and inaccurate insofar as it implies that all hospital services that are available to patients should be included in the relevant product market without regard to the similarity of the competitive conditions of those services. It is inappropriate to

include services where the competitive conditions are dissimilar. (CCPFF ¶¶ 192, 202). For example, outpatient and quaternary services are available in the Lucas County market, but even the Respondent's expert agrees that these services should be excluded from the relevant product market. (Guerin-Calvert, Tr. 7191-7192; *see* RPFF ¶ 1013).

1. MCOs Contract for All General Acute Care Inpatient Services Together

1010. MCOs demand, and contract for, a broad array of inpatient services together, such as medical/surgical care. (Guerin-Calvert, Tr. 7190; Town, Tr. 3686-3687).

Response to Finding No. 1010

Complaint Counsel has no specific response.

1011. There is no difference in services that a hospital provides to commercially insured patients and government-insured patients. The MCO may be different, but the services are not. (Guerin-Calvert, Tr. 7202-7203).

Response to Finding No. 1011

Complaint Counsel has no specific response.

1012. When MCOs contract with hospitals, they do not distinguish between services available to commercially insured patients and government insured patients; they look at all services available at that hospital to any patient. (Guerin-Calvert, Tr. 7202).

Response to Finding No. 1012

Complaint Counsel has no specific response.

1013. On the other hand, outpatient and quaternary services are excluded from this relevant product market because they are often excluded or contracted for separately. (Guerin-Calvert, Tr. 7191-7192).

Response to Finding No. 1013

This proposed finding is incorrect, directly contradicted by the testimony of every MCO that testified at trial, and directly contradicted by the testimony of Ms. Guerin-Calvert. Although Complaint Counsel agrees that outpatient services and quaternary services are excluded from the relevant product market, the reason is not that they are contracted for separately. Outpatient, and

quaternary services, as well as tertiary services, are excluded from the relevant product market in this case because they have different competitive conditions, making it inappropriate to analyze them within the relevant general acute-care product market. (CCPFF ¶¶ 192-195, 198). Outpatient services are offered in locations other than hospitals resulting in a different mix of market competitors. (Guerin-Calvert, Tr. 7637, 7640; CCPFF ¶ 198). Tertiary and quaternary services are not offered at all hospitals because they require more resources and specialized technology. (CCPFF ¶ 193). Patients are willing to travel farther for tertiary and quaternary services, resulting in a wider geographic market. (CCPFF ¶ 194). Additionally, St. Luke's performs few, if any, tertiary and quaternary services, which means the Acquisition does not potentially create or enhance market power for those services. (CCPFF ¶ 195).

The evidence also directly contradicts this proposed finding. All six MCOs testified that outpatient services are negotiated for and included in the same contract as general acute-care inpatient services. (Pirc, Tr. 2205-2206; Radzialowski, Tr. 756; Pugliese, Tr. 1549; Sheridan, Tr. 6626-6627; Sandusky, Tr. 1322; McGinty, Tr. 1240). Ms. Guerin-Calvert also acknowledges that outpatient services are negotiated and contracted for at the same time as inpatient services and are excluded from the relevant product market for other reasons. (Guerin-Calvert, Tr. 7196).

1014. In addition, services such as rehabilitation, skilled care, psychiatric care, and detoxification are excluded from general acute care inpatient services because these services are separately contracted and negotiated for and are sometimes provided as outpatient services. (Guerin-Calvert, Tr. 7195; Town, Tr. 3687).

Response to Finding No. 1014

This proposed finding is incorrect, unsupported by the cited testimony, and misstates Professor Town's testimony. Complaint Counsel does not disagree that rehabilitation, skilled care, psychiatric care, and detoxification services should be excluded from general acute-care inpatient services. However, this is not because they are separately contracted and negotiated

for, or because they are sometimes provided as outpatient services. In fact, Professor Town explicitly states that he excluded these services from the GAC product market despite the fact that they are likely to be negotiated for at the same time as inpatient services. (Town, Tr. 3686-3687). The cited testimony for Ms. Guerin-Calvert does not state why she excluded the above listed services, only that she excluded them for many of the same reasons that Professor Town did. (Guerin-Calvert, Tr. 7195).

1015. Other courts have also excluded outpatient, rehabilitation and psychiatric care from the relevant product market for hospital services. (Guerin-Calvert, Tr. 79).

Response to Finding No. 1015

Complaint Counsel does not disagree with this proposed finding. However, it is unsupported by the cited testimony.

1016. Ms. Guerin-Calvert and Prof. Town both agree that MDC codes 2, 19, 20, and 17 should be excluded from the relevant product market as these are codes for behavioral health services and have traditionally been excluded. (Guerin-Calvert, Tr. 7197; Town, Tr. 4211, 4221).

Response to Finding No. 1016

Complaint Counsel has no specific response.

2. Hospitals Provide All General Acute Care Services in the Same Facilities And Use Similar Resources

1017. Services in the cluster market of all general acute care inpatient services use the same assets, the same operating rooms, the same beds, the same wards, the same nursing staff, and all require an overnight stay. (Guerin-Calvert, Tr. 7188, 7191).

Response to Finding No. 1017

Complaint Counsel has no specific response.

1018. Hospitals do not discriminate between commercial and non-commercial patients when offering services to patients. (Guerin-Calvert, Tr. 7202-7203).

Response to Finding No. 1018

Complaint Counsel has no specific response.

1019. Hospitals treat patients based on their condition, not whether they are commercially or government-insured. (Town, Tr. 3981-3982).

Response to Finding No. 1019

Complaint Counsel has no specific response.

3. No Independent Market Exists for Inpatient Obstetrical Services

1020. Negotiations between hospital providers and MCOs cover the full range of inpatient services that the MCO's members may need, including inpatient OB services. (Pugliese, Tr. 1550; McGinty, Tr. 1240; Town, Tr. 4049-4050; Guerin-Calvert, Tr. 7229-7230; Randolph, Tr. 6960).

Response to Finding No. 1020

Complaint Counsel has no specific response.

1021. There is no evidence that hospitals can or do price-discriminate for inpatient OB services. (Guerin-Calvert, Tr. 7230).

Response to Finding No. 1021

This proposed finding is incorrect. Contracts between hospitals and MCOs often have separate rates for OB services. These OB rates are listed separately from other GAC services within the contract and are subject to separate back-and-forth rate negotiations. (CCPFF ¶ 205).

1022. For example, for high-risk inpatient OB services, prices are competitive for those services, even though only two hospitals offer those services, TTH and St. Vincent. (Guerin-Calvert, Tr. 7231).

Response to Finding No. 1022

This proposed finding is unfounded and contradicted by other evidence in the record. Ms. Guerin-Calvert never defined how she determined that high-risk inpatient OB prices are "competitive," and provided no competitive benchmark against which to test the prevailing prices. In fact, Mr. Guerin-Calvert conducted no analysis – nor has Respondent put forth any evidence in this trial – of what level of pricing would prevail for high-risk inpatient OB services if there were three, or four, hospitals offering them instead of just two. Further, the evidence that

Ms. Guerin-Calvert bases her statement on is her assertion that there no price discrimination in high-risk OB such as the "selective contracting or carving out OB services," (Guerin-Calvert, Tr. 7231), which is incorrect. (*See* RPFF ¶¶ 392, 718, 1260; CCPFF ¶ 146, 205).

1023. Thus, the joinder does not change the number of competitors offering more complex, high-risk OB services. (Town, Tr. 3968).

Response to Finding No. 1023

Complaint Counsel does not disagree that there are only two competitors for OB services in Lucas County following the Acquisition, whether it is for low-risk or high-risk OB services.

1024. When MCOs had only one provider of high-risk OB services in their networks, no evidence shows that the hospitals could price-discriminate, charge higher prices or that prices were any different than what cost, quality and competition would have dictated. (Guerin-Calvert, Tr. 7231).

Response to Finding No. 1024

This proposed finding is contradicted by other evidence in the record. Whether MCOs had one high-risk OB provider or both in their networks, they found prices in Lucas County to be among the highest in Ohio. (PX00153 at 001 (ProMedica Jan. 2009 e-mail) ("we hear from payors we are among the most expensive in ohio [sic]"); Oostra, Tr. 5996). They attribute these high prices to the market power of the hospitals in Lucas County. (Pirc, Tr. 2244-2245, *in camera*). Further, this proposed finding is unfounded because Mr. Guerin-Calvert conducted no analysis – nor has Respondent put forth any evidence in this trial – detailing what pricing levels would have prevailed for high-risk OB services if, instead of having only one provider in their networks, they had two, three, or even four providers.

1025. Inpatient OB services are provided in conjunction with other services, and the terms and conditions on which they are being negotiated are very similar. (Guerin-Calvert, Tr. 7230).

Response to Finding No. 1025

This proposed finding is misleading to the extent that it implies OB services should be included in the GAC relevant product market for the above-stated reasons. These same statements could be said of outpatient services, which Respondent agrees are also excluded from the GAC product market. Inpatient OB services should be excluded from the GAC relevant market for the same reasons that outpatient services are: the competitive conditions for OB services in Lucas County are different from the competitive conditions for other GAC services. (CCPFF ¶ 198, 202).

Further, this proposed finding is incorrect because there is substantial evidence that contracts between hospitals and major MCOs in Lucas County often specify case rates for inpatient obstetrics services that are different from the case rates charged for general acute inpatient care. (*See* Response to RPFF ¶ 1026).

1026. { } (Pugliese, Tr. 1622, *in camera*; RX-1886, *in camera*; RX-1882, *in camera*; RX-1890, *in camera*; RX-1045, *in camera*; PX02385, *in camera*; PX02533, *in camera*; RX-305; RX-306, *in camera*; RX-329, *in camera*).

Response to Finding No. 1026

This proposed finding is incorrect, misleading, and incomplete. Contracts with some major MCOs in Lucas County (Radzialowski, Tr. 808, *in camera*; 752-753; Sheridan, Tr. 6662, *in camera*, 6683-6684; *see, e.g.*, PX00365 at 030 (ProMedica-United Contract), *in camera*; PX00363 at 019, 022 (ProMedica-Aetna Contract)).

1027. In prior hospital merger cases, inpatient OB services have been included in the general acute care inpatient services market. (Guerin-Calvert, Tr. 7229-7230).

Response to Finding No. 1027

This proposed finding is misleading and incomplete. Complaint Counsel does not disagree that in prior hospital cases, OB services have been included in the GAC service market. However, to Complaint Counsel's knowledge, no previous case cited by Respondent had different competitive conditions for OB such that there was a merger to duopoly for OB services, with additional competitors remaining for GAC services. (*See, e.g.*, *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd,* 121 F.3d 708, 1997 WL 420543 (6th Cir. 1997); *In re Evanston Nw. Healthcare Corp*., No. 9315, 2007 WL 2286195 (Aug. 6, 2007); *United States v. Rockford Mem'l Hosp.,* 898 F.2d 1278 (7th Cir. 1990); *United States v. Tenet Healthcare Corp*., 17 F. Supp. 2d 937, 942 (E.D. Mo. 1998)). It is the differing competitive conditions for OB services that warrant their exclusion from the regular GAC market in this case. (CCPFF ¶ 192, 202). Other cases have recognized narrower relevant product markets in addition to a GAC market. For example, in *Butterworth*, the court recognized both a GAC market and a market for primary care inpatient hospital services. (*Butterworth*, 946 F. Supp. at 1291).

B. The Relevant Geographic Market Is No Narrower than the Area Served by Hospitals Located in Lucas County, Ohio

1028. Lucas County constitutes a relevant geographic market for the purposes of analyzing the likely effects of the joinder in the general acute care services market. (RX-1860 at 000007).

Response to Finding No. 1028

Complaint Counsel does not disagree, but notes that Respondent does not address the relevant geographic market for the inpatient obstetrical services market. As a result, the fact that the relevant geographic market for inpatient obstetrical services is Lucas County is unrebutted. (*See* CCPFF ¶¶ 229-242).

1029. The relevant geographic market is properly defined on the basis of the hospitals' locations because that is where the services are provided and hospitals cannot price

discriminate based on the location of their patients or MCOs, or self-insured employers. (Town, Tr. 4068; Guerin-Calvert, Tr. 7236-7237).

Response to Finding No. 1029

The proposed finding is misleading and irrelevant. Although it is correct to define a relevant geographic market based on the location of the service-providing hospitals, the criteria for defining a relevant geographic market as set forth in the *Horizontal Merger Guidelines* asks whether a monopolist controlling all of the hospitals in Lucas County could profitably raise prices by a small but significant amount. (CCPFF ¶ 209; PX02148 at 025-026 (¶ 45) (Town Expert Report), *in camera*). Because the unrebutted evidence makes clear that a health plan could not resist such a price increase by utilizing a network that consisted solely of hospitals outside of Lucas County, the answer clearly is "yes." In fact, defining the relevant geographic market as Lucas County is supported by abundant witness testimony and ordinary course planning documents from both ProMedica and St. Luke's. (CCPFF ¶¶ 208-272). As a result, Lucas County hospitals' ability or inability to price discriminate is irrelevant and such analysis is irrelevant and unnecessary for purposes of defining the relevant geographic market in which to analyze this transaction.

1030. Both Complaint Counsel's and Respondent's economic experts agree that the relevant geographic market is no narrower than hospitals in Lucas County. (Guerin-Calvert, Tr. 7155; Town, Tr. 3688-3689, 4068-4069).

Response to Finding No. 1030

This proposed finding is incorrect, incomplete, and misleading. Professor Town testified that the relevant geographic market in which to analyze this transaction was *no broader than* Lucas County. (Town, Tr. 3690). In fact, Professor Town noted, "[I]f you were to follow the guidelines specifically, you actually could argue for a smaller geographic market here[.]" (Town, Tr. 3690). It is important to note that even within the relevant geographic market of

Lucas County, party, health plan, third-party hospital, and employer witnesses have all testified that location is important. (CCPFF ¶¶ 264-272). Focusing on the southwestern area of Lucas County shows that St. Luke's and ProMedica were significant competitors to each other prior to the Acquisition, throughout Lucas County, but particularly in southwestern Lucas County. (CCPFF ¶¶ 333-334). Nonetheless, both Complaint Counsel's and Respondent's economic experts accept Lucas County as the relevant geographic market. (CCPFF ¶ 209).

1. MCOs Must Contract with at least One Hospital Located within Lucas County To Serve Their Members in the Toledo, Ohio Area

1031. No MCOs have marketed a health plan to Lucas County customers without including at least one Lucas County hospital. (Randolph, Tr. 7064-7065).

Response to Finding No. 1031

Complaint Counsel does not disagree. In fact, this proposed finding makes clear that a hypothetical monopolist controlling all Lucas County hospitals could profitably raise prices by a small but significant increase in price, without fear of health plans declining to accept the price increase and replacing it with non-Lucas County hospitals. (*See* CCPFF ¶ 210).

1032. ProMedica's Lucas County hospitals offer general acute care inpatient services. (JX-2 at 1).

Response to Finding No. 1032

Complaint Counsel does not disagree.

1033. St. Luke's offers general acute care inpatient services. (JX-2 at 1).

Response to Finding No. 1033

Complaint Counsel does not disagree.

1034. Mercy's Lucas County hospitals offer general acute care inpatient services. (JX-2 at 1).

Response to Finding No. 1034

Complaint Counsel does not disagree, but notes that Mercy's St. Anne Hospital does not offer inpatient obstetrical services. (Shook, Tr. 899-900).

1035. UTMC offers general acute care inpatient services. (JX-2 at 1).

Response to Finding No. 1035

This proposed finding is incomplete. UTMC does offer general acute-care inpatient services, but is notable because it does not offer, nor has it ever offered, inpatient obstetrical services. (Gold, Tr. 203). UTMC is also not considering beginning to offer inpatient obstetrical services. (Gold, Tr. 220-221).

2. Complaint Counsel Overstates St. Luke's Competitive Significance by Focusing on only a Subset of St. Luke's Service Area

1036. A market share and concentration analysis based solely on St. Luke's core service area is irrelevant. (Guerin-Calvert, Tr. 7248).

Response to Finding No. 1036

This proposed finding is misleading and incorrect. St. Luke's core service area represents the area from which the largest portion of St. Luke's patients reside, (RPFF ¶ 1037), and as such, the localized area subject to the most competitive harm as a result of the Acquisition. Not only does St. Luke's analyze its core service area in the ordinary course of its business, but (PX01169 at 010 (Great Lakes Marketing Survey); Shook, Tr. 934-935, 1012-1013, *in camera*; *see* PX02290 at 003, *in camera*). Respondent's economic expert, Ms. Guerin-Calvert, also presented market share analyses of the Top 10 zip codes from which St. Luke's draws its patients. (RX-71(A) at 162-165 (Guerin-Calvert Expert Report, Ex. 42(a)-(d)), *in camera*). Finally, health plans testified that, based on analysis of draw data, patient stay close to home for hospital services. (CCPFF ¶¶ 216-218, 221, 247, 264).

As party, health plan, third-party hospital, and employer witnesses have all testified, a hospital's location within Lucas County is important. (CCPFF ¶¶ 264-272). Specifically for inpatient general acute-care services, market share analysis shows that residents of St. Luke's core service area overwhelmingly choose either St. Luke's or one of ProMedica's hospitals. (PX02148 at 161 (Ex. 11) (Town Expert Report), *in camera*). Within the geographic market of Lucas County, some hospitals are closer substitutes than others. (PX02148 at 041 (¶ 77) (Town Expert Report), *in camera*). The core service area market share analysis shows that for the majority of St. Luke's patients, St. Luke's and ProMedica's hospitals are first and second choices. (CCPFF ¶¶ 333-334). After the Acquisition, ProMedica's share of inpatient general acute-care admissions from St. Luke's core service area jumps to { } percent. (PX02148 at 161 (Ex. 11) (Town Expert Report), *in camera*). This focus on St. Luke's core service area enables one to determine a key area where harm from the Acquisition will be direct, immediate, and particularly acute.

1037. First, St. Luke's "core service area" represents only approximately 60 percent of its discharges. (Guerin-Calvert, Tr. 7247-7248).

Response to Finding No. 1037

Complaint Counsel has no specific response.

1038. Second, there is no evidence that hospitals can price discriminate against the residents of St. Luke's core service area and charge them a higher or lower price. (Guerin-Calvert, Tr. 7248-7249).

Response to Finding No. 1038

This proposed finding is irrelevant. (*See* Response to RPFF ¶ 1029)

1039. Neither St. Luke's nor ProMedica's hospitals have a separate chargemaster that applies to Maumee residents. (Town, Tr. 4067).

Response to Finding No. 1039

Complaint Counsel does not disagree.

1040. St. Luke's does not charge MMO a different rate for MMO's insureds that live in St. Luke's eight core zip codes than it charges to MMO insureds that live outside those eight core zip codes. (Town, Tr. 4068).

Response to Finding No. 1040

Complaint Counsel does not disagree.

1041. Third, residents of St. Luke's core service area, like other Lucas County residents, use all eight hospitals in Lucas County, which renders market share analysis for St. Luke's core service area meaningless as an indicator of market power. (Guerin-Calvert, Tr. 7248-7249).

Response to Finding No. 1041

This proposed finding is misleading and incorrect. While the residents of St. Luke's core service area can use all eight hospitals in Lucas County, market share analysis shows that they do not use them all equally. (PX02148 at 161 (Ex. 11) (Town Expert Report), *in camera*). Market share analysis of St. Luke's core service area shows that ProMedica was St. Luke's closest competitor in Lucas County and in St. Luke's core service area in particular. (*See* Response to RPFF ¶ 1036).

1042. Fourth, St. Luke's draws patients from many of the same areas as all other hospitals in Lucas County. (Guerin-Calvert, Tr. 7243-7244).

Response to Finding No. 1042

This proposed finding is misleading. St. Luke's draws patients from many of the same areas as other hospitals in Lucas County, but St. Luke's – as do all hospitals – draws a significantly higher percentage of patients from nearby areas. (RPFF ¶ 1037).

1043. St. Lucas draws approximately half of its patients from Lucas County and the remainder come from outside of Lucas County (Wood, Henry, and Fulton Counties). (Johnston, Tr. 5382).

Response to Finding No. 1043

Complaint Counsel has no specific response.

1044. Similarly, TTH draws patients from Monroe, Fulton, Wood, Henry, Sandusky and Seneca Counties, as well as Lucas County. (Guerin-Calvert, Tr. 7240).

Response to Finding No. 1044

Complaint Counsel does not disagree, except to note that ProMedica draws the majority of its patients from Lucas County and the Metro Toledo area. (PX00159 at 011 (ProMedica 2010 Environmental Assessment), *in camera*; PX02148 at 149 (Ex. 9) (Town Expert Report), *in camera*). Not surprisingly, TTH draws patients from other counties for tertiary services for which patients will travel greater distances. (Town, Tr. 3677-3678).

1045. Bay Park also draws from Wood and Sandusky Counties as well as Lucas County. (Guerin-Calvert, Tr. 7240-7241).

Response to Finding No. 1045

Complaint Counsel does not disagree.

1046. Like St. Luke's, Flower draws from Monroe, Fulton, Wood, Sandusky and Seneca Counties as well as Lucas County. (Guerin-Calvert, Tr. 7241).

Response to Finding No. 1046

This proposed finding is incorrect and in direct contradiction to Respondent's proposed finding No. 1043; St. Luke's does not draw from Monroe, Sandusky, or Seneca Counties. (RPFF ¶ 1043).

1047. UTMC and St. Vincent draw from all the same counties as St. Luke's. (Guerin-Calvert, Tr. 7241-7242).

Response to Finding No. 1047

Complaint Counsel does not disagree.

1048. St. Charles draws from Wood and Sandusky Counties as well as Lucas County. (Guerin-Calvert, Tr. 7242).

Response to Finding No. 1048

Complaint Counsel does not disagree.

1049. St. Anne draws from Henry, Wood, Monroe and Sandusky Counties as well as Lucas County, like St. Luke's. (Guerin-Calvert, Tr. 7242).

Response to Finding No. 1049

This proposed finding is incorrect and in direct contradiction to Respondent's proposed finding No. 1043; St. Luke's does not draw from Henry, Monroe, or Sandusky Counties. (RPFF ¶ 1043).

C. Market Concentration

1050. Market concentration analysis based on the number and relative size of competitors is only the starting point of a merger analysis. (Guerin-Calvert, Tr. 7719).

Response to Finding No. 1050

This proposed finding is incomplete. Complaint Counsel does not disagree that market concentration analysis is the starting point of a merger analysis. However, under the *Merger Guidelines* and case law, when a market is found to be highly concentrated, such as in the current case, there is a presumption that the acquisition is anticompetitive. (PX02214 at 021-022 (*Merger Guidelines* § 5.3; *see* CCPFF ¶¶ 308-309).

1051. Nevertheless, St. Luke's share of registered beds (less non-acute care) in 2009 was 9.4 percent. (PX02123 at 025).

Response to Finding No. 1051

This proposed finding is irrelevant. Market shares based on registered beds, also known as licensed beds, do not give an accurate view of the marketplace. Hospitals physically do not have the number of beds that they are licensed for, nor do they have enough staff to run that many beds. (Korducki, Tr. 476-477). Usually hospitals have taken over the space that could have been used for additional beds with other services or equipment; therefore, they do not have the space to be able to instantly add additional beds. (Gold, Tr. 200; Johnston, Tr. 5364; Town, Tr. 3837-3838; PX02148 at 079-081 (¶¶ 144-145) (Town Expert Report), *in camera*). Even

ProMedica's CEO, Randall Oostra, has stated that "licensed beds are irrelevant." (PX01906 at 26 (Oostra, IHT at 99), *in camera*).

1052. The ProMedica legacy hospitals had a 34.3 percent share of registered beds in 2009; in comparison Mercy had a 32.5 percent share and UTMC had 9.6 percent, giving St. Luke's the lowest share based on registered beds of the hospitals in Lucas County. (PX02123 at 025).

Response to Finding No. 1052

This proposed finding is irrelevant. Market shares based on registered beds, also known as licensed beds, do not give an accurate view of the marketplace. (*See* Response to RPFF ¶ 1051).

1053. St. Luke's share of staffed beds (less non-acute care beds) in 2009 was 8.4 percent. (PX02123 at 025). The ProMedica legacy hospitals had 39.4 percent while Mercy had 31.7 percent and UTMC had 8.9 percent, again giving St. Luke's the lowest shares based on staffed beds in 2009. (PX02123 at 025).

Response to Finding No. 1053

Complaint Counsel has no specific response.

1054. { } (RX-71(A) at 000036-000037, 000162*, in camera*). { } (RX-71(A) at 000162, *in camera*). { } (RX-71(A) at 000036-000037, 000163, *in camera*). { } (RX-71(A) at 000163, *in camera*). { } (RX-71(A) at 000036-000037, 000162-000163, *in camera*).

Response to Finding No. 1054

This proposed finding is irrelevant. Market shares based on billed charges do not give an accurate view of the marketplace, because commercial insurers pay discounted prices for services, not the full chargemaster price. (Town, Tr. 3707-3708; Korducki, Tr. 534-535; Pugliese, Tr. 1507; McGinty, Tr. 1195-1196; Sandusky, Tr. 1346-1347).

Discharges are also not the best measure of market shares. Discharge numbers do not account for the acuity of the illness or procedure that a patient has. (Town, Tr. 3701). Market shares based on patient days, on the other hand, takes this into account because the number of days a patient is in the hospital is a proxy for acuity. (Town, Tr. 3701).

Additionally, based on discharges, St. Luke's is the third-largest hospital in Lucas County. Only TTH and St. Vincent had a greater number of discharges from third quarter of 2009 through the first quarter of 2010. (PX2148 at 082 (¶ 147) (Town Expert Report), *in camera*).

1055. { } (RX-71(A) at 000036-000037, 000162, *in camera*).

Response to Finding No. 1055

This proposed finding incorrect, misleading, and irrelevant. Using Respondent's own market shares for general acute-care services provided in RPFF ¶¶ 1056-1058 and in RX-71(A) at 000162, ProMedica has a higher market share than Mercy and UTMC combined based on billed charges. ProMedica has a 46 percent market share while Mercy combined with UTMC is only 45 percent. Using discharges, Mercy and UTMC combined only have a 1 percent greater market share than ProMedica. Further, for OB services, ProMedica's market share is at least three times greater than Mercy and UTMC combined whether by billed charges or discharges. (RPFF ¶¶ 1056-1058; RX-71(A) at 000162-000163 (Guerin-Calvert Expert Report), *in camera*).

Professor Town's analysis based on patient days also concluded that ProMedica had a greater market share for both GAC and OB than Mercy and UTMC combined. (PX02148 at 143 (Ex. 6) (Town Expert Report), *in camera*).

Further, this finding is irrelevant because the focus of the concentration analysis is on the post-Acquisition shares and resulting HHIs. (PX02214 at 021 (§ 5.3) (*Merger Guidelines*)).

Post-Acquisition, ProMedica had a combined share of 58.3 percent and a post-Acquisition HHI increase of 1078 for a total HHI of 4391 for the GAC market using patient days. For OB, ProMedica had a 80.5 percent share and a post-Acquisition HHI increase of 1323 for a total HHI of 6854 using patient days. (PX02148 at 143 (Ex. 6) (Town Expert Report), *in camera*). Using the Respondent's provided market shares, ProMedica has a combined share of 52 percent by billed charges and 54 percent by discharges for the GAC product market, and a combined share of 81 percent by billed charges and 80 percent by discharges for OB services. All of these market shares are much greater than Mercy and UTMC combined. (RPFF ¶¶ 1054, 1056-1058).

1056. {

} (RX-71(A) at 000162, *in camera*). {
} (RX-71(A) at 000162, *in camera*). {
} (RX-71(A) at 000163, *in camera*). {
} (RX-71(A) at 000163, *in camera*).

Response to Finding No. 1056

This proposed finding is irrelevant. (*See* Response to RPFF ¶ 1054).

1057. {

}
(RX-71(A) at 000162, *in camera*). {
}
(RX-71(A) at 000162, *in camera*). {
}(RX-71(A) at 000163, *in camera*).
{
}. RX-71(A) at 000163, *in camera*).

Response to Finding No. 1057

This proposed finding is irrelevant. (*See* Response to RPFF ¶ 1054).

1058. {

}
(RX-71(A) at 000162, *in camera*). {
}
(RX-71(A) at 000162, *in camera*).

Response to Finding No. 1058

This proposed finding is irrelevant. (*See* Response to RPFF ¶ 1054).

1059. For the ProMedica/St. Luke's joinder, market share computation does not provide a comprehensive view of competitive effects, because it is a "four-to-three" transaction, which means that it would not fall into the *Horizontal Merger Guidelines'* market concentration safe harbor regardless of how shares are calculated. Therefore, it is important to analyze the competitive effects of the joinder. (Guerin-Calvert, Tr. 7256).

Response to Finding No. 1059

This proposed finding is misleading. Complaint Counsel does not disagree that it is important to analyze the competitive effects of the joinder. However, market shares and the resulting degree of market concentration is an "indicator of likely competitive effects of a merger." (PX02214 at 021-022 (§ 5.3) (*Merger Guidelines*)). When a market is highly concentrated and the transaction results in a significant increase in concentration, such as in the current "four-to-three" transaction in the GAC market, a presumption of anticompetitive effects is created due to likely increases in market power. (PX02214 at 021-022 (§ 5.3) (*Merger Guidelines*)). In the OB product market, the current transaction is a 3-to-2, merger to duopoly. This resulting market is even more concentrated resulting in a stronger presumption of anticompetitive effects. (PX02214 at 021 (§ 5.3) (*Merger Guidelines*)). Professor Town analyzed the pre- and post-Acquisition market concentration levels and found the market to be highly concentrated in both the GAC and OB markets. (*See* CCPFF ¶ 309).

III. THE JOINDER WILL NOT RESULT IN ANTICOMPETITIVE EFFECTS

1060. The joinder is unlikely substantially to lessen competition for general acute care services in the Toledo area. (Guerin-Calvert, Tr. 7156; RX-71(A) at 000005, *in camera*).

Response to Finding No. 1060

This proposed finding is incorrect and against the weight of the evidence. (*See* CCPFF ¶ 399-692).

1061. Post-joinder, the key questions are whether sufficient alternatives, in terms of capacity, services and locations, exist to keep prices competitive, taking into consideration the

steps that MCOs can take and taking into account the incentives and abilities of market participants to reposition. (Guerin-Calvert, Tr. 7265).

Response to Finding No. 1061

This proposed finding is incorrect and against the weight of evidence. The Acquisition significantly increases St. Luke's bargaining leverage. (*See* CCPFF ¶¶ 399-417).The critical question is: whether the Acquisition of St. Luke's renders it more difficult for MCOs to walk away from contract negotiations with ProMedica. (Town, Tr. 3785, *in camera*). Put another way, whether the Acquisition increases ProMedica's bargaining leverage with MCOs such that it can increase rates for hospital services. (CCPFF ¶¶ 171-184). Every MCO believes that the Acquisition has increased ProMedica's bargaining leverage, and this increase is likely to result in higher rates. (CCPFF ¶¶ 418-424). Post-Acquisition, the only alternative network available to MCOs is a network that has never been offered, a network of only Mercy and UTMC. (CCPFF ¶¶ 509-533). Health plan testimony reveals that a network of Mercy and UTMC would not be a marketable network. (CCPFF ¶¶ 503-538).

A. MCOs and Hospitals Bargain over a Complex Set of Price and Non-Price Terms

1062. MCOs negotiate directly with hospitals for the services that those hospitals will provide to both their fully-insured and self-insured members. (Pugliese, Tr. 1546; McGinty, Tr. 1239).

Response to Finding No. 1062

Complaint Counsel does not disagree.

1063. Hospital-MCO negotiations are complex negotiations during which each side tries to obtain the best possible rates it can. (Radzialowski, Tr. 750; McGinty, Tr. 1240; Pugliese, Tr. 1553; Pirc, Tr. 2211-2212).

Response to Finding No. 1063

Complaint Counsel does not disagree.

1064. Negotiations between hospitals and MCOs typically last six to nine months or even a year or more for especially complex negotiations. (Radzialowski, Tr. 658; Pugliese, Tr. 1458; Sandusky, Tr. 1317-1318).

Response to Finding No. 1064

Complaint Counsel has no specific response.

1065. Contract negotiations between MCOs and hospitals can be triggered by the expiration of the current contract or various other factors, including: changes or growth in volumes, changes in service levels, changes in industry standard conventions, shifts in reimbursement patterns, or changes in market dynamics. (Sandusky, Tr. 1317).

Response to Finding No. 1065

Complaint Counsel has no specific response.

1066. An MCO and a provider may choose to renegotiate a contract prior to the termination date of the contract; that may be initiated by either the MCO or the hospital. (Radzialowski, Tr. 749-750; Pugliese, Tr. 1548; Pirc, Tr. 2283-2284).

Response to Finding No. 1066

Complaint Counsel has no specific response.

1067. MCOs typically negotiate three to five year contracts with "evergreen" provisions that allow them to continue in effect. (Radzialowski, Tr. 658; McGinty, Tr. 1239; Pugliese, Tr. 1547; Pirc, Tr. 2207; Sheridan, Tr. 6626).

Response to Finding No. 1067

Complaint Counsel has no specific response.

1068. {

} (Pugliese, Tr. 1471, *in camera*).

Response to Finding No. 1068

The proposed finding is misleading. A contract's evergreen status does not prevent the renegotiation of rates. (Radzialowski, Tr. 681, *in camera*).

1069. MCOs may seek to negotiate a shorter contract term if they are unable to obtain satisfactory rates. (Pugliese, Tr. 1553; Pirc, Tr. 2288-2290).

Response to Finding No. 1069

Complaint Counsel has no specific response.

1. Negotiations Cover Both Reimbursement Rates and Non-Compensation Terms

1070. Contract negotiations between hospitals and MCOs include negotiations over price and other terms. (Radzialowski, Tr. 660; McGinty, Tr. 1240; Sandusky, Tr. 1318-1319; Pirc, Tr. 2205; RX-18 (Marcus, Dep. at 79-80)).

Response to Finding No. 1070

Complaint Counsel has no specific response.

a. Rates for the Hospitals' Full Range of Inpatient and Outpatient Services Are Negotiated Together

1071. Contract negotiations include both inpatient and outpatient services as part of an all-inclusive package. (Shook, Tr. 1074; Sandusky, Tr. 1326; Pugliese, Tr. 1547; McGinty, Tr. 1240; Pirc, Tr. 2205-2206; Radzialowski, Tr. 802, *in camera*; Sheridan, Tr. 6626-6627; Korducki, Tr. 533).

Response to Finding No. 1071

This finding is directly contradicted by Respondent's RPFF ¶ 1013.

1072. Included among the inpatient services for which hospitals and MCOs may negotiate reimbursement rates are intensive care services, intermediate care services, medical-surgical care, skilled care, acute rehabilitation services, sub acute care, various levels of nursery services, and various types of maternity care. (Radzialowski, Tr. 750-752).

Response to Finding No. 1072

Complaint Counsel has no specific response.

1073. Inpatient rates are not more important than any other factor when negotiating contracts. (Town, Tr. 3953-3954)

Response to Finding No. 1073

This proposed finding is inaccurate. Despite multiple items in contracts between MCOs and hospitals, reimbursement rates are the most important point of negotiation because they determine the cost of care at the hospital for the MCO and the amount of revenue the hospital

stands to earn from the MCO. (*See* CCPFF ¶ 124). Further, this proposed finding mischaracterizes Professor Town's testimony. (*See* Town, Tr. 3623-3624).

1074. Outpatient rate negotiations may cover up to nine different levels of ambulatory surgery and five different levels of emergency care. (Radzialowski, Tr. 756-757).

Response to Finding No. 1074

This proposed finding is irrelevant.

1075. Outpatient negotiations also cover services like observation services, chemotherapy drugs, sleep studies, radiology and lab services. (Radzialowski, Tr. 757).

Response to Finding No. 1075

This proposed finding is irrelevant.

1076. Each outpatient service commonly has its own rate that will vary from provider to provider. (Radzialowski, Tr. 756-757).

Response to Finding No. 1076

This proposed finding is irrelevant.

1077. Negotiations between hospitals and MCOs may address separate carve-out rates for many different services, including emergency room services, MRI services, laboratory services, physical therapy services, mammograms, and/or CAT scans. (Beck, Tr. 430; Radzialowski, Tr. 753; Pugliese, Tr. 1549-1550; Pirc, Tr. 2287).

Response to Finding No. 1077

Complaint Counsel has no specific response.

1078. Negotiations over rates may include negotiation of reimbursement methodologies, including fixed pricing methodologies, like DRGs or per diems, or percentage-of-charge methodologies. (Pirc, Tr. 2205).

Response to Finding No. 1078

Complaint Counsel has no specific response.

1079. Hospitals and MCOs also may negotiate over whetherthe hospital will participate in all of the MCO's products or just some of them. (Radzialowski, Tr. 763-764).

Response to Finding No. 1079

Complaint Counsel has no specific response.

1080. MCOs and hospitals also may negotiate different inpatient and outpatient rates for different types of insurance products. For example, Aetna negotiated different rates with ProMedica for its HMO and PPO products. (Radzialowski, Tr. 753, 758).

Response to Finding No. 1080

Complaint Counsel has no specific response.

1081. Rate negotiations include various trade-offs, whereby a party seeking a higher rate in one service area (e.g. outpatient services) agrees to accept lower rates elsewhere (e.g. inpatient services) in exchange. (Pugliese Tr. 1550; Pugliese, Tr. 1625-1628, *in camera*; Pirc, Tr. 2287-2288; Radzialowski, Tr. 758; Sheridan, Tr. 6627-6628).

Response to Finding No. 1081

This proposed finding is inaccurate. While rate negotiations may involve trade-offs, these trade-offs do not mitigate the hospital's bargaining leverage. (*See* CCPFF ¶¶ 92-188). Further, this finding is directly contradicted by evidence. Although there may be some trade-offs between inpatient and outpatient rates in dollar terms, there are limits. For example, Aetna testified it would not push outpatient rates toward zero and "ratchet up" inpatient rates. (Radzialowski, Tr. 758-759). {

}. (Sandusky, Tr. 1338-1348, *in camera*).

{

}. (Pirc, Tr. 2245-2247, *in camera*).

1082. MCOs approach contract negotiations with a view toward the overall cost for inpatient, outpatient and all other services for their entire insured patient base at a particular hospital or hospital system. (Radzialowski, Tr. 759-760; Sheridan, Tr. 6627-6628; Pirc, 2287-2288).

Response to Finding No. 1082

This proposed finding is incomplete. (*See* CCPFF ¶ 124).

1083. {

}(Radzialowski, Tr. 798-799, *in camera*; RX-132, *in camera*).

Response to Finding No. 1083

Complaint Counsel has no specific response.

b. Other Terms that May Impact Compensation Are Also Negotiated Together With Rates

1084. Non-compensation terms are as important as the compensation terms. (RX-18 (Marcus, Dep. at 79-80)).

Response to Finding No. 1084

See Response to RFPP ¶ 1073.

1085. The non-compensation terms in a hospital's contract with an MCO often translate into compensation or the lack thereof. (RX-18 (Marcus, Dep. at 79-80)).

Response to Finding No. 1085

Complaint Counsel has no specific response.

1086. In addition to rates, the negotiations between hospitals and MCOs cover many other contractual terms including, for example, claims adjudication procedures, payment outliers, payment escalators, hold-harmless provisions, chargemaster limits, reimbursement methods, renewal or renegotiation provisions, grievance procedures, medical necessity provisions, coordination of benefits provisions, pay-for-performance provisions, pre-certification requirements, nondiscrimination provisions, "never event" provisions, contract length provisions, termination provisions, and other specific provisions that may be important to the hospital or MCO. (Shook, Tr. 949-950, 1074; Pugliese, Tr. 1550-1553; McGinty, Tr. 1241, 1258; Pirc, Tr. 2206-2207, 2288-2290; Radzialowski, Tr. 760-763; Radzialowski, Tr. 804, 806, *in camera*; Sheridan, Tr. 6627; Randolph, Tr. 6951).

Response to Finding No. 1086

Complaint Counsel has no specific response.

1087. MCOs and providers also may negotiate for the right to act as the third-party administrator of the provider's health plan for its own employees. For example, Anthem

raised the issue of administering St. Luke's employee health benefit plan in 2010 in the context of a possible renegotiation of St. Luke's rates. (Pugliese, Tr. 1551-1552).

Response to Finding No. 1087

Complaint Counsel has no specific response.

1088. Anthem's contract negotiations with providers also include discussions relating to the provider's participation in Blue Cross and Blue Shield's BlueCard program. (Pugliese, Tr. 1551).

Response to Finding No. 1088

Complaint Counsel has no specific response.

1089. Trade-offs also occur with respect to these non-compensation terms. If a hospital seeks changes to any of these terms, MCOs may seek reconsideration of other terms, including price-related terms. (Radzialowski, Tr. 764).

Response to Finding No. 1089

Complaint Counsel has no specific response.

c. Other Factors Also Influence Negotiations

1090. Disputes and other issues between a hospital and an MCO that are outside the scope of their contract may impact negotiations about a contract between them. RX-18 (Marcus, Dep. at 79-80)).

Response to Finding No. 1090

Complaint Counsel has no specific response.

1091. { } (Sandusky, Tr. 1354-1360, *in camera*; RX-1700 at 000007, *in camera*).

Response to Finding No. 1091

Complaint Counsel has no specific response.

1092. { } (Sandusky, Tr. 1354-1360, *in camera*; RX-1700 at 000007, *in camera*).

Response to Finding No. 1092

Complaint Counsel has no specific response.

1093.

}(Sandusky, Tr. 1358-1359, *in camera*).

Response to Finding No. 1093

Complaint Counsel has no specific response.

2. Negotiations with Hospital *Systems* Add Additional Complexity to Negotiations

1094. Negotiations with hospitals that are part of integrated hospital systems involve not only inpatient and outpatient services, but also employed physician groups and the whole continuum of care, including skilled nursing facilities, home health services and even hospice services. (McGinty, Tr. 1178)

Response to Finding No. 1094

This proposed finding is incomplete. A hospital system comprised of hospitals that are close substitutes to each other will confer additional bargaining leverage to that system. (*See* CCPFF ¶ 159).

1095. In negotiating with hospital systems, MCOs may seek a decrease in rates at one hospital if the system seeks as increase at another hospital. (Radzialowski, Tr. 770-771; Pirc, Tr. 2290).

Response to Finding No. 1095

Complaint Counsel has no specific response.

1096. {

} (Radzialowski, Tr. 806-807, *in camera*).

Response to Finding No. 1096

Complaint Counsel has no specific response.

3. Prof. Town's Analysis Fails To Capture the Complexity of MCO Contracting

1097. Prof. Town's bargaining framework does not reflect the overall reality and the richness of how bargaining takes place in Lucas County. It fails to account for key elements that take place in setting prices. (Guerin-Calvert, Tr. 7448-7450).

Response to Finding No. 1097

This proposed finding is incorrect and against the weight of the evidence. Professor Town's bargaining framework is entirely consistent with the testimony of third party MCOs. Within this framework, the hospital's bargaining leverage comes from the loss in value to the MCO's network resulting from the exclusion of that hospital. Testimony from MCOs fully corroborates Professor Town's theory. (*See* CCPFF ¶¶ 92-188).

1098. Prof. Town posits two stages of bargaining – first, the bargaining between hospitals and MCOs for inclusion in a network; second, how hospitals in-network then compete for patients. (Guerin-Calvert, Tr. 7448).

Response to Finding No. 1098

Complaint Counsel does not disagree. (*See* CCPFF ¶¶ 92-96).

1099. Prof. Town's model implies that what MCOs bring versus what hospitals bring to the bargaining table are the two elements that largely determine the price of reimbursement, which is inaccurate. (Guerin-Calvert, Tr. 7449-7451).

Response to Finding No. 1099

This proposed finding mischaracterizes Professor Town's work. *See* CCPFF ¶¶ 69-188. for a full discussion of Professor Town's bargaining model and related evidence.

1100. For example, Prof. Town's bargaining framework does not reflect the bargaining between MMO and Mercy that resulted in a lower price level for MMO payments to Mercy when MMO did not include ProMedica in its network. (Guerin-Calvert, Tr. 7451).

Response to Finding No. 1100

This finding is incorrect. The bargaining model would capture the bargaining between MMO and Mercy. That is, because MMO was able to offer Mercy more volume by excluding ProMedica, MMO had more bargaining leverage with Mercy and was able to negotiate lower rates of reimbursement. (*See* CCPFF ¶¶ 121-170).

1101. Prof. Town's model also does not reflect trade-offs such as higher outpatient rates in exchange for lower inpatient rates. (Guerin-Calvert, Tr. 7454).

Response to Finding No. 1101

This finding is incorrect and against the weight of the evidence. Respondent has admitted and stipulated to the fact that outpatient services are not a relevant product market in this matter. (Joint Stipulations of Law and Fact, JX00002A ¶¶ 1, 3). The bargaining framework accounts for the possibility that trade-offs may occur in negotiations between MCOs and hospitals. (*See* CCPFF ¶¶ 92-188). Moreover, increased leverage in inpatient services may be spread over inpatient and outpatient services. (Town, Tr. 3918-3920). Professor Town's willingness-to-pay model measures increased leverage on inpatient services only, but does not preclude the possibility that the increased leverage may be spread across a broader set of services. Finally, testimony in this matter indicates that as a result of the Acquistion,

(PX01944 at 27 (Pirc, Dep. at 102-103), *in camera*). Additionally, there is no evidence that ProMedica has high inpatient rates to offset low outpatient rates. Indeed, FrontPath's testimony indicates { }.

(Sandusky, Tr. 1338-1348, *in camera*).

1102. Examples of terms over which MCOs and hospitals negotiate include: exclusivity, inpatient and outpatient rates, term of the contract, and MFN clauses. (Guerin-Calvert, Tr. 7455-7457).

Response to Finding No. 1102

Complaint Counsel has no specific response.

1103. The size and exclusivity of the network affects the bargaining process between providers and MCOs, because if an MCO can configure a narrow network it can result in lower rates being paid to the provider; open networks tend to have to pay higher rates. (Guerin-Calvert, Tr. 7458).

Response to Finding No. 1103

This proposed finding is misleading. The bargaining framework accounts for both broad and narrow network configurations. (Town, Tr. 4326-4329; *see generally* Response to RPFF ¶ 783, 801).

1104. The history a provider and MCO have of negotiating with each other will also affect bargaining dynamics, because MCOs and providers with a longer history will have more information about each other to use during negotiations. Prof. Town's bargaining model ignores this factor. (Guerin-Calvert, Tr. 7462-7463).

Response to Finding No. 1104

Complaint Counsel has no specific response.

B. Mercy and ProMedica Were and Remain Each Other's Closest Competitors

1. Mercy and ProMedica Consider Each Other To Be Their Closest Competitor

1105. The three large and vigorous hospital competitors in Lucas County are ProMedica, Mercy, and UTMC. (Guerin-Calvert, Tr. 7747).

Response to Finding No. 1105

This proposed finding is misleading. UTMC is not much larger than St. Luke's. Based on volume of commercially insured patients, St. Luke's was a more significant competitor than UTMC. (CCPFF ¶ 347). And by July 2010, St. Luke's was treating more patients in the market than UTMC, based on total discharges and outpatient visits. (CCPFF ¶ 347). The weight of the evidence indicates that health plans will not be able to turn to Mercy and UTMC to counteract the exercise of additional bargaining leverage that ProMedica has gained from the Acquisition. (CCPFF ¶¶ 503-538).

1106. { } (Shook, Tr. 1091-1092, *in camera*).

Response to Finding No. 1106

Complaint Counsel has no specific response.

1107. {
} (Shook, Tr. 1091, *in camera*; PX02534 at 003, 006, 013, 020, 023*, in camera*; RX-250 at 000005, 000013, 000018, *in camera*).

Response to Finding No. 1107

Complaint Counsel has no specific response.

1108. Likewise, ProMedica considers Mercy to be its most significant competitor in the Toledo area. (Oostra, Tr. 5803-5804; Wachsman, Tr. 4866; Randolph, Tr. 6934-6935).

Response to Finding No. 1108

Complaint Counsel has no specific response.

1109. ProMedica considers Mercy to be its most significant competitor because of Mercy's size and backing by CHP, its access to capital, ability to make investments in communities, re-entry into the physician employment business, and because it is a multi-hospital system that virtually mirrors ProMedica. (Oostra, Tr. 5804-5805).

Response to Finding No. 1109

Complaint Counsel has no specific response.

1110. {
} (RX-46 (Pirc, IHT at 23-24), *in camera*).

Response to Finding No. 1110

This proposed finding is misleading because it refers to "MCOs," but cites the testimony of only one health plan. (RPFF ¶ 1110).

1111. The history of MCO networks also shows that ProMedica and Mercy are next best substitutes in terms of their array of services, and the areas they serve, because MCOs successfully established competing networks with only one of the two in the network. (Guerin-Calvert, Tr. 7329).

Response to Finding No. 1111

This proposed finding is misleading. Immediately prior to the acquisition, Mercy was not a near-perfect substitute for ProMedica. (*See* PX02148 at 063-064 (¶¶ 113-115) (Town Expert Report), *in camera*). As a result of the Acquisition, health plans' ability to substitute Mercy for ProMedica without harming the marketability of their networks has diminished because no

health plan in the past 10 years has used Mercy as a substitute for ProMedica without also including St. Luke's. (*See* PX02148 at 064-066 (¶¶ 116-119) (Town Expert Report), *in camera*; CCPFF ¶ 510). {

} (Sheridan, Tr. 6691-6693, *in camera*). Prior to negotiating a contract with ProMedica in 2010, {

}

(Sheridan, Tr. 6693, *in camera*).

1112. {

} (PX01902 (Sheridan, IHT at 48-49, *in camera*)).

Response to Finding No. 1112

This proposed finding is incomplete and misleading. While United's network excluded ProMedica, United's health insurance products performed poorly in the Lucas County market, even when it included Mercy, UTMC, *and* St. Luke's. (Sheridan, Tr. 6691-6693, *in camera*). In fact, prior to entering into a contract with ProMedica in September 2010, {

} (Sheridan, Tr. 6693, *in camera*).

1113. United considers either ProMedica or Mercy to be the largest hospital or hospital system in Lucas County. (Sheridan, Tr. 6616).

Response to Finding No. 1113

Complaint Counsel has no specific response.

1114. United considers the ProMedica and Mercy hospitals to be extremely similar in terms of their location and the types of services and acuity of care they offer. (Sheridan, Tr. 6616-6618).

Response to Finding No. 1114

Complaint Counsel has no specific response.

1115. United considers UTMC to be the next biggesthospital or hospital system after ProMedica and Mercy. (Sheridan, Tr. 6618).

Response to Finding No. 1115

Complaint Counsel has no specific response.

1116. Prof. Town agrees that "Mercy is ProMedica's closest substitute." (Town, Tr. 4058).

Response to Finding No. 1116

This proposed finding is incomplete. Professor Town's analysis shows that, immediately before the Acquisition, St. Luke's was ProMedica's second-closest substitute, with a significant margin over UTMC, for commercially insured members of Aetna, Anthem, BlueCross BlueShield of Michigan, Cigna, FrontPath, and MMO. (PX01850 at 020 (Table 3) (Town Rebuttal Report), *in camera*). Professor Town's analysis shows that, immediately before the Acquisition, ProMedica was St. Luke's closest competitor, with a significant margin over Mercy, for commercially insured members Aetna, Anthem, BlueCross BlueShield of Michigan, Cigna, and FrontPath. (PX01850 at 020 (Table 3) (Town Rebuttal Report), *in camera*). Although ProMedica was St. Luke's second-closest substitute, after Mercy, for MMO's commercially insured members, ProMedica's degree of substitutability for St. Luke's for this group of insureds has been increasing over time. (PX01850 at 018 (Table 2) (Town Rebuttal Report), *in camera*). St. Luke's combined inpatient revenue from Anthem, Aetna, FrontPath, CIGNA, and United was 56 percent higher than its revenue from MMO in the period beginning in the third quarter of 2009 and running through the second quarter of 2010. (PX01850 at 017 (¶ 25) (Town Rebuttal Report), *in camera*). It is worth noting that, as the *Merger Guidelines* point out, a merger can produce significant price effects even though the merging parties do not have the highest diversions to one another. (PX01850 at 020 (¶ 28) (Town Rebuttal Report), *in camera*).

1117. Draw area analysis shows that ProMedica hospitals draw from almost exactly the same zip codes as their Mercy counter-parts. (Guerin-Calvert, Tr. 7315-7319; RX-71(A) at 000195-000199*, in camera*).

Response to Finding No. 1117

This proposed finding is incomplete and inaccurate. There is a high degree of overlap between the primary service areas of St. Luke's and ProMedica, indicating direct competition between St. Luke's and ProMedica prior to the Acquisition. (PX02148 at 041 (¶76), 148-154 (Exhibit 9) (Town Expert Report), *in camera*). Maps of each hospital's share of patients by zip code of origin indicate that St. Luke's and ProMedica possess the first- and second-largest market shares for general acute care and obstetric services in a significant number of zip codes, suggesting that St. Luke's and ProMedica are each other's closest competitors in these zip codes. (PX02148 at 042 (¶79), 155-159 (Exhibit 10) (Town Expert Report), *in camera*). In St. Luke's core service area, in particular, ProMedica and St. Luke's have the first- and second-highest shares in both inpatient general acute care services and inpatient obstetrics services. (PX02148 at 044 (¶ 83) (Town Expert Report), *in camera*). Moreover, ProMedica's and St. Luke's market shares are each significantly higher than Mercy's corresponding market shares in this area for these services. (PX02148 at 044 (¶ 83) (Town Expert Report), *in camera*).

1118. On the other hand, St. Luke's has significantly less overlap with ProMedica hospitals' draw areas. (Guerin-Calvert, Tr. 7315-19).

Response to Finding No. 1118

This proposed finding is incorrect with respect to certain significant areas within Lucas County. (*See* Response to RFPP ¶ 1117).

1119. {

} (RX-0027 (Sheridan, Dep. at 15), *in camera*; PX02067 at 3, *in camera*).

Response to Finding No. 1119

This proposed finding is misleading. The weight of the evidence indicates that health plans will face substantial difficulty in marketing a hospital network consisting of only Mercy and UTMC. (*See* CCPFF ¶¶503-538).

1120. Patients cannot get all of the services they may need from only St. Luke's. (Buehrer, Tr. 3092).

Response to Finding No. 1120

Complaint Counsel has no specific response.

1121. The average case weight severity at ProMedica across all DRGs would be higher than at St. Luke's because ProMedica offers services with higher acuity than St. Luke's offers. (Town, Tr. 4356).

Response to Finding No. 1121

This proposed finding is incomplete and misleading. For the services in which ProMedica and St. Luke's competed before the Acquisition, St. Luke's average case weight was very similar to ProMedica's. (PX02148 at 024-025 (¶ 43), 137-138 (Exhibit 4) (Town Expert Report), *in camera*).

1122. Prof. Town agrees that "St. Luke doesn't offer the same breadth of services that Mercy does...." (Town, Tr. 4059).

Response to Finding No. 1122

Complaint Counsel has no specific response.

1123. {

} (Town, Tr. 3785-3786, *in camera*).

Response to Finding No. 1123

This proposed finding is incomplete and irrelevant. Professor Town goes on to explain that the relevant issue for the analysis of the Acquisition's competitive effects is the loss in

incremental value that St. Luke's added to the health plans' walk-away network with respect to ProMedica before the Acquisition. (Town, Tr. 3786-3787, *in camera*).

1124. ProMedica and St. Luke's are not reasonably interchangeable and ProMedica could not be substituted with St. Luke's in a MCO's network. (Town, Tr. 4057, 4081).

Response to Finding No. 1124

This proposed finding is irrelevant and misleading. The fact that St. Luke's was not a stand-alone substitute for ProMedica before the Acquisition is not particularly relevant to the analysis of the Acquisition's competitive effects. (Town, Tr. 3787, *in camera*). Rather, the relevant issue is the way in which the Acquisition has changed the value of health plans' walk-away network with respect to ProMedica by eliminating St. Luke's as a component of that walk-away network. (Town, Tr. 3786-3787, *in camera*; CCPFF ¶¶ 171-184).

2. A Diversion Analysis Confirms that Mercy and ProMedica Are Closest Substitutes

1125. {

} (Guerin-Calvert, Tr. 7373, *in camera*).

Response to Finding No. 1125

This proposed finding is incomplete. In the context of a hospital merger, the diversions ask and answer the question: If patients of a particular hospital lost access to that hospital, to which other hospitals would they likely go for inpatient care? (CCPFF ¶ 338). The diversion ratio measures the predicted share of a hospital's patients that would go to a specific alternative if that hospital were no longer available. (PX02148 at 044 (¶ 88) (Town Expert Report), *in camera*). Diversion analysis is a commonly used method to quantify the degree of substitutability between hospitals or hospital systems. (CCPFF ¶ 338). Diversion analysis relies on actual choices of patients among hospitals, as reflected in the claims data routinely collected by the health plans. (*See* CCPFF ¶ 339). The higher the diversion between two hospitals, the

higher is the substitutability of the hospitals. (CCPFF ¶ 340). The *Merger Guidelines* acknowledge the usefulness of diversion calculations in assessing the proximity of substitutes. (PX02148 at 046-047 (¶ 88) (Town Expert Report), *in camera*). As the *Merger Guidelines* point out, a merger can produce significant price effects even though the merging parties do not have the highest diversions to one another. (PX01850 at 020 (¶ 28) (Town Rebuttal Report), *in camera*).

1126. {

} (Guerin-Calvert, Tr. 7375, *in camera*).

Response to Finding No. 1126

This proposed finding is misleading. The addition of a price variable to Professor Town's diversion analysis would be relevant only if within-network price differences across hospitals affected consumer and physician choices over hospitals. (*See* Town, Tr. 4301). The evidence indicates that this is not the case, as it demonstrates that health plans in Lucas County do not engage in in-network steering and that physicians and patients do not choose hospitals based on differences in the rates that health plans pay. (CCPFF ¶¶ 539-628). The appropriate approach to diversion in this matter is to predict how patients and physicians would respond to a hypothetical exclusion of a particular hospital. (*See* Response to RPFF ¶ 1125). This approach, which Professor Town used, assesses the degree of substitutability, or closeness of competition, between hospitals in a particular market based on patient-level data. (*See* Response to RPFF ¶ 1125).

1127. {

} (Guerin-Calvert, Tr. 7376, *in camera*).

Response to Finding No. 1127

Complaint Counsel has no specific response.

1128. { } (Guerin-Calvert, Tr. 7377, *in camera*).

Response to Finding No. 1128

This proposed finding is incomplete and misleading because it does not provide results from the most current and relevant data. For all DRGs in 2010, if St. Luke's were not available to MMO's members, percent of MMO-insured patients who would have gone to St. Luke's would likely go to Mercy, percent would likely go to ProMedica, and percent would likely go to UTMC. (PX01850 at 020 (Table 3) (Town Rebuttal Report), *in camera*).

1129. { }(Guerin-Calvert, Tr. 7377*, in camera*).

Response to Finding No. 1129

This proposed finding is incomplete and misleading because it does not provide results from the most current and relevant data. For all DRGs in 2010, if ProMedica were not available to MMO's members, percent of MMO-insured patients who would have gone to ProMedica would likely go to Mercy, percent would likely go to St. Luke's, and percent would likely go to UTMC. (PX01850 at 020 (Table 3) (Town Rebuttal Report), *in camera*).

1130. { } (Guerin-Calvert, Tr. 7380, *in camera*; PX01850 at 018, *in camera*).

Response to Finding No. 1130

This proposed finding is misleading. See Response to RPFF ¶ 1116.

1131. { } (Guerin-Calvert, Tr. 7380-7381, *in camera*; PX01850 at 018, *in camera*).

Response to Finding No. 1131

This proposed finding is misleading. This result is not relevant to competitive conditions immediately before the Acquisition, because ProMedica was not an in-network provider with MMO in 2007. (*See* PX01850 at 017-018 (¶26, Table 2) (Town Rebuttal Report), *in camera*).

1132. { } (Guerin-Calvert, Tr. 7383, *in camera*; RX-71(A) at 000191-000193, *in camera*).

Response to Finding No. 1132

This proposed finding is incomplete and misleading because it does not provide results from the most current and relevant data. For all DRGs in 2010, if ProMedica were not available to Aetna's members, percent of Aetna-insured patients who would have gone to ProMedica would likely go to Mercy, percent would likely go to St. Luke's, and percent would likely go to UTMC. (*See* PX01850 at 020 (Table 3) (Town Rebuttal Report), *in camera*).

1133. { } (Guerin-Calvert, Tr. 7384, *in camera*; RX-71(A) at 000191-000193, *in camera*).

Response to Finding No. 1133

This proposed finding is misleading and irrelevant, because it does not indicate the degree of competition to St. Luke's from ProMedica relative to that from each other hospital in Lucas County. Therefore, it glosses over the important fact that the diversion analysis indicates that, immediately before the Acquisition, ProMedica was St. Luke's closest competitor, with a significant margin over Mercy, for commercially insured members of Aetna, Anthem, BlueCross BlueShield of Michigan, Cigna, and FrontPath. (PX01850 at 020 (Table 3) (Town Rebuttal Report), *in camera*; *see also* Response to RPFF ¶ 1116).

1134. The 2010 rate of diversion in the MMO network shows that diversion from ProMedica to Mercy is twice the diversion from ProMedica to St. Luke's. (Town, Tr. 4338; PX01850 at 018*, in camera*).

Response to Finding No. 1134

This proposed finding is incomplete. The 2010 diversion ratios for MMO insureds also show that St. Luke's is ProMedica's second-closest competitor and that the diversion from ProMedica to St. Luke's is more than twice the diversion from ProMedica to UTMC. (PX01850 at 018 (Table 2) (Town Rebuttal Report), *in camera*).

1135. {

} (RX-71(A) at 000029, *in camera*).

Response to Finding No. 1135

Complaint Counsel has no specific response.

1136. Even after ProMedica had been in the MMO network for three full years (2008-2010), there is more diversion from St. Luke's to Mercy than from St. Luke's to ProMedica. (Town, Tr. 4338-4339).

Response to Finding No. 1136

This proposed finding is incomplete. In the course of the three full years during which ProMedica was in MMO's network, the diversion from St. Luke's to ProMedica increased from percent in 2008 (as compared to a percent diversion to Mercy) to percent in 2010 (as compared to a percent diversion to Mercy). (PX01850 at 018 (Table 2) (Town Rebuttal Report), *in camera*).

1137. Prof. Town agrees that at least with respect to MMO members, Mercy and St. Luke's are closer substitutes than ProMedica and St. Luke's. (Town, Tr. 4340).

Response to Finding No. 1137

Complaint Counsel has no specific response.

1138. {

} (Guerin-Calvert, Tr. 7378, *in camera*).

Response to Finding No. 1138

Complaint Counsel has no specific response.

1139. {

} (Guerin-Calvert, Tr. 7379, *in camera*).

Response to Finding No. 1139

This proposed finding is incorrect and misleading. The diversion analysis indicates the high degree of competition that existed between St. Luke's and ProMedica prior to the Acquisition. (*See* Response to RPFF ¶ 1116, 1125). The weight of the evidence indicates that the presence of Mercy and UTMC will not constrain ProMedica's ability to exercise the additional bargaining leverage it has gained from the Acquisition. (*See* CCPFF ¶¶ 503-592).

C. St. Luke's Is Vulnerable To Losing Patients to UTMC

1140. UTMC is the closest hospital to St. Luke's and is approximately five to seven miles away. (Shook, Tr. 928; Radzialowski, Tr. 738-739).

Response to Finding No. 1140

This proposed finding is incomplete. Flower Hospital is the closest hospital to St. Luke's according to drive time analysis. (PX02148 at 139 (Ex. 5) (Town Expert Report), *in camera*).

1141. When St. Luke's stopped participating in the Paramount and Anthem networks, UTMC was the biggest beneficiary in terms of increased market share. (PX01111 at 001; PX01352, at 020; Wakeman, Tr. 2789-2790, 2807-2808, 2831, 3046).

Response to Finding No. 1141

Complaint Counsel has no specific response.

1142. From 2000 to 2007, St. Luke's in-patient admissions, not including obstetrics, decreased by 11.3 percent. At the same time, UTMC's admissions increased by 56 percent, significantly more than any other hospital in the Toledo area; no other hospital had an increase of more than 13.7 percent during that time period. (RX-2162 at 000001).

Response to Finding No. 1142

Complaint Counsel has no specific response.

1143. In October 2008, St. Luke's assessed "the shift of patients away from St. Luke's to other providers due to [its] exclusion from Paramount and Anthem BCBS networks" and concluded that for non-obstetrical discharges the main beneficiary was UTMC. (RX-2162 at 000001).

Response to Finding No. 1143

This proposed finding is misleading and incomplete. ProMedica projected a significant loss of Paramount patients to St. Luke's resulting from the joinder. (PX040 at 001 (Incremental Volume at St. Luke's), *in camera*).

1144. Most new St. Luke's Paramount inpatient activity after the joinder was coming from UTMC. (Wakeman, Tr. 3025, *in camera*, 3045-3046, 3049-3050).

Response to Finding No. 1144

This proposed finding is incomplete. Mr. Wakeman testified that St. Luke's has not conducted a study to establish that any loss of admissions at UTMC were a result of St. Luke's inclusion in the Paramount network. (Wakeman, Tr. 3050).

1145. After St. Luke's joined Paramount, UTMC's admissions went down while TTH increased its admissions and admissions at Flower and Bay Park remained stable. (Wakeman, Tr. 3049-3051).

Response to Finding No. 1145

This proposed finding is incomplete. (*See* Response to RPFF ¶ 1144).

D. Complaint Counsel Overstate St. Luke's Competitive Significance

1146. Hospital competitors acknowledge that the majority of patients residing in the southwest area of Toledo seek treatment from hospitals other than St. Luke's, that are farther from their homes than St. Luke's. (Shook, Tr. 1039-1040).

Response to Finding No. 1146

This proposed finding is misleading to the extent that it refers to "competitors," but cites to only one source.

1147. St. Luke's serves approximately ten commercially insured patients per day, across all MCOs. (Guerin-Calvert, Tr. 7544).

Response to Finding No. 1147

This proposed finding is incorrect, misleading, and directly contradicted by evidence. St. Luke's has the third-highest volume of patients in Lucas County. (*See* CCPFF ¶ 347). St.

Luke's serves, on average, 30.1 commercial patients per day. (*See* PX02148 at 171 (Ex. 16) (Town Expert Report), *in camera* (SLH had 8236 commercial patient days between 7/1/2009-3/31/2010).

1148. St. Luke's is not a "must have" hospital. (Town, Tr. 4093).

Response to Finding No. 1148

This proposed finding is misleading and ambiguous. St. Luke's is an important competitor in Lucas County and all hospitals in the last ten years have been excluded from one or more health plan networks at some point in time. (*See* CCPFF ¶¶ 346-354).

1149. MCOs acknowledge that there are no acute care inpatient services that St. Luke's provides that patients cannot otherwise obtain from any other hospitals in Lucas County. (Pugliese, Tr. 1540-1541; Pirc, Tr. 2202; Radzialowski, Tr. 737; McGinty, Tr. 1237; Sandusky, Tr. 1402; Sheridan, Tr. 6619).

Response to Finding No. 1149

Complaint Counsel has no specific response.

1150. Mercy recognized that St. Luke's does not offer any services that are not also offered by Mercy's Lucas County hospitals. (Shook, Tr. 1065).

Response to Finding No. 1150

Complaint Counsel has no specific response.

1151. { } (PX02288 at 002-003, *in camera;* Shook, Tr. 1113, *in camera*).

Response to Finding No. 1151

This proposed finding is misleading. ProMedica excluded St. Luke's from Paramount and pressured Anthem to do so, because of the competitive threat posed by St. Luke's. (*See* CCPFF ¶ 365-386). Further, if ProMedica has not been included in a health plan's network, St. Luke's has been an essential component of the network. (Pirc, Tr. 2261).

1152. { } (PX02288 at 003, *in camera*; Shook, Tr. 1112, *in camera*).

Response to Finding No. 1152

Complaint counsel has no specific response.

1153. All else equal, the more valuable a product or service is, the more willing someone is to pay for that product or service. (Town, Tr. 4098-4099).

Response to Finding No. 1153

Complaint Counsel has no specific response.

1154. However, MCOs in Lucas County have paid lower rates to St. Luke's than they have paid to other hospitals located in Lucas County, indicating that St. Luke's is less valuable than other hospitals in Lucas County. (Town, Tr. 4099-4100).

Response to Finding No. 1154

This proposed finding mischaracterizes Professor Town's testimony. Professor Town testified that the payment rates St. Luke's receives from MCOs are reflective of its bargaining leverage. St. Luke's pre-Acquisition bargaining leverage was a result of its available substitutes and its positive attributes such as location. (Town, Tr. 4100).

1155. In addition, some MCOs that have not had St. Luke's in their network were able to serve their members and remain competitive in Lucas County. (Guerin-Calvert, Tr. 7779, 7783; Pugliese, Tr. 1586-1587, *in camera*).

(RX-27 (Sheridan, Dep. at 16), *in camera*).

Response to Finding No. 1155

This proposed finding is misleading. First, Respondent cites to only one MCO for each proposition, thus, "MCOs" is inapt. Further, Mr. Pugliese testified that Anthem needed St. Luke's to compete successfully in the marketplace. (Pugliese, Tr. 1478-1482; PX02381 at 003 (Email from Pugliese re: Toledo Market Developments). United testified that during its negotiations with ProMedica after the Acquisition, {

} (Sheridan, Tr. 6693, *in camera*). (*See also* CCPFF ¶ 346-354).

E. Competing Hospitals Have the Incentive and Ability To Respond Competitively

1156. Ohio does not have certificate of need ("CON") requirements for building a new hospital; Ohio only has certificate of need requirements for skilled nursing beds. (RX-11 (Oppenlander, Dep. at 37)).

Response to Finding No. 1156

Complaint Counsel has no specific response.

1157. Around 2004 or 2005, Mercy considered building a new inpatient hospital southwest of Toledo, in Monclova, Ohio. (Shook, Tr. 963-964).

Response to Finding No. 1157

Complaint Counsel has no specific response.

1158. { } (RX-272 at 000006, *in camera*). Mercy purchased land on which to build the new hospital for $2.6 million. (Shook, Tr. 966).

Response to Finding No. 1158

Complaint Counsel has no specific response.

1159. The new inpatient hospital would have included a 34-bed general medical-surgical hospital with emergency rooms, surgical suites, diagnostic capabilities, and a medical offices building. (Shook, Tr. 965; RX-783 at 000001).

Response to Finding No. 1159

Complaint Counsel has no specific response.

1160. Mercy had architectural line drawings completed for the potential facility and also sought zoning approval for the project. (Shook, Tr. 1067; RX-783 at 000001).

Response to Finding No. 1160

Complaint Counsel has no specific response.

1161. Mercy planned a joint venture with physicians to build a 35-37 bed specialty hospital at 20A and Strayer Road about a mile and a half from St. Luke's. (Wakeman, Tr. 2770).

Response to Finding No. 1161

Complaint Counsel has no specific response.

1162. Mercy received zoning approval for the project. (Shook, Tr. 1067).

Response to Finding No. 1162

Complaint Counsel has no specific response.

1163. Mercy later abandoned its plans to construct a new inpatient hospital in Monclova for two reasons: healthcare reform precluded physicians from having an ownership interest in the hospital, as Mercy had desired; and Mercy concluded that additional inpatient beds were not needed. (Shook, Tr. 966-968).

Response to Finding No. 1163

Complaint Counsel has no specific response.

1164. {

} (PX02288 at 003, *in camera*; Shook, Tr. 1112, *in camera*).

Response to Finding No. 1164

Complaint Counsel has no specific response.

1165. Mercy examined trends that revealed that inpatient admissions had decreased as more services shifted to an outpatient setting instead of inpatient, and inpatient lengths of stay were becoming much shorter than in the past. (Shook, Tr. 967).

Response to Finding No. 1165

Complaint Counsel has no specific response.

1166. {

} (PX01940 (Shook, Dep. at 13, *in camera*)).

Response to Finding No. 1166

Complaint counsel has no specific response.

1167. {

} (PX01940 (Shook, Dep. at 14, *in camera*)).

Response to Finding No. 1167

Complaint Counsel has no specific response.

1168. Mercy believes that it can continue to compete in the Toledo market following the joinder. (Shook, Tr. 1120, *in camera*; RX-695 at 000001).

Response to Finding No. 1168

Complaint Counsel has no specific response.

1169. {

} (PX01940 (Shook, Dep. at 45, *in camera*)).

Response to Finding No. 1169

The proposed finding is incomplete and misleading. Mercy's presence in the relevant markets will not constrain ProMedica's exercise of increased market power resulting from the Acquistion. (*See* CCPFF ¶ 478-502). Further, at trial Mr. Shook testified that {

}.

(Shook, Tr. 987, *in camera*).

1170. {

}

(PX01940 (Shook, Dep. at 15-17, *in camera*)).

Response to Finding No. 1170

This proposed finding is misleading. (*See* Response to RPFF ¶ 1169).

1171. {

} (PX01940 (Shook, Dep. at 17, *in camera*)).

Response to Finding No. 1171

Complaint Counsel has no specific response.

1172. {

} (PX01030 at 021, *in camera*; Wakeman, Tr. 2962, *in camera*).

Response to Finding No. 1172

This proposed finding is misleading. Mr. Shook testified that Mercy has "scrapped" its plans to construct a hospital in southwest Lucas County. (CCPFF ¶768; *see generally* CCPFF ¶ 767-778).

1173. {

} (PX01018 at 014, *in camera*).

Response to Finding No. 1173

This proposed finding is misleading. (*See* Response to RPFF ¶ 1172).

1174. Likewise, ProMedica understood, through a Mercy publication issued in May 2010, that Mercy intended to move forward with its plans to expand in the southwest area of Toledo in response to ProMedica's joinder with St. Luke's. (Oostra, Tr. 5807-5808; RX-475 at 000001).

Response to Finding No. 1174

Complaint Counsel has no specific response.

1175. {

}

(Shook, Tr. 971, 982, *in camera*; Guerin-Calvert, Tr. 7386-7388, *in camera*; PX02288 at 004-005, *in camera*).

Response to Finding No. 1175

The proposed finding is incomplete, misleading, and against the weight of evidence. Respondent has admitted and stipulated to the fact that outpatient services are not a relevant product market in this matter. (Joint Stipulations of Law and Fact, JX00002A ¶ 1, 3). To date, { }. (*See* CCPFF ¶ 494-496). Further, at trial Mr. Shook testified that {

}. (Shook, Tr. 987, *in camera*).

1176. {

} (Shook, Tr. 985, *in camera*).

Response to Finding No. 1176

Complaint Counsel has no specific response.

1177. {
} (Shook, Tr. 973, *in camera*; PX02288 at 001*, in camera*; Guerin-Calvert Tr. 7388-7389, *in camera*).

Response to Finding No. 1177

The proposed finding is inaccurate and misleading. {

}. (Shook, Tr. 973, *in camera*).

1178. {
} (Shook, Tr. 982, 1115, *in camera*; RX-296 at 000001, *in camera*). {

} (Shook, Tr. 984-985, 1115, *in camera*).

Response to Finding No. 1178

Complaint Counsel has no specific response.

1179. {
} (Shook, Tr. 983, *in camera*; RX-295, *in camera*). {
} (Shook, Tr. 1018-1019, *in camera*).

Response to Finding No. 1179

Complaint Counsel has no specific response.

1180. {

(Wakeman, Tr. 2667-2668, *in camera*).

Response to Finding No. 1180

Complaint Counsel has no specific response.

1181. {
} (Wakeman, Tr. 2667-2668, *in camera*). {

} (Wakeman, Tr. 2667-2668, *in camera*).

Response to Finding No. 1181

Complaint Counsel has no specific response.

1182. {
} (RX-286 at 000015, *in camera*).

Response to Finding No. 1182

This proposed finding is incomplete and inaccurate. {

}. (PX01940 at 008 (Shook, Dep. at 28), *in camera*). {

}. (*See* CCPFF ¶¶ 488-496).

1183. Separate from its Southwest Strategy, Mercy routinely recruits physicians for employment or to join the active staff at Mercy's hospitals. (Shook, Tr. 907-909).

Response to Finding No. 1183

Complaint Counsel has no specific response.

1184. In doing so, Mercy creates annual physician recruiting goals. (Shook, Tr. 909). Mercy exceeded its physician recruiting goals in 2007, 2008, 2009, and 2010. (Shook, Tr. 1055-1056; RX-281 at 000007, *in camera*; RX-293 at 000002, *in camera*).

Response to Finding No. 1184

Complaint Counsel has no specific response.

1185. In fact, Mercy exceeded its 2009 physician recruitinggoal of 20 physicians and its 2010 goal of another 20 physicians. (Shook, Tr. 909-910).

Response to Finding No. 1185

Complaint Counsel has no specific response.

1186. Mercy recruits physicians with the hope that the physicians will refer patients to Mercy's hospitals for inpatient services. (Shook, Tr. 1056).

Response to Finding No. 1186

Complaint Counsel has no specific response.

1187. {

} (Guerin-Calvert, Tr. 7390-7391, *in camera*).

Response to Finding No. 1187

This proposed finding is incomplete, inaccurate, and against the weight of the evidence. Respondent can point to no evidence, aside from its expert's opinion, that provides any basis for RPFF ¶ 1187. Respondent has admitted and stipulated to the fact that outpatient services are not a relevant product market in this matter. (Joint Stipulations of Law and Fact, JX00002A ¶¶ 1, 3). To date, { }. (*See* CCPFF ¶¶ 494-496). Further, at trial Mr. Shook testified that {

}. (Shook, Tr. 987, *in camera*); *see also* CCPFF ¶¶ 478-502; Response to RPFF ¶ 1175).

1188. {

} (Guerin-Calvert, Tr. 7391-7392, *in camera*).

Response to Finding No. 1188

Complaint Counsel has no specific response.

1189. Mercy's ability to implement its Southwest Strategy, convert semi-private rooms to private rooms, recruit physicians and use its excess capacity is a means of entry or expansion into the southwest Toledo area and provides a competitive constraint against ProMedica. (Guerin-Calvert, Tr. 7541-7543).

Response to Finding No. 1189

This proposed finding is incorrect, misleading, and against the weight of evidence. Mercy's plans do not constitute cognizable entry under Horizontal Merger Guidelines analysis. (*See* PX02214 at 030-031 (§ 9) (Horizontal Merger Guidelines)). Mercy's Southwest Strategy was not a successful constraint on ProMedica prior to the Acquisition and it is even less likely to

be successful post-Acquisition. (RPFF ¶ 1175; *see generally* CCPFF ¶ 478-502). Professor Town testified that Mercy's Southwest Strategy will not impact ProMedica's ability to exercise its increased bargaining leverage with MCOs because 1) it is an outpatient strategy, not an inpatient strategy and; 2) it is best viewed as product repositioning outside of the relevant product market. (Town, Tr. 3824-3825, *in camera*).

1190. UTMC also recently completed a number of renovations, expanded its facilities and engaged in outreach activity, which is also a means of entry or expansion and offers a competitive constraint against ProMedica. (Guerin-Calvert, Tr. 7543).

Response to Finding No. 1190

This proposed finding is incorrect, misleading, and against the weight of evidence. Expansion of existing facilities by market participants is not entry. (*See* PX02214 (Horizontal Merger Guidelines)). About two years ago, UTMC converted 12 to 15 geriatric psychiatry beds to medical-surgical beds, but Dr. Gold testified that this was a straight swap, not an expansion. (Gold, Tr. 224). UTMC is currently converting all of its two-bed rooms to one-bed rooms, which does not alter UTMC's maximum patient census of 225. (Gold, Tr. 224).

1191. UTMC has outreach clinics located in and around Lucas County. (Gold, Tr. 262-263).

Response to Finding No. 1191

Complaint Counsel has no specific response.

1192. One of these clinics is located in Lucas County and offers primary care services as well as some specialty services, such as pulmonary medicine. (Gold, Tr. 263).

Response to Finding No. 1192

Complaint Counsel has no specific response.

1193. Another one of these clinics is located just outside of Lucas County, in Perrysburg, and is a specialty clinic offering cardiac and vascular services. (Gold, Tr. 263).

Response to Finding No. 1193

Complaint Counsel has no specific response.

1194. UTMC chose to develop an outreach clinic in Perrysburg because UTMC considers that area to be part of its referral base. (Gold, Tr. 263-264).

Response to Finding No. 1194

Complaint Counsel has no specific response.

1195. UTMC is also examining sites for two more outreach clinics in and around Lucas County. (Gold, Tr. 264).

Response to Finding No. 1195

Complaint Counsel has no specific response.

1196. UTMC hopes that patients that visit its outreach clinics will seek inpatient services from UTMC in the future. (Gold, Tr. 265).

Response to Finding No. 1196

Complaint Counsel has no specific response.

1197. UTMC's board recently approved an expenditure of $25 million for private room conversion, implementation of electronic medical records, improving outpatient care, and constructing a cancer center. (Gold, Tr. 334).

Response to Finding No. 1197

Complaint Counsel has no specific response.

1198. The private room conversion project involves extensive renovations to convert all two-patient rooms to single patient, private rooms and will cost between $5 and $7 million. (Gold, Tr. 224, 285).

Response to Finding No. 1198

Complaint Counsel has no specific response.

1199. UTMC is performing the private room conversion because it believes that the standard of care is shifting from semi-private rooms to private rooms. (Gold, Tr. 285).

Response to Finding No. 1199

Complaint Counsel has no specific response.

1200. Recently, UTMC completed renovations on a portion of its third floor and opened a new 22-bed intensive care unit at a cost of approximately $7 million. (Gold, Tr. 266).

Response to Finding No. 1200

Complaint Counsel has no specific response.

1201. The new ICU unit features advanced beds, sound therapy, automated hand-washing, and 42-inch patient monitors. (Gold, Tr. 332).

Response to Finding No. 1201

Complaint Counsel has no specific response.

1202. In the past few years, UTMC also completed inpatient and outpatient facility modernization that included renovated spaces for heart and vascular services, and renovated space for outpatient orthopedics; which cost about $5.8 million. (Gold, Tr. 333-334).

Response to Finding No. 1202

Complaint Counsel has no specific response.

1203. In 2010, UTMC completed an emergency department renovation to buffer overflow volume from the emergency room. (Gold, Tr. 333).

Response to Finding No. 1203

Complaint Counsel has no specific response.

1. Physician Privileges at Multiple, Competing Hospitals and Participation in Multiple Plans Facilitate Patient Switching

1204. Physicians in Lucas County generally have privileges at more than one hospital. (RX-26 (Riordan, Dep. at 98-99); Gbur, Tr. 3105; RX-35 (Hammerling, IHT at 16-17, 18, *in camera*)).

Response to Finding No. 1204

Complaint Counsel has no specific response.

1205. Even physicians employed by hospital systems may hold privileges at competing hospitals. For example, PPG does not limit where its physicians may admit patients. (RX-26, (Riordan, Dep. at 94, 99); RX-1858 at 000010-000011, *in camera*; Oostra, Tr. 5799; RX-1908 at 000005, *in camera*).

Response to Finding No. 1205

This proposed finding is incorrect. Dr. Riordan, a ProMedica physician, testified that he is not able to admit patients to either UTMC or Mercy hospitals due to exclusive contracting

arrangements. (PX01949 at 014-015, 027 (Riordan, Dep. at 49-50, 98)). Further, physicians employed by a hospital system generally admit patients to that system. (*See* CCPFF ¶ 614).

1206. Physicians in Lucas County believe that they can refer patients away from ProMedica and St. Luke's if rates increase following the joinder. (RX-21 (Peron, Dep. at 167-168)).

Response to Finding No. 1206

The proposed finding is incorrect and against the weight of the evidence. Respondent cites to one physician's testimony, thus the conclusion regarding "physicians" is inappropriate. Physicians do not admit patients to hospitals based on the cost to the patients' health plans. (Marlowe, Tr. 2417; Read, Tr. 5293; Andreshak, Tr. 1782-1783; PX01932 at 033 (Bazeley, Dep. at 127), *in camera*; PX01948 at 044-045 (Peron, Dep. at 166-167, 169-170)). Physicians are not even aware of the rates that hospitals charge health plans, and Respondent points to no evidence of any mechanism that will induce physicians to steer patients away from ProMedica in response to a price increase. (Gold, Tr. 206-207; Pirc, Tr. 2379, *in camera*; Pugliese, Tr. 1467-1468; Sandusky, Tr. 1325). Further, Respondent's finding fails to account for patient preferences, which play a major role in where a patient will receive care. (*See* CCPFF ¶ 600-602).

1207. {

} (Guerin-Calvert, Tr. 7363-7365, *in camera*).

Response to Finding No. 1207

The proposed finding is incorrect and against the weight of evidence. A high degree of overlap in physician's admitting privileges has not and will not constrain ProMedica's exercise of increased market power resulting from the Acquisition. (CCPFF ¶ 593-628).

1208. {

} (Guerin-Calvert, Tr. 7366-7367, *in camera*).

Response to Finding No. 1208

This proposed finding is incorrect and directly contradicted by the evidence. There is no evidence on the record that hospital prices affect physician behavior. Physicians are unaware of the rates hospitals charge health plans. (*See* Response to RPFF ¶ 1206). Respondent points to no evidence to support the existence of a mechanism that would induce a physician to steer patients based on contracted reimbursement rates. (*See generally* CCPFF ¶ 618-628).

1209. { } (Guerin-Calvert, Tr. 7367-7368, *in camera*).

Response to Finding No. 1209

This proposed finding is incorrect and against the weight of the evidence. (*See* CCPFF ¶ 593-628; *see also* Response to RPFF ¶ 1207-1208).

2. Travel Times between Competing Hospitals Are Not a Deterrent to Patients Switching Hospitals

1210. Respondent's economic expert's drive time analysis shows that hospitals in the Toledo area are all located conveniently to patients; that the overall drive time to reach hospitals in Toledo is short; and the incremental drive time between them is minimal. (Guerin-Calvert, Tr. 7344-7345; RX-71(A) at 000030-000034, 000175-000177, 000183, *in camera*).

Response to Finding No. 1210

This finding is misleading. Respondent's economic expert did not attempt to measure the impact of additional travel time on consumer welfare and, therefore, had no objective basis on which to assess the degree of inconvenience to patients that additional travel would impose. (Town, Tr. 3814-3815, Guerin-Calvert, Tr. 7698). Complaint Counsel's economic expert, on the other hand, accounted for the impact of additional travel time on consumer welfare in his estimation of Willingness-To-Pay. (Town, Tr. 3816-3818). Moreover, the weight of the evidence indicates that location, distance, and travel times are important to hospital patients even within Lucas County, as shown by, among other things, ProMedica's to build

inpatient hospitals in southwestern Lucas County. (*See* PX01850 at 25 (¶ 35) (Town Rebuttal Report), *in camera*; CCPFF ¶¶ 27, 101-106, 216-219, 224-228, 264-272, 488-496).

1211. This means that location or distance is not an impediment to MCOs' ability to offer alternative networks that do not include ProMedica and St. Luke's. (Guerin-Calvert, Tr. 7344-7345, 7352; RX-71(A) at 000035, *in camera*).

Response to Finding No. 1211

This proposed finding is contradicted by extensive evidence that demonstrates the importance and attractiveness of St. Luke's location to patients in southwestern Lucas County, to health plans seeking to market their products in Lucas County, and to ProMedica and Mercy. (*See* CCPFF ¶ 27, 265, 267-271, 488-496). This proposed finding is also contradicted by evidence which demonstrates that health plans would face great difficulty marketing a network in Lucas County that included only Mercy and UTMC due to, in part, the loss in geographic coverage and additional travel that such a network would impose on members. (CCPFF ¶ 420(c), 488-496, 505-508, 522; *see also* 503-504, 509-521, 523-538).

1212. The drive time analysis also shows that St. Luke's location does not increase the number of patients willing to travel there, because many patients for whom St. Luke's is the closest hospital travel to other hospitals that are farther away. (Guerin-Calvert, Tr. 7351-7352; RX-71(A) at 000032-000034, 000186, *in camera*).

Response to Finding No. 1212

This proposed finding is misleading. The data on which this analysis is based include Paramount insureds, for whom St. Luke's was an out-of-network – and, therefore, a more expensive and less attractive – option at the time these data were collected. RX-71(A) at 30-31 (¶¶ 48-49, n. 44), *in camera*; Town, Tr. 4438-4439; CCPFF ¶ 108-109). Therefore, these results overstate the number of patients who would bypass St. Luke's for a more distant hospital if they did not have to pay more to use St. Luke's. (*See* Town, Tr. 4438-4439).

1213. For approximately half of those patients, a hospital was located closer to them than St. Luke's; thus, to the extent that those patients were diverted from St. Luke's, they would travel *less* far compared to going to St. Luke's. (Guerin-Calvert, Tr. 7347; RX-71(A) at 000184-000186, *in camera*).

Response to Finding No. 1213

This proposed finding is misleading. (*See* Response to RPFF ¶ 1212).

1214. For those patients who would have to drive further, the incremental time would increase for just over half of the patients and for a very large number of those, the incremental travel time would increase only one to two minutes. (Guerin-Calvert, Tr. 7347; RX-71(A) at 000032, 000184, *in camera*).

Response to Finding No. 1214

This proposed finding is misleading. (*See* Response to RPFF ¶ 1210).

1215. Prof. Town's drive time calculations for generalacute care inpatient services show similar results; about 49 percent of patients would have a negative drive time (that is, they would save driving time) if diverted from St. Luke's, while travel times would increase from one to ten minutes for approximately 51 percent of patients. (Guerin-Calvert, Tr. 7350; PX02148 at 140-141, *in camera*).

Response to Finding No. 1215

This proposed finding is incomplete. Based on this statement, for 51 percent of St. Luke's commercial general acute care patients, St. Luke's was the closest hospital, which constitutes additional strong evidence that hospital proximity is important to a substantial portion of St. Luke's general acute care patients. (*See* RPFF ¶ 1215). Moreover, Respondent's proposed finding is not supported by the results presented by Complaint Counsel's economic expert; rather it is derived from analysis performed by Respondent's economic expert. (Guerin-Calvert, Tr. 7350).

1216. For Prof. Town's inpatient OB patients, 37 percent have a hospital located closer to them than St. Luke's, 63 percent would have to travel further, with 75 percent of those having to travel only 10 minutes or less. (Guerin-Calvert, Tr. 7351; PX02148 at 140-141, *in camera*).

Response to Finding No. 1216

This proposed finding is incomplete. Based on this statement, for 63 percent of St. Luke's commercial obstetrics patients, St. Luke's was the closest hospital, which constitutes additional strong evidence that hospital proximity is important to a substantial portion of St. Luke's obstetrics patients. (*See* RPFF ¶ 1216). Moreover, Respondent's proposed finding is not supported by the results presented by Complaint Counsel's economic expert; rather it is derived from analysis performed by Respondent's economic expert. (Guerin-Calvert, Tr. 7350).

1217. This analysis shows that a large number and proportion of patients are not choosing the hospital located closest to them. (Guerin-Calvert, Tr. 7352; RX-71(A) at 000032-000034, *in camera*).

Response to Finding No. 1217

Complaint Counsel has no specific response.

1218. Moreover, for any hospital in the Toledo area, the drive time analysis shows that all patients are willing to travel to more distant hospitals than their closest available hospital for both general acute care inpatient services and inpatient OB services, indicating that location is not a material factor when patients choose a hospital. (Guerin-Calvert, Tr. 7352-7353; RX-71(A) at 000032-000034, *in camera*).

Response to Finding No. 1218

This proposed finding is misleading. The weight of the evidence indicates that location is an important factor for patients in choosing a hospital. (*See* CCPFF ¶¶ 27, 101-106, 216-219, 224-228, 264-272, 488-496; *see also* RPFF 1748 (indicating the importance of hospital location to patients seeking emergent care)).

3. The Demographics and Economic Conditions of Toledo Mean that Rivals Can Reposition Themselves To Attract Patients and Physicians Away from ProMedica

1219. The declining population of the Toledo area means that there are fewer patients overall. (Guerin-Calvert, Tr. 7274-7275).

Response to Finding No. 1219

This proposed finding is misleading. Lucas County's long-run trends show positive economic growth and a small population decline. (PX02148 at 008-009 (¶ 12) (Town Expert Report), *in camera*). These long-run trends do not suggest meaningful demographic- or growth-induced change in demand for hospital services by privately-insured patients. (PX02148 at 008-009 (¶ 12), *in camera*).

1220. The high unemployment rate in Toledo means more residents are covered by Medicaid or Medicare or are uninsured. (Guerin-Calvert, Tr. 7274-7275).

Response to Finding No. 1220

This proposed finding is incomplete. Economic conditions are rapidly improving in Lucas County, at a rate greater than the rest of the United States. (PX02148 at 009-010 (¶ 13), *in camera*). The unemployment rate in Lucas County has declined to 10.1 percent as of December 2010, while the unemployment rate for the United States was 9.2 percent for the same period. (PX02148 at 009-010 (¶ 13), *in camera*). The steepness of the decline in unemployment and the relatively quick improvement in economic conditions in Lucas County suggest that the long-run trends discussed above are better indicators of demand for hospital services than reliance on conditions present during the recession. (PX02148 at 009-010 (¶ 13), *in camera*). Also, under the implementation of the Patient Protection and Affordable Care Act, the number of individuals without health insurance will meaningfully decline with significant increases in the number of hospital patients covered by private insurance. (PX02148 at 008-009 (¶ 12), *in camera*). As a consequence, the amount of uncompensated hospital care will significantly decline. (PX02148 at 008-009 (¶ 12), *in camera*).

1221. The Toledo area also has an aging population, which means that Medicare, not commercial insurance, covers an increasing number of residents. (Guerin-Calvert, Tr. 7274-7275).

Response to Finding No. 1221

This proposed finding is misleading. (*See* Response to RPFF ¶ 1219).

1222. As a result, the Toledo area has substantially declining commercially insured admissions. (Guerin-Calvert, Tr. 7274-7275). The number of commercially insured patients in the Toledo area has declined since 2004 to 2009 from 45,000 to 35,000; TTH experienced much of this decline. (Guerin-Calvert, Tr. 7300).

Response to Finding No. 1222

This proposed finding is incomplete. (*See* Response to RPFF ¶ 1220).

1223. These factors mean that the total number of commercially insured patients available to hospitals is smaller; therefore, hospitals are going to try to attract MCOs and their commercially insured patients in order to cover their costs. (Guerin-Calvert, Tr. 7275, 7297-7298).

Response to Finding No. 1223

This proposed finding is incomplete and misleading. (*See* Response to RPFF ¶¶ 1219-1220.)

1224. This combination puts increasing financial pressures on hospitals because a higher percentage of the hospital's revenue comes from the government, which does not cover a hospital's total cost of providing care. (Guerin-Calvert, Tr. 7274-7275, 7302-7303).

Response to Finding No. 1224

Complaint Counsel has no specific response.

1225. A decreasing percentage of revenues to hospitals from commercially insured patients has also put MCOs in a stronger position to reconfigure and move patients to other networks in order to get better prices. (Guerin-Calvert, Tr. 7275).

Response to Finding No. 1225

This proposed finding is contradicted by the weight of the evidence indicating that health plans will not be able to use the remaining hospital competitors in Lucas County – Mercy and UTMC – to counteract ProMedica's increased bargaining leverage in the foreseeable future. (CCPFF ¶¶ 503-592).

1226. It has also created a dynamic of hospitals repositioning to realign services to attract more patients and physicians. (Guerin-Calvert, Tr. 7274-7275).

Response to Finding No. 1226

This proposed finding is incomplete and misleading. Mercy and UTMC cannot constrain ProMedica's exercise of the additional bargaining leverage it has gained from the Acquisition. (CCPFF ¶¶ 503-538; *see also* CCPFF ¶¶ 539-628). Repositioning by Mercy and UTMC has produced minimal changes in the dynamics of the Lucas County market, particularly in southwestern Lucas County, and any foreseeable repositioning is likely to produce modest results as well. (*See* CCPFF ¶¶ 493-496; 767-778, 1168-1172).

1227. This means that if ProMedica attempted to raise its prices, rival hospitals can and already have begun to reposition to attract patients, hire more physicians, and put new or expanded facilities to use. (Guerin-Calvert, Tr. 7275).

Response to Finding No. 1227

This proposed finding is incomplete and misleading. (See Response to RPFF ¶ 1226).

1228. Healthcare reform also will impact the competitive conditions in the Toledo area, because the rate of reimbursement from Medicare and Medicaid will decrease, the rate of reimbursement for commercial insurance will also decrease, and there will be fewer inpatients and more outpatients, all of which put increased financial pressures on the hospitals. (Guerin-Calvert, Tr. 7307-7310).

Response to Finding No. 1228

This finding is misleading. (*See* Response to RPFF ¶ 1220).

4. Excess Bed Capacity Creates Heightened Competitive Pressures and Allows Rivals To Reposition in Response to a Price Increase

1229. New entry is not necessary to provide substantial additional capacity in the Toledo area; it can come from more efficient and lower cost realignment and utilization of existing capacity. (Guerin-Calvert, Tr. 7291).

Response to Finding No. 1229

This proposed finding is misleading. The presence of capacity at hospitals in the Toledo area says nothing about patients' preferences as to where they receive inpatient care. (*See generally* CCPFF ¶ 216-222). The joinder does not change the number of hospitals in Lucas

County. (Guerin-Calvert, Tr. 7762). ProMedica has no plans to eliminate or reduce bed capacity as a result of the Acquisition. (Guerin-Calvert, Tr. 7762-7763). ProMedica is adding inpatient capacity by opening Wildwood Orthopedic hospital. (Guerin-Calvert, Tr. 7763).

1230. There were approximately 2,200 staffed beds in 2009 in Lucas County. (Guerin-Calvert, Tr. 7276).

Response to Finding No. 1230

Complaint Counsel has no specific response.

1231. All hospitals in Lucas County, except Bay Park, have many more registered beds than staffed beds. (Guerin-Calvert, Tr. 7276, 7283-7284; RX-71(A) at 000208, *in camera*).

Response to Finding No. 1231

Complaint Counsel has no specific response.

1232. MCO configurations in the past have excluded about 40 percent to 50 percent of the bed capacity in the market at any point in time. (Guerin-Calvert, Tr. 7278).

Response to Finding No. 1232

Complaint Counsel has no specific response.

1233. Based upon the number of beds per thousand, a standard metric used in healthcare, Toledo, as compared to other similar metropolitan areas in the U.S., has substantially more beds per thousand residents. (Guerin-Calvert, Tr. 7278-7279).

Response to Finding No. 1233

This proposed finding is incorrect and unfounded. Ms. Guerin-Calvert's claims regarding excess capacity in the Toledo area lack evidentiary foundation. Ms. Guerin-Calvert's analysis demonstrates that Toledo is not an outlier in terms of number of beds per thousand residents. Further, her analysis demonstrates that the Toledo area has fewer competitors than other MSAs. (*See* CCPFF ¶ 1156-1158).

1234. For example, Toledo has 3.63 beds per thousand residents, while Grand Rapids, Michigan, an area similar to Toledo, has just over 2 beds per thousand residents, and Detroit has approximately 2.5 beds per thousand residents. (Guerin-Calvert, Tr. 7280-7283; RX 71(A) at 000150, *in camera*).

Response to Finding No. 1234

This proposed finding is incorrect and unfounded. (*See* Response to RPFF ¶ 1233).

1235. This shows that there is excess capacity that exceeds the current level of demand. (Guerin-Calvert, Tr. 7283-7284).

Response to Finding No. 1235

This proposed finding is incorrect. The Acquisition does not change the number of hospitals in Lucas County, nor does ProMedica have any plans to eliminate or reduce capacity as a result of the Acquisition. In fact, ProMedica is adding capacity by opening Wildwood Orthopedic hospital. (*See* CCPFF ¶ 1156-1158; *see* Response to RPFF ¶¶ 1229, 1233-1234).

1236. Another metric that shows the excess capacity for Toledo area hospitals is the occupancy rate, which divides the average daily census of a hospital by the number of staffed beds or registered beds. (Guerin-Calvert, Tr. 7284-7285).

Response to Finding No. 1236

Complaint Counsel has no specific response.

1237. { } (Guerin-Calvert, Tr. 7284-7286; RX-71(A) at 000208, *in camera*).

Response to Finding No. 1237

Complaint Counsel has no specific response.

1238. { } (Guerin-Calvert, Tr. 7284-7286; RX-71(A) at 000208, *in camera*).

Response to Finding No. 1238

Complaint Counsel has no specific response.

1239. { } (Guerin-Calvert, Tr. 7284-7286; RX-71(A) at 000208, *in camera*).

Response to Finding No. 1239

Complaint Counsel has no specific response.

1240. {
} (Guerin-Calvert, Tr. 7284-7286; RX-71(A) at 000208, *in camera*).

Response to Finding No. 1240

Complaint Counsel has no specific response.

1241. { } (Guerin-Calvert, Tr. 7284-7286; RX-71(A) at 000208, *in camera*).

Response to Finding No. 1241

Complaint Counsel has no specific response.

1242. {
}That ranks as the seventh lowest occupancy rates of the eight Toledo hospitals. (Guerin-Calvert, Tr. 7284-7286; RX-71(A) at 000208, *in camera*).

Response to Finding No. 1242

Complaint Counsel has no specific response.

1243. {
} (Guerin-Calvert, Tr. 7284-7286; RX-71(A) at 000208, *in camera*).

Response to Finding No. 1243

Complaint Counsel has no specific response.

1244. {
} (Guerin-Calvert, Tr. 7284-7286; RX-71(A) at 000208, *in camera*).

Response to Finding No. 1244

Complaint Counsel has no specific response.

1245. That registered beds far outnumber staffed beds indicates that hospitals have adjusted to the decline in population and, in turn, the decline in demand for inpatient hospital services, by reducing their staffing levels. (Guerin-Calvert, Tr. 7276-7278).

Response to Finding No. 1245

Complaint Counsel has no specific response.

1246. Similarly, it shows that hospitals could adjust their staffing and use of currently unused beds to accommodate an increase in demand and counter an attempted price increase by ProMedica, because they have the capacity to do so. (Guerin-Calvert, Tr. 7277, 7279, 7283-7284).

Response to Finding No. 1246

Complaint Counsel has no specific response.

1247. The low occupancy rates also show that hospitals have the capability to respond and reposition to serve patients and attract additional volume in response to an attempted price increase by ProMedica. (Guerin-Calvert, Tr. 7286-7287).

Response to Finding No. 1247

This proposed finding is misleading and inaccurate. Mr. Shook testified that Mercy could treat additional patients, but the number would be limited to the number of beds Mercy could staff, which would not amount to the number of Mery's registered beds. (Shook, Tr. 1042). Additionally, Dr. Gold testified that if UTMC wanted to expand its number of staffed inpatient beds, it would have to find a new place for the services it displaces. (Gold, Tr. 199-200). Further, UTMC has no plans to increase its capacity in response to the ProMedica-St. Luke's acquisition. (Gold, Tr. 224). Tellingly, not one health plan testified that the low occupancy rates would defeat an attempted price increase by ProMedica.

1248. The excess capacity at ProMedica will motivate it to attract and serve additional patients. (Guerin-Calvert, Tr. 7289).

Response to Finding No. 1248

Complaint Counsel has no specific response.

F. The Joinder Will Not Enable ProMedica To Raise Rates above Competitive Levels

1. The History of Closed Network Contracting Demonstrates MCOs Can Offer a Viable Network without ProMedica and St. Luke's

1249. A Mercy-UTMC only network has not been offered in the past; however, there is no evidence that shows how consumers would choose between a lower priced Mercy-UTMC network and a higher priced ProMedica-St. Luke's network. (Town, Tr. 4259-4260).

Response to Finding No. 1249

This proposed finding mischaracterizes Professor Town's cited testimony. Professor Town testified that a Mercy-UTMC only network has never been offered, even when ProMedica's pre-Acquisition prices were already very high, and that this fact is evidence of this network configuration's unattractiveness from a marketing and viability standpoint. (Town, Tr. 4259-4260).

1250. { } (Town, Tr. 4311; Radzialowski, Tr. 715, *in camera*).

Response to Finding No. 1250

This proposed finding is unfounded and directly contradicted by evidence. Professor Town and numberous health plans testified that a network of Mercy and UTMC has never been offered and would not be marketable. (*See* CCPFF ¶¶ 514-533).

1251. { } (Shook, Tr. 1132, *in camera*).

Response to Finding No. 1251

This proposed finding is misleading. Mr. Shook testified that a Mercy-UTMC only network would be

(Shook, Tr. 1132, *in camera*). Health plans, those actually marketing and selling provider networks, do not believe a Mercy-UTMC only network would be marketable. (*See* CCPFF ¶¶ 514-533).

1252. The option of having an open network has always been available to MCOs in the Toledo area, but members found narrow networks attractive and sufficient to serve their needs. (Guerin-Calvert, Tr. 7329-7331).

Response to Finding No. 1252

This proposed finding is inaccurate. Health plan members prefer broader networks and Lucas County employers testified that employees prefer health plan networks that include broad access to hospitals. (*See* CCPFF ¶ 540-541). Further, health plans currently place greater emphasis on open-access networks than they did prior to 2008. (*See* CCPFF ¶¶ 539).

1253. A narrower network can be more valuable to aparticipating hospital than a broader network, because the hospital in the narrower network would get more patients from that MCO. (Town, Tr. 4108).

Response to Finding No. 1253

Complaint Counsel has no specific response.

1254. As a result, a hospital and an MCO may agree to lower reimbursement rates for a narrower network than for a broader network. (Town, Tr. 4109; Radzialowski, Tr. 657-658).

Response to Finding No. 1254

Complaint Counsel has no specific response.

1255. Conversely, if an MCO goes from a narrow network to a broad network, the network becomes less valuable to the in-network hospitals, making those in-network hospitals less willing to agree to a lower price or discount. (Town, Tr. 4111-4112).

Response to Finding No. 1255

Complaint Counsel has no specific response.

1256. For example, during the period of time when Aetna offered a broader network than MMO, Anthem and Paramount, it was not able to gain patients from those three MCOs, which may be attributable to the higher prices patients would have had to pay for a broader network as compared to the narrow networks offered by MMO, Anthem and Paramount. (Town, Tr. 4327-4328).

Response to Finding No. 1256

This finding is incomplete. Professor Town testified that health plans have moved away from narrow networks since 2008. (Town, Tr. 4328; *see also* CCPFF ¶ 539-541).

1257. {

} (Radzialowski, Tr. 819-821, *in camera*; PX02504 at 001-002, *in camera*).

Response to Finding No. 1257

Complaint Counsel has no specific response.

1258. In addition, an MCO does not need each individual hospital in its network to provide a full spectrum of services, so long as its network consists of enough hospitals to provide all the services its members may. (Guerin-Calvert, Tr. 7778; Radzialowski, Tr. 656-657).

Response to Finding No. 1258

Complaint Counsel has no specific response.

1259. {

} (Guerin-Calvert, Tr. 7355, *in camera*).

Response to Finding No. 1259

Complaint Counsel has no specific response.

1260. {

} (Guerin-Calvert, Tr. 7356, *in camera*).

Response to Finding No. 1260

This proposed finding is misleading. Although physicians maintain privileges at multiple hospitals, many choose to admit most of their patients to one hospital. (*See* CCPFF ¶¶ 595-598). Further, physicians maintain privileges at multiple hospitals in order to accommodate patient preferences, not because of prior network configurations. (*See* CCPFF ¶ 600).

a. MCOs Have Not Studied Whether and to What Extent Patients Are Willing To Travel for General Acute Care Inpatient Services and Inpatient Obstetrical Services

1261. Anthem has not performed any analysis in Lucas County regarding how far Anthem's insureds will travel for general acute care services. (Pugliese, Tr. 1563).

Response to Finding No. 1261

Complaint Counsel has no specific response.

1262. Anthem has not studied where its insureds in Lucas County obtain general acute care services relative to where those persons actually live. (Pugliese, Tr. 1563).

Response to Finding No. 1262

Complaint Counsel has no specific response.

1263. In determining whether a hospital is a viable alternative in its network, MMO considers a hospital located 35 minutes away too far. A hospital located within 10 minutes driving distance is considered a viable alternative. A hospital located 20 minutes away could be acceptable if another hospital were not located within 10 minutes. (Pirc, Tr. 2267-2268).

Response to Finding No. 1263

Complaint Counsel has no specific response.

1264. MMO has not, however, actually performed any market study regarding how far its members will travel for general acute care services. (Pirc, Tr. 2297-2298).

Response to Finding No. 1264

Complaint Counsel has no specific response.

1265. MMO has not performed any study of where expectant mothers went to deliver their babies in Lucas County. (Pirc, Tr. 2298).

Response to Finding No. 1265

Complaint Counsel has no specific response.

1266. {
} (Pirc, Tr. 2303, *in camera*).

Response to Finding No. 1266

Complaint Counsel has no specific response.

1267. United does not know whether there is an outer limit for how far patients in Lucas County would be willing to travel for general acute care inpatient services. (Sheridan, Tr. 6681).

Response to Finding No. 1267

Complaint Counsel has no specific response.

1268. { } RX-27 (Sheridan, Dep. at 20, *in camera*)).

Response to Finding No. 1268

Complaint Counsel has no specific response.

1269. Aetna has not performed any studies within the last five years of Lucas County members' willingness to travel to different hospitals in Lucas County. (Radzialowski, Tr. 774).

Response to Finding No. 1269

Complaint Counsel has no specific response.

1270. Aetna has not performed any studies within the last five years of Lucas County members' patient preferences. (Radzialowski, Tr. 774).

Response to Finding No. 1270

Complaint Counsel has no specific response.

1271. Aetna has not studied travel patterns for tertiary services. (Radzialowski, Tr. 637-638).

Response to Finding No. 1271

Complaint Counsel has no specific response.

2. MCOs and Employers Can Incentivize Patients To Use Certain Providers and Not Others

1272. MCOs may use multiple tools to steer insureds to utilize certain healthcare providers, including affirmative financial or other incentives. MCOs may also provide information to members to assist their healthcare decision-making, such as posting relative cost information on their websites. (Radzialowski, Tr. 723-724; Pugliese, Tr. 1463-1464; Town, Tr. 4342-4343).

Response to Finding No. 1272

Complaint Counsel has no specific response.

1273. Steerage can produce lower costs for health plans and lower out-of-pocket costs for plan members. (Pugliese, Tr. 1464).

Response to Finding No. 1273

The proposed finding is incomplete. The weight of evidence from this proceeding demonstrates that patients do not like health plans steering them to particular hospitals, *see* CCPFF ¶ 543, and thus, implementation of a steering mechanism is costly to health plans because it devalues the health plan's product. (Town, Tr. 3810, *in camera*). Moreover, hospital systems with bargaining leverage resist steering programs, and often negotiate anti-steering language into contracts with health plans. (*See* CCPFF ¶ 561). Even if in-network steering were implemented, it would be unlikely to defeat a price increase. Indeed, mergers of close competitors in markets where consumers directly face prices still raise competitive concern. (*See* CCPFF ¶ 549; *see also* CCPFF ¶¶ 539-592).

1274. { }
(Pirc, Tr. 2307, *in camera*).

Response to Finding No. 1274

The proposed finding is incorrect, unfounded, and directly contradicted by evidence. Respondent cites to one MCO, thus the use of "MCOs" is inapt. Additionally, several health plans testified that patients do not like health plans steering them to particular hospitals. (Radzialowski, Tr. 657-658; Pugliese, Tr. 1465, 1544-1545; PX01917 at 018 (Radzialowski, Dep. at 68), *in camera*). In fact, two of the thousands of employers in Lucas County use steering mechanisms. (Town, Tr. 4461-4462).

1275. { }
(Randolph, Tr. 7039, *in camera*).

Response to Finding No. 1275

This proposed finding is incomplete and misleading. Aetna's steering program is just a pilot program. (*See* CCPFF ¶ 573). Aetna's employees do not like the program and it is unclear if this steering has altered utilization patterns. (*See* CCPFF ¶ 573-574). United has not employed a steering mechanism in Northwest Ohio. (Randolph, Tr. 7039, *in camera*).

1276. {

} (Guerin-Calvert, Tr. 7411-7413, *in camera*).

Response to Finding No. 1276

This proposed finding is directly contradicted by testimony. *See* CCPFF ¶¶ 563, 572, 586. Aetna testified that "soft steering" efforts have not been effective at steering members to low-cost hospitals because informational and transparency measures "don't have teeth, they haven't had [an] impact[.]" (Radzialowski, Tr. 724; PX01938 at 004 (Radzialowski, Dep. at 12), *in camera*). ProMedica claims to accept price transparency, but only to the extent it will not steer significant business away from ProMedica hospitals. (Wachsman, Tr. 4880-4881). { } has negotiated anti-transparency language into its MMO contracts with { } that prohibits MMO from disclosing to its members the rates it pays to these hospitals and thus allowing its members to price shop for services. (Pirc, Tr. 2247-2248, *in camera*; *see also* PX01944 at 021-022, 024 (Pirc, Dep. at 81-82, 91), *in camera*).

1277. There is no prohibition on MCOs providing hospital cost information to physicians. (Town, Tr. 4343). { } (Guerin-Calvert, Tr. 7358, *in camera*).

Response to Finding No. 1277

This proposed finding is incorrect and directly contradicted by the evidence. Physicians do not make admissions decisions based on the hospital's rates with health plans. Rather, they consider the patient's preference and clinical condition. (*See* CCPFF ¶¶ 599-603, 628). Hospital prices do not affect physician behavior because physicians simply do not have the financial "skin in-the-game." (PX01850 at 013-014 (¶ 17) (Town Rebuttal Report), *in camera*).

1278. {

}

(Guerin-Calvert, Tr. 7413, *in camera*).

Response to Finding No. 1278

Complaint Counsel has no specific response.

a. The Lucas County Government Steers Its Employees toward Particular Hospital Networks

1279. {

} (Shook, Tr. 1093-1094, 1096, *in camera*).

Response to Finding No. 1279

Complaint Counsel has no specific response.

1280. {

} (Randolph, Tr. 7039-7040, *in camera*; RX-261 at 000004, *in camera*).

Response to Finding No. 1280

Complaint Counsel has no specific response.

1281. {

} (Shook, Tr. 1092, *in camera*).

Response to Finding No. 1281

Complaint Counsel has no specific response.

1282. {
} (Shook, Tr. 1095, *in camera*).

Response to Finding No. 1282

Complaint Counsel has no specific response.

1283. {
}(Shook, Tr. 1093-1094*, in camera*).

Response to Finding No. 1283

Complaint Counsel has no specific response.

1284. {

} (PX00524 at 001, *in camera*).

Response to Finding No. 1284

Complaint Counsel has no specific response.

1285. In 2011, the Lucas County Government contributed a greater percentage to its employees' healthcare costs if they chose to enroll with PHC instead of their two other options, Paramount or FrontPath. (Guerin-Calvert, Tr. 7294-7295; Shook, Tr. 1096, *in camera*; Guerin-Calvert, Tr. 7395-7396 *in camera*).

Response to Finding No. 1285

Complaint Counsel has no specific response.

1286. {

} (Randolph, Tr. 7043, *in camera*; PX00524 at 001, *in camera*).

Response to Finding No. 1286

Complaint Counsel has no specific response.

1287. {

} (Oostra, Tr. 5940, *in camera*).

Response to Finding No. 1287

Complaint Counsel has no specific response.

1288. {

}

(Randolph, Tr. 7043, 7050, *in camera*).

Response to Finding No. 1288

Complaint Counsel has no specific response.

1289. {

}

(Shook, Tr. 1092-1093, *in camera*).

Response to Finding No. 1289

Complaint Counsel has no specific response.

1290. {

} (Oostra, Tr. 5942, *in camera*).

Response to Finding No. 1290

This proposed finding is misleading. Lucas County Government is not steering its employees, it offers its employees three health plans to choose from. (Shook, Tr. 1095-1096, *in camera*).

1291. The Lucas County model of offering different tiers of health plans is a new technique employers are using to offer multiple health plans and control their costs. (Guerin-Calvert, Tr. 7902).

Response to Finding No. 1291

This proposed finding is misleading. Lucas County offers three health plans for its employees to choose from. (Shook, Tr. 1095-1096, *in camera*).

1292. {

} (Randolph, Tr. 7050, *in camera*).

Response to Finding No. 1292

Complaint Counsel has no specific response.

1293. {

} (Guerin-Calvert, Tr. 7397-7398, *in camera*).

Response to Finding No. 1293

This proposed finding is misleading. The implementation of health care reform is uncertain at this time. (*See* CCPFF ¶ 882). Furthermore, employers and MCOs already take costs into consideration. (*See* generally CCPFF ¶¶ 76-91).

b. The Catholic Diocese of Toledo Steers Its Employees Exclusively to the Mercy Hospitals

1294. The Catholic Diocese of Toledo has used United as its health insurance provider for its approximately 1500 insureds. (Sheridan, Tr. 6628).

Response to Finding No. 1294

Complaint Counsel has no specific response.

1295. Because the Diocese prefers its employees use the Catholic hospitals in Lucas County, , the Mercy system hospitals are the only participating hospitals in United's network for the Diocese. (Sheridan, Tr. 6628-6629).

Response to Finding No. 1295

Complaint Counsel has no specific response.

1296. For this narrow network product, United and Mercy negotiated lower rates for Diocese members. (Sheridan, Tr. 6629; Sheridan, Tr. 6631 *in camera*).

Response to Finding No. 1296

This proposed finding is unfounded and misleading. The Diocese prefers Mercy as a provider based on religious preferences, not because of cost. (Sheridan, Tr. 6628-6629).

c. Mercy Steers Its Employees toward Mercy Hospitals

1297. Mercy is one of the ten largest employers in Lucas County. (Shook, Tr. 1067-1068).

Response to Finding No. 1297

Complaint Counsel has no specific response.

1298. Mercy offers health insurance benefits to its employees and provides health insurance to approximately 8,000 insureds. (Shook, Tr. 1068, 1072).

Response to Finding No. 1298

Complaint Counsel has no specific response.

1299. Mercy is self-insured and contracts with MMO to manage its health insurance plan. (Shook, Tr. 1068).

Response to Finding No. 1299

Complaint Counsel has no specific response.

1300. Mercy's health plan puts its provider hospitals into three tiers in order to steer, or incentivize, its employees to seek services from Mercy's hospitals instead of other Lucas County hospitals. (Shook, Tr. 1068; Marlowe, Tr. 2427-2428; Read, Tr. 5287-5288; Guerin-Calvert, Tr. 7294-7295; Town, Tr. 4383, *in camera*; Guerin-Calvert, Tr. 7395 *in camera*).

Response to Finding No. 1300

This proposed finding is incomplete. It is quite common for hospitals and hospital systems to offer a tiered network to its employees with incentives for employees to utilize the employer hospitals for care. This ensures they are "writing checks" to themselves, rather than a competitor. (Guerin-Calvert, Tr. 7903). Mr. Randolph testified that ProMedica steers its employees to its own hospitals because it "is fairly common in the industry. It's kind of like . . . if you work for Ford, they're not giving you a discount on a Chrysler car; they're giving you a discount on a Ford car." (Randolph, Tr. 7006-7007).

1301. Tier one is the preferred tier and includes Mercy's facilities. (Shook, Tr. 1072).

Response to Finding No. 1301

Complaint Counsel has no specific response.

1302. Mercy believes that commercial health plans can protect themselves from increased hospital rates by steering their enrollees to lower cost hospitals. (Shook, Tr. 1070).

Response to Finding No. 1302

This proposed finding mischaracterizes testimony. Mr. Shook testified that commercial health plans can protect themselves through steering only if they can sell a narrow panel of providers to enrollees. (Shook, Tr. 1070). This is distinguishable from in-network steering. (CCPFF ¶ 544).

d. UTMC Steers to Its Own Physicians

1303. UTMC offers its employees health insurance benefits. (Gold, Tr. 259). UTMC employees can choose from three health insurance plans: FrontPath, MMO, and Paramount. (Gold, Tr. 259).

Response to Finding No. 1303

Complaint Counsel has no specific response.

1304. The plans contain incentives for insured members to seek services from UTMC's faculty physicians. (Gold, Tr. 259).

Response to Finding No. 1304

This proposed finding is incomplete. (*See* Response to RPFF ¶ 1300).

1305. UTMC has a faculty practice group, known as the University of Toledo Physicians, which employs approximately 175-full time physicians. (Gold, Tr. 204).

Response to Finding No. 1305

Complaint Counsel has no specific response.

e. Aetna's Steering Program

1306. { } (Town, Tr. 4383, *in camera*).

Response to Finding No. 1306

This proposed finding is incomplete. Aetna's pilot program is targeted at 100 or fewer of Aetna's employees in Toledo. Aetna does not have results as to the program's success, but has received a fair number of complaints from members. Furthermore, hospitals including

ProMedica have complained about the pilot and placement in the high-cost tier of providers.

(*See* CCPFF ¶¶ 571-577).

1307. Aetna offers "soft" steerage programs to employers that provide information to patients and providers to try to change where care is provided. (Radzialowski, Tr. 723-724).

Response to Finding No. 1307

This proposed finding is incomplete and misleading. Mr. Radzialowski testified that soft steering efforts have not been effective. (*See* CCPFF ¶ 572).

1308. Aetna is also piloting a "hard" steerage program that offers financial incentives to patients to obtain care from specific, lower-cost providers. (Radzialowski, Tr. 724).

Response to Finding No. 1308

This proposed finding is misleading. (*See* Response to RPFF ¶ 1306).

1309. Aetna launched the pilot steerage program on January 1, 2011 with a select population of Aetna employees to encourage patients to use services at lower-cost hospitals. (Radzialowski, Tr. 775; Guerin-Calvert, Tr. 7396, *in camera*). Aetna typically tests new insurance products with its own employees before launching them in the market. (Radzialowski, Tr. 724).

Response to Finding No. 1309

This proposed finding is misleading. The "select population" consists of 100 or fewer Aetna employees. (*See* Response to RPFF ¶ 1306).

1310. The program is in effect in Lucas County and throughout Ohio. (Radzialowski, Tr. 775-776). None of Aetna's existing contracts in Northern Ohio have any language restricting its ability to implement a steerage program. (Radzialowski, Tr. 726-727).

Response to Finding No. 1310

This proposed finding is misleading. Hospitals including ProMedica have complained about the pilot and placement in the high-cost tier of providers. (*See* CCPFF ¶¶ 571-577).

1311. As part of the program, Aetna categorizes hospitals into various tiers. (Radzialowski, Tr. 775). The placement of a hospital in a particular tier is determined, in part, by the cost of care at that hospital. (Radzialowski, Tr. 775).

Response to Finding No. 1311

Complaint Counsel has no specific response.

1312. All Lucas County hospital providers are represented in Aetna's lower-cost hospital tier, which includes St. Luke's, UTMC, Bay Park, St. Charles, and St. Anne. (Radzialowski, Tr. 776).

Response to Finding No. 1312

This proposed finding is misleading. ProMedica's Flower and TTH are in the disfavored, highest priced tier. (*See* CCPFF ¶ 576).

1313. Aetna has not yet compiled enough data to determine whether the program will be successful. (Radzialowski, Tr. 725-726). At the end of the year, Aetna will evaluate the effectiveness of the program and determine whether to expand it to include other members and markets. (Radzialowski, Tr. 776-777).

Response to Finding No. 1313

Complaint Counsel has no specific response.

f. Other Employers

1314. Some FrontPath sponsors that are also healthcare providers have designed three-tiered networks that encourage employees to use the sponsor's services before using other in-network providers. (Sandusky, Tr. 1328).

Response to Finding No. 1314

Complaint Counsel has no specific response.

1315. FrontPath would negotiate for tiered networks with providers if its sponsors requested it. (Sandusky, Tr. 1328-1329).

Response to Finding No. 1315

Complaint Counsel has no specific response.

3. MCOs Can Use Excess Bed Capacity to Their Advantage

1316. The excess capacity of available beds in Lucas County means that MCOs do not have to have every hospital in their networks because there are enough beds for their members with just a few hospitals. (Guerin-Calvert, Tr. 7291-7294).

Response to Finding No. 1316

This proposed finding is incomplete. Patients prefer broad access to providers in health plan networks, despite the existence of excess capacity. (*See* CCPFF ¶¶ 539-543). Respondent can point to no evidence that health plans consider the number of beds available in the market as something to be leveraged in negotiations with hospitals—instead, health plans are concerned with the rates hospitals charge and the location of the hospitals. (*See* CCPFF ¶¶ 92-170).

1317. For example, MMO grew into one of the largest MCOs in the Toledo area without ProMedica in its network; the hospitals that were in MMO's network were able to serve its member volume. (Guerin-Calvert, Tr. 7291-7292).

Response to Finding No. 1317

This proposed finding is incomplete. Health plans currently place greater emphasis on open-access networks than they did prior to 2008. (*See* CCPFF ¶ 539-543). At the time MMO offered a network without ProMedica, Anthem offered a network without Mercy. (*See* RPFF ¶ 1318). Thus, RPFF ¶ 1317 cannot support the proposition of RPFF ¶ 1316, that excess capacity in the Lucas County hospital market allowed for MMO's narrow network configuration.

1318. Similarly, Anthem's members were all able to be served with only ProMedica and UTMC in its network for several years and, during that time, Anthem became one of the top four MCOs in the Toledo area. (Guerin-Calvert, Tr. 7292).

Response to Finding No. 1318

This proposed finding is incomplete. Health plans currently place greater emphasis on open-access networks than they did prior to 2008. (*See* CCPFF ¶¶ 539-543). At the time Anthem offered a network without Mercy, MMO offered a network without ProMedica. (*See* RPFF ¶ 1317). Thus, RPFF ¶ 1318 cannot support the proposition of RPFF ¶ 1316, that excess capacity in the Lucas County hospital market allowed for Anthem's narrow network configuration.

1319. Moreover, MCOs can take advantage of the excess bed capacity in the hands of non-ProMedica hospitals to discipline ProMedica's pricing and seek opportunities to get more

attractive pricing from Mercy or UTMC by making those hospitals the principal providers in a network, because sufficient beds will exist to serve the MCO's members. (Guerin-Calvert, Tr. 7292-7294).

Response to Finding No. 1319

This proposed finding is incorrect and against the weight of evidence. A hospital network consisting of Mercy and UTMC is not a viable substitute for one including ProMedica. (*See* CCPFF ¶¶ 503-538). Notably, a network consisting of Mercy and UTMC only has never been offered in Lucas County despite the existence of excess bed capacity and very substantial price differences between ProMedica and the other Lucas County hospital competitors for several years prior to the Acquisition. (*See* CCPFF ¶¶ 503-538; Town, Tr. 3761-3762, *in camera*). Moreover, testimony from health plans confirms that this network would not be marketable. (*See* CCPFF ¶¶ 514-533).

4. ProMedica's Pre- and Post-Joinder Negotiations with MCOs Resulted in Competitive Contracts

1320. "Bargaining leverage" is the advantage, or perception of advantage, of a particular entity at the bargaining table to try to make use of certain attributes in the negotiation. (Guerin-Calvert, Tr. 7440).

Response to Finding No. 1320

This proposed finding is misleading, because the term "bargaining leverage" describes a precise and different meaning in the context of Complaint Counsel's presentation of the Acquisition's anticompetitive effects. (*See* CCPFF ¶¶ 139-184). In a negotiation, the bargaining leverage of each party depends upon how the other party would fare if it failed to reach an agreement. (CCPFF ¶ 140). This dynamic applies to negotiations between hospitals and health plans. (CCPFF ¶ 139). The bargaining leverage of a hospital against a health plan depends on the amount of value the health plan's network would lose if it failed to contract with the hospital. (CCPFF ¶¶ 147-151). The more bargaining leverage a hospital has against a health plan, the

higher the reimbursement rates that the hospital will be able to obtain from the health plan. (CCPFF ¶ 152). The degree to which a hospital merger will harm consumers depends on the degree to which the merger increases the merged entities' bargaining leverage by eliminating competition between the merged entities. (*See* CCPFF ¶¶ 171-184).

1321. Bargaining leverage is not an economic term and does not necessarily equate with or cause an anticompetitive effect. (Guerin-Calvert, Tr. 7440).

Response to Finding No. 1321

This proposed finding is misleading. (*See* Response to RPFF ¶ 1320).

1322. A hospital's bargaining leverage is a function of the available substitutes in the area. If other hospitals in the area are close substitutes for a given hospital, the marketability of a MCO's product would be impacted little by failing to reach an agreement with the hospital. (Town, Tr. 3644-3645).

Response to Finding No. 1322

Complaint Counsel has no specific response.

1323. "Bargaining power" is not the same as bargaining leverage. (Guerin-Calvert, Tr. 7441).

Response to Finding No. 1323

This proposed finding is incorrect and misleading. In his testimony in this matter, Professor Town used "bargaining power" interchangeably with "bargaining leverage." (*Compare, e.g.,* Town, Tr. 3600-3601 *with* Town, Tr. 3602-3603). Professor Town also correctly equates in his testimony the enhancement of a hospital's bargaining leverage (or bargaining power) from the acquisition of a competitor to an increase in that hospital's market power. (*See, e.g.,* Town, Tr. 4082-4083).

1324. While bargaining power is used in economic literature, it refers to the concept of the share of the available profits or the available rents that a party gets, but it does not equate with or cause anticompetitive effect. (Guerin-Calvert, Tr. 7441-7442).

Response to Finding No. 1324

This proposed finding is incorrect and misleading. While "bargaining power" can have this meaning in economics, this is not the term's only meaning. (*See* Response to RPFF ¶ 1323).

1325. "Market power" means that an entity has some ability to price above its marginal cost because of some differentiation it has compared to its competitors. (Guerin-Calvert, Tr. 7442).

Response to Finding No. 1325

Complaint Counsel has no specific response.

1326. That a competitor has market power does not necessarily mean an anticompetitive market exists, because most firms face a less than perfectly elastic demand; they can differentiate themselves in some respect. (Guerin-Calvert, Tr. 7442).

Response to Finding No. 1326

This proposed finding is incomplete. The evidence indicates that the Lucas County market was already highly concentrated before the Acquisition. (CCPFF ¶ 4). Markets that are highly concentrated are presumed to be less competitive than less concentrated markets. (PX02148 at 032 (¶ 56) (Town Expert Report, *in camera*)). In less competitive markets, firms will charge higher prices to consumers, and generally have less incentive to innovate and offer high quality goods and services. (PX02148 at 032 (¶ 56) (Town Expert Report, *in camera*)). The evidence also indicates that ProMedica had a significant amount of bargaining leverage against health plans even before the Acquisition due to its dominant presence in the market, and that ProMedica was able to use this bargaining leverage to charge the highest prices in Lucas County. (CCPFF ¶¶ 425-431; PX2148 at 37-38 (¶¶ 68-69) (Town Expert Report), *in camera*).

1327. Bargaining leverage and market power are related to the extent that a firm is able to differentiate itself. (Guerin-Calvert, Tr. 7443).

Response to Finding No. 1327

Complaint Counsel has no specific response.

1328. Bargaining power is distinguished from market power in that the outcomes of bargains can vary based on the skill and capability of the parties and the value of their offerings. (Guerin-Calvert, Tr. 7443-7444).

Response to Finding No. 1328

This finding is incorrect and misleading. (*See* Response to RPFF ¶ 1323).

1329. A party's negotiating skills will affect its bargaining leverage. (Guerin-Calvert, Tr. 7445).

Response to Finding No. 1329

Complaint Counsel has no specific response.

1330. All hospitals and MCOs in Lucas Countyeach have bargaining leverage, bargaining power and market power. (Guerin-Calvert, Tr. 7445-7446).

Response to Finding No. 1330

Complaint Counsel has no specific response.

1331. Complaint Counsel's economic expert would not characterize the bargaining leverage in Lucas County pre-joinder as anticompetitive. (Town, Tr. 4142-4143).

Response to Finding No. 1331

This proposed finding is misleading. Complaint Counsel's economic expert testified that he focused on analyzing the Acquisition's anticompetitive increase of bargaining leverage and that he reserves judgment about whether pre-Acquisition bargaining leverage in Lucas County was anticompetitive. (Town, Tr. 4142-4143).

1332. Higher reimbursement rates, in and of themselves, are not anticompetitive. (Town, Tr. 4200-4201).

Response to Finding No. 1332

This proposed finding is incomplete. (*See* Response to RPFF ¶ 1326).

1333. {

} (Guerin-Calvert, Tr. 7436-7439, *in camera*).

Response to Finding No. 1333

This proposed finding is incorrect and misleading. Professor Town's economic model is based on and consistent with standard intuition and economic analyses of bargaining between hospitals and health plans, and with standard economic theory on mergers in differentiated product markets. (CCPFF ¶¶ 465-466). Other scholars' analysis of the Willingness-to-Pay merger simulation model has shown it to make accurate and conservative estimates of the impact of hospital mergers. (CCPFF ¶ 467). Ms. Guerin-Calvert's criticisms of Professor Town's economic model lack foundation and demonstrate a fundamental misunderstanding of the Willingness-to-Pay model. (*See* CCPFF 1185-1198; *see also* PX01850 at 056-072 (¶¶ 86-104) (Town Rebuttal Report), *in camera*). Even after Ms. Guerin-Calvert's inappropriate "corrections" to Professor Town's model, the analysis predicts an economically and statistically significant (at the 3.8 percent level) price increase of 7.3 percent as a result of the Acquisition's elimination of competition between ProMedica and St. Luke's. (CCPFF ¶ 1197-1198).

a. Pre-Joinder

(i) MMO

1334. {

} (Pirc, Tr. 2286, *in camera*).

Response to Finding No. 1334

Complaint Counsel has no specific response.

1335. {

} (Wachsman, Tr. 4996, *in camera*).

Response to Finding No. 1335

Complaint Counsel has no specific response.

(ii) FrontPath

1336. { }
(Sandusky, Tr. 1362, *in camera*).

Response to Finding No. 1336

Complaint Counsel has no specific response.

1337. {

} (Sandusky, Tr. 1362-1363, *in camera*).

Response to Finding No. 1337

Complaint Counsel has no specific response.

1338. {

} (Sandusky, Tr. 1367-1368, *in camera*).

Response to Finding No. 1338

Complaint Counsel has no specific response.

1339. {
} (Sandusky, Tr. 1368, *in camera*)

Response to Finding No. 1339

Complaint Counsel has no specific response.

1340. {

} (Sandusky, Tr. 1368-1369, *in camera*).

Response to Finding No. 1340

Complaint Counsel has no specific response.

1341. {

} (Sandusky, Tr. 1369, *in camera*).

Response to Finding No. 1341

Complaint Counsel has no specific response.

(iii) Anthem

1342. Anthem's pre-joinder negotiations with ProMedica resulted in a contract that was mutually agreeable and executed by both parties. (Pugliese, Tr. 1554).

Response to Finding No. 1342

Complaint Counsel has no specific response.

1343. {
} (Pugliese, Tr. 1475, *in camera*).

Response to Finding No. 1343

Complaint Counsel has no specific response.

(iv) Aetna

1344. { } (Radzialowski, Tr. 788, *in camera*; RX-129 at 000002, *in camera*).

Response to Finding No. 1344

Complaint Counsel has no specific response.

1345. {
} (Radzialowski, Tr. 788, *in camera*; RX-129 at 000001-000002, *in camera*).

Response to Finding No. 1345

Complaint Counsel has no specific response.

1346. {
} (Radzialowski, Tr. 788, *in camera*; RX-129 at 000001, *in camera*).

Response to Finding No. 1346

Complaint Counsel has no specific response.

1347. {
}
(Radzialowski, Tr. 789-790, *in camera*; RX-128 at 000001, *in camera*).

Response to Finding No. 1347

Complaint Counsel has no specific response.

1348. {
} (Radzialowski, Tr. 809, *in camera*).

Response to Finding No. 1348

Complaint Counsel has no specific response.

1349. {
} (Radzialowski, Tr. 820, *in camera*).

Response to Finding No. 1349

Complaint Counsel has no specific response.

1350. {
} (Radzialowski, Tr. 790, *in camera*).

Response to Finding No. 1350

Complaint Counsel has no specific response.

b. Post-Joinder

1351. {
} (Oostra, Tr. 5942-5943, *in camera*). {
} (Wachsman, Tr. 5080, *in camera*).

Response to Finding No. 1351

This proposed finding is misleading and contradicted by the evidence, which indicates that ProMedica bargains aggressively with commercial health plans to obtain the highest possible reimbursement rates in order to maximize revenues and profits. (CCPFF ¶ 440-441, 445-456).

(i) Anthem

(a) Negotiations Relating to ProMedica Legacy Hospitals

1352. {
} (Pugliese, Tr. 1475, *in camera*).

Response to Finding No. 1352

Complaint Counsel has no specific response.

1353. {

} (Pugliese, Tr. 1649*, in camera*).

Response to Finding No. 1353

This proposed finding is misleading. After the expiration of Anthem's provider contracts for ProMedica's Lucas County hospitals,

(PX00091 at 005, *in camera*; PX00093 at 005, *in camera*; PX00095 at 005, *in camera*).

1354. {

} (Pugliese, Tr. 1475, 1649-1650, *in camera*).

Response to Finding No. 1354

Complaint Counsel has no specific response.

1355. {

} (Pugliese, Tr. 1650, *in camera*).

Response to Finding No. 1355

Complaint Counsel has no specific response.

1356. {
} (Pugliese, Tr. 1650, *in camera*).

Response to Finding No. 1356

Complaint Counsel has no specific response.

(b) Negotiations Relating to St. Luke's

1357. There have been no negotiations between ProMedica and Anthem since the joinder of ProMedica and St. Luke's relating to Anthem's contracts with St. Luke's. (Pugliese, Tr. 1583).

Response to Finding No. 1357

Complaint Counsel has no specific response.

1358. Since the joinder of ProMedica and St. Luke's, ProMedica has not sought to modify any of St. Luke's rates to be comparable to the rates that ProMedica is presently getting from Anthem for any of its hospitals. (Pugliese, Tr. 1583-1584).

Response to Finding No. 1358

Complaint Counsel has no specific response.

1359. ProMedica has not sought to terminate St. Luke's contract with Anthem since the joinder. (Pugliese, Tr. 1584).

Response to Finding No. 1359

Complaint Counsel has no specific response.

1360. Terminating St. Luke's contract with Anthem would be detrimental to ProMedica because ProMedica would lose access to Anthem's fully-insured and self-insured patient base. (Pugliese, Tr. 1584).

Response to Finding No. 1360

Complaint Counsel has no specific response.

(ii) MMO

(a) Negotiations Relating to ProMedica Legacy Hospitals

1361. { } (Pirc, Tr. 2372-2373, *in camera*).

Response to Finding No. 1361

Complaint Counsel has no specific response.

(b) Negotiations Relating to St. Luke's

1362. On August 27, 2010, St. Luke's CEO Mr. Wakeman sent a letter to MMO giving St. Luke's "formal notice of [its] intent to discontinue [its] arrangement of providing

services at current rates to MMOH beneficiaries as of December 31, 2010." (PX00485 at 001).

Response to Finding No. 1362

Complaint Counsel has no specific response.

1363. {

} (Wakeman, Tr. 3017-3018, *in camera*).

Response to Finding No. 1363

Complaint Counsel has no specific response.

1364. St. Luke's sent this termination letter to MMO because St. Luke's wanted to renegotiate rates with MMO at the end of the contract; St. Luke's believed that it was being underpaid and not receiving market rates. (RX-43 (Wagner, IHT at 83)).

Response to Finding No. 1364

This proposed finding is incomplete and misleading. In the last four months of 2010, St. Luke's received sufficient reimbursement to cover all direct and indirect costs – in other words, total costs – associated with treating { } members. (CCPFF ¶ 959). Even before the Acquisition, St. Luke's covered its direct costs when treating {

}. (CCPFF ¶ 960). {

1365. {

}(Wakeman, Tr. 3018, *in camera*).

Response to Finding No. 1365

Complaint Counsel has no specific response.

1366. {

} (Pirc, Tr. 2249-2250*, in camera*).

Response to Finding No. 1366

This proposed finding is incomplete. These negotiations took place during the FTC's investigation and challenge of the Acquisition and under restrictions of the Hold-Separate Agreement between the FTC and ProMedica, which obligated ProMedica to give health plans the option to extend their existing rates with ProMedica through the duration of the Hold-Separate Agreement. (*See* CCPFF ¶¶ 2, 54-56, 1240-1242). Rates negotiated after the Acquisition but while the Acquisition is being scrutinized on antitrust grounds are not good proxies for post-Acquisition equilibrium rates. (PX01850 at 049 (¶ 76) (Town Rebuttal Report), *in camera*). Given ProMedica's incentive to present the Acquisition as competitively benign in the preliminary injunction proceeding and this trial, it stands to reason that PHS will refrain from exercising all of its market power, lest it create damning evidence against itself. (PX01850 at 049 (¶ 76) (Town Rebuttal Report), *in camera*). Moreover, the terms of the Hold-Separate Agreement further restrained ProMedica's bargaining power. (PX01850 at 050 (¶ 76) (Town Rebuttal Report), *in camera*; *see also* CCPFF ¶ 1183).

1367. {
} (Pirc, Tr. 2254, *in camera*).

Response to Finding No. 1367

Complaint Counsel has no specific response.

1368. {
} (Pirc, Tr. 2357**,** *in camera*; PX02350 at 001, *in camera*).

Response to Finding No. 1368

This proposed finding is incorrect. ProMedica initially informed MMO that it was seeking a (Pirc, Tr. 2250-2251, *in camera*).

1369. {

} **(**Pirc, Tr. 2357, *in camera*; PX02350 at 001, *in camera*; Wachsman, Tr. 5065, *in camera*; RX-741 at 000002, *in camera*).

Response to Finding No. 1369

Complaint Counsel has no specific response.

1370. {
} (Pirc, Tr. 2358, *in camera*; PX02350 at 001, *in camera*).

Response to Finding No. 1370

Complaint Counsel has no specific response.

1371. { }
(Pirc, Tr. 2358, *in camera*).

Response to Finding No. 1371

Complaint Counsel has no specific response.

1372. {

} (Pirc, Tr. 2360-2361, *in camera*; RX-737 at 000005, *in camera*; Guerin-Calvert, Tr. 7429, *in camera*).

Response to Finding No. 1372

Complaint Counsel has no specific response.

1373. {

} **(**Pirc, Tr. 2361, *in camera*; RX-737 at 000005, *in camera*).

Response to Finding No. 1373

Complaint Counsel has no specific response.

1374. {
} (Pirc, Tr. 2362, *in camera*; RX-737 at 000004, *in camera*).

Response to Finding No. 1374

Complaint Counsel has no specific response.

1375. {

} (Pirc, Tr. 2363, *in camera*; Guerin-Calvert, Tr. 7429-7430, *in camera*; RX-737 at 000004, *in camera*).

Response to Finding No. 1375

Complaint Counsel has no specific response.

1376. {

} (Pirc, Tr. 2364, 2367-2369, *in camera*; RX-736 at 000001, *in camera*).

Response to Finding No. 1376

This proposed finding is incomplete. MMO decided to keep St. Luke's existing rates in effect after it was informed by ProMedica of its right to do so under the Hold-Separate Agreement between ProMedica and the FTC. (Pirc, Tr. 2367-2368, *in camera*).

1377. {

} (Pirc, Tr. 2369-2370, *in camera*).

Response to Finding No. 1377

Complaint Counsel has no specific response.

1378. {

} (Pirc, Tr. 2370, *in camera*)

Response to Finding No. 1378

Complaint Counsel has no specific response.

1379. {

} (Pirc, Tr. 2370, *in camera*).

Response to Finding No. 1379

Complaint Counsel has no specific response.

1380. {
} (Pirc, Tr. 2251, *in camera*).

Response to Finding No. 1380

Complaint Counsel has no specific response.

1381. {
} (PX02385 at 032-033, *in camera*; Wachsman, Tr. 5064, *in camera*).

Response to Finding No. 1381

Complaint Counsel has no specific response.

1382. {
} (Pirc, Tr. 2271, *in camera*; PX02385 at 032-033, *in camera*).

Response to Finding No. 1382

Complaint Counsel has no specific response.

1383. {
} (Pirc, Tr. 2371-2372, *in camera*).

Response to Finding No. 1383

Complaint Counsel has no specific response.

1384. {
} (Guerin-Calvert, Tr. 7429-7430, *in camera*).

Response to Finding No. 1384

This finding is misleading. The "pre-joinder rates St. Luke's negotiated with MMO" refers to the terms which were ultimately rejected by MMO when St. Luke's failed to meet MMO's conditions. (RX-71(A) at 53-54 (¶¶ 97-98) (Guerin-Calvert Expert Report), *in camera*).

It makes little sense to view proposed rates of a failed contract negotiation as markers of future prices. (PX01850 at 048 (¶ 73) (Town Rebuttal Report),*in camera*). SLH attempted and failed to negotiate a rate increase with MMO and, thus, the rejected rates do not reflect any price – but-for or otherwise. (PX01850 at 048 (¶ 73) (Town Rebuttal Report), *in camera*).

1385. { } (Guerin-Calvert, Tr. 7429-7430, *in camera*; Wachsman, Tr. 5066, *in camera*).

Response to Finding No. 1385

Complaint Counsel has no specific response.

1386. { } (Guerin-Calvert, Tr. 7430-7431, *in camera*).

Response to Finding No. 1386

Complaint Counsel has no specific response.

1387. MMO and ProMedica negotiated a contract for St. Luke's effective January 19, 2011, that reflects equilibrium prices, because both parties felt that they were better off with the contract than they were without it. (Town, Tr. 3847, 4418-4419, *in camera*).

Response to Finding No. 1387

This proposed finding is misleading. (*See* Response to RPFF ¶ 1366).

1388. { } (Pirc, Tr. 2367-2369, *in camera*; Wachsman, Tr. 5074, 5076-5077, *in camera*; PX00487 at 003, *in camera*; PX00488 at 001, *in camera*).

Response to Finding No. 1388

Complaint Counsel does not dispute this proposed finding.

(iii) United

(a) Negotiations Relating to ProMedica Legacy Hospitals

1389. {

} (Sheridan, Tr. 6652, *in camera*).

Response to Finding No. 1389

Complaint Counsel has no specific response.

1390. {

} (Wachsman, Tr. 5068, *in camera*).

Response to Finding No. 1390

This proposed finding is contradicted by evidence which indicates that ProMedica approaches health plan negotiations with the goal of maximizing commercial reimbursement rates. (*See* Response to RPFF ¶ 1351).

1391. {

} (RX-27 (Sheridan, Dep. at 50), *in camera*).

Response to Finding No. 1391

Complaint Counsel has no specific response.

1392. United successfully negotiated a lower final base rate than the rate initially proposed by ProMedica at the start of negotiations. (RX-27 (Sheridan, Dep. at 50)).

Response to Finding No. 1392

Complaint Counsel has no specific response.

1393. {

} (Sheridan, Tr. 6653, 6661, *in camera*).

Response to Finding No. 1393

Complaint Counsel has no specific response.

1394. {

} (Sheridan, Tr. 6661, 6666-6667, *in camera*).

Response to Finding No. 1394

Complaint Counsel has no specific response.

1395. {

} (Sheridan, Tr. 6663-6664*, in camera*).

Response to Finding No. 1395

Complaint Counsel has no specific response.

1396. {

} (Sheridan, Tr. 6668, *in camera*).

Response to Finding No. 1396

Complaint Counsel has no specific response.

(b) Negotiations Relating to St. Luke's

1397. {

} (Guerin-Calvert, Tr. 7432-7433, *in camera*).

Response to Finding No. 1397

This proposed finding is incomplete. (*See* Response to RPFF ¶ 1366).

1398. {

} (Wachsman, Tr. 5068-5069, *in camera*; PX02118 at 422, *in camera*).

Response to Finding No. 1398

This proposed finding is incomplete and misleading. Even before the Acquisition, St. { Luke's covered its direct costs when treating }. (CCPFF ¶ 960). Respondent's financial expert testified that St. Luke's was profitable in the { treatment of } members during the first eight months of 2010. (CCPFF ¶ 958).

1399. {

} (Guerin-Calvert, Tr. 7432-7433, *in camera*).

Response to Finding No. 1399

Complaint Counsel has no specific response.

1400. { } (Wachsman, Tr. 5074, 5227-5228, *in camera*; RX-759).

Response to Finding No. 1400

Complaint Counsel has no specific response.

1401. { } (Guerin-Calvert, Tr. 7433, *in camera*).

Response to Finding No. 1401

This proposed finding is incomplete. United had this option due to the Hold-Separate Agreement between ProMedica and the FTC. (*See* Response to RPFF ¶ 1366).

1402. { } (RX-27 (Sheridan, Dep. at 124-25, *in camera*)).

Response to Finding No. 1402

This proposed finding is incomplete and misleading. The reimbursement rates that United pays to { } are { } than the rates United paid to { }, despite the fact that { } offer a similar mix of services that excludes most higher-acuity procedures. (Sheridan, Tr. 6695-6696, *in camera*).

(iv) Aetna

(a) Negotiations Relating to ProMedica's Legacy Hospitals

1403. { } (Radzialowski, Tr. 714, *in camera*).

Response to Finding No. 1403

This proposed finding is incomplete. After being informed about the Acquisition, Aetna performed a rate comparison between ProMedica and St. Luke's in anticipation of a rate increase at St. Luke's. (CCPFF ¶ 420(j)). This comparison projected a { } in Aetna's rates to St. Luke's if these were to rise to the level of Aetna's rates to ProMedica, taking into account differences in the severity of cases treated by St. Luke's and at ProMedica. (CCPFF ¶ 420(j)). Mr. Radzialowski believes that the Acquisition could lead to an even greater rate increase for Aetna, because this analysis did not account for the additional bargaining leverage that the Acquisition has imparted upon ProMedica as a whole. (CCPFF ¶ 420(k)).

(b) Negotiations Relating to St. Luke's

1404. { } (Radzialowski, Tr. 836, *in camera*).

Response to Finding No. 1404

Complaint Counsel has no specific response.

1405. { } (Radzialowski, Tr. 827-832, *in camera*; Wachsman, Tr. 5069, *in camera*).

Response to Finding No. 1405

This proposed finding is incomplete. In early December 2010, ProMedica asked Aetna to increase St. Luke's reimbursement rates to { }. (Radzialowski, Tr. 717, *in camera*). These negotiations took place during the FTC's investigation/challenge of the Acquisition and under restrictions of the Hold-Separate Agreement between the FTC and ProMedica, which obligated ProMedica to give health plans the option to

extend their existing rates with ProMedica through the duration of the Hold-Separate Agreement. (*See* Response to RPFF ¶ 1366).

1406. { } (Radzialowski, Tr. 828-829, *in camera*; PX02295 at 003, *in camera*).

Response to Finding No. 1406

Complaint Counsel has no specific response.

1407. { } (Radzialowski, Tr. 829, *in camera*; PX02295 at 002, *in camera*).

Response to Finding No. 1407

Complaint Counsel has no specific response.

1408. { } (Radzialowski, Tr. 829-830, *in camera*; PX02295 at 002, *in camera*).

Response to Finding No. 1408

Complaint Counsel has no specific response.

1409. { } (Radzialowski, Tr. 830-831, *in camera*; Wachsman, Tr. 5070-5071, *in camera*).

Response to Finding No. 1409

Complaint Counsel has no specific response.

1410. { } (Radzialowski, Tr. 831, *in camera*; PX02295 at 001, *in camera*).

Response to Finding No. 1410

Complaint Counsel has no specific response.

1411. { } (Radzialowski, Tr. 831, *in camera*).

Response to Finding No. 1411

Complaint Counsel has no specific response.

1412. { } (Radzialowski, Tr. 831, *in camera*; PX00491 at 001, *in camera*).

Response to Finding No. 1412

This proposed finding is incomplete and misleading. (*See* Response to RPFF ¶ 1366).

1413. { } (Radzialowski, Tr. 831-832, *in camera*).

Response to Finding No. 1413

This proposed finding is incomplete and misleading. (*See* Response to RPFF ¶ 1366).

1414. { } (Radzialowski, Tr. 832, *in camera*).

Response to Finding No. 1414

This proposed finding is incomplete and misleading. (*See* Response to RPFF ¶ 1366).

1415. { } (Radzialowski, Tr. 836, *in camera*; PX02519 at 002).

Response to Finding No. 1415

Complaint Counsel does not dispute this proposed finding.

1416. { } (Radzialowski, Tr. 836-837, *in camera*).

Response to Finding No. 1416

Complaint Counsel has no specific response.

1417. { } (Radzialowski, Tr. 837, *in camera*; PX02519 at 002).

Response to Finding No. 1417

Complaint Counsel has no specific response.

1418. {

} (Radzialowski, Tr. 837-838, *in camera*).

Response to Finding No. 1418

Complaint Counsel has no specific response.

1419. {

} (Radzialowski, Tr. 838, *in camera*).

Response to Finding No. 1419

Complaint Counsel has no specific response.

1420. {

}

(Radzialowski, Tr. 846, *in camera*).

Response to Finding No. 1420

Complaint Counsel has no specific response.

(v) Humana

(a) Negotiations Relating to ProMedica's Legacy Hospitals

1421. Humana also has not engaged in negotiations with ProMedica about ProMedica's participation in Humana's health plans since the joinder with St. Luke was consummated. (McGinty, Tr. 1224).

Response to Finding No. 1421

Complaint Counsel has no specific response.

(b) Negotiations Relating to St. Luke's

1422. Humana has not had any discussions with ProMedica about its contract with St. Luke's since the consummation of the joinder. (McGinty, Tr. 1209).

Response to Finding No. 1422

Complaint Counsel has no specific response.

G. ProMedica's Ownership of Paramount Does Not Enhance Its Ability To Raise Rates above Competitive Levels

1. Members of Broad Access Plans that Might Terminate with ProMedica Are Most Likely To Switch to Other Broad Access Plans

1423. Anthem has not attempted to quantify how many insureds it might lose if ProMedica was not a part of its provider network. (Pugliese, Tr. 1578).

Response to Finding No. 1423

Complaint Counsel has no specific response.

1424. Anthem believes that if it were unable to reach agreement with ProMedica to have the ProMedica hospitals participate in its network, it would lose members to plans that offer a broad open-access network, like MMO or United. (Pugliese, Tr. 1575).

Response to Finding No. 1424

This proposed finding is inconsistent with Respondent's proposed findings on the attractiveness of limited or restricted provider networks. (*See* RPFF ¶ 718-729, 779-783, 800-808).

1425. ProMedica experiences no net benefit when Anthem members switch to competing health plans other than Paramount. (Pugliese, Tr. 1576).

Response to Finding No. 1425

Complaint Counsel has no specific response.

1426. The bulk of Aetna's business is with large, national customers. These large, national customers are less tolerant of smaller networks and would not switch to Paramount's smaller network if ProMedica terminated participation with Aetna. (Radzialowski, Tr. 772-773).

Response to Finding No. 1426

This proposed finding is incomplete. Aetna's clients in Lucas County include a number of small businesses, which would be more open to switching to Paramount's smaller network, particularly if these employers strongly desired access to ProMedica's hospitals. (Radzialowski, Tr. 620, 772-773). As a result, Aetna expects that it would lose business to Paramount if

ProMedica terminated its participation with Aetna. (Radzialowski, Tr. 773). This proposed finding also is inconsistent with Respondent's proposed findings on the attractiveness of limited or restricted provider networks. (*See* Response to RPFF ¶1424).

1427.

} (RX-27 (Sheridan Dep. at 76, *in camera*)).

Response to Finding No. 1427

Complaint Counsel has no specific response.

2. Members that Remain with Broad Access Plans that Terminate with ProMedica Are Less Likely To Use ProMedica Hospitals

1428. In the event that Anthem and ProMedica were unable to reach agreement for ProMedica's hospitals to participate in Anthem's network, fewer Anthem insureds are likely to use ProMedica hospitals than they would have been if ProMedica were an in-network provider. (Pugliese, Tr. 1577).

Response to Finding No. 1428

Complaint Counsel has no specific response.

3. Plans that Terminate ProMedica May Obtain Lower Rates from Other Hospitals

1429. In the event that Anthem and ProMedica were unable to reach agreement for ProMedica's hospitals to participate in Anthem's network, Anthem could be able to obtain lower rates from other hospital providers like Mercy because Anthem would be able to assure those hospitals a greater volume of patients than it could if ProMedica were part of its network. (Pugliese, Tr. 1577).

Response to Finding No. 1429

Complaint Counsel has no specific response.

1430. Obtaining lower rates by pushing a greater volume of patients to a narrower network of hospitals could enable an MCO to reduce premiums for fully insured employers and to lower costs for self-insured employers. (Pugliese, Tr. 1577).

Response to Finding No. 1430

Complaint Counsel has no specific response.

H. The Joinder Will Not Adversely Impact St. Luke's Quality

1. "Quality" Metrics Vary

1431. Quality of care can be defined by various measures, including mortality rates, patient satisfaction scores, and other common measures of hospitals and hospital systems across the country. (RX-18 (Marcus, Dep. at 46)).

Response to Finding No. 1431

Complaint Counsel has no specific response.

1432. There are varying degrees of reliability for quality metrics. (RX-1652).

Response to Finding No. 1432

Complaint Counsel has no specific response.

1433. National and regulatory groups that produce quality scores based on evidence, clinical guidelines, and outcome indicators are considered the most reliable. This group includes sources such as CMS and the Joint Commission on Accreditation of Hospitals Organization ("JCAHO"), ACC, STS, and Acute Physiology And Chronic Health Evaluations ("APACHE"). (RX-1652; PX01930 (Reiter, Dep. at 184)).

Response to Finding No. 1433

This proposed finding is misleading, unreliable, and inaccurate to the extent that it claims these groups create the "most reliable" quality scores. The cited evidence for this proposition is the opinion of one ProMedica employee and one document created by ProMedica. There is no third-party evaluation of the different types of quality rankings, and many third-parties rely extensively on quality evaluations not in this subgroup. (*See* Response to RPFF ¶ 1435).

1434. ProMedica believes that the CMS core measures are important quality indicators. (PX01930 (Reiter, Dep. at 184)).

Response to Finding No. 1434

Complaint Counsel has no specific response.

1435. Less reliable quality sources include non-profit organizations such as LeapFrog and the Institute for Healthcare Improvement. (RX-1652).

Response to Finding No. 1435

This proposed finding is misleading, unreliable, inaccurate, and contradicted by Respondent. The only evidence cited to support this proposition is a diagram made by Respondent. Meanwhile, there has been testimony stating that LeapFrog is "highly regarded" in the healthcare industry, and MCOs use LeapFrog to track the quality of hospitals within their health plans. (Gold, Tr. 227; Sandusky, Tr. 1309-1310; McGinty, Tr. 1165). ProMedica's CEO testified that quality data from LeapFrog has been used in incentive evaluations for compensation for about 60 of ProMedica's executives. (PX01918 at 018 (Oostra, Dep. at 64-65), *in camera*). Additionally, Respondent's expert previously listed LeapFrog as one of the four places she looked to evaluate St. Luke's quality in 2010. (PX01925 at 047 (Guerin-Calvert, Dep. at 178)).

1436. The least reliable group of sources include for-profit organizations that base their scores on coding-based indicators and studies with poor validity. This group includes sources such as HealthGrades and Thomson Reuters. (RX-1652).

Response to Finding No. 1436

This proposed finding is misleading, unreliable, inaccurate, and contradicted by Respondent. The only evidence cited to support this proposition is a diagram made by Respondent. Additionally, Respondent's expert previously listed HealthGrades as one of the four places she looked to evaluate St. Luke's quality in 2010. (PX01925 at 047 (Guerin-Calvert, Dep. at 178)).

1437. MMO believes that the healthcare industry does not presently know how to measure quality. (Pirc, Tr. 2214).

Response to Finding No. 1437

Complaint Counsel has no specific response.

1438. {

} (Pirc, Tr. 2310, *in camera*).

Response to Finding No. 1438

Complaint Counsel has no specific response.

1439. Anthem has since 1992 had its own internal quality assessment program to measure hospital quality, and uses it to gauge quality in its hospital network and to determine quality-based components of reimbursement for some provider contracts. (Pugliese, Tr. 1425).

Response to Finding No. 1439

Complaint Counsel does not disagree.

1440. Anthem does not rely upon external quality ratings to determine hospital quality. (Pugliese, Tr. 1425).

Response to Finding No. 1440

Complaint Counsel does not disagree.

1441. Aetna relies upon the Joint Commission's quality accreditation program to assess hospital quality. (Radzialowski, Tr. 632).

Response to Finding No. 1441

Complaint Counsel does not disagree.

1442. Humana's claims data alone offers an insufficient sample size to offer a valid assessment of hospital quality. (McGinty, Tr. 1166-1167).

Response to Finding No. 1442

Complaint Counsel has no specific response.

1443. Humana relies primarily on third party organizations for assessments of hospital quality. (McGinty, Tr. 1165-1166).

Response to Finding No. 1443

Complaint Counsel has no specific response.

1444. LeapFrog's 2008 Highest Value Hospital report was not based upon a review of all services offered by participating hospitals. It only covered four service areas, including some cardiac services and pneumonia care. (Pugliese, Tr. 1569-1570; PX02449 at 002).

Response to Finding No. 1444

Complaint Counsel has no specific response.

1445. It is typical for hospitals to be high quality in one dimension, but low quality in other dimensions; it is challenging to come up with one measure of quality for a given hospital. (Town, Tr. 4192-4193).

Response to Finding No. 1445

Complaint Counsel has no specific response.

2. Hospitals, MCOs, and Patients View All Hospitals in Toledo As Quality Hospitals and Do Not Perceive Quality To Be Superior at St. Luke's

1446. Data, documents and testimony reveal that all of the hospitals in Lucas County are quality hospitals. (Guerin-Calvert, Tr. 7553-7554).

Response to Finding No. 1446

This proposed finding is contradicted by evidence in the record. In fact, data, documents, and testimony reveal that ProMedica's hospitals in Lucas County are not high quality hospitals. (*See* CCPFF ¶¶ 673, 675, 676, 685-687,689, 691, 695-696, 698, 701-702). For example, evidence shows that TTH repeatedly ranks below other hospitals in Lucas County, and below the state average. (*See* CCPFF ¶ 673).

1447. Lucas County residents perceive the quality of care at Lucas County hospitals to be on par with one another. (Shook, Tr. 945-946).

Response to Finding No. 1447

Complaint Counsel has no specific response.

1448. Physicians in Lucas County also perceive quality to be comparable among TTH, St. Vincent, and St. Luke's. (Gbur, Tr. 3117; Marlowe, Tr. 2417-2419; Andreshak, Tr. 1819-1820; Read, Tr. 5272; RX-21 (Peron, Dep. at 187)).

Response to Finding No. 1448

This proposed finding is incomplete. While these physicians may believe that TTH, St. Vincent, and St. Luke's are all of comparable quality, many of them testified that the nurses, administrative staff, continuity of care, and OB facilities were superior at St. Luke's. (*See* CCPFF ¶¶ 693-702).

1449. ProMedica believes that all of its hospitals, including St. Luke's following the joinder, have comparable quality. (Hanley, Tr. 4723).

Response to Finding No. 1449

Complaint Counsel has no specific response.

1450. Mercy believes that the quality of its physicians is comparable to physicians that practice primarily at ProMedica's hospitals. (Shook, Tr. 1032-1033).

Response to Finding No. 1450

Complaint Counsel has no specific response.

1451. MMO considers that all hospitals in Lucas County do well in terms of quality. (Pirc, Tr. 2296).

Response to Finding No. 1451

Complaint Counsel has no specific response.

1452. Aetna believes all hospitals in Lucas County are high-quality hospitals. (Radzialowski, Tr. 640).

Response to Finding No. 1452

Complaint Counsel has no specific response.

1453. FrontPath considers all hospitals in Lucas County to be quality hospitals. (Sandusky, Tr. 1402).

Response to Finding No. 1453

Complaint Counsel has no specific response.

1454. {

} (RX-250 at 000013, *in camera*).

Response to Finding No. 1454

This proposed finding is misleading.

(RX-250 at 2, *in*

camera).

(PX01334 at 002, *in camera*). St. Luke's Hospital is one of the farthest Lucas County hospitals from St. Charles. (PX00900 (Map of Lucas County)).

1455. {

} (RX-250 at 000047, *in camera*).

Response to Finding No. 1455

This proposed finding is misleading. (*See* Response to RPFF ¶ 1454).

3. MCOs Were Unwilling To Increase St. Luke's Rates in Recognition of Its Allegedly Superior Quality

1456. The rates Anthem pays to St. Luke's are lower than the rates it pays to other Lucas County hospitals. (Pugliese, Tr. 1564).

Response to Finding No. 1456

Complaint Counsel has no specific response.

1457. The rates that MCOs pay to St. Luke's are not tied to St. Luke's quality measures. (Pugliese, Tr. 1564; McGinty, Tr. 1248-1249).

Response to Finding No. 1457

Complaint Counsel has no specific response.

1458. "Pay for performance" rewards healthcare providers like hospitals for their performance on quality and other metrics. (Pugliese, Tr. 1564).

Response to Finding No. 1458

Complaint Counsel does not disagree.

1459. Anthem offers "pay for performance" to some hospitals, but it does not offer it to St. Luke's. (Pugliese, Tr. 1564).

Response to Finding No. 1459

Complaint Counsel has no specific response.

1460. St. Luke's did not qualify for any quality incentive from Anthem in 2010. (Pugliese, Tr. 1567-1568).

Response to Finding No. 1460

This proposed finding is misleading, in that it implies St. Luke's did not receive any quality incentive due to low quality. St. Luke's was not a part of Anthem's pay-for-performance program and therefore was not eligible for quality incentives. (RPFF ¶ 1459; Pugliese, Tr. 1564-1564).

4. More Recent Quality Data Shows ProMedica's Hospitals Performing Higher than St. Luke's

1461. In the beginning of 2009, other hospitals in Toledo were quickly catching up to St. Luke's quality and service levels. (Wakeman, Tr. 2494).

Response to Finding No. 1461

Complaint Counsel has no specific response.

1462. { } (Wakeman, Tr. 3020-3023, *in camera*; PX00559, *in camera*).

Response to Finding No. 1462

This proposed finding is incomplete; it is also unreliable and unfounded to the extent that it relies on PX00559. In 2010, St. Luke's improved its quality core measures in MI care, emergency, obstetrics, and cardiac intervention. St. Luke's also improved its patient satisfaction scores for emergency, obstetrics, outpatient surgery, and outpatient laboratory services. (Wakeman, Tr. 2497).

PX00559 is an email string discussing St. Luke's quality scores using the new proposed CMS attainment model, which is a new government payment method designed to encourage hospitals to increase their quality levels. (Oostra, Tr. 6029-6030; Wakeman, Tr. 3022-3023, *in camera*). In the email,

based on the CMS attainment model. However, this claim is unreliable because the final rules for the CMS attainment model were released on May 6, 2011, and the email is dated February 1, 2011. (Oostra, Tr. 6031). There were major changes to the model between February and May 2011. The final rules use only 11 indicators for the attainment model, compared to 17 used by the proposed rules, which would have been used to create the model in PX00559. (Oostra, Tr. 6031).

Additionally, this proposed finding cites PX00559 for the proposition that

This conclusion cannot be drawn from one snapshot in time, using a model that changes the way quality data is presented. Mr. Wakeman testified that he

(Wakeman, Tr. 3022, *in camera*).

1463. {

} (Wakeman, Tr. 3021-3023, *in camera*; PX00559 at 003, *in camera*.)

Response to Finding No. 1463

This proposed finding is also unreliable and unfounded to the extent that it relies on PX00559. (*See* Response to RPFF ¶ 1462).

1464. {

} (PX0559 at 001, *in camera*; Wakeman, Tr. 3022, *in camera*).

Response to Finding No. 1464

This proposed finding is incomplete and misleading. Mr. Wakeman says that the reason

(Wakeman, Tr. 3022, *in camera*).

The finding is misleading because ProMedica created these quality scores based on the proposed CMS attainment model, which was later changed. Additionally,

cannot be determined from a single timeframe when a new methodology for determining the scores is used. (*See* Response to RPFF ¶ 1462).

1465. American College of Cardiology data through third quarter of 2010 ranked TTH higher than St. Luke's for cardiology services. (RX-1653 at 000002, 000005).

Response to Finding No. 1465

Complaint Counsel has no specific response.

1466. Quality data collected for CMS reporting requirements from the fourth quarter of 2010 ranked Bay Park, Flower, and TTH higher than St. Luke's. (RX-1655).

Response to Finding No. 1466

This proposed finding is unreliable to the extent that it does not verify whether it was created based on CMS's final rules or proposed rules for the new CMS attainment model. (*See* Response to RPFF ¶ 1462).

1467. In fact, as of March 2011, St. Luke's was the lowest performing hospital of ProMedica's Toledo-area hospitals according to CMS scores. (RX-25 (Reiter, Dep. at 169-170)).

Response to Finding No. 1467

This proposed finding is unreliable. The cited testimony does not state whether the "composite scores" refered to is the data reported directly to CMS or the score that ProMedica created based on the proposed CMS rules, which later changed. (*See* Response to RPFF ¶ 1462).

1468. TTH also outperformed St. Luke's with regard to heart services on two outcome-validated measures, issued by the Society of Thoracic Surgeons ("STS") and the American College of Cardiology Foundation ("ACC"). (RX-25 (Reiter, Dep. at 158-159)).

Response to Finding No. 1468

Complaint Counsel has no specific response.

1469. TTH has a three-star rating for its open-heartprogram, according to STS which is in the top 12 percent, nationally. St. Luke's has a two-star rating from STS, which is about the 65th percentile. RX-25 (Reiter, Dep. at 135)).

Response to Finding No. 1469

Complaint Counsel has no specific response.

1470. TTH's STS ranking for cardiac surgery places it at the same level as The Cleveland Clinic, in the top tier in the nation. (RX-26 (Riordan, Dep. at 84)).

Response to Finding No. 1470

Complaint Counsel has no specific response.

1471. TTH ranks in the third quartile for the ACC scores that reflect a national cardiac data registry, while St. Luke's is in the bottom quartile. (RX-25 (Reiter, Dep. at 135-136)).

Response to Finding No. 1471

Complaint Counsel has no specific response.

1472. ProMedica ranks in the top decile for critical care under the APACHE measurements, which assess critical care outcomes. (RX-25 (Reiter, Dep. at 136)).

Response to Finding No. 1472

Complaint Counsel has no specific response.

1473.

}

(PX01221 at 068, *in camera*).

Response to Finding No. 1473

This proposed finding is incomplete. The cited document also shows that St. Luke's has an overall heart attack score which was higher than TTH, with a score of percent compared to TTH's percent and a national average of . St. Luke's also outperformed TTH on the heart failure mortality rate, scoring a percent compared to TTH's percent and a national average of percent. (PX01221 at 068, *in camera*).

1474.

} (Nolan, Tr. 6399, *in camera*).

Response to Finding No. 1474

This proposed finding is misleading to the extent that it implies that a larger program necessarily would have higher quality scores. (*See* Response to RPFF ¶ 1473; PX01221 at 068, *in camera*; Nolan, Tr. 6347-6348, *in camera*).

1475. {

} (Nolan, Tr. 6401, *in camera*).

Response to Finding No. 1475

This proposed finding is misleading to the extent that it implies that a larger program necessarily would have higher quality scores. (*See* Response to RPFF ¶ 1473; PX01221 at 068, *in camera*; Nolan, Tr. 6347-6348, *in camera*).

1476. {

}

(Nolan, Tr. 6400, *in camera*; PX01221 at 074, *in camera*).

Response to Finding No. 1476

Complaint Counsel has no specific response.

1477. {

} (Nolan, Tr. 6400, *in camera*).

Response to Finding No. 1477

Complaint Counsel has no specific response.

I. Prof. Town's Analysis Is Fatally Flawed and Does Not Reflect Competitive Realities

1478. Generally, merger simulation models have not been shown, based on real-world follow-up studies to yield reliable or accurate and precise predictions for a given merger case. (Guerin-Calvert, Tr. 7511-7512).

Response to Finding No. 1478

This proposed finding is incomplete and misleading. Other scholars' analysis of the Willingness-to-Pay merger simulation model has shown it to make accurate and conservative estimates of the impact of hospital mergers. (PX01850 at 063-064 (¶ 97) (Town Rebuttal Report), *in camera*; CCPFF ¶ 467). Economists have employed merger simulation methodology to study price effects in two of the hospital mergers where Ms. Guerin-Calvert testified that prices were unlikely to increase. In both instances, the economists found price increases resulting from increases in the merged hospitals' bargaining power. (CCPFF ¶ 1565-1566; *see also* Town, Tr. 3888-3889). Further, Professor Town testified that he is unaware of any better alternative methodology than the peer-reviewed willingness-to-pay approach to predict price increases in hospital merger. (Town, Tr. 3888). Finally, Professor Town testified that the predicted price increases are corroborated by MCO testimony and the broad array of evidence on the record that ProMedica's bargaining leverage will increase as a result of the Acquisition, allowing ProMedica to increase prices. (Town, Tr. 3827-3830, *in camera*).

1. Location Is Not as Important as Prof. Town Suggests

1479. Town testified that a hospital's location is important because patients are unwilling to travel an additional six minutes to get to a hospital. (Town, Tr. 3936-3937).

Response to Finding No. 1479

This proposed finding mischaracterizes Professor Town's testimony. Professor Town testified that location is one of the important factors to patients making the choice of where to seek inpatient care. (Town, Tr. 3937). Virtually every witness testified that location matters when seeking inpatient care. (*See* CCPFF ¶¶ 216-246). Further, the fact that St. Luke's has approximately 36 percent market share in its core service area for GAC compared to about a 12 percent share in Lucas County is direct evidence of the importance of location. (PX01352 at

006 (St. Luke's Board and Medical Staff Planning Retreat, April 2008); Town, Tr. 3938, 761-3764, *in camera*; PX02148 at 143, 161 (Ex. 6, 11) (Town Expert Report), *in camera*).

1480. However, the vast majority, approximately 60 percent, of the patients who reside in St. Luke's service area travel to hospitals other than St. Luke's to receive general acute care inpatient services. (Town, Tr. 3938). These patients considered other hospitals as more attractive alternatives than St. Luke's for general acute care inpatient services. (Town, Tr. 3944).

Response to Finding No. 1480

This proposed finding is incomplete. Professor Town's analysis of market share by zip code demonstrates that St. Luke's receives a disproportionate amount of patients from the area surrounding St. Luke's. (Town, Tr. 3758-3759). Further, the patient population contains Paramount patients for whom St. Luke's was an out-of-network provider at the time the data was collected. Had St. Luke's been in Paramount's network at the time these data were collected, St. Luke's share in its core service area would have been higher. (Town, Tr. 4438-4439).

1481. Similarly, with respect to OB services, 82.4 percent of the expectant mothers who resided in St. Luke's core service area went to hospitals other than St. Luke's, even though those hospitals were further away than St. Luke's. (Town, Tr. 3944-3945).

Response to Finding No. 1481

This proposed finding mischaracterizes Professor Town's testimony. The cited testimony pertains to one zip code—not the eight zip codes that comprise St. Luke's core service area. (Town, Tr. 3944-3945; *see also* Response to RPFF ¶ 1480).

1482. A patient origin analysis reveals that patients are already willing to travel across county lines, across areas and from across the metro area to receive services in Toledo. (Guerin-Calvert, Tr. 7244-7245; RX-71(A) at 000186, *in camera*).

Response to Finding No. 1482

Complaint Counsel has no specific response.

1483. In addition, patient origin and drive time analyses show that patients do not necessarily go to the next closest hospital. (Guerin-Calvert, Tr. 7244-45; RX-71(A) at 000034, *in camera*).

Response to Finding No. 1483

Complaint Counsel has no specific response.

1484. Patients usually rank availability of a service, access to a particular physician, and alignment of a patient's insurance company ahead of the geographic location of the hospital. (Wakeman, Tr. 2510).

Response to Finding No. 1484

This proposed finding is misleading. The evidence in this matter demonstrates that patients seek care at facilities that are in their health plans' networks. (*See* Response to RPFF ¶ 1479; CCPFF ¶¶ 112-113).

1485. Distance is not as big a deterrent for patient travel in Lucas County as much as the out-of-pocket costs required by insurers. (Read, Tr. 5286-5287).

Response to Finding No. 1485

This proposed finding mischaracterizes Dr. Read's testimony. The portion of the transcript cited refers to Dr. Read losing "preferred provider status" at Mercy hospitals when she terminated her employment at Mercy hospitals and became a ProMedica employed physician. (Read, Tr. 5286-5287).

2. The "Relevant Product Market" on which Prof. Town Performs His Competitive Effects Analysis is Different from the Market for General Acute Care Inpatient Services as Defined by the Complaint and Ignores Relevant Patient Data

1486. The Complaint defines the relevant product market as general acute care inpatient services sold to commercial health plans, which encompasses a broad cluster of basic medical and surgical diagnostic and treatment services that include an overnight hospital stay, such as emergency services, internal medicine, and minor surgeries. (Town, Tr. 3977-3978; Compl. ¶ 12).

Response to Finding No. 1486

Complaint Counsel has no specific response.

1487. The Complaint excludes outpatient services and more sophisticated and specialized tertiary and quaternary services such as major surgeries and organ transplants. (Town, Tr. 3978; Compl. ¶ 13).

Response to Finding No. 1487

Complaint Counsel has no specific response.

1488. Professor Town's product market definition is inconsistent with the FTC's definition in the complaint. (Town, Tr. 3977-3986). For example, Prof. Town's market definition includes some primary, some secondary and some tertiary services, but excludes others. (Guerin-Calvert, Tr. 7212).

Response to Finding No. 1488

This proposed finding is incomplete and misleading. Professor Town defines two relevant product markets, inpatient general acute care services and inpatient obstetrics services, by focusing on the services in which St. Luke's and ProMedica competed before the Acquisition (PX02148 at 022-024 (¶ 40-41) (Town Expert Report), *in camera*; Town, Tr. 3594, 3668-3669). Professor Town defined a separate inpatient obstetrics market because the competitive conditions for these services in Lucas County are significantly different from those for other inpatient general acute care services, as both UTMC and Mercy St. Anne do not offer inpatient obstetrics services. (PX02148 at 023-024 (¶ 40, n. 59) (Town Expert Report), *in camera*; PX01850 at 007 (¶ 7) (Town Rebuttal Report), *in camera*; Town, Tr. 3595, 3665-3668). Professor Town focused on those services in which St. Luke's and ProMedica competed because, as the *Merger Guidelines* make clear, product market definition is an exercise intended "[to] identify one or more relevant markets in which the merger may substantially lessen competition." (PX01850 at 006 (¶ 6) (Town Rebuttal Report), *in camera*; Town, Tr. 3594; PX02214 at 010 (§ 4) (*2010 Horizontal Merger Guidelines*)). It is therefore axiomatic that the product market must be defined with precision to include only those products or services over which the merging parties competed prior to the merger. (PX01850 at 006 (¶ 6) (Town Rebuttal Report), *in camera*; Town, Tr. 3594, 3668-3669). For the purposes of his structural analysis of the Acquisition, Professor Town also appropriately excluded from his relevant product markets those services which, by

virtue of their severity and patient travel patterns, likely fall into a geographic market broader than Lucas County. (Town, Tr. 3676-3679; PX02148 at 024 (¶42, n. 60) (Town Expert Report), *in camera*). Professor Town's approach to product market definition is consistent with the principles of cluster market analysis endorsed by courts in other hospital cases. (*See* PX02148 at 023 (¶ 40, n. 55) (Town Expert Report), *in camera*). Even if one expanded the relevant product market to include a much broader group of inpatient hospital services, pre- and post-Acquisition market concentration measures would still support a presumption of competitive harm. (PX01850 at 009-010 (¶ 11) (Town Rebuttal Report), *in camera*; *see also* Guerin-Calvert, Tr. 7695, 7729-7732).

1489. Prof. Town's relevant product market excludes services that were included in contracts between MCOs and St. Luke's and ProMedica, as well as contracts negotiated with Mercy and UTMC. (Guerin-Calvert, Tr. 7210).

Response to Finding No. 1489

This proposed finding is incomplete and misleading. Professor Town's relevant product markets appropriately exclude certain services based on the requirements of correct merger analysis and correct cluster market analysis. (*See* Response to RPFF ¶ 1488).

1490. Professor Town also arbitrarily excludes a large number of services from his general acute care inpatient services product market that were provided across all Lucas County hospitals that were not excluded from MCO contracts and that were available to commercially-insured patients. (Guerin-Calvert, Tr. 7225).

Response to Finding No. 1490

This proposed finding is incorrect and misleading. Professor Town did not exclude these services arbitrarily. (*See* Response to RPFF ¶ 1488).

1491. Prof. Town also excludes any overlapping DRGs between St. Luke's and ProMedica in which there are less than three commercially insured discharges for St. Luke's and ProMedica. (Town, Tr. 3983-3984).

Response to Finding No. 1491

This proposed finding is incomplete and misleading. Professor Town excludes overlapping DRGs between St. Luke's and ProMedica in which there were fewer than three commercially insured DRGs *over the entire course of a three-year period*. (*See* RX-71(A) at 000158 (¶¶ 1, 4) (Guerin-Calvert Expert Report), *in camera*). In other words, this filter did *not* exclude any DRGs with three or more commercial discharges within a three-year span. (*See* RX-71(A) at 000158 (¶¶ 1, 4) (Guerin-Calvert Expert Report), *in camera*). Professor Town applied this filter in order to avoid counting incorrect discharges that were generated by coding errors. (Town, Tr. 3675-3676).

1492. In contrast, the FTC's complaint does not limit the relevant product market to only those services that both St. Luke's and ProMedica provide. (Town, Tr. 3986).

Response to Finding No. 1492

This proposed finding is incomplete and misleading. There is no language in the FTC's complaint that is inconsistent with limiting the relevant product markets to only those services that both St. Luke's and ProMedica provide. (Town, Tr. 3985).

1493. By excluding services that had less than three commercially insured discharges, Prof. Town is ignoring available services that were provided to up to one hundred government-insured patients, that are also available to commercially insured patients. (Guerin-Calvert, Tr. 7218).

Response to Finding No. 1493

This proposed finding mischaracterizes the testimony on which it relies for support and is misleading. Ms. Guerin-Calvert testified that Professor Town's filtering excluded DRGs "even if there *might* have been 50 or 75 or a hundred government-insured patients." (Guerin-Calvert, Tr. 7218 (emphasis added)).

1494. In addition, Prof. Town excludes DRGs that overlap between St. Luke's and ProMedica, but that fall into a different geographic market, meaning that those DRGs that experience outflow from Lucas County are not included in Prof. Town's relevant product market or competitive effects analysis. (Town, Tr. 3986-3988).

Response to Finding No. 1494

This proposed finding is incomplete and misleading. For the purposes of the structural analysis of the Acquisition, Professor Town excluded from the relevant product markets certain DRGs for which the relevant geographic market is likely broader than Lucas County. (Town, Tr. 3676-3679; PX02148 at 024 (¶ 42, n. 60) (Town Expert Report), *in camera*). Because the geographic market is likely broader for these services, the competitive conditions will be different due to a larger number of competitors than just the hospitals in Lucas County. (Town, Tr. 3676-3679). The exclusion of these services from the relevant product markets in the Lucas County geographic market is consistent with correct cluster market analysis, which groups products and services that are provided under similar competitive conditions. (*See* PX02148 at 021-022 (¶¶ 38-39) (Town Expert Report), *in camera*; Town, Tr. 3665-3668). For the purposes of calculating case-mix-adjusted prices and performing the Willingness-to-Pay merger simulation, Professor Town used the broad range of inpatient general acute care services, excluding only those DRGs in Major Diagnostic Categories 0, 2, 19, 20. (*See* Response to RPFF ¶¶ 1554, 1564).

1495. Prof. Town excludes these DRGs, despite that fact that both St. Luke's and ProMedica may provide these services, simply because St. Luke's and ProMedica compete with hospitals outside of Lucas County for these services. (Town, Tr. 3988).

Response to Finding No. 1495

This proposed finding is incomplete and misleading. (*See* Response to RPFF ¶ 1494).

1496. Professor Town also excludes DRGs with a case weight index greater than two with outmigration, where the percentage of patients residing in Lucas County going outside of that area to seek care exceeds 15 percent and there are more than 20 discharges. No other litigated hospital merger case has used that criterion. (Town, Tr. 3991-3992).

Response to Finding No. 1496

This proposed finding is incomplete and misleading. (*See* Response to RPFF ¶ 1494).

1497. Prof. Town also excludes DRGs with a case weight index greater than three with outmigration, where the percentage of patients residing in Lucas County going outside of that area to seek care exceeds 15 percent. (Town, Tr. 3992-3993). No other litigated hospital merger case has used that criterion either. (Town, Tr. 3994-3995).

Response to Finding No. 1497

This proposed finding is incomplete and misleading. (*See* Response to RPFF ¶ 1494).

1498. Prof. Town used DRG weights to distinguish tertiary and quaternary services from those services that otherwise should be included in the relevant product market. (Town, Tr. 3995-3996).

Response to Finding No. 1498

This proposed finding is incomplete and misleading. Professor Town used a combination of DRG weight and patient outflow from Lucas County to identify the inpatient services that likely fall into a broader geographic market. (Town, Tr. 3995-3996; PX02148 at 024 (¶ 42, n. 60), *in camera*).

1499. However, the Complaint does not exclude DRGs with a case weight index greater than two, outmigration of greater than 15 percent, with more than 20 discharges. And, no other prior litigated hospital merger has used such criteria to define the relevant product market. (Town, Tr. 3991-3992).

Response to Finding No. 1499

Complaint Counsel has no specific response.

1500. Moreover, Prof. Town includes in his relevant market DRGs with case weights higher than four, which captures some services that could be classified as tertiary or quaternary medical services and which the Complaint excludes from its relevant product market definition. (Town, Tr. 4014-4015).

Response to Finding No. 1500

This proposed finding is misleading to the extent it suggests that Professor Town testified about DRG-weight thresholds that demarcate tertiary or quaternary services. (*See* Town, Tr. 4015). Instead of drawing bright lines between general acute care, tertiary, and quaternary services, Professor Town's analysis relied on a combination of DRG weights and patient travel

behavior to identify the services that likely fall into a broader geographic market than Lucas County and thus should be excluded from the relevant product markets within Lucas County. (*See* Response to RPFF ¶¶ 1494, 1498).

1501. Similarly, for his separate inpatient OB services product market, Prof. Town excludes OB services that are not offered by both St. Luke's and ProMedica, where the case weight was greater than two, outmigration was greater than 15 percent, and more than 20 discharges occurred, even though the Complaint contains none of these exclusions. (Town, Tr. 4003-4006).

Response to Finding No. 1501

This proposed finding is incomplete and misleading. (*See* Response to RPFF ¶¶ 1488, 1494, 1498, 1500).

1502. The Complaint alleges that all inpatientOB services comprise a separate relevant product market. (Guerin-Calvert, Tr. 7228-7230).

Response to Finding No. 1502

Complaint Counsel has no specific response.

1503. On the other hand, Prof. Town includes in his definition of general acute care relevant market normal newborns, but includes the mothers who delivered the normal newborns in his market for inpatient OB services. (Town, Tr. 4007-4008).

Response to Finding No. 1503

This proposed finding is incomplete and misleading. The inclusion of normal newborns in either relevant market does not affect the strong presumption of competitive harm from the Acquisition. (Town, Tr. 4009).

1504. Professor Town excludes DRGs for which Mercy, ProMedica and UTMC have considerable discharges, which understates their competitive influences and overstates St. Luke's influence. (Guerin-Calvert, Tr. 7218-7220).

Response to Finding No. 1504

This proposed finding is incomplete and misleading. Professor Town's definition of relevant product markets is consistent with established principles of merger analysis and cluster market analysis. (*See* Response to RPFF ¶ 1488, 1494, 1498, 1500).

1505. Prof. Town's exclusions and filtering captures only about 30 percent of the total commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (Town, Tr. 4032-4034).

Response to Finding No. 1505

This proposed finding is incorrect and unsupported by the citation. The testimony cited refers to "total discharges" and not "total *commercial* discharges." (Town, Tr. 4032-4034). In fact, the DRGs in Professor Town's relevant product markets comprise approximately 90 percent of commercial inpatient discharges in Lucas County. (PX 2148 at 024 (¶ 42) (Town Expert Report), *in camera*).

1506. In fact, Prof. Town ignores data from almost two-thirds of the patients that are treated at St. Luke's and ProMedica. (Town, Tr. 4357).

Response to Finding No. 1506

This proposed finding is incomplete and misleading. This elimination occurred because Professor Town's analysis focused on commercially-insured patients. (Town, Tr. 4357). Notably, the analysis of Respondent's expert also focused on commercially-insured patients. (Guerin-Calvert, Tr. 7506-7507).

1507. By focusing on only commercially insured patients, Prof. Town ignores information on 201,000 discharges and services obtained by patients. (Guerin-Calvert, Tr. 7214).

Response to Finding No. 1507

This proposed finding is incomplete and misleading. (*See* Response to RPFF ¶ 1506).

1508. The contracts that MCOs negotiate with ProMedica and St. Luke's incorporate reimbursement rates for the DRGs that Prof. Town excluded from his relevant product market analysis. (Town, Tr. 4044).

Response to Finding No. 1508

This proposed finding is misleading and irrelevant. Health plans and hospitals typically bargain over a broad range of services within a single contract negotiation, such as inpatient services, outpatient services, psychiatric services, rehabilitation services, and hospice care. (Town, Tr. 3686-3688). They do so for the sake of administrative convenience. (Town, Tr. 3686-3688). Therefore, this fact alone does not justify the inclusion of all of these services in the same relevant product market as general acute care services. (Town, Tr. 3686-3688). On the contrary, these services should not be grouped with inpatient general acute care services, and hospital merger analysis has consistently excluded these services from the inpatient general acute care market. (Town, Tr. 3686-3688).

1509. Prof. Town's method of defining a relevant product market is based solely on numerical filters; he does not evaluate how the services he excludes from his relevant product markets relate to the prices reflected in contracts negotiated between MCOs and providers. (Guerin-Calvert, Tr. 7227-7228).

Response to Finding No. 1509

This proposed finding is incorrect. Professor Town's relevant product markets are based on filters relating to considerations of correct economic reasoning, case severity, patient-travel preferences, and appropriate data processing. (*See* Response to RPFF ¶¶ 1488, 1491, 1494, 1498, 1500). For the purposes of calculating case-mix-adjusted prices and performing the Willingness-to-Pay merger simulation, Professor Town used the broad range of inpatient general acute care services, excluding only those DRGs in MDCs -1, 0, 19, 20. (*See* RPFF ¶ 1543; Response to RPFF ¶¶ 1554, 1564).

1510. This prevents Prof. Town from correctly evaluating the true competitive dynamics of the Toledo area hospital market. (Guerin-Calvert, Tr. 7227-7228). {

} (RX-71(A) at 000015-000018, *in camera*).

Response to Finding No. 1510

This proposed finding is incorrect. (*See* Response to RPFF ¶ 1509).

1511. Prof. Town's relevant product market definitions are inconsistent with each other -- he defines a separate inpatient OB services market based on the premise that two Lucas County hospitals do not provide inpatient OB services; however, he includes some DRGs in his general acute care inpatient product market regardless of the number of Lucas County hospitals that offer the services. (Guerin-Calvert, Tr. 7235).

Response to Finding No. 1511

This proposed finding is incomplete and misleading. Professor Town analyzed pre- and post-Acquisition concentration measures by Major Diagnostic Category ("MDC"), and this analysis showed that the presumption of harm stands for every MDC included in either the inpatient general acute care relevant market or the inpatient obstetrics relevant market. (Town, Tr. 4432-4433).

1512. For purposes of defining a relevant product market, the number of other competitors providing the service is irrelevant, because at this stage one must determine substitute services demanded by consumers, not the number of suppliers. (Guerin-Calvert, Tr. 7221).

Response to Finding No. 1512

This proposed finding is incorrect and demonstrates a misunderstanding of cluster market analysis. Professor Town's analysis does address the issue of "substitute services demanded by consumers, clearly explaining that virtually each service within the cluster market is a distinct relevant product market—*i.e.*, the services in the cluster market are *not* substitutes for each other in the eyes of consumers. (PX01850 at 007 (¶ 7) (Town Rebuttal Report), *in camera*; Town, Tr. 3664-3668; *see also* Guerin-Calvert, Tr. 7631-7633). This is the case because, generally, a patient demanding one particular hospital service could not meet that demand by substituting another hospital service. (PX01850 at 007 (¶ 7) (Town Rebuttal Report), *in camera*; Town, Tr. 3664-3668). For example, a patient needing hip surgery could not meet that need by having

heart surgery instead, regardless of changes in the price of hip surgery. (Town, Tr. 3664-3666). Cluster markets are useful and accepted in hospital merger analysis because they allow one to avoid the impractical task of analyzing market structure for each of the hundreds of services that hospitals typically provide. (PX02148 at 021-023 (¶¶ 38-40, n. 55) (Town Expert Report), *in camera*; Guerin-Calvert, Tr. 7633). Cluster market analysis allows one to group products or services that are sold and consumed under similar competitive conditions—*i.e.*, by the same group of competitors in the relevant marketplace. (PX02148 at 021-022 (¶¶ 38-39) (Town Expert Report), *in camera*; Town, Tr. 3664-3668). When competitive conditions are different for a significant group of products or services, cluster market analysis requires that these products or services be grouped and analyzed in a separate cluster. (Town, Tr. 3666-3668, 3672-3674; PX02148 at 022 (¶ 39) (Town Expert Report), *in camera*). In this matter, inpatient obstetrics services warrant a separate cluster market from other inpatient general acute care services because the set of competitors in the relevant geographic market is different across these two clusters, as UTMC and St. Anne do not provide inpatient obstetrics services. (Town, Tr. 3672-3673; PX01850 at 007 (¶ 7) (Town Rebuttal Report), *in camera*; (PX02148 at 022 (¶ 39) (Town Expert Report), *in camera*). Professor Town's approach to relevant product market definition is a demand-side approach. (Town, Tr. 3665-3668, 3684-3688, 3714-3715).

1513. There is no evidence that hospitals can price discriminate for certain services based on the number of suppliers of that service in the area. (Guerin-Calvert, Tr. 7236).

Response to Finding No. 1513

This proposed finding is incomplete and misleading. A hospital may have greater bargaining leverage with respect to some of its services by virtue of the attractiveness of its offerings and/or the lack of alternative providers for those services. (CCPFF ¶ 188). This hospital may exercise this greater bargaining leverage by negotiating carve-outs or case rates for

the specific services to which this greater bargaining leverage applies. (CCPFF ¶¶ 134, 188). In the process of negotiating rates with commercial health plans, hospitals "carve-out" obstetrics services from other general acute care services and separate back and forth rate negotiations are had specifically for obstetrics services. (CCPFF ¶ 205).

1514. Prof. Town's methodology for defining a relevant product market does not comport with the *Horizontal Merger Guidelines*. (Guerin-Calvert, Tr. 7236).

Response to Finding No. 1514

This proposed finding is incorrect. Professor Town's methodology for defining relevant product markets is informed by and consistent with the *Horizontal Merger Guidelines*. (*See* Response to RPFF ¶¶ 1488, 1512; Town, Tr. 3585-3587, 3685-3686, 3697; PX02148 at 021 (¶ 37), 23 (¶ 40) (Town Expert Report), *in camera*; PX01850 at 006-007 (¶¶ 6-7) (Town Rebuttal Report), *in camera*).

3. Professor Town's Case-Mix Adjusted Prices Are "Constructed" Prices That Do Not Reflect Actual Real-World Rates

1515. Prof. Town's case-mix-adjusted price estimations do not indicate the reason for the difference in prices across hospitals in Lucas County, and Prof. Town agrees that the presence of price differences alone are not sufficient to determine the exercise of market power. (Town, Tr. 4151-4152, 4155; PX02148 at 145, *in camera*).

Response to Finding No. 1515

This proposed finding is incomplete. Health plans have confirmed Professor Town's analysis of the relative price difference between ProMedica and St. Luke's by testifying that ProMedica's rates are the highest and St. Luke's rates are the lowest in Lucas County. (Pirc, Tr. 2238-2242, *in camera*; Radzialowski, Tr. 684, *in camera*, 687-688, *in camera*, 698-700, *in camera*; Sandusky, Tr. 1338-1348, *in camera*, 1350, *in camera*; PX02296 at 001, *in camera*; *see* Pugliese, Tr. 1512-1513, *in camera*; McGinty, Tr. 1210; *see also* CCPFF ¶ 431). Respondent can cite to no health plan testimony that indicates these price differences are attributable to

differences in quality or cost. (*See generally* CCPFF ¶ 399-439). Mr. Pirc, for example, testified that ProMedica's prices are not explained by higher cost or quality. (Pirc, Tr. 2238-2242, *in camera.*) Further, it is worth nothing that the case-mix adjusted pricing methodology was used and cited by the Court in the Evanston matter. (Town, Tr. 4457).

1516. Prof. Town's methodology for his constructed prices controlled for basic patient characteristics – age, gender, DRG, and length of stay – and the hospital's "fixed effect." (Guerin-Calvert, Tr. 7467-7468).

Response to Finding No. 1516

Complaint Counsel has no specific response.

1517. Prof. Town's hospital "fixed effect" variable estimates the average change in the price holding constant age, gender, DRG and length of stay. In other words, the "fixed effect" variable attributes any other change in price to the hospital's characteristics. (Guerin-Calvert, Tr. 7467-7468).

Response to Finding No. 1517

See Response to RPFF ¶ 1517.

1518. Prof. Town's "fixed effect" variable does not explain why there is a difference in price between hospitals, nor does it take into account the complexity of the negotiating process. (Town, Tr. 4155; Guerin-Calvert, Tr. 7469-7471).

Response to Finding No. 1518

This proposed finding is misleading. Ms. Guerin-Calvert provides no evidence that the complexities of the negotiation process introduce any systematic bias, and the hospital fixed-effects capture the relevant consideration: the systematic differences in prices across hospitals for a given patient population. (PX01850 at 066 (¶ 101)(Town Rebuttal Report), *in camera*).

1519. Prof. Town's case-mix-adjusted price estimations also do not control for the differences in the cost of care across the hospitals, even though hospitals do not necessarily incur the same costs to deliver general acute care inpatient services. (Town, Tr. 4103, 4165-4166, 4168; Guerin-Calvert, Tr. 7467).

Response to Finding No. 1519

This proposed finding is irrelevant and misleading. Professor Town's merger simulation regression controls for year, MCO, and hospital characteristics, such as cost or quality that may affect the relationship between bargaining power and price. (PX02148 at 108 (Technical Appendix (¶ 27)(Town Expert Report), *in camera*). The purpose of case-mix adjusting prices is to control for the case mix at a hospital. (CCPFF ¶ 429).

1520. Prof. Town has no specific variable in his regression analysis that measures the differences in the cost of care across the hospitals; even though cost of care may potentially account for differences in prices. (Town, Tr. 4165-4166).

Response to Finding No. 1520

See Response to RPFF ¶ 1519.

1521. These case-mix-adjusted prices also do not take into consideration the complexity of the bargaining process. (Guerin-Calvert, Tr. 7471).

Response to Finding No. 1521

This proposed finding is misleading. (*See* Response to RPFF ¶ 1518).

1522. Prof. Town agrees that prices for a hospital may differ across MCOs for a number of reasons such as cost or quality. (Town, Tr. 4191).

Response to Finding No. 1522

Complaint Counsel has no specific response.

1523. Prof. Town's case-mix-adjusted prices assume that reimbursement rates are in equilibrium, which is not necessarily true, especially because St. Luke's sought to renegotiate its contract with Anthem in 2009 soon after it was negotiated. (Guerin-Calvert, Tr. 7471-7473).

Response to Finding No. 1523

This proposed finding is misleading. Equilibrium occurs when both parties to a negotiation agree to the terms and conclude they are better off with the deal than without it. (Town, Tr. 3847). St. Luke's did not terminate the Anthem contract, thus St. Luke's determined

it was better off with the deal than without it. Respondent acknowledges this definition of equilibrium in RPFF ¶ 1387.

1524. A correlation may exist between market shares and prices for competitively benign reasons such as quality and costs; Prof. Town's calculations do not acknowledge this. (Guerin-Calvert, Tr. 7252-7256).

Response to Finding No. 1524

Respondent can cite to no evidence or testimony that quality or costs explain these price differences. (*See also* CCPFF ¶ 399-439).

1525. Prof. Town's purported relationship between price and market shares uses ProMedica's share across all of its commercial MCOs and hospitals, which means he is aggregating contracts with different reimbursement rates, different time periods and other terms that differ. (Guerin-Calvert, Tr. 7252-7256).

Response to Finding No. 1525

This proposed finding is misleading and incorrect insofar as it claims that Professor Town used "different time periods." It is meaningless insofar as "other terms" are not specified. Professor Town used the most recent data available from OHA and the MCOs. (*See* PX02148 at 142-145 (Town Expert Report, Ex. 6, 7), *in camera*).

1526. Moreover, general acute care inpatient services are differentiated products, which means that factors such as cost, quality, underestimating the increase in inflation or cost escalation, and the time period for which a contract is negotiated can cause differences in price. (Town, Tr. 4157-4161; Guerin-Calvert, Tr. 7266, 7474).

Response to Finding No. 1526

This proposed finding is incorrect and incomplete. Professor Town testified that the large differences between St. Luke's prices and ProMedica's prices cannot be explained by differences in costs. (Town, Tr. 4103-4104). Moreover, Professor Town testified that based on his assessment of the evidence, ProMedica's case-mix adjusted prices are reflective of significant bargaining leverage with payers. (Town, Tr. 4199-4200).

1527. {
} Radzialowski, Tr. 684, *in camera*; RX-129 at 000001, *in camera*, PX02148 at 145, *in camera*). However, Prof. Town's case-mix-adjusted price calculations result in Mercy's prices being higher. (Town, Tr. 4181-4182).

Response to Finding No. 1527

Complaint Counsel has no specific response.

1528. {
}. (Radzialowski Tr. 684, *in camera*; PX02148 at 145, *in camera*)
{
} (Town Tr. 4183, 4185-4186).

Response to Finding No. 1528

Complaint Counsel has no specific response.

1529. Prof. Town's case-mix-adjusted prices are derived from a methodology that predicts prices under the hypothetical scenario of each hospital in Lucas County treating exactly the same patient population; that is, it computed prices for patients at hospitals where the patients were not actually treated. (Town, Tr. 4168-4170, 4187-4188).

Response to Finding No. 1529

Complaint Counsel has no specific response.

1530. Prof. Town's case-mix-adjusted prices predict that if ProMedica raised MMO's rates with St. Luke's to the level of Bay Park, that would represent about a 120 percent to 134 percent increase. (Town, Tr. 4189-4191). {
} (Pirc, Tr. 2356-2372, *in camera*; PX02148 at 145, *in camera*).

Response to Finding No. 1530

This proposed finding is inaccurate and misleading. Prices determined post-Acquisition, during the pendency of antitrust litigation, are not good proxies for ProMedica's post-Acquisition bargaining leverage. (PX01850 at 047-048 (¶72) (Town Rebuttal Report), *in camera*). Further, Respondent is referencing a failed negotiation between MMO and St. Luke's

pre-joinder. That is, the { } percent rate increase was never agreed upon, and the contract proposal to that rate increase was rejected by MMO. (*See* CCPFF ¶ 1181-1184).

1531. Furthermore, if Prof. Town's estimated price increases are analyzed at a disaggregated level, by hospitals and MCO, it shows that ProMedica's prices are not higher than all other hospitals in Lucas County. (Guerin-Calvert, Tr. 7480).

Response to Finding No. 1531

Complaint Counsel has no specific response.

1532. Prof. Town's case weight adjusted price for St. Vincent is higher than for any other hospital for Aetna and ProMedica's system price is lower than Mercy's system price for Aetna. (Town, Tr. 4177).

Response to Finding No. 1532

Complaint Counsel has no specific response.

1533. Similarly, for Anthem, each of the Mercy hospitals' case weight adjusted prices is higher than TTH, about the same as Bay Park, but lower than Flower; St. Luke's has the lowest adjusted price. For Anthem, the estimated system price for Mercy is higher than the system price for ProMedica. (Town, Tr. 4177-4178; Guerin-Calvert, Tr. 7483).

Response to Finding No. 1533

Complaint Counsel has no specific response.

1534. For Blue Cross Blue Shield of Michigan ("BCBS of Michigan"), St. Vincent's price is higher than that of TTH's. (Town, Tr. 4178).

Response to Finding No. 1534

Complaint Counsel has no specific response.

1535. For FrontPath, St. Anne's price is higher than TTH's, St. Vincent's, UTMC's, and Flower's. (Town, Tr. 4180).

Response to Finding No. 1535

Complaint Counsel has no specific response.

a. Overview of Prof. Town's Merger Simulation Model

1536. Prof. Town's econometric, or merger simulation model, tries to predict what the change in price would be to MCOs from the joinder, taking into consideration the change in the network configuration. (Guerin-Calvert, Tr. 7485).

Response to Finding No. 1536

Complaint Counsel has no specific response.

1537. Step one of Prof. Town's merger simulation model identifies the price differences among hospitals, but does not explain the differences in price. (Town, Tr. 4203-4205).

Response to Finding No. 1537

This finding is incomplete and misleading. First, Professor Town's case-mix-adjusted hospital prices control for differences in age, gender, diagnostic code, and length of stay by assuming that each hospital treated an identical patient population. (Town, Tr. 3722-3723, *in camera*; PX02148 at 104 (Technical Appendix ¶ 14) (Town Expert Report), *in camera*). As a result, these prices allow for an "apples-to-apples" comparison across hospitals. (PX02148 at 104 (Technical Appendix ¶ 14) (Town Expert Report), *in camera*; Town, Tr. 3723-3724, *in camera*). Second, evidence collected from health plans indicates that ProMedica generally receives higher reimbursement rates relative to the other hospitals in Lucas County. (*See* CCPFF ¶ 431). Yet the record lacks evidence indicating that ProMedica's higher prices are due to higher quality or higher costs, or a disproportionate volume of more complex cases. (PX02148 at 034-035 (¶¶ 68-69), 073 (¶ 130), *in camera*). While Respondent's expert argues that elements and conditions of contracting may explain differences in prices across hospitals, she does not conclude that any of these elements and conditions actually explain ProMedica's higher prices. (RX-71(A) at 67-68 (¶¶ 129-130) (Guerin-Calvert Expert Report), *in camera*; *see also* RX-71(A) at 37-50, *in camera*). Similarly, Respondent's expert does not conclude that any of the "competitively benign factors" listed in her report explain the price differentials found by

Professor Town or by fact witnesses in this matter. (*See* RX-71(A) at 37-50 (Guerin-Calvert Expert Report), *in camera*).

1538. For step one, Prof. Town starts with MCO data for discharges at greater Toledo area hospitals from January 1, 2004 through December 31, 2009, which includes inpatient discharges from Aetna, Anthem, BCBS of Michigan, MMO, FrontPath, Paramount, Cigna and United. (Guerin-Calvert, Tr. 7488; Town, Tr. 4208-4209).

Response to Finding No. 1538

Complaint Counsel has no specific response.

1539. In step one, Prof. Town's predicted price for each hospital is calculated under the hypothetical that each hospital treats exactly the same patient population. (Guerin-Calvert, Tr. 7488).

Response to Finding No. 1539

Complaint Counsel has no specific response.

1540. Prof. Town then excludes all discharges from hospitals outside of Lucas County, except WCH and FCHC. (Town, Tr. 4210).

Response to Finding No. 1540

Complaint Counsel has no specific response.

1541. Prof. Town then excludes data for managed care organization/hospital-year combinations for which there were fewer than 30 discharges. (Town, Tr. 4210).

Response to Finding No. 1541

Complaint Counsel has no specific response.

1542. Prof. Town also excludes all discharges for which the patient was older than 64 years of age even though those patients may have commercial insurance as their primary insurance. (Town, Tr. 4210-4211).

Response to Finding No. 1542

This proposed finding is misleading. Professor Town testified that Medicare Advantage patients are excluded because the competitive conditions for these patients are very different. (Town, Tr. 4466-4467).

1543. Prof. Town excludes discharges coded MDC 0, 19, 20 and -1. (Town, Tr. 4211-4212).

Response to Finding No. 1543

Complaint Counsel has no specific response.

1544. Prof. Town excludes discharges in which the amount paid to the hospital by the MCO was less than $100. (Town, Tr. 4212).

Response to Finding No. 1544

Complaint Counsel has no specific response.

1545. Prof. Town excludes 2004 discharges reimbursed by Aetna and CIGNA. (Town, Tr. 4212).

Response to Finding No. 1545

Complaint Counsel has no specific response.

1546. Prof. Town uses the remaining data to run a regression that shows only the difference in prices between hospitals, but not any hospital-specific factors that account for any of these differences in the hospital prices. (Town, Tr. 4212-4215).

Response to Finding No. 1546

Complaint Counsel has no specific response.

1547. Step two measures bargaining power as "willingness-to-pay" at a system level. (Town, Tr. 4206).

Response to Finding No. 1547

Complaint Counsel has no specific response.

1548. In other words, step two predicts the value that consumers (MCOs) place on the individual hospital or system in a MCO's network by analyzing patient discharge data. (Guerin-Calvert, Tr. 7485-7486, 7489-7490).

Response to Finding No. 1548

This proposed finding is incorrect. Willingness-to-Pay does not simply measure the value consumers place on having access to a hospital or system; rather, it measures the *incremental value* consumers place on having access to a hospital or system *given the*

availability of alternative hospitals. (PX02148 at 103 (Technical Appendix ¶11) (Town Expert Report), *in camera*).

1549. The willingness-to-pay measure is not expressed in dollars or prices; it is expressed in utils. (Guerin-Calvert, Tr. 7490; Town, Tr. 3800, *in camera*). If the util is higher, then what is being measured is more valuable than if the util is lower. (Guerin-Calvert, Tr. 7490; Town, Tr. 3800, *in camera*).

Response to Finding No. 1549

Complaint Counsel has no specific response.

1550. To calculate an MCO's "willingness-to-pay", Prof. Town includes OB patients in the data, but excludes newborns. Prof. Town also does not estimate a separate willingness-to-pay for inpatient OB services, even though in his report he states that "competitive conditions for OB services are substantially different from those in the broad market of general acute care services." (Town Tr. 4248, 4291-4292; PX02148 at 023-024, *in camera*).

Response to Finding No. 1550

This proposed finding is incomplete and misleading. The patient population used by Professor Town to calculate Willingness-to-Pay excludes normal newborns so as not to double-count discharges, as the mother is already in the sample. (PX02148 at 105-106 (Technical Appendix ¶ 19) (Town Expert Report), *in camera*).

1551. Prof. Town admits that his willingness-to-pay regression model is not a tool to forecast prices. (Town, Tr. 3883).

Response to Finding No. 1551

This proposed finding is incomplete and misleading. Professor Town testified that the Willingness-to-Pay model is not a tool to forecast prices into future years. (Town, Tr. 3883). Rather, the Willingness-to-Pay regression model is a tool to predict the effect of the elimination of competition on prices – that is, to isolate and quantify the Acquisition's impact on the bargaining leverage of the merged hospitals. (Town, Tr. 3883).

1552. Prof. Town's willingness-to-pay analysis estimates the probability, based on patient data in a number of counties, that a given hospital is going to be chosen across a range of

services, but it does not take into account relative prices. (Guerin-Calvert, Tr. 7169-7170).

Response to Finding No. 1552

This proposed finding is misleading. The addition of a price variable to Professor Town's diversion analysis would be relevant only if within-network price differences across hospitals affected consumer and physician choices over hospitals. (*See* Town, Tr. 4301). The evidence indicates that this is not the case, as it demonstrates that health plans in Lucas County do not engage in in-network steering and that physicians and patients do not choose hospitals based on differences in the rates that health plans pay. (*See* CCPFF ¶¶ 539-628).

1553. Prof. Town admits that there are several factors that may affect the bargaining relationship, such as the leverage of the MCOs, costs, number of interns per bed, and the fact that prices change over time. (Town, Tr. 3884-3886).

Response to Finding No. 1553

Complaint Counsel has no specific response.

1554. Prof. Town includes all but four DRGs, even ones he previously excluded from his case-mix-adjusted price estimate, to calculate his willingness-to-pay. (Town, Tr. 4247-4248).

Response to Finding No. 1554

This proposed finding is incorrect. Professor Town excluded four MDC categories – -1, 0, 19, and 20 – from the data used to calculate *both* case-mix-adjusted prices and Willingness-to-Pay. (Town, Tr. 4211, 4221; RPFF ¶ 1543). These MDC categories correspond to missing/invalid, pre-MDC, mental diseases and disorders, and alcohol- and drug-induced disorders, respectively. (Town, Tr. 4027-4028). Prof. dropped these categories because the services within each do not qualify as inpatient general acute care services. (Town, Tr. 4027-4028). The only difference between the patient population used to calculate case-mix-adjusted prices and the patient population used to calculate Willingness-to-Pay is that the latter excludes

normal newborns, so as not to double-count discharges, as the mother is already in the sample.

(PX02148 at 105-106 (Technical Appendix ¶ 19) (Town Expert Report), *in camera*).

1555. Step three then estimates the relationship between willingness-to-pay and price. (Town, Tr. 4206).

Response to Finding No. 1555

Complaint Counsel has no specific response.

1556. Prof. Town uses his predicted prices and his willingness-to-pay utils in step three, and also controls for other factors including a MCO's size, year fixed effects, MCO fixed effects, interns per bed and average cost in the regression. (Guerin-Calvert, Tr. 7492-7493).

Response to Finding No. 1556

Complaint Counsel has no specific response.

1557. In other words, in step three, Prof. Town tries to explain his case mix adjusted price based on the willingness-to-pay utils and the additional factors added at this step. (Guerin-Calvert, Tr. 7493).

Response to Finding No. 1557

Complaint Counsel has no specific response.

1558. Prof. Town uses the coefficient on the system willingness-to-pay that results from this regression to measure the effect of bargaining power on price. (Guerin-Calvert, Tr. 7494-7495).

Response to Finding No. 1558

This proposed finding is incomplete. Professor Town used the relationship between System Willingness-to-Pay coefficient and the system-volume-fraction coefficient to translate the change in ProMedica's bargaining power into a change in price. (Town, Tr. 4285-4288).

1559. Steps four and five attempt to estimate the magnitude of the likely price effects from the joinder. (Town, Tr. 4206).

Response to Finding No. 1559

Complaint Counsel has no specific response.

1560. Prof. Town estimates in his system willingness-to-pay regression, the first of two regressions, the overall system increase to be 16.2 percent. (Guerin-Calvert, Tr. 7495-7496).

Response to Finding No. 1560

Complaint Counsel has no specific response.

1561. Prof. Town then tries to estimate an overall measure of harm of this 16.2 percent by using his diversion ratios to allocate proportions of harm between ProMedica and St. Luke's. (Guerin-Calvert, Tr. 7496-7497).

Response to Finding No. 1561

Complaint Counsel has no specific response.

1562. He then takes that allocated harm attributed to St. Luke's and compares it to St. Luke's existing pre-joinder rates and calculates the percentage change, arriving at 38.38 percent change in rates for St. Luke's and a 10.75 percent increase for ProMedica's rates. (Guerin-Calvert, Tr. 7497).

Response to Finding No. 1562

Complaint Counsel has no specific response.

1563. Finally, Prof. Town takes the residual, or the unexplained portion, from his regression and adds that amount to the 38.38 percent for St. Luke's to arrive at his predicted rise in rates at St. Luke's of 56 percent. (Guerin-Calvert, Tr. 7497-7498).

Response to Finding No. 1563

Complaint Counsel has no specific response.

b. Critiques of Prof. Town's Merger Simulation Model

1564. Prof. Town defines a general acute care inpatient services market for the purpose of his report that is narrower than the market for which he provides results from his merger simulation model. (Town, Tr. 4291)

Response to Finding No. 1564

This proposed finding is incomplete and misleading. The general acute care inpatient services market used by Professor Town in his structural analysis of the Acquisition is properly limited to the services in which St. Luke's and ProMedica competed before the Acquisition.

(PX02148 at 021-025 (¶¶ 38-44) (Town Expert Report), *in camera*; PX01850 at 006-011 (¶¶ 6-13) (Town Rebuttal Report), *in camera*). For the purposes of calculating case-mix adjusted prices and performing the Willingness-to-Pay merger simulation, Professor Town used all of the services that fall into the inpatient general acute care market. (Town, Tr. 3730-3731, *in camera*). He did so because reimbursement methodologies in contracts usually cover the full range of inpatient services, and thus one must account for the possibility that a contract's reimbursement methodology might compensate services within the relevant product markets differently than services outside the relevant product markets. (Town, Tr. 3731, *in camera*). Calculating prices over the full range of inpatient general acute care services prevents such variations in reimbursement methodology from biasing the calculations and preventing a meaningful comparison of prices. (Town, Tr. 3731, *in camera*).

1565. Prof. Town also includes data from hospitals located in counties other than Lucas County, including The Cleveland Clinic, the University of Michigan Health System and St. Joseph Mercy in his merger simulation model, even though hospitals outside Lucas County are not in the relevant geographic market. (Town, Tr. 4221-4222; PX02148 at 173, *in camera*).

Response to Finding No. 1565

This proposed finding is incomplete and misleading. Professor Town used a broad geographic market in the Willingness-to-Pay merger simulation to demonstrate that the approach does not depend upon geographic market definition. (PX02148 at 101 (Technical Appendix ¶ 2) (Town Expert Report), *in camera*). If the Acquisition is likely to substantially lessen competition, the analysis is likely to predict meaningful price increases even if one includes a broad patient population and a large number of hospitals outside of Lucas County as potential competitors for ProMedica and St. Luke's. (PX02148 at 101 (Technical Appendix ¶ 2) (Town

Expert Report), *in camera*). The Willingness-to-Pay model's insensitivity to geographic market definition is one of its primary advantages. (Town, Tr. 3801, *in camera*).

1566. Prof. Town's merger simulation model does not allow one to independently or directly observe an individual's second choice of hospitals if his or her first choice becomes unavailable or more expensive. (Town, Tr. 4240-4242).

Response to Finding No. 1566

This proposed finding is incomplete and misleading. Because, generally, each patient visits only one hospital per admission, the admission data do not contain information that would allow one to directly observe a patient's second-choice hospital. (Town, Tr. 4240-4241). However, the model does predict a patient's second-choice hospital in a systematic way that is highly consistent with economic theory. (Town, Tr. 4241).

1567. Prof. Town, however, admits that "the realized choice is almost, by definition, going to be different than the probability choice." (Town, Tr. 4243).

Response to Finding No. 1567

This proposed finding is incomplete and misleading. Professor Town's testimony explains that the choice model he employed in his analysis estimates, for each individual patient, a probability associated with each alternative hospital in the choice set. (Town, Tr. 3722, *in camera*, 3774-3775, *in camera*, 3817, *in camera*, 4233-4234, 4241-4243, 4303). Each such probability reflects the likelihood that that patient would use the associated hospital if that patient's first-choice hospital were not an in-network provider under the patient's health plan. (Town, Tr. 3722, *in camera*, 3774-3775, *in camera*, 3817, *in camera*, 4233-4234, 4241-4243, 4303). The patient's first choice hospital is the hospital he or she actually used—his or her realized choice. (Town, Tr. 3722, *in camera*, 3774-3775, *in camera*, 3817, *in camera*, 4233-4234, 4241-4243, 4303). Because the model assumes that the patient's actual hospital is unavailable in order to determine the probability choice, the realized choice will be different

from the probability choice. (Town, Tr. 3722, *in camera*, 3774-3775, *in camera*, 3817, *in camera*, 4233-4234, 4241-4243, 4303).

1568. Prof. Town acknowledges that there is a need to appropriately control for the intrinsic value associated with each hospital, i.e., the extent to which patients like a hospital due to quality, reputation, location and services, which is reflected in patient preference for a hospital. (Town, Tr. 4280-4283; PX01850 at 062, *in camera*).

Response to Finding No. 1568

Complaint Counsel has no specific response.

1569. Prof. Town's system willingness-to-pay captures the effect of the intrinsic value of member hospitals and the effect of system membership (i.e., the diversion or substitution between member hospitals). (Town, Tr. 4280-4281).

Response to Finding No. 1569

Complaint Counsel has no specific response.

1570. Prof. Town agrees that the joinder does not affect a person's intrinsic value of a given hospital. (Town, Tr. 4281-4282).

Response to Finding No. 1570

Complaint Counsel does not dispute this proposed finding.

1571. To predict the acquisition-related pricechanges, one must isolate the substitution or diversion effect on price from the effect of the intrinsic value on price by holding the characteristics of individual hospitals fixed. (Town, Tr. 4282).

Response to Finding No. 1571

This proposed finding is incomplete and misleading. The estimated 13.5-percent increase in the bargaining power of post-Acquisition ProMedica that is derived from the Willingness-to-Pay analysis and presented by Professor Town is due solely to the Acquisition's elimination of competition between St. Luke's and ProMedica. (*See* Town, Tr. 3875-3876; PX02148 at 107 (¶ 25), 165 (Exhibit 13) (Town Expert Report), *in camera*). Hospital attributes that are valued by consumers are, by definition, held constant in evaluating the change in bargaining power, because the increase in the merged entity's bargaining power is calculated based on the

difference between the merged entity's Willingness-to-Pay and the sum of ProMedica and St. Luke's independent, pre-Acquisition Willingness-to-Pay. (*See* Town, Tr. 3875-3876; PX02148 at 107 (¶ 25), 165 (Exhibit 13) (Town Expert Report), *in camera*).

1572. Prof. Town's model assumes there is no difference in price or cost to the consumer of MCOs offering different networks. (Town, Tr. 4324-4325).

Response to Finding No. 1572

This proposed finding is incorrect and mischaracterizes Professor Town's testimony. The cited testimony does not imply that Professor Town's model assumes no price differences among different network offerings because Professor Town testified that the Willingness-to-Pay model is "agnostic" about differences in price across different network configurations. (Town, Tr. 4324-4325). Rather, Willingness-to-Pay calculates the welfare that consumers would derive from having access to various network configurations. (Town, Tr. 4324-4325).

1573. The results from Prof. Town's merger simulation model are subject to misinterpretation because the system willingness-to-pay variable captures all the things that go to the intrinsic value of the hospital, including those qualities that are competitively benign. (Guerin-Calvert, Tr. 7502).

Response to Finding No. 1573

This proposed finding is incorrect and misleading. Professor Town used the Willingness-to-Pay merger simulation exercise to quantify the Acquisition's increase in bargaining leverage due *solely* to the Acquisition's elimination of competition between ProMedica and St. Luke's. (See Response to RPFF ¶¶ 1551, 1571).

1574. Prof. Town does not control for case mix index, assets per bed, percent Medicare reimbursements, percent Medicaid reimbursement and hospital-level willingness-to-pay, all of which can affect the intrinsic value associated with a hospital. (Town, Tr. 4283-4284; Guerin-Calvert, Tr. 7499-7550).

Response to Finding No. 1574

This proposed finding is misleading. Including additional explanatory variables, as Ms. Guerin-Calvert did in her critique of Professor Town's merger simulation, is a well-known means to diminish the magnitude and statistical significance of any regression result. (PX01850 at 067 (¶ 102) (Town Rebuttal Report), *in camera*). This is because the additional variables included by Ms. Guerin-Calvert are correlated with the variable of interest but add no explanatory power that is not already captured by the variables included by Professor Town in the regression model. (PX01850 at 067 (¶ 102) (Town Rebuttal Report), *in camera*). The addition of redundant explanatory variables can render regression coefficient estimates highly unreliable. (PX01850 at 068-072 (¶ 104) (Town Rebuttal Report), *in camera*). Adding correlated but unrelated variables can produce unreliable results, particularly when sample sizes are modest, as they are in hospital merger simulation models. (Town, Tr. 3886). Notably, even with the inappropriately added variables, Ms. Guerin-Calvert's analysis predicts a 7.3-percent price increase, which is economically significant and also statistically significant at the 3.8 percent level. (RX-71(A) at 80-81 (¶ 152) (Guerin-Calvert Expert Report), *in camera*).

1575. When included in his model, the variables that Prof. Town does not include can explain the reason for the price differences. (Guerin-Calvert, Tr. 7501).

Response to Finding No. 1575

This proposed finding is misleading. (*See* Response to RPFF ¶ 1574).

1576. The case mix index variable accounts for the distribution of the patient population at a hospital. In addition, hospitals with a greater case mix index have different staffing, different attributes and possible different reputations, all of which could affect prices. (Guerin-Calvert, Tr. 7513-7514).

Response to Finding No. 1576

This proposed finding is incomplete and misleading. Including case-mix index is inappropriate because Professor Town's prices are already case-mix adjusted. (PX01850 at 068-072 (¶ 104) (Town Rebuttal Report), *in camera*).

1577. The assets per bed variable is a measure of equipment and facilities at a hospital that could explain prices. (Guerin-Calvert, Tr. 7514-7515).

Response to Finding No. 1577

This proposed finding is incomplete and misleading. Including assets per bed is inappropriate because, even if one assumed that it is a reasonable proxy measure for the quality of a hospital, all hospital attributes that affect patient preferences over hospitals are already captured in Willingness-to-Pay. (PX01850 at 069 (¶ 104) (Town Rebuttal Report), *in camera*).

1578. The percent of Medicaid and Medicare discharges variables explains that the larger the proportion of Medicaid and Medicare patients a hospital has, the more it may have shortfalls it needs to cover with its MCO contracts, which may also explain prices. (Guerin-Calvert, Tr. 7515-7516).

Response to Finding No. 1578

This proposed finding is incomplete and misleading. Ms. Guerin Calvert's addition of Medicare share in the Willingness-to-Pay merger simulation model is inappropriate. (PX01850 at 068-072 (¶ 104) (Town Rebuttal Report), *in camera*). Ms. Guerin-Calvert puts forward no rationale for including Medicare share that is consistent with the facts of this case. (PX01850 at 068-072 (¶ 104) (Town Rebuttal Report), *in camera*). The cost-shifting rationale is inconsistent with economic intuition and Ms. Guerin-Calvert's testimony. (PX01850 at 068-072 (¶ 104) (Town Rebuttal Report), *in camera*). St. Luke's has low prices, and low Willingness-to-Pay, and high Medicare share, while ProMedica has high prices, high Willingness-to-Pay, and low Medicare share. Moreover, Ms. Guerin-Calvert finds a negative relationship between Medicare share and prices and puts forward no rationale to support it. (PX01850 at 068-072 (¶ 104) (Town

Rebuttal Report), *in camera*). Including additional explanatory variables such as this one is a well-known means to diminish the magnitude and statistical significance of any regression result. (PX01850 at 067 (¶ 102) (Town Rebuttal Report), *in camera*).

1579. The hospital average willingness-to-pay per person variable accounts for differences in specific hospitals, rather than aggregating the willingness-to-pay at a system level. (Guerin-Calvert, Tr. 7516-7517).

Response to Finding No. 1579

This proposed finding is incomplete and misleading. Including average hospital Willingness-to-Pay is incorrect because doing so is inconsistent with standard bargaining theory. (Town, Tr. 3903-3904). No peer-reviewed, published research includes average hospital Willingness-to-Pay. (PX01850 at 069-070 (¶ 104) (Town Rebuttal Report), *in camera*). Respondent's economic expert states that this variable measures hospital quality, yet provides no explanation for why or what it adds that is not incorporated by the system Willingness-to-Pay that I use in the model. PX01850 at 068 (¶ 104) (Town Rebuttal Report), *in camera*). It should not be included in the analysis because the model already accounts for differences in hospitals' quality and it correlates strongly with another variable in the specification. PX01850 at 068 (¶ 104) (Town Rebuttal Report), *in camera*). Indeed, by definition, for most hospital systems in the sample (the exceptions are Mercy and PHS), the hospital Willingness-to-Pay is the system hospital Willingness-to-Pay, meaning that hospital and system Willingness-to-Pay are perfectly correlated. PX01850 at 068 (¶ 104) (Town Rebuttal Report), *in camera*).

1580. Adding all these variables into Prof. Town's model results in a 7.3 percent calculated price change but the coefficient on the system willingness-to-pay that generated the 7.3 percent is not statistically significant, which means that there is no confidence that the relationship between system willingness-to-pay and price is different from zero. (Guerin-Calvert, Tr. 7525-7526; RX-71(A) at 000081, *in camera*).

Response to Finding No. 1580

This proposed finding is incomplete and misleading. The 7.3-percent price increase is statistically significant at the 3.8-percent level when one takes into account, as Professor Town did, the relationship (or covariance) between the Willingness-to-Pay variable and the system-volume-fraction-variable. (RX-71(A) at 80-81 (¶ 152) (Guerin-Calvert Expert Report), *in camera*; Response to RPFF ¶ 1558; Guerin-Calvert, Tr. 7930-7931). The coefficient on Willingness-to-Pay, while not statistically significant at the 5-percent level, is statistically significant at the 5.5-percent level. (Guerin-Calvert, Tr. 7929).

1581. These variables that Prof. Town does not include are variables identified in economic literature and are ones that other economists, including some employed by the FTC, have included in past hospital merger analyses and regressions. (Guerin-Calvert, Tr. 7505-7506, 7510; RX-71(A) at 000077-000079, *in camera*).

Response to Finding No. 1581

This proposed finding is incomplete and misleading. As Professor Town explained in his testimony, differences between his specification of the Willingness-to-Pay model and specifications that have appeared in peer-reviewed academic literature are due to two primary factors. (*See* Town, Tr. 4246-4247). First, Professor Town's specification of the Willingness-to-Pay model was designed to account for hospital competition in the Toledo-area market in which the Acquisition took place, while other studies did not focus on this particular market. (*See* Town, Tr. 4246-4247). Second, the data that Professor Town used in his merger simulation were much richer than the data typically available to researchers. (*See* Town, Tr. 4246-4247).

1582. On the other hand, the variables Prof. Town uses in his choice model have not appeared in any peer-reviewed academic literature. (Town, Tr. 4247).

Response to Finding No. 1582

This proposed finding is incomplete and misleading. (*See* Response to RPFF ¶ 1581).

1583. Prof. Town's willingness-to-pay model has not been accepted in any other hospital merger cases. (Town, Tr. 3969).

Response to Finding No. 1583

This proposed finding is incomplete and misleading. No other court reviewing a hospital merger has had the opportunity to consider the Willingness-to-Pay model. (Town, Tr. 3969-3970).

1584. In addition, the multinomial logit functional form that Prof. Town uses has been criticized in economic literature for generating restrictive substitution patterns. (Town, Tr. 4236)

Response to Finding No. 1584

This proposed finding is incomplete and misleading. Professor Town's testimony explains that concerns about restrictive substitution patterns from the multinomial logit functional form are mitigated by the richness of the data set that Professor Town used in his analysis of the Acquisition. (Town, Tr. 4236).

1585. There are no peer-reviewed studies that Prof. Town, or Ms. Guerin-Calvert, are aware of that validate the accuracy of the price predictions Prof. Town's merger simulation model generates. (Town, Tr. 4288-4289; Guerin-Calvert, Tr. 7511-7512).

Response to Finding No. 1585

This proposed finding is incomplete. There is a working paper that validates the accuracy of the price predictions generated by the Willingness-to-Pay merger simulation model. (Town, Tr. 4288; CCPFF ¶ 1566).

1586. Prof. Town has not confirmed with MCOs or hospitals in Toledo that his model accurately captures the bargaining process between the MCOs and hospitals. (Town, Tr. 4297).

Response to Finding No. 1586

This proposed finding is misleading. Testimony from health plans and hospitals in this case supports the bargaining framework underlying Professor Town's analysis of the Acquisition. (*See generally* CCPFF ¶¶ 92-184, 418-424, 514-533).

1587. Further, Prof. Town's model does not predict a price effect specific to St. Luke's; rather it allocates a price effect to St. Luke's based on the price effect predicted for a ProMedica Health System that contains St. Luke's. (Town, Tr. 4297-4298).

Response to Finding No. 1587

Complaint Counsel has no specific response.

1588. {

} (Guerin-Calvert, Tr. 7375, *in camera*).

Response to Finding No. 1588

Diversion ratios based on relative price changes are irrelevant because within-network price differences across hospitals do not affect consumer and physician choices over hospitals. (*See* Town, Tr. 4301; CCPFF ¶¶ 539-628). Hence, Professor Town correctly estimates diversions based on a hypothetical network exclusion. (*See* Town, Tr. 4301).

1589. Prof. Town also did not validate his allocation of price effect between St. Luke's and ProMedica. (Town, Tr. 4307).

Response to Finding No. 1589

This proposed finding is misleading. The *total* harm to consumers implied by the model remains the same, regardless of how the predicted price effect is allocated between St. Luke's and ProMedica. (PX02148 at 108 (Technical Appendix ¶ 28) (Town Expert Report), *in camera*).

1590. Prof. Town performs this allocation by using diversion ratios that are calculated using data which includes DRGs outside his defined relevant product market. (Town, Tr. 4299-4300).

Response to Finding No. 1590

Complaint Counsel has no specific response.

1591. However, the diversion rates Prof. Town uses were not calculated based upon a price increase at St. Luke's or at ProMedica. (Town Tr. 4301-4302).

Response to Finding No. 1591

This proposed finding is misleading. The addition of a price variable to Professor Town's diversion analysis would be relevant only if within-network price differences across hospitals affected consumer and physician choices over hospitals. (*See* Town, Tr. 4301). The evidence indicates that this is not the case, as it demonstrates that health plans in Lucas County do not engage in in-network steering and that physicians and patients do not choose hospitals based on differences in the rates that health plans pay. (CCPFF ¶¶ 539-628).

1592. Prof. Town's methodology for estimating the change in price at ProMedica and St. Luke's post-joinder does not take into consideration any response by rivals. (Town, Tr. 4309).

Response to Finding No. 1592

This proposed finding is misleading. The weight of the evidence indicates that the presence of ProMedica's rivals, Mercy and UTMC, will not be able to constrain the exercise of the additional bargaining leverage ProMedica gained from the Acquisition. (*See generally* CCPFF ¶¶ 478-628). The weight of the evidence also indicates that potential or actual entry is unlikely to discipline ProMedica in the foreseeable future. (*See generally* CCPFF ¶¶ 703-778).

1593. Prof. Town agrees that hospitals generally negotiate prices over a broad range of services, and, therefore, he uses a broader set of DRGs to calculate his willingness-to-pay model than he uses in his definition of relevant product market. (Town, Tr. 4295-4296).

Response to Finding No. 1593

This proposed finding is incomplete. Because reimbursement contracts usually cover a broad range of inpatient services, one must account for the possibility that a contract's reimbursement methodology might compensate services within the relevant product markets differently than services outside the relevant product markets. (Town, Tr. 3731, *in camera*). Calculating prices over the full range of inpatient general acute care services prevents such

variations in reimbursement methodology from biasing the calculations and preventing a meaningful comparison of prices. (Town, Tr. 3731, *in camera*).

1594. Prof. Town's model shows that UTMC has the lowest willingness-to-pay per person, but UTMC is the most unique hospital in Lucas County and has few proximate hospitals, thus, it should have a high willingness-to-pay per person. (Town, Tr. 3874-3879).

Response to Finding No. 1594

This proposed finding is unsupported by the citation, as the portion following the first comma has no basis in the cited testimony. (*See* Town, Tr. 3874-3879).

1595. Prof. Town's merger simulation model also cannot predict *when* ProMedica will be able to raise St. Luke's rates, only that it would occur over time. (Town, Tr. 4256).

Response to Finding No. 1595

This proposed finding is misleading. The Willingness-to-Pay regression model is a tool to predict the effect of the elimination of competition on prices – that is, to isolate and quantify the Acquisition's impact on the bargaining leverage of the merged hospitals. (Town, Tr. 3883).

1596. In general, merger simulation models have been shown to yield imprecise predictions than what is shown to actually occur in a merger case when studied after the fact. (Guerin-Calvert, Tr. 7511-7512). {

} (Guerin-Calvert, Tr. 7437*, in camera*)

Response to Finding No. 1596

This proposed finding is incomplete and misleading. Other scholars' analysis of the Willingness-to-Pay merger simulation model has shown it to make accurate and conservative estimates of the impact of hospital mergers. (PX01850 at 063-064 (¶ 97) (Town Rebuttal Report), *in camera*). Additionally, the negotiations between ProMedica (on behalf of St. Luke's) and MMO took place during the FTC's investigation and challenge of the Acquisition and under restrictions of the Hold-Separate Agreement between the FTC and ProMedica, which obligated ProMedica to give health plans the option to extend their existing rates with ProMedica through

the duration of the Hold-Separate Agreement. (*See* CCPFF ¶¶ 2, 54-56, 1240-1242). Rates negotiated after the Acquisition but while the Acquisition is being scrutinized on antitrust grounds are not good proxies for post-Acquisition equilibrium rates. (PX01850 at 049 (¶ 76) (Town Rebuttal Report), *in camera*). Given ProMedica's incentive to present the Acquisition as competitively benign in this proceeding, it stands to reason that PHS will refrain from exercising all of its market power, lest it create damning evidence against itself. (PX01850 at 049 (¶ 76) (Town Rebuttal Report), *in camera*). Moreover, the terms of the Hold-Separate Agreement further restrained ProMedica's bargaining power. (PX01850 at 050 (¶ 76) (Town Rebuttal Report), *in camera*; *see also* CCPFF ¶ 1183).

4. Prof. Town's Conclusion that Competing Hospitals Cannot Constrain ProMedica Is Not Based on Actual Post-Joinder Data

1597. Prof. Town's willingness-to-pay model does not test whether patients or MCOs would prefer a Mercy-UTMC network offered at a lower price than a ProMedica-St. Luke's network because the price to employers and consumers of the network does not factor into the calculation of willingness-to-pay. (Town, Tr. 4258).

Response to Finding No. 1597

This proposed finding is incomplete and against the weight of evidence. A Mercy-UTMC only network has never been offered, and testimony indicates it would not be marketable. (*See* CCPFF ¶¶ 503-538). The willingness-to-pay model calculates the value that consumers place on having a hospital in network. (Town, Tr. 3861-3682). The willingness-to-pay model can be used to compare the value of a network without ProMedica pre- and post-Acquistion. (Town, Tr. 3808-3809, *in camera*). The willingness-to-pay model assesses the value of a network comprised of Mercy, UTMC, and St. Luke's as 35% more valuable than a network of only Mercy and UTMC. (PX02148 at 165 (Exhibit 13) (Town Expert Report), *in camera*). Further, it is inappropriate to put price into willingness-to-pay because within network

reimbursement rates from health plans do not affect hospital choice. (Town, Tr. 4301; PX01953 at 038; Town Dep., 144; *cf*. Town, Tr. 3800, *in camera*).

1598. Prof. Town has not done any analysis to determine at what price a UTMC-Mercy network would be marketable for MCOs. (Town, Tr. 4323-4324).

Response to Finding No. 1598

This proposed finding is irrelevant and against the weight of evidence. Health plans have testified that a network of Mercy and UTMC has never been offered, and would not be marketable. (*See* CCPFF ¶¶ 503-538; Response to RPFF ¶ 1597).

1599. Prof. Town bases his opinion that the presence of Mercy and UTMC will not prevent ProMedica from raising prices on the differences in market share between Mercy and ProMedica, the differences in share between a network that includes ProMedica and St. Luke's compared to one that includes just Mercy and UTMC, and the difference in his estimated post-acquisition willingness-to-pay for a network with ProMedica and St. Luke's as opposed to a network comprised only of Mercy and UTMC. (Town, Tr. 4253-4254).

Response to Finding No. 1599

This proposed finding is incomplete. Professor Town also relies on the testimony of health plans that a network of Mercy and UTMC has never been offered, and would not be marketable. (*See* CCPFF ¶¶ 503-538; *see also* Town Tr. 3827-3828, *in camera*).

1600. The differences in shares that Prof. Town uses are for the period July 2009 through March 2010, less than one year. (Town, Tr. 4254).

Response to Finding No. 1600

Complaint Counsel has no specific response except to note that Professor Town utilized this data because it was the most recent data available from the date at which St. Luke's re-entered Anthem's network. (Town, Tr. 4254). Further, Professor Town's calculations of market shares comport with ordinary course shares from ProMedica and other market participants. (*See e.g.* PX02290, *in camera*; PX01352; PX01235).

1601. For the post-joinder share configurations, Prof. Town rearranged the shares that existed prior to the joinder; he did not measure how the shares for ProMedica and St. Luke's have changed since the joinder was consummated on September 1, 2010. (Town, Tr. 4254).

Response to Finding No. 1601

This proposed finding is misleading. Since post-Acquisition data are not available, Respondent's expert also did not evaluate post-Acquisition shares. (Town, Tr. 4254).

1602. There is no actual share data showing the results of a ProMedica-St. Luke's network competing against a Mercy-UTMC network. (Town, Tr. 4254-4255).

Response to Finding No. 1602

This proposed finding is irrelevant. Post-Acquisition data are not available and a Mercy-UTMC network has not existed for at least twenty years. Thus it is impossible to perform the share comparison. (Town, Tr. 4254; *see* CCPFF ¶¶ 509-513).

1603. Moreover, one cannot calculate a difference in price from a change in market shares alone. (Guerin-Calvert, Tr. 7476-7480).

Response to Finding No. 1603

This proposed finding is incomplete. Market shares are suggestive of price differences in this matter as Professor Town found a correlation between market share and prices, and there is no evidence that other factors explain price differences. (Town, Tr. 3645-3646; *see* Response to RPFF ¶ 1597.).

1604. There is not enough data available to be able to explain the price levels, such as how an MFN clause affected the price levels, how the point at which the contract was negotiated affected prices, whether a contract was likely to be re-negotiated or adjusted, how the prices take into account trade-offs between inpatient and outpatient prices, and the general strategy of each party. (Guerin-Calvert, Tr. 7477-7479).

Response to Finding No. 1604

The proposed finding is vague and misleading. Respondent can point to no evidence on the record that these factors impacted price levels. Respondent's expert did not calculate prices

or test Professor Town's calculations of these prices to account for these factors. (*See* CCPFF ¶¶ 1162-1167). Further, health plans perform price comparisons in the ordinary course without looking to these factors and relies on these calculations to guide important business decisions and strategies. (*See e.g.* Radzialowski, Tr. 849-851; Pugliese, Tr. 1512-1514, *in camera*; Pirc, Tr. 2228-2229, *in camera*; Wakeman, Tr. 3037). Professor Town's case-mix adjusted prices capture the effect of MFN clauses, the point in time at which the contract was negotiated, and the general strategy of each party in that they capture the relevant consideration: the systematic difference in price across hospitals for a given patient population. (PX01850 at 066 (¶ 101) (Town Rebuttal Report), *in camera*). Respondent's expert has put forward no evidence in this matter that trade-offs between inpatient and outpatient prices occur in the Toledo market. (PX01850 at 036 (¶ 58) (Town Rebuttal Report), *in camera*). Professor Town's analysis is based on more than 130,000 discharge events, and his results have a high degree of precision. (PX02148 (Technical Appendix at ¶ 15) (Town Expert Report), *in camera*; PX01850 at 066 (¶ 101) (Town Rebuttal Report), *in camera*; PX02148 (Ex. 18) (Town Expert Report), *in camera*).

1605. Prof. Town has not attempted to quantify his predicted higher out-of-pocket expenses, reduced coverage, or lower wages that will be passed on to employees as a result of the joinder. (Town, Tr. 4346-4347).

Response to Finding No. 1605

This proposed finding is incomplete and misleading. Professor Town quantified the total harm that results from increases in ProMedica's bargaining leverage as a result of the Acquisition. CCPFF ¶¶ 445-477. Testimony from health plans and employers confirms that these price increases will be passed on. CCPFF ¶¶ 76-91. Further, Professor Town testified that a welfare loss will still occur if employers do not pass along all of the increases, as it will raise the cost of labor to the employer thereby reducing employment. (Town, Tr. 3604).

5. Prof. Town Can Cite No Post-Joinder Evidence of Reduced Non-Price Competition

1606. Prof. Town cannot cite any evidence that post-joinder there had been a reduction in non-price competition. (Town, Tr. 4330-4331).

Response to Finding No. 1606

This proposed finding is misleading. ProMedica is prohibited by the Hold Separate Agreement from consolidating services provided at St. Luke's. (PX00069 at 001 (Hold Separate Agreement). Further, Professor Town testified that the Acquisition reduces the incentives for hospitals to compete on nonprice dimensions. (Town, Tr. 3605).

1607. Nor has Prof. Town attempted to quantify his statement that quality-promoting, non-price competition will be eliminated as a result of the joinder. (Town, Tr. 4332-4333).

Response to Finding No. 1607

This propsed finding is misleading. (*See* Response to RPFF ¶ 1606).

1608. Prof. Town has not examined any evidence of adverse patient outcomes specifically resulting from the joinder, nor has he examined how future patient outcomes will change as a result of the joinder. (Town, Tr. 4348).

Response to Finding No. 1608

This propsed finding is misleading. (*See* Response to RPFF ¶ 1606).

1609. There is no evidence of longer patient wait times or a reduction in patient care as a result of the joinder. (Town, Tr. 4348-4349).

Response to Finding No. 1609

This propsed finding is misleading. (*See* Response to RPFF ¶ 1606).

6. Prof. Town Has Not Analyzed the Effects of the Joinder on the Inpatient Obstetrical Services Market Defined by the Complaint

1610. Prof. Town's merger simulation model combines his inpatient OB services and general acute care inpatient services into one price effect. (Town, Tr. 4290-4291).

Response to Finding No. 1610

This proposed finding is misleading. This approach is consistent with the way hospitals and health plans negotiate for services. (*See* CCPFF ¶¶ 92-188; *see generally* RPFF ¶¶ 1094-1104).

1611. Prof. Town provides no evidence, prediction or expectation of the predicted price in his inpatient OB services market. (Guerin-Calvert, Tr. 7163-7165).

Response to Finding No. 1611

This proposed finding is misleading. A hospital could limit additional bargaining leverage over rates for obstetrics services through the use of already-utilized case rates or it could be spread across a broader set of services. (Town, Tr. 4291). Professor Town's model does not preclude this possibility.

IV. Absent the Joinder, St. Luke's Financial Condition Would Have Diminished Its Competitive Significance

A. St. Luke's Pre-Joinder Financial Condition Was Weak and Deteriorating

1. Operational Losses and Deteriorating Financial Performance

1612. St. Luke's suffered from poor operating financial performance throughout the 2000s, breaking even and making money in only two years. (RX-33 (Deacon, IHT at 76)).

Response to Finding No. 1612

This proposed finding is inaccurate and against the weight of the evidence. According to figures submitted to this court by Kathleen Hanley, St. Luke's CFO, St. Luke's generated positive operating cash flow in all years from 2000 through 2008, and was profitable during four years since 2000. (PX02129 at 002 (Ex. 1) (Hanley, Decl.)). St. Luke's total net revenues increased from $104,662 in 2000 to $147,707 in 2009, and an annualized $156,114 in 2010 (based on St. Luke's performance through August 31, 2010). (PX02129 at 002 (Ex. 1) (Hanley, Decl.)). Until the 2008 recession, St. Luke's had grown its unrestricted cash and investments to $82 million. (PX02129 at 002 (Ex. 1) (Hanley, Decl.)). During the decade, St. Luke's spent an

average of over $11 million per year on capital expenditures. (PX02147 at 014 (¶ 28) (Dagen Expert Report)). Mr. Dagen's analysis revealed that, throughout the last decade, St. Luke's has consistently provided high quality patient care, invested in its operations, and increased its patient volume. (PX02147 at 019 (¶ 37) (Dagen Expert Report)).

In contrast to the weight of the evidence discussed above, this proposed finding is also unreliable because it cites a single source: the September 2010 investigational hearing of a witness, Doug Deacon, who did not testify in this court and who is not even a financial executive. (*See* CCPFF ¶ 1583-1584). Mr. Den Uyl, Respondent's financial expert, testified that he did not seriously consider St. Luke's financial condition prior to the mid-2000s in his analysis. (Den Uyl, Tr. 6416-6417).

1613. The most important time period in analyzing St. Luke's financial viability is from 2008 when Mr. Wakeman arrived, through 2010 when the joinder occurred. (Dagen, Tr. 3337-3338).

Response to Finding No. 1613

Complaint Counsel has no specific response.

1614. Respondent's financial expert, Mr. Den Uyl, focused his analysis on the time period starting with Mr. Wakeman's arrival, through 2010 when the joinder occurred. He also included 2007, just before Mr. Wakeman's arrival, to help him assess what, if any, impact Mr. Wakeman had and to account for any distortions that might be caused by the financial crisis in 2008. (Den Uyl, Tr. 6416-6417).

Response to Finding No. 1614

Complaint Counsel has no specific response.

1615. To determine whether St. Luke's could be a viable competitor as an independent community hospital, one has to remove any of the effects that the joinder might have had on St. Luke's financial performance. It would be inappropriate to incorporate any post-joinder effects. (Dagen, Tr. 3353-3354).

Response to Finding No. 1615

This finding is incorrect and misleading, and it misstates the testimony of Mr. Dagen, to the extent it implies that all of St. Luke's financial performance after August 31, 2010 is an "effect" of the Acquisition. Mr. Dagen did not testify that all post-Acquisition performance must be attributed to the Acquisition; rather, a proper assessment of St. Luke's financial performance but-for the Acquisition requires removing *only* those positive effects the Acquisition had on St. Luke's that St. Luke's would not have accomplished on its own as a standalone hospital. (*See* Dagen, Tr. 3354).

Indeed, Mr. Dagen's analysis of St. Luke's financial performance in the last four months of 2010 controls for and eliminates the distortionary effects of any benefits that St. Luke's derived from being acquired by ProMedica. (*See, e.g.*, PX02147 at 013 (¶ 26 n.22) (Dagen Expert Report) (Mr. Dagen removes $5 million when calculating St. Luke's reserve fund at the end of 2010 in order to account for the fact that ProMedica transferred that money to St. Luke's Foundation under the terms of the Joinder Agreement); *see also* PX01852 at 010 (¶ 13 n.31) (Dagen Rebuttal Report)).

St. Luke's financial performance during the last four months of 2010 was informative to Mr. Dagen's analysis because it allowed him to assess whether St. Luke's upward financial trend at the time of the Acquisition continued after August 31, 2010. (Dagen, Tr. 3193-3194). Further, looking at St. Luke's *actual* post-Acquisition performance allowed Mr. Dagen to "test the reliability" of the assumptions he used in a pro forma analysis quantifying St. Luke's *projected* financial performance absent the Acquisition. (Dagen, Tr. 3193-3194). Mr. Dagen found that St. Luke's *actual* financial performance post-Acquisition – after removing the impact of any alleged benefits attributed to the Acquisition – confirmed the reasonableness of the assumptions and results of his pro forma analysis. (Dagen, Tr. 3193-3196, 3358). The analysis

suggested to Mr. Dagen that, if anything, his projections were "extremely conservative."

(Dagen, Tr. 3196).

1616. OhioCare, St. Luke's parent, experienced significant financial losses from 2007 through the joinder in 2010. OhioCare's operating loss was $8.2 million in 2007, $12.7 million in 2008, $20.3 million in 2009, and $7.7 million in the first eight months of 2010. This amounted to operating margins of -6.2 percent in 2007, -9.1 percent in 2008, -13 percent in 2009, and -6.9 percent for the first eight months of 2010. (Den Uyl, Tr. 6418-6419; RX-56 at 000006, *in camera*).

Response to Finding No. 1616

Complaint Counsel has no specific response.

1617. St. Luke's itself also experienced high financial losses. St. Luke's loss was $7.6 million in 2007, $8.8 million in 2008, $15.1 million in 2009, and $2.7 million for the first eight months of 2010. This amounted to operating margins of -5.9 percent in 2007, -6.5 percent in 2008, -10.3 percent in 2009, and -2.6 percent in the first eight months of 2010. (Den Uyl, Tr. 6418-6419; RX-56 at 000006, *in camera*; Dagen, Tr. 3304-3305).

Response to Finding No. 1617

Complaint Counsel has no specific response.

1618. St. Luke's operating performance was significantly below that of other Ohio hospitals. St. Luke's had negative operating margins in the years leading up to the joinder, while other Ohio hospitals were profitable. The average operating margin for Ohio hospitals was 4.0 percent in 2007, 1.5 percent in 2008, and 5 percent in 2009. (Den Uyl, Tr. 6420-6421; RX-56 at 000006, *in camera*).

Response to Finding No. 1618

Complaint Counsel has no specific response.

1619. St. Luke's operating performance was significantly below that of similarly sized (100-249 beds) non-profit urban hospitals. St. Luke's had negative operating margins in the years leading up to the joinder, while those other hospitals were profitable. The average operating margin for similarly sized non-profit urban hospitals was 3.2 percent in 2007, 1.8 percent in 2008, and 3 percent in 2009. (Den Uyl, Tr. 6420-6421; RX-56 at 000006, *in camera*).

Response to Finding No. 1619

Complaint Counsel has no specific response.

1620. St. Luke's operating performance was significantly below that of hospitals with comparable Moody's bond ratings as St. Luke's. St. Luke's had negative operating margins in the years leading up to the joinder while those other hospitals were profitable. The average operating margin for Moody's A-2 rated hospitals was 2.6 percent in 2007 when St. Luke's bond rating was A-2; the average operating margin for Moody's Baa1 rated hospitals was 0.3 percent in 2008 and 1.6 percent in 2009 when St. Luke's bond rating was Baa1. (Den Uyl, Tr. 6420-6422; RX-56 at 000006, *in camera*).

Response to Finding No. 1620

Complaint Counsel has no specific response.

1621. EBITDA is earnings before interest, taxes, depreciation, and amortization. EBITDA is calculated by adding interest, depreciation, taxes, and amortization expenses to the operating income. (Den Uyl, Tr. 6424-6425; RX-56 at 000006, *in camera*).

Response to Finding No. 1621

Complaint Counsel does not disagree.

1622. EBITDA does not reflect the true cash flow of a hospital because it does not consider capital expenditures. At certain times, it also does not reflect pension expenses or gains and losses from investments. These items need to be examined as well to get a full picture of the true cash flow of a hospital. (Den Uyl, Tr. 6427-6428).

Response to Finding No. 1622

Complaint Counsel has no specific response.

1623. Improving EBITDA does not necessarily indicate financial strength. (Dagen, Tr. 3188).

Response to Finding No. 1623

Complaint Counsel has no specific response.

1624. EBITDA is not a number that can be obtained off of the financial statements; it needs to be calculated. (Den Uyl, Tr. 6427; Dagen Tr. 3313).

Response to Finding No. 1624

Complaint Counsel has no specific response.

1625. OhioCare's EBITDA and EBITDA margin were negative from 2008 through the joinder. (Dagen, Tr. 3313-3314).

} (RX-56 at 000007, *in camera*).

Response to Finding No. 1625

Complaint Counsel has no specific response.

1626. {

} (Den Uyl, Tr. 6591-6592, *in camera*).

Response to Finding No. 1626

Complaint Counsel has no specific response.

1627. {

} (RX-56 at 000007, *in camera*).

Response to Finding No. 1627

This proposed finding is incomplete because it omits St. Luke's EBITDA margin during the first eight months of 2010, which was positive 3.8%, as well as the EBITDA margin during that same time period for comparably rated hospitals, which is not included in Mr. Den Uyl's analysis. (*See* RX-56 at 000007 (Table 3) (Den Uyl Expert Report), *in camera*).

1628. {

} (RX-56 at 000007, *in camera*).

Response to Finding No. 1628

This proposed finding is incorrect and incomplete. Mr. Den Uyl relied on a flawed and misleading financial metric to estimate St. Luke's cash flow. (CCRFF ¶¶ 1213-1216). Mr. Den Uyl's "operating cash flow minus capital expenditures" metric is in fact flawed because it is "based on the incorrect premise that cash flow from operations must be sufficient to cover the entire cost of capital expenditures in a given year." (PX01852 at 011-012 (¶¶ 15-17) (Dagen Rebuttal Report)). Further, the metric can provide meaningless results because it does not take

into account the value of a hospital's reserve fund. (Dagen, Tr. 3227; Den Uyl, Tr. 6539). Whereas operating cash flow minus capital expenditures was not used by St. Luke's in its ordinary course, there is extensive evidence in the record that EBITDA is a commonly used proxy for cash flow, and that it is used in the ordinary course by both St. Luke's and ProMedica. (*See* Response to RPFF ¶ 1632; PX01852 at 011-012 (¶¶ 16) (Dagen Rebuttal Report)).

1629. It is important to consider capital expenditures as part of the measurement of a hospital's true cash flow, because hospitals are very capital intensive. They need to spend much capital, "just to stay even." (Den Uyl, Tr. 6431-6432).

Response to Finding No. 1629

Complaint Counsel has no specific response.

1630. St. Luke's could not have operated the hospital as a stand-alone hospital and met all the capital needs that it faced without access to some type of financing. (Johnston, Tr. 5459-5461).

Response to Finding No. 1630

This proposed finding is inaccurate, given St. Luke's substantial cash reserves at the time of the Acquisition. As of August 31, 2010, St. Luke's had approximately $65 million in cash and investment balances. (Joint Stipulations of Law and Fact, JX00002A ¶ 34). These substantial reserves are more than double the total capital needs alleged by Ms. Johnston. (Johnston, Tr. 5493-5494, *in camera* (claiming St. Luke's had in total capital needs)). The projects that Ms. Johnston alleged St. Luke's must complete are exactly the type of capital expenditures that St. Luke's reserve fund is intended to support. (*See* Response to RPFF ¶ 1635). Further, Mr. Black, Chair of St. Luke's Board, testified that he believed St. Luke's had the necessary financial resources to fund private room conversions and implementation of EMR. (Black, Tr. 5695-5696; *see also* CCPFF ¶ 1083).

1631. Operating cash flow and capital expenditures are reported on OhioCare's financial statements on the consolidated statement of cash flows. Operating cash flow and capital

expenditures are typically reported on a company's financial statements. (PX01006 at 007; Den Uyl, Tr. 6428-6429).

Response to Finding No. 1631

Complaint Counsel has no specific response.

1632. St. Luke's and ProMedica's executives considered operating cash flow in conjunction with capital expenditures in assessing the financial condition of their respective hospitals. (Den Uyl, Tr. 6432-6433; Wakeman, Tr. 3013-3014, *in camera*).

Response to Finding No. 1632

This proposed finding is incorrect and not supported by the cited testimony of Mr. Wakeman. In fact, Mr. Wakeman testified just the opposite at trial: St. Luke's executives "weren't really concentrating" on the financial metric "operating cash flow minus capital expenditures" and previous hospitals he worked at did not focus on the metric, either. (Wakeman, Tr. 2596-2597).

1633. {

} (RX-56 at 000008, *in camera*).

Response to Finding No. 1633

Complaint Counsel has no specific response.

1634. The cash flow losses that OhioCare, St. Luke's parent, was running from 2007 through the joinder were not sustainable, because St. Luke's could not draw down on its reserves indefinitely. St. Luke's was facing significant capital expenditures, and St. Luke's had to fund its underfunded pension plan. Moreover, St. Luke's struggling financial situation would make it more difficult for St. Luke's to borrow money. (Den Uyl, Tr. 6434-6435; RX-56 at 000015*, in camera*).

Response to Finding No. 1634

This proposed finding is incorrect and directly contradicted by the analysis of Mr. Dagen, who concluded that "[a]bsent the joinder, St. Luke's was heading toward further financial growth and stability in 2011 and beyond." (PX02147 at 006-007 (¶ 16) (Dagen Expert Report)). Mr.

Dagen reached this conclusion after he conducted a pro forma analysis of St. Luke's likely operating performance absent the Acquisition based on its financial trajectory as of August 31, 2010, and found that a standalone St. Luke's would have had adequate financial resources to "invest in its infrastructure, modernize its facilities, and remain a financially-sound independent hospital." (PX02147 at 006-007 (¶ 16) (Dagen Expert Report)). In contrast, Respondent's financial expert – who is the sole source cited for this proposed finding – did not provide any expert opinion or conclusions about how long St. Luke's would have survived absent the Acquisition, or whether its cash reserves would have been depleted at any point in the future due to capital needs. (Den Uyl, Tr. 6519-6522, 6588-6589*, in camera*; CCPFF ¶ 1202).

This proposed finding also misrepresents Mr. Den Uyl's testimony, in which he never makes any conclusion about St. Luke's ability to take on additional debt in the future absent the Acquisition. (Den Uyl, Tr. 6434-6435). Rather, Mr. Den Uyl explicitly testified that he has no expert opinion on whether St. Luke's, as a standalone hospital absent the Acquisition, could have issued additional debt. (Den Uyl, Tr. 6530-6531). In contrast, Complaint Counsel's expert witness, Errol Brick, concluded that a standalone St. Luke's was well positioned to issue as much as $75 million in debt at a reasonable interest rate. (Brick, Tr. 3483-3490).

1635. Reserve funds exist for emergency cash needs that may arise outside of normal operations. (Johnston Tr. 5521-5522).

Response to Finding No. 1635

This proposed finding, to the extent it implies that use of St. Luke's reserves is or should be limited to only emergency situations, is inaccurate and contradicted by an extensive body of evidence. Indeed, Ms. Johnston's own testimony indicates that emergency situations are only one – and not the *only* – proper use of the reserve fund. (Johnston, Tr. 5521-5522). OhioCare's audited financial reports indicate that St. Luke's reserves "include assets designated by the board

of directors for future capital improvements" as well as Foundation money that "exists for the sole purpose of supporting and promoting the activities and purposes of the Hospital." (PX01006 at 008, 010 (OhioCare Consolidated Financial Report Dec. 31, 2009); *see also* PX01264 at 003-004 (Articles of Incorporation stating that St. Luke's Foundation is "to operate exclusively for the benefit of and to carry out the purposes, activities and programs of and in connection with St. Luke's Hospital")).

Not a single other witness in this proceeding even suggested that St. Luke's reserves are intended for only emergency purposes. In fact, witnesses have testified to the contrary. St. Luke's CFO from 2003-2009, David Oppenlander, testified that St. Luke's reserves could be used to purchase "any types of capital . . . equipment, a table, chairs, anything that essentially is capital." (PX01933 at 042 (Oppenlander, Dep. at 161), *in camera*; CCPFF ¶¶ 1600-1601). Mr. Wakeman testified that St. Luke's reserves are intended to "fund [St. Luke's] strategic plan." (Wakeman, Tr. 2564). For instance, when St. Luke's made a strategic investment in four offsite imaging centers at the close of 2008, it paid with cash from its reserves. (PX01908 at 009 (Deacon, IHT at 27-28), *in camera*). Respondent's own expert witness, Mr. Den Uyl, testified that a hospital's reserves are "for capital expenditures, strategic capital expenditures" *or* "for unforeseen events." (Den Uyl, Tr. 6457, *in camera*).

1636. St. Luke's does not have a high level of reserves in comparison to other hospitals. (Johnston, Tr. 5522).

Response to Finding No. 1636

This proposed finding is contradicted by the weight of the evidence. Party witnesses like Mr. Wakeman (St. Luke's CEO) and third party fact witnesses like Bruce Gordon (AMBAC analyst) testified that St. Luke's had a substantial sum of reserves, particularly when compared to the size of its outstanding debt. (*See* Wakeman, Tr. 2568-2569; Gordon, Tr. 6858-6859). Even

expert witnesses representing Respondent and Complaint Counsel agreed on at least this one issue: Ms. Guerin-Calvert described St. Luke's "days of cash on hand" as "above its comparables" and Mr. Brick testified that St. Luke's cash-to-debt ratio was almost four times that of the average Moody's-rated hospital. (PX02136 at 060 (¶ 74) (Guerin-Calvert, Supp. Decl.), *in camera*; Brick, Tr. 3474).

1637. Because St. Luke's has a very low debt level, its cash-to-debt ratio is not the only measure that should be examined to assess the adequacy of its reserve funds. (Johnston, Tr. 5525-5526).

Response to Finding No. 1637

Complaint Counsel has no specific response.

1638. The metric that St. Luke's and bond rating agencies use to evaluate the state of its reserve fund is days cash on hand. (Johnston, Tr. 5527).

Response to Finding No. 1638

Complaint Counsel has no specific response.

1639. St. Luke's strives to have its days cash on hand at a level comparable to Aa-rated hospital organizations. (Johnston, Tr. 5527).

Response to Finding No. 1639

This proposed finding is misleading to the extent it implies that benchmarking to days cash on hand was St. Luke's practice prior to the Acquisition. Ms. Johnston never worked a single day at St. Luke's prior to the Acquisition, and the testimony cited in this proposed finding speaks only to St. Luke's practices post-Acquisition. (Johnston, Tr. 5306, 5527).

1640. The amount of days cash on hand held by Aa-rated institutions is about double what St. Luke's currently holds. (Johnston, Tr. 5527).

Response to Finding No. 1640

Complaint Counsel has no specific response.

1641. {
} (RX-56 at 000016, *in camera*).

Response to Finding No. 1641

Complaint Counsel has no specific response.

1642. {
} (Den Uyl, Tr. 6460, *in camera*).

Response to Finding No. 1642

This proposed finding is misleading to the extent it implies that St. Luke's was using significant sums of its reserve fund since 2007 in order to fund losses and capital commitments. In reality, the primary cause for the drop in the value of St. Luke's reserves since 2007 is the performance of the financial markets. (*See* PX00923 at 001 (Wakeman Mar. 2010 Email), *in camera* (despite the fact that a "drop in the financial markets in late 2008 accounted for a { } swing between the reserves and the defined benefit pension accounts[,]" St. Luke's has "only accessed the reserves for about { } on [sic] the past 24 months"); *see also* PX02147 at 025-026 (¶¶ 47-48) (Dagen Expert Report)).

1643. {
}
(Den Uyl, Tr. 6461, *in camera*).

Response to Finding No. 1643

This proposed finding is incomplete and misleading to the extent it implies that St. Luke's would have spent $1.7 million on capital expenditures in 2010 were it not participating in joinder negotiations with ProMedica. Mr. Den Uyl testified that St. Luke's capital spending was lower in the first eight months of 2010 than it was in the last four months of 2010 because St.

Luke's was "waiting for the [Acquisition] to go through." (PX01951 at 063 (Den Uyl, Dep. at 246-247), *in camera*; Den Uyl, Tr. 6567, *in camera*).

This proposed finding is also incomplete and misleading because it fails to account for the fact that, starting in 2009, St. Luke's began to lease some of its new equipment rather than buy it. (PX02147 at 035-036 (¶ 64) (Dagen Expert Report)). This new practice had the effect of decreasing St. Luke's capital expenditures, even though it continued to obtain needed equipment. (PX02147 at 035-036 (¶ 64) (Dagen Expert Report)).

1644. In 2010, St. Luke's "didn't really have the wherewithal to borrow money." St. Luke's "was not seeking to borrow money because it was running losses. And to borrow money would put more leverage on the hospital" and "put them in a more difficult situation." From a financial standpoint "it wouldn't have been prudent" for St. Luke's to borrow money. (Den Uyl, Tr. 6547).

Response to Finding No. 1644

This proposed finding is inaccurate and unsupported by the full body of evidence. Mr. Den Uyl pointed to no testimony or ordinary course documents to substantiate his conclusion – which was presented for the first time during his testimony in court, and was not expressed during his deposition or in his expert report – concerning St. Luke's "wherewithal to borrow money." (Den Uyl, Tr. 6547-6548). Indeed, there is no testimony or ordinary course evidence that indicates St. Luke's did not borrow – or did not attempt to borrow – in 2010 because it did not have the *capability* to do so. On the contrary, Mr. Brick concluded that investors and capital markets have an appetite for debt issuers of the medium grade risk that St. Luke's was rated pre-Acquisition, and that in August 2010, St. Luke's could have issued as much as $75 million in debt for a reasonable interest rate. (CCPFF ¶¶ 1017-1020). Mr. Den Uyl, on the other hand, has admitted that he has no expert opinion on whether St. Luke's would have been able to borrow funds – and if so, at what interest rate – absent the Acquisition. (CCPFF ¶¶ 1021-1022).

2. Pension Funding Challenges

1645. St. Luke's has two pension plans, a defined benefit pension plan and a 403(b) defined contribution pension plan. (Johnston, Tr. 5331).

Response to Finding No. 1645

Complaint Counsel has no specific response.

1646. A defined benefit pension plan promises employees certain benefits payable over a period of years upon retirement. That promise is backed by the assets in the pension plan account. The employer must contribute enough money to the plan to have sufficient assets to live up to the pension plan's obligations. (Arjani, Tr. 6729).

Response to Finding No. 1646

Complaint Counsel does not disagree.

1647. {

} (Johnston, Tr. 5397, *in camera*).

Response to Finding No. 1647

Complaint Counsel has no specific response.

1648. Employers who offer a defined benefit pension plan face various risks, including the risk that plan assets may shrink through investment losses and that benefit obligations may increase due to higher salaries, longer life expectancies, or extended employee tenures. (Arjani, Tr. 6730).

Response to Finding No. 1648

Complaint Counsel has no specific response.

1649. The state of St. Luke's pension funding in early 2009 was "shocking." Where St. Luke's pension fund had been about 108 percent funded at the end of 2007 it was about 63 percent funded at the end of 2008 and there was an approximately $50 million shortfall in the funding requirement which had to be booked as a current liability for 2008. (Wakeman, Tr. 2838-2839).

Response to Finding No. 1649

This proposed finding is misleading to the extent it implies that St. Luke's $50 million pension liability determined St. Luke's cash funding requirement for its pension plan, which it did not. (*See* Response to RPFF ¶ 1652). Further, the proposed finding is also misleading and

incomplete because St. Luke's pension liability improved to approximately { } by December 31, 2010. (RX-214 at 000001 (St. Luke's Pension Plan Financial Statement Disclosure), *in camera*).

1650. { } (Den Uyl, Tr. 6451-6452, *in camera*).

Response to Finding No. 1650

Complaint Counsel has no specific response.

a. St. Luke's Defined Benefit Pension Plan Was Under-Funded According to Both Primary Measures of a Pension Plan's Financial Status

1651. There are two primary ways that the health of a defined benefit pension plan is evaluated. On the one hand, plans are examined according to generally accepted accounting principles; they are also examined under rules established by ERISA, as modified by the Pension Protection Act. (Johnston, Tr. 5331-5332; Arjani, Tr. 6731-6732).

Response to Finding No. 1651

Complaint Counsel has no specific response.

1652. { } (Arjani, Tr. 6768, *in camera*).

Response to Finding No. 1652

This proposed finding is misleading to the extent it implies that there are no differences in the financial ramifications of the funded status according to accounting rules and the funded status according to ERISA rules. A pension fund's funded status based on accounting rules (*i.e.*, "pension liability") has no impact on the cash contributions that a company must make into its pension fund; as a result, it does not reflect an actual cash obligation. (Arjani, Tr. 6767-6768, *in camera*; PX01951 at 043 (Den Uyl, Dep. at 168), *in camera*). A pension fund's ERISA funded status (*i.e.*, "AFTAP") is the only figure that determines the cash contributions a company like

St. Luke's is required to make into its pension fund. (*See* Arjani, Tr. 6757, *in camera*; PX01951 at 043 (Den Uyl, Dep. at 167), *in camera*; *see also* CCPFF ¶¶ 998-1003). Despite fluctuations in its funded status under the accounting rules, St. Luke's has never been certified with an ERISA funded status of below 80% and, therefore, has never been "at risk." (CCPFF ¶¶ 1002-1003).

1653. At the close of the joinder, St. Luke's defined benefit pension plan was under-funded from both an accounting and funding perspective. (Johnston, Tr. 5336).

Response to Finding No. 1653

Complaint Counsel does not disagree.

b. St. Luke's Pension Plan Was Significantly Under-Funded according to Accounting Calculations Used for Determining the Plan's Liability on St. Luke's Financial Statements

1654. The "accounting calculation" determines the liability that must be entered on an organization's annual financial statements. {

} (Johnston, Tr. 5331; Johnston, Tr. 5389, *in camera*).

Response to Finding No. 1654

Complaint Counsel has no specific response.

1655. The accounting liability is essentially the difference between the market value of the plan's assets and its projected benefit obligation. The liability is calculated by outside actuaries and audited by external auditors. (Johnston, Tr. 5331-5332; Arjani, Tr. 6731; Arjani, Tr. 6742, *in camera*).

Response to Finding No. 1655

Complaint Counsel has no specific response.

1656. The accounting liability is an important measure of a defined benefit pension plan's health that is reviewed by an organization's board members and rating agencies. (Johnston, Tr. 5331).

Response to Finding No. 1656

Complaint Counsel has no specific response.

1657. {

} (Johnston, Tr. 5391, *in camera*; PX01006 at 002).

Response to Finding No. 1657

Complaint Counsel does not disagree.

1658. {

} (Johnston, Tr. 5391, *in camera*; Arjani, Tr. 6743, *in camera*; RX-214 at 000001, *in camera*).

Response to Finding No. 1658

Complaint Counsel has no specific response.

1659. {

} (Johnston, Tr. 5395-5396*, in camera*; Arjani, Tr. 6743-6745, *in camera*; RX-214 at 000001*, in camera*).

Response to Finding No. 1659

This proposed finding is misleading and incomplete because it fails to present St. Luke's pension liability as of December 31, 2010, at which point in time it had improved by {

} from its August 31, 2010, level as a result of improvements in the financial markets. (*See* CCPFF ¶ 1012; see also Dagen, Tr. 3165-3166).

c. St. Luke's Pension Plan Was Also Significantly Under-Funded according to Funding Calculations Used for Compliance with Federal Statutes

(i) ERISA, as Modified by the Pension Protection Act, Defines the Rules To Assess Pension Plan Funding Requirements

1660. A separate funding calculation analysis conducted under the ERISA rules determines the funding level of a defined benefit pension plan by comparing the "funding target" of the plan to the actuarial value of the assets of the plan. (Johnston, Tr. 5332; Arjani, Tr. 6731).

Response to Finding No. 1660

Complaint Counsel has no specific response.

1661. The "funding target" is an assessment for ERISA purposes of the benefit obligations of the pension plan. It is calculated by examining the census of plan participants, which provides data on how long employees have been with the employer and the level of their accrued pension benefits, as well as the level of accrued benefits for retirees and terminated vested employees who are entitled to future benefits. (Arjani, Tr. 6779).

Response to Finding No. 1661

Complaint Counsel has no specific response.

1662. {

} (Arjani, Tr. 6757-6758, *in camera*).

Response to Finding No. 1662

Complaint Counsel does not disagree.

(ii) Under Federal Law, Employers Must Bring Their Defined Benefit Pension Plans to 100 Percent Funding

1663. Each year, actuaries are required to certify the funding level of St. Luke's defined benefit pension plan. (Johnston, Tr. 5333, 5337-5338).

Response to Finding No. 1663

Complaint Counsel has no specific response.

1664. Under ERISA, as modified by the PPA, if St. Luke's defined benefit pension plan is less than 100 percent funded, it is required to amortize the amount of the under-funding and make payments over seven years to bring the plan to 100 percent funding. (Arjani, Tr. 6736-6737; Den Uyl, Tr. 6446-6447*, in camera*).

Response to Finding No. 1664

This proposed finding is incomplete because, depending on how the financial markets perform, St. Luke's pension fund could return to a 100% funded status without the need for any additional cash contributions into the plan. (*See* PX01943 at 009 (Arjani, Dep. at 30-33), *in camera*).

1665. Even if St. Luke's is able to make current payments to its defined benefit pension plan beneficiaries, it must still restore the plan to full funding. (Johnston, Tr. 5343).

Response to Finding No. 1665

Complaint Counsel has no specific response.

1666. Actuaries calculate the amount of contributions required for St. Luke's defined benefit pension plan; the required annual contributions are made on a quarterly basis. Depending on the actuarial valuation of the plan, additional contributions beyond the planned quarterly payments may be required to satisfy the annual contribution requirement. (Arjani, Tr. 6737-6738).

Response to Finding No. 1666

Complaint Counsel has no specific response.

1667. { } (Arjani, Tr. 6759-6760, *in camera*).

Response to Finding No. 1667

Complaint Counsel has no specific response.

1668. { } (Arjani, Tr. 6759-6760*, in camera*).

Response to Finding No. 1668

Complaint Counsel has no specific response.

(iii) Employers May Need To Accelerate Funding To Prevent Pension Plans from Being Under 80 Percent Funded

1669. { } (Arjani, Tr. 6758-6759, *in camera*; RX-56 at 000011, *in camera*.)

Response to Finding No. 1669

Complaint Counsel does not disagree.

1670. If a plan falls below 80 percent funding, an employer may be required to accelerate contributions into the plan in order to get the plan above the 80 percent level. (Johnston, Tr. 5336-5337).

Response to Finding No. 1670

Complaint Counsel has no specific response.

1671. Accelerating payments means that payments made during the current plan year are re-allocated to the prior plan year for purposes of measuring the funding level of the plan as of January 1st of the current year. (Arjani, Tr. 6739).

Response to Finding No. 1671

Complaint Counsel has no specific response.

1672. {

} (Johnston, Tr. 5397, 5400, *in camera*).

Response to Finding No. 1672

Complaint Counsel does not disagree.

1673. If St. Luke's plan risks being certified below 80 percent funded, its actuaries will notify St. Luke's and recommend corrective actions that can be taken. (Johnston, Tr. 5339).

Response to Finding No. 1673

Complaint Counsel has no specific response.

1674. Prior to January 1, 2011, St. Luke's obtained actuarial services for its defined benefits pension plan from Towers Watson; after that date, Findley Davies replaced Towers Watson. (Johnston, Tr. 5342; Arjani, Tr. 6723-6724).

Response to Finding No. 1674

Complaint Counsel has no specific response.

d. St. Luke's Had To Accelerate Contributions to Its Pension Plan in 2010 To Attain the 80 Percent Funding Level as of January 1, 2010

1675. In order to be certified as 80 percent funded as of January 1, 2010, St. Luke's had to accelerate contributions from 2010 into 2009 and also had to apply or "forfeit" a credit balance. (Arjani, Tr. 6739-6740; PX01397).

Response to Finding No. 1675

Complaint Counsel has no specific response.

1676. St. Luke's applied approximately $800,000 from its 2010 plan year contributions back to the 2009 plan year. (Arjani, Tr. 6739; PX01397; Johnston, Tr. 5401, *in camera*; PX01392 at 005, *in camera*).

Response to Finding No. 1676

Complaint Counsel has no specific response.

1677. At the same time, St. Luke's also forfeited its prior credit balance of approximately $1.4 million dollars. (Arjani, Tr. 6739-6740; PX01397; PX01392 at 005, *in camera*).

Response to Finding No. 1677

Complaint Counsel has no specific response.

1678. As a result of forfeiting the credit balance and reallocating 2010 plan year contributions to the 2009 plan year, St Luke's was able to get its defined benefit pension plan to 80 percent funding. (Arjani, Tr. 6739; PX01392 at 006*, in camera*).

Response to Finding No. 1678

Complaint Counsel has no specific response.

1679. {

} (Johnston, Tr. 5402, *in camera*; PX01392*, in camera*).

Response to Finding No. 1679

Complaint Counsel does not disagree.

e. St. Luke's Also Had To Accelerate Contributions in 2011 To Achieve 80 Percent Funding as of January 1, 2011

1680. {

} (Johnston, Tr. 5403-5404, *in camera*; PX00474 at 004, *in camera*).

Response to Finding No. 1680

Complaint Counsel has no specific response.

1681. {

} (Johnston, Tr. 5407, *in camera*; Arjani, Tr. 6748-6749*, in camera*; PX00474 at 004*, in camera*).

Response to Finding No. 1681

Complaint Counsel has no specific response.

1682. {

} (Johnston, Tr. 5406, *in camera*; Arjani, Tr. 6749, *in camera*; PX00474 at 001, *in camera*).

Response to Finding No. 1682

Complaint Counsel does not disagree.

1683. St. Luke's made the required $5 million contribution to its defined benefit pension plan prior to March 31, 2011. (Arjani, Tr. 6740-6741).

Response to Finding No. 1683

Complaint Counsel has no specific response.

1684. {

} (Johnston, Tr. 5408, *in camera*).

Response to Finding No. 1684

This proposed finding is incomplete because it is also possible that St. Luke's will not be required to make any additional cash contributions into its pension plan. (*See* Response to RPFF ¶ 1664).

1685. {

} (Arjani, Tr. 6751-6752, 6765, *in camera*).

Response to Finding No. 1685

This proposed finding is incomplete because there are numerous assumptions in addition to the 8 percent return on plan assets that were used to calculate the annual funding requirement (*e.g.*, discount rates, employee terminations, and employee retirements). (PX01943

at 016 (Arjani, Dep. at 54-55), *in camera*). Furthermore, it is possible that St. Luke's required cash contributions will actually be lower than the estimated (Arjani, Tr. 6765, 6767, *in camera*).

3. Deferred Capital Needs

1686. Due to St. Luke's poor operating performance, the hospital had deferred basic capital investments for two years prior to the joinder. (Johnston, Tr. 5351).

Response to Finding No. 1686

This proposed finding is incorrect and directly contradicted by ordinary course evidence. Two years prior to the Acquisition, in 2008, St. Luke's spent $14 million on capital expenditures – $3 million above its historical average. (*See* Dagen, Tr. 3319-3320; RPFF ¶ 1706). In 2009 and 2010 St. Luke's spent $7 and $5 million on capital expenditures, (CCPFF ¶¶ 1051-1053); it continued to replace medical equipment as needed, and as of April 2010, Mr. Wakeman believed that St. Luke's capital spending was sufficient to enable St. Luke's to keep its plant and grounds in great condition. (Den Uyl, Tr. 6566-6567, *in camera*; Wakeman, Tr. 2615-2616; PX01279 at 002 (Apr. 2010 Wakeman Self-Evaluation)).

This proposed finding is also unreliable because it is supported solely by the testimony of an executive who never worked a single day at St. Luke's prior to the Acquisition. (Johnston, Tr. 5303, 5306). Respondent never called to the stand Dennis Wagner or David Oppenlander, the two individuals who actually held CFO positions at St. Luke's in the two years prior to the joinder.

1687. The type of basic capital expenditures that St. Luke's had been deferring included routine and ongoing upgrades of facilities and replacement of equipment, and not strategic or one-time expenditures like major new construction or the IT investments required for "meaningful use" compliance. (Johnston, Tr. 5351-5353).

Response to Finding No. 1687

This proposed finding is incorrect, unreliable and against the weight of the evidence. (*See* Response to RPFF ¶ 1686).

1688. Some examples of the type of routine capital expenditures that St. Luke's was forced to defer include the replacement of air handlers, patient beds, surgical tables, and a sleep lab system. (Johnston, Tr. 5354).

Response to Finding No. 1688

This proposed finding is misleading to the extent it implies that St. Luke's did not have the ability to pay for these projects as a standalone hospital. At the time of the Acquisition, St. Luke's had $65 million in cash and investments. (Joint Stipulations of Law and Fact, JX00002A ¶ 34). By contrast, Ms. Johnston's list of capital projects allegedly deferred by St. Luke's totals only $1.8 million. (Den Uyl, Tr. 6571-6572, *in camera*).

1689. St. Luke's deferred the purchase of two types of hospital beds: regular hospital beds and birthing beds. (Johnston, Tr. 5355).

Response to Finding No. 1689

Complaint Counsel has no specific response.

1690. The beds were beyond their useful life. Many were no longer supported by their manufacturers and were experiencing mechanical problems. (Johnston, Tr. 5355). The estimated cost of replacing the regular hospital beds was $150,000. (Johnston, Tr. 5356).

Response to Finding No. 1690

This proposed finding is misleading to the extent it implies that these hospital beds required immediate replacement. Respondent's actions, or lack thereof, contradict this proposed finding. Despite ProMedica's $1 billion in reserves and the fact that it would take only eight to fourteen weeks to purchase new hospital beds, ProMedica had still not purchased all of the new hospital beds for St. Luke's nearly a year after the Acquisition. (PX00015 at 004 (ProMedica and Subsidiaries Consolidated Financial Statements 2009: sum of "Cash and cash equivalents," "Marketable securities," and "Internally designated for capital acquisition" lines); Johnston, Tr.

5488, 5495-5496, *in camera*). This proposed finding is also inaccurate to the extent it implies that St. Luke's did not have the ability to pay for this project as a standalone hospital. (*See* Response to RPFF ¶ 1688).

1691. The purchase of new hospital beds had been deferred for several years. No specific date for replacement had been determined. (Johnston, Tr. 5356).

Response to Finding No. 1691

Complaint Counsel has no specific response.

1692. A birthing bed is a bed used in St. Luke's labor, delivery, recovery and postpartum area. It has many features a regular hospital bed does not have. (Johnston, Tr. 5356). A birthing bed cannot be replaced by a regular hospital bed. (Johnston, Tr. 5357).

Response to Finding No. 1692

Complaint Counsel has no specific response.

1693. St. Luke's needed to replace all 11 beds in its maternity unit, but had deferred doing so for several years. (Johnston, Tr. 5356-5357). The estimated cost of replacing all 11 birthing beds was $110,000. (Johnston, Tr. 5357).

Response to Finding No. 1693

Complaint Counsel has no specific response.

1694. St. Luke's had also deferred the purchase of areplacement radiographic surgical table used in urological surgeries that needed to be replaced, because it was beyond its useful life and its imaging quality had started to deteriorate. (Johnston, Tr. 5358). The estimated cost of replacing the radiographic surgical table was $450,000. (Johnston, Tr. 5358).

Response to Finding No. 1694

Complaint Counsel has no specific response.

1695. St. Luke's had also needed to replace its sleep lab system, because the existing system had been going down and interrupting patient care. A sleep lab is a department where patients come to be tested for sleep apnea. (Johnston, Tr. 5359).

Response to Finding No. 1695

Complaint Counsel has no specific response.

1696. The sleep lab system is software that tracks brain activity while the patient is sleeping. (Johnston, Tr. 5359). St. Luke's existing sleep lab software is old and no longer supported by the manufacturer. (Johnston, Tr. 5359). The estimated cost of replacing the sleep lab system is $125,000 to $150,000. (Johnston, Tr. 5359-5360).

Response to Finding No. 1696

This proposed finding is misleading to the extent it implies that the sleep lab system required immediate replacement. Respondent's actions, or lack thereof, contradict this proposed finding. Despite ProMedica's $1 billion reserves and the fact that, "start to finish[,]" it would only take three to four months to replace St. Luke's sleep lab system, ProMedica had still not replaced St. Luke's sleep lab system nearly a year after the Acquisition. (PX00015 at 004 (ProMedica and Subsidiaries Consolidated Financial Statements 2009: sum of "Cash and cash equivalents," "Marketable securities," and "Internally designated for capital acquisition" lines); Johnston, Tr. 5489, 5496-5497, *in camera*). This proposed finding is also inaccurate to the extent it implies that St. Luke's did not have the ability to pay for this project as a standalone hospital. (*See* Response to RPFF ¶ 1688).

1697. St. Luke's also had to replace two of the 31 air handlers that it has on its campus. (Johnston, Tr. 5360). An air handler system provides air temperature control for the hospital. (Johnston, Tr. 5360).

Response to Finding No. 1697

Complaint Counsel has no specific response.

1698. The two air handlers that require replacement are beyond their useful life and service the cafeteria, pulmonary life systems, and patient rooms in the intermediate care and intensive care units; an outage of these air handlers would mean that temperature control for these areas could not be maintained. (Johnston, Tr. 5360-5361). The estimated cost of replacing the air handlers is $250,000. (Johnston, Tr. 5361).

Response to Finding No. 1698

This proposed finding is misleading to the extent it implies that the air handlers required immediate replacement. Respondent's actions, or lack thereof, contradict this proposed finding.

Despite its $1 billion reserves, ProMedica had still not replaced St. Luke's air handlers nearly a year after the Acquisition. (PX00015 at 004 (ProMedica and Subsidiaries Consolidated Financial Statements 2009: sum of "Cash and cash equivalents," "Marketable securities," and "Internally designated for capital acquisition" lines); Johnston, Tr. 5497, *in camera*). This proposed finding is also inaccurate to the extent it implies that St. Luke's did not have the ability to pay for this project as a standalone hospital. (*See* Response to RPFF ¶ 1688).

1699. St. Luke's has also deferred replacement of its nurse call system. (Johnston, Tr. 5363). The nurse call system is the system patients use to contact a nurse when they need help in their rooms. (Johnston, Tr. 5362).

Response to Finding No. 1699

Complaint Counsel has no specific response.

1700. A nurse call system is a critical, core system for the hospital. A failing nurse call system poses a risk for patient care. (Johnston, Tr. 5363).

Response to Finding No. 1700

Complaint Counsel has no specific response.

1701. St. Luke's nurse call system is beyond its useful life, and keeps going down. (Johnston, Tr. 5362). The estimated cost of replacing St. Luke's nurse call system was approximately $700,000. (Johnston, Tr. 5363).

Response to Finding No. 1701

This proposed finding is misleading to the extent it implies that the nurse call system required immediate replacement. Respondent's actions, or lack thereof, contradict this proposed finding. Despite ProMedica's $1 billion in reserves and the fact that, "starting from scratch[,]" it would take only three months to replace St. Luke's nurse call system, ProMedica had still not replaced St. Luke's nurse call system nearly a year after the Acquisition. (PX00015 at 004 (ProMedica and Subsidiaries Consolidated Financial Statements 2009: sum of "Cash and cash equivalents," "Marketable securities," and "Internally designated for capital acquisition" lines);

Johnston, Tr. 5488, 5495, *in camera*). This proposed finding is also inaccurate to the extent it implies that St. Luke's did not have the ability to pay for this project as a standalone hospital. (*See* Response to RPFF ¶ 1688).

1702. St. Luke's also deferred the purchase of a backup transformer for the electrical substation that services all of the outpatient centers on the hospital campus, including laboratory and radiology sites and ambulatory physician practices. (Johnston, Tr. 5354-5355). Without the backup transformer, St. Luke's will lose power for the outpatient centers when the primary transformer is shut down for required testing. (Johnston, Tr. 5354-5355).

Response to Finding No. 1702

Complaint Counsel has no specific response.

1703. {

} (RX-22 (Perron, Dep. at 50-51, *in camera*)).

Response to Finding No. 1703

Complaint Counsel has no specific response.

1704. {

} (RX-22 (Perron, Dep. at 52, *in camera*)). {

} (RX-22 (Perron, Dep. at 52, *in camera*)). {

} (RX-22 (Perron, Dep. at 52, *in camera*)).

Response to Finding No. 1704

Complaint Counsel has no specific response.

1705. St. Luke's also deferred many other basic projects beyond these limited examples. (Johnston, Tr. 5361-5362).

Response to Finding No. 1705

This proposed finding is vague and misleading because Ms. Johnston did not specifically identify any additional deferred projects or estimate their costs. (*See* Johnston, Tr. 5361-5362).

1706. Prior to its capital spending freeze, St. Luke's normal annual capital spend was approximately $11-$12 million. (Johnston, Tr. 5352).

Response to Finding No. 1706

Complaint Counsel has no specific response.

1707. { } (Johnston, Tr. 5411-5412, *in camera*).

Response to Finding No. 1707

This proposed finding is inaccurate and misrepresents the testimony of Ms. Johnston. Ms. Johnston and the capital budget she discusses in her testimony indicate that St. Luke's identified in capital needs over the course of the (as misstated in the proposed finding). (*See* Johnston, Tr. 5411-5412, *in camera*; RX-679, *in camera*). In fact, there is not a single ordinary course document, nor any fact witness testimony, that indicates St. Luke's ever had anywhere near in capital needs for 2011 alone. (*See* CCPFF ¶¶ 1233-1235). In actuality, ordinary course documents and testimony suggest that the most St. Luke's has ever contemplated spending on capital projects in 2011 is less than half the sum stated in the proposed finding. (*See* CCPFF ¶ 1236).

1708. { } (Johnston, Tr. 5412, *in camera*).

Response to Finding No. 1708

This proposed finding is inaccurate and misleading. (*See* Response to RPFF ¶ 1707).

4. Federal Healthcare Reform Requirements

1709. The HITECH Act, passed in 2009, provides hospitals with increased Medicare reimbursement if they implement and upgrade their electronic medical record ("EMR") systems, document a portion of patient care, to meet statutory "meaningful use" requirements by certain deadlines. (Johnston, Tr. 5344; Wakeman, Tr. 2849-2850; RX-22 (Perron, Dep. at 45-46)).

Response to Finding No. 1709

Complaint Counsel does not disagree.

1710. The "meaningful use" requirements mean that the different technological systems related to a patient's care need to be connected and able to share information back and forth. (Johnston, Tr. 5343).

Response to Finding No. 1710

Complaint Counsel does not disagree.

1711. An EMR exists in each patient care setting: hospitals, physician offices, etc. (Johnston, Tr. 5344, 5520-5521).

Response to Finding No. 1711

Complaint Counsel does not disagree.

1712. "Meaningful use" not only requires that healthcare providers employ EMR systems, but also that the EMRs have the ability to connect with one another to create an overall EHR, or electronic health record, for each patient. (Johnston, Tr. 5343-5344, 5520-5521).

Response to Finding No. 1712

Complaint Counsel has no specific response.

1713. St. Luke's has numerous IT systems that are implicated by the "meaningful use" requirements, including, for example, its patient registration, patient billing, nursing documentation, radiology, laboratory, surgery, pharmacy, cardiac cath lab, and pulmonary medicine systems. (Johnston, Tr. 5345-5346).

Response to Finding No. 1713

Complaint Counsel has no specific response.

1714. In addition to these systems, St. Luke's also requires network and infrastructure systems. (Johnston, Tr. 5346). New laptop and desktop work stations are also needed to work with the new systems. (Johnston, Tr. 5346).

Response to Finding No. 1714

Complaint Counsel has no specific response.

1715. St. Luke's cannot simply update its current systems. Many are no longer supported by the manufacturers and creating new interfaces between the old systems is costly and inefficient. (Johnston, Tr. 5346; RX-22 (Perron, Dep. at 39-40)).

Response to Finding No. 1715

Complaint Counsel has no specific response.

1716. Hospitals that meet "meaningful use" requirements by 2013 will receive additional Medicare reimbursements for being compliant. (Johnston, Tr. 5344-5345). But, hospitals that fail to do so by 2015 will face penalties in the form of reduced Medicare reimbursements. (Johnston, Tr. 5344-5345; RX-22 (Perron, Dep. at 81)).

Response to Finding No. 1716

Complaint Counsel does not disagree.

1717. In addition to "meaningful use," St. Luke's information technology systems required significant investments to meet health information exchanges, HIPAA 5010, ICD-10, patient centered medical home, and accountable care requirements. (RX-22 (Perron, Dep. at 43)).

Response to Finding No. 1717

Complaint Counsel has no specific response.

1718. {

} (RX-22 (Perron, Dep. at 37, *in camera*)).

Response to Finding No. 1718

Complaint Counsel has no specific response.

1719. Prior to the joinder, St. Luke's had begun planning for compliance with "meaningful use" requirements. (Johnston, Tr. 5347).

Response to Finding No. 1719

Complaint Counsel does not disagree.

1720. St. Luke's had selected AllScripts as the vendor for the physician practice EMR that its employed physicians would use. (Johnston, Tr. 5347).

Response to Finding No. 1720

Complaint Counsel has no specific response.

1721. St. Luke's had also selected Eclipsys as the vendor for its hospital-based EMR system. (Johnston, Tr. 5347).

Response to Finding No. 1721

Complaint Counsel does not disagree.

1722. St. Luke's selected Eclipsys as its clinical software vendor, but the St. Luke's internal multi-disciplinary team that made the selection felt that either Eclipsys or McKesson would have been satisfactory. (PX-1933 (Oppenlander, Dep. at 210)).

Response to Finding No. 1722

Complaint Counsel has no specific response.

1723. Eclipsys's proposal to St. Luke's was slightly more costly than McKesson's. (RX-22 (Perron, Dep. at 90).

Response to Finding No. 1723

Complaint Counsel has no specific response.

1724. Eclipsys's proposal to St. Luke's contained a total estimated cost of $20,776,511 over seven years. (PX01495; PX01496 at 003; Den Uyl, Tr. 6453, *in camera*).

Response to Finding No. 1724

This proposed finding is incorrect: in June 2010, Eclipsys lowered the final price tag by $1 million from the November bid represented in PX01495. (PX01502 at 001).

1725. Eclipsys' hospital EMR system would cover most, but not all of the hospital systems that St. Luke's required. (Johnston, Tr. 5347, 5349).

Response to Finding No. 1725

This proposed finding is directly contradicted by the testimony of Eric Perron, St. Luke's Computer Information Systems Director since 2006, who stated that the $20 million Eclipsys product would enable St. Luke's to satisfy all of its significant information technology needs for the next seven years. (PX01928 at 004, 032 (Perron, Dep. at 7, 119-120), *in camera*). In fact, Mr. Perron believed that the Eclipsys product contains everything St. Luke's needs to be a technologically modern hospital. (PX01928 at 032 (Perron, Dep. at 119-120), *in camera*).

1726. St. Luke's estimated that to support the implementation of EMR it would have to upgrade its information technology infrastructure, networking, storage, and servers, for an additional cost of 25 percent of the cost of the EMR system itself. (RX-22 (Perron, Dep. at 71-72), *in camera*).

Response to Finding No. 1726

This proposed finding is unreliable because the cited testimony is unclear as to the cost of these upgrades. (*See* RX-22 at 20 (Perron, Dep. at 71-72), *in camera*). Mr. Perron never testified at trial and, as a result, no additional testimony is available to clarify this point.

1727. At the time of the joinder, St. Luke's did not have sufficient IT staff to comply with the "meaningful use" requirements. (Johnston, Tr. 5346-5347). { } (Den Uyl, Tr. 6454–6455, *in camera*; RX-56 at 000014, *in camera*).

Response to Finding No. 1727

Complaint Counsel has no specific response.

1728. Eclipsys' proposal to St. Luke's for a hospital-based EMR system, did not account for the operational expenses associated with implementing and maintaining that system, such as additional clinical and non-clinical staff. (PX01496; RX-22 (Perron, Dep. at 101-106); Johnston, Tr. 5348-5349).

Response to Finding No. 1728

Complaint Counsel has no specific response.

1729. { } (Den Uyl, Tr. 6454–6455, *in camera*; RX-56 at 000014, *in camera*).

Response to Finding No. 1729

Complaint Counsel has no specific response.

1730. Although some government subsidies exist that could help reduce the cost of meaningful use compliance, St. Luke's would first have to pay out the full cost of purchasing and implementing the system before the required deadline in order to qualify for any available subsidies. (Johnston, Tr. 5349).

Response to Finding No. 1730

Complaint Counsel has no specific response.

1731. { } (Den Uyl, Tr. 6455-6456, *in camera*; PX01496 at 003).

Response to Finding No. 1731

Complaint Counsel has no specific response.

1732. {

} (RX-22 (Perron, Dep. at 111, *in camera*)).

Response to Finding No. 1732

This proposed finding is unsupported and misleading because the only concern Mr. Perron expressed about the availability of federal incentive dollars was that "[t]he federal government may rescind that legislation." (RX-22 at 30 (Perron, Dep. at 111), *in camera*)). Respondent has offered no evidence whatsoever to suggest that this may actually occur.

Further, St. Luke's fully intended to roll out its EMR in time to take advantage of all ARRA federal incentive payments. (*See* CCPFF ¶ 821). An updated bid from Eclipsys shows that, as of June 2010, St. Luke's was still "[c]apable of qualifying for meaningful use incentives[,]" even if it began implementation in 2011. (PX01502 at 001; PX01503 at 001, *in camera*).

1733. St. Luke's had budgeted $6 million for 2010 to begin implementation of the EMR system, but given the capital freeze, never allocated funds to purchase a new system. (Wakeman, Tr. 2851-2852; PX01928 (Perron, Dep. at 23, *in camera*)).

Response to Finding No. 1733

This proposed finding is misleading and contradicted by the weight of the evidence because the reason St. Luke's did not spend the $6 million on implementing EMR in 2010 is because Acquisition talks with ProMedica caused St. Luke's to halt its EMR plans. (*See* Response to RPFF ¶ 1737). Before the Acquisition talks with ProMedica began, St. Luke's fully intended to begin implementing EMR at the start of 2010. (*See* Response to RPFF ¶ 1737).

1734. Patient centered medical home regulations promulgated in July 2010 mean that St. Luke's would also have to ensure that its ambulatory and hospital-based EMR systems can

communicate with each other, requiring the purchase of additional middleware products from a vendor. (RX-22 (Perron, Dep. at 120-124)).

Response to Finding No. 1734

Complaint Counsel has no specific response.

1735. ICD-10 is comprised of diagnosis codes required to transmit claims to Medicare for reimbursement, and ICD-10 represents a 900 percent increase in the number of codes over the prior version, ICD-9. (RX-22 (Perron, Dep. at 124-125)).

Response to Finding No. 1735

Complaint Counsel has no specific response.

1736. ICD-10 imposes additional information technology needs on St. Luke's (RX-22 (Perron, Dep. at 124-125)).

Response to Finding No. 1736

Complaint Counsel has no specific response.

1737. Like all hospitals, St. Luke's is obliged to comply with these statutory requirements, but would have been unable to do so in any financially prudent manner. (Johnston, Tr. 5351; Johnston, Tr. 5482-5483, *in camera*).

Response to Finding No. 1737

This proposed finding is against the weight of the evidence. Mr. Oppenlander, St. Luke's CFO through the end of 2009, testified that he recommended to Mr. Wakeman that St. Luke's sign a contract with a vendor and begin implementing EMR in 2010. (PX01933 at 039 (Oppenlander, Dep. at 147-148), *in camera*). Mr. Oppenlander understood that his recommendation to Mr. Wakeman was then passed along to St. Luke's Board. (PX01933 at 039 (Oppenlander, Dep. at 147-148), *in camera*). Likewise, Eric Perron, St. Luke's Computer Information Systems Director, testified it was his recommendation – one supported by Mr. Wakeman – that St. Luke's sign a contract with a vendor and begin implementing EMR in early 2010. (PX01928 at 021, 023, 030 (Perron, Dep. at 75-76, 84-85, 113), *in camera*).

Respondent's own expert witness, Mr. Den Uyl, testified that, absent the Acquisition, St. Luke's "fully intended" to implement EMR starting in 2010. (PX01951 at 044 (Den Uyl, Dep. at 170-171), *in camera*). The only reason for not starting EMR implementation in early 2010 expressed by the St. Luke's employees who, unlike Ms. Johnston, were actually involved with the decision making, was the uncertainty caused by Acquisition talks. (CCPFF ¶ 895).

This proposed finding is also unreliable because it concerns decisions that executives made while St. Luke's was still an independent hospital prior to the Acquisition, or decisions they might have made absent the Acquisition, but it is based solely on the testimony of Ms. Johnston, who never worked a single day for a standalone St. Luke's before it was acquired by ProMedica. (*See* Johnston, Tr. 5303, 5306).

5. St. Luke's Poor Financial Condition Forced It To Divert ER Patients

1738. Between 2003 and 2008, St. Luke's patient volumes dropped significantly. (Johnston, Tr. 5363-5364). As a consequence of this drop in patient volume, St. Luke's converted patient care areas into support areas, like offices and conference rooms. (Johnston, Tr. 5364).

Response to Finding No. 1738

This proposed finding is incorrect and contradicts another of Respondent's witnesses. According to Ms. Hanley, St. Luke's had 9,981 acute admissions in 2003. (PX02129 at 002 (Ex. 1) (Hanley, Decl.)). By 2008, its acute admissions had *increased* to 10,055. (PX02129 at 002 (Ex. 1) (Hanley, Decl.)). By August 31, 2010, St. Luke's was on track to increase acute admissions to over 10,422 for the full year (based on annualized figures as of August 31, 2010). (PX02129 at 002 (Ex.1) (Hanley, Decl.)).

This proposed finding is also unreliable because it relies on the testimony of Ms. Johnston for facts that occurred well before her arrival at St. Luke's in September 2010. (Johnston, Tr. 5421).

1739. As a further result of the decline in patient volume, St. Luke's also reduced its staffing levels by not replacing employees who left the hospital. (Johnston, Tr. 5365).

Response to Finding No. 1739

This proposed finding is incorrect and misleading because ordinary course evidence shows that St. Luke's engaged in prudent evaluations of positions before replacing employees. (CCPFF ¶ 1045). Mr. Wakeman testified that any employee who left St. Luke's would be replaced if the position had a direct impact on the quality of patient care. (Wakeman, Tr. 2574). In fact, St. Luke's was the only hospital in Lucas County that did not lay off any employees – as well as the only to actually hire additional full-time employees – during both 2009 and 2010. (CCPFF ¶¶ 1046-1047).

This proposed finding is also unreliable because it relies on the testimony of Ms. Johnston for facts that occurred well before her arrival at St. Luke's in September 2010. (Johnston, Tr. 5421).

1740. When patient volumes increased again, St. Luke's lacked adequate space to care for patients. (Johnston, Tr. 5364).

Response to Finding No. 1740

Complaint Counsel has no specific response.

1741. St. Luke's lacked the capital to convert these spaces back to patient care rooms as patient volumes increased. (Johnston, Tr. 5365-5366).

Response to Finding No. 1741

This proposed finding is incorrect and unreliable. St. Luke's had $65 million in cash and investments as of August 31, 2010, while its ordinary course estimate for the cost of a private room conversion project was only $1.8 million. (*See* Joint Stipulations of Law and Fact, JX00002A ¶ 34; Black, Tr. 5695-5696). St. Luke's reserves have been, and can continue to be, used for appropriate capital projects. (*See* Response to RPFF ¶ 1635). As volumes increased –

as they indeed continued to do right up until the time of the Acquisition, (CCPFF Section XVI.B.2.) – St. Luke's significant capital reserves could have been used for any needed room conversions. (CCPFF Section XVI.B.3.b.). Indeed, Mr. Black testified that St. Luke's had adequate capital to fund its private room conversion project as a standalone hospital. (Black, Tr. 5695-5696).

This proposed finding is also unreliable because it relies on the testimony of Ms. Johnston for facts that occurred well before her arrival at St. Luke's in September 2010. (Johnston, Tr. 5421).

1742. St. Luke's reduced number of available beds led it to divert patients from its emergency room on a regular basis. (Johnston, Tr. 5364-5365).

Response to Finding No. 1742

Complaint Counsel has no specific response.

1743. Under EMTALA laws, if a hospital does not have a bed in which it can place a patient, it cannot accept the patient into the facility. (Johnston, Tr. 5366).

Response to Finding No. 1743

Complaint Counsel has no specific response.

1744. A hospital may have to divert ER patients because it does not have either*adequate* patient rooms or *appropriate* patient rooms. (Johnston, Tr. 5369).

Response to Finding No. 1744

Complaint Counsel has no specific response.

1745. When a hospital has a lack of*appropriate* patient rooms, this means the hospital lacks the *type* of beds that may be needed to serve ER patients or it lacks the staff needed to serve those types of patients. (Johnston, Tr. 5369-5370).

Response to Finding No. 1745

Complaint Counsel has no specific response.

1746. For example, if St. Luke's only had a bed available in a semi-private room and that room already had one male patient, St. Luke's would have to divert patients because it may get female patients presenting at the ER. (Johnston, Tr. 5369).

Response to Finding No. 1746

Complaint Counsel has no specific response.

1747. When St. Luke's could not accept patients, it contacted the county EMS system to alert them that they did not have capacity for new ER patients and ambulances were then diverted from St. Luke's to the next nearest hospital. (Johnston, Tr. 5366).

Response to Finding No. 1747

Complaint Counsel has no specific response.

1748. Emergency room diversions pose a risk to patients having true emergencies like heart attacks since traveling to a more distant hospital can have an effect on patient outcomes. (Johnston, Tr. 5366-5367).

Response to Finding No. 1748

Complaint Counsel does not disagree. In fact, one physician testified that he was concerned that the Acquisition will result in an elimination of open heart services at St. Luke's. (CCPFF ¶ 639). If that program is transferred to a less convenient and less preferred ProMedica facility, Dr. Gbur testified that some patients will have to add "another 10 to 15 minutes to their transit time" for these services. (Gbur, Tr. 3112-3113).

1749. Emergency room diversions may result in a patient being diverted to a hospital where his physician does not have privileges. (Johnston, Tr. 5367).

Response to Finding No. 1749

Complaint Counsel has no specific response.

1750. According to Lucas County EMS reports, St. Luke's had one of the highest emergency room diversion rates in Lucas County between January 1 and November 20, 2010. (Johnston, Tr. 5368-5369; PX02109 at 009-017).

Response to Finding No. 1750

Complaint Counsel has no specific response.

1751. At the time of the joinder, the majority of St. Luke's capacity was in semi-private rooms. (Johnston, Tr. 5370).

Response to Finding No. 1751

Complaint Counsel has does not disagree, except to note that the majority of ProMedica's capacity was also in semi-private rooms. (Nolan, Tr. 6377).

1752. At the time of the joinder, St. Luke's was attempting to address patient volume increases by doubling up some private rooms to create semi-private rooms. (Johnston, Tr. 5371).

Response to Finding No. 1752

Complaint Counsel has no specific response.

1753. The lack of private rooms impacted St. Luke's ER diversion rate. (Johnston, Tr. 5370).

Response to Finding No. 1753

Complaint Counsel has no specific response.

1754. ER patients presenting with contagious infections or other conditions requiring isolation must be placed in private rooms. (Johnston, Tr. 5370; Guerin-Calvert, Tr. 7288).

Response to Finding No. 1754

Complaint Counsel has no specific response.

1755. Gender issues also prevent patients of the opposite gender from being placed in the same semi-private room, and this can impact the hospital's ER diversion rate. (Johnston, Tr. 5370).

Response to Finding No. 1755

Complaint Counsel has no specific response.

1756. Due to its financial condition, St. Luke's had very limited capacity to increase its overall bed capacity prior to the joinder. (Johnston, Tr. 5370-5371; Guerin-Calvert, Tr. 7288-7289).

Response to Finding No. 1756

This proposed finding is misleading. St. Luke's had significant cash reserves that would have allowed it to finance all planned capital expenditures. (*See* Response to RPFF ¶ 1741).

1757. This inability to convert to private rooms puts St. Luke's at a competitive disadvantage in attractiveness to patients. (Guerin-Calvert, Tr. 7288-7289).

Response to Finding No. 1757

This proposed finding is incorrect, incomplete, and misleading. Mr. Black estimated the cost of private room conversion to be $1.8 million. (Black, Tr. 5694-5695). St. Luke's had sufficient funds to complete private room conversions as well as additional planned capital projects prior to the Acquisition. (CCPFF ¶¶ 1071-1079). Even before additional conversions of its semi-private rooms, though, St. Luke's was not at a competitive disadvantage with respect to private room offerings. Approximately { } of St. Luke's medical-surgical beds are already located in private rooms. (Nolan, Tr. 6282, *in camera*). And while all obstetrical patients at St. Luke's have private labor, delivery, recovery, and post-partum rooms, not all rooms in TTH's obstetrical ward are private. (CCPFF ¶¶ 701-702). Mr. Nolan testified that ProMedica legacy hospitals have a low percentage of private rooms (with the exception of its newest hospital, Bay Park). (Nolan, Tr. 6377, *in camera*). Mercy's hospitals similarly have semi-private rooms. (Shook, Tr. 903-904). UTMC is only now starting to convert to private rooms. (Gold, Tr. 283-284).

B. St. Luke's Contracts with MCOs Yielded Below-Cost Reimbursement Rates

1. St. Luke's Payor Mix

1758. Medicare payments make up approximately 50 percent of St. Luke's revenues. Medicare is by far St. Luke's largest payor. (Wakeman, Tr. 2751; Den Uyl, Tr. 6440, *in camera*).

Response to Finding No. 1758

Complaint Counsel has no specific response.

1759. Medicaid payments make up close to 10 percent of St. Luke's revenues. (Wakeman, Tr. 2751).

Response to Finding No. 1759

Complaint Counsel has no specific response.

1760. MCOs represent approximately 40 percent of St. Luke's revenues. (Wakeman, Tr. 2751).

Response to Finding No. 1760

Complaint Counsel has no specific response.

1761. {
} (RX-56 at 000010, *in camera*).

Response to Finding No. 1761

Complaint Counsel has no specific response.

1762. Outpatient reimbursement rates provide agreater return to a hospital than inpatient reimbursement rates. (Dagen, Tr. 3183).

Response to Finding No. 1762

Complaint Counsel does not disagree.

2. St. Luke's Reimbursements Were Not Covering Its Costs

1763. {
} (Hanley, Tr. 4806, *in camera*).

Response to Finding No. 1763

Complaint Counsel has no specific response.

1764. {
} (Dagen, Tr. 3395, *in camera*).

Response to Finding No. 1764

This proposed finding is misleading and incomplete to the extent it implies St. Luke's was not covering its total costs on the treatment of *every* patient – indeed, St. Luke's was covering total costs with all but one commercial health plan prior to the Acquisition. (CCPFF ¶ 1208). Further, even though there were some payors who, on average, did not cover St. Luke's *total* costs, St. Luke's reimbursement from all payors, including government and commercial health plans, covered all *direct* costs of treating those patients. (Response to RPFF ¶ 1777).

1765. St. Luke's internal financial systems provide reports that allow it to track its revenue per discharge on a case-mix adjusted basis as well as its cost per discharge on a case-mix adjusted basis. (Johnston, Tr. 5318-5819).

Response to Finding No. 1765

Complaint Counsel has no specific response.

1766. The difference between revenue per case-mix adjusted discharge and cost per case-mix adjusted discharge is earnings per case-mix adjusted discharge. (Johnston, Tr. 5319).

Response to Finding No. 1766

Complaint Counsel has no specific response.

1767. Earnings per case-mix adjusted discharge is also referred to as "earnings per adjusted discharge" or by the acronym "EPAD." (Johnston, Tr. 5319).

Response to Finding No. 1767

Complaint Counsel has no specific response.

1768. The earnings data reviewed by St. Luke's was adjusted to account for the relative portions of revenue derived from inpatient and outpatient services. (Johnston, Tr. 5320).

Response to Finding No. 1768

Complaint Counsel has no specific response.

1769. The earnings data reviewed by St. Luke's was also adjusted for the case-mix to account for the different acuity of patients being treated; this adjustment permits proper comparisons of hospitals providing different levels of service. (Johnston, Tr. 5320-5321).

Response to Finding No. 1769

Complaint Counsel has no specific response.

1770. St. Luke's reviewed its revenue per adjusted discharge and expense per adjusted discharge data against industry benchmarks. (Johnston, Tr. 5319-5320).

Response to Finding No. 1770

Complaint Counsel has no specific response.

1771. At the time of the joinder, St. Luke's earnings per adjusted discharge figures showed that, on average, St. Luke's was losing money on every commercially insured patient it treated. (Johnston, Tr. 5318-5322).

Response to Finding No. 1771

This proposed finding is incorrect and directly contradicted both by Ms. Johnston's own testimony and the full weight of the evidence. Ms. Johnston testified later during her examination in court that St. Luke's negative "earnings per adjusted discharge" is an average across all patients and does not mean that St. Luke's was losing money on *every* patient:

"Q. And that's an aggregated number, right?

A. It is, yes.

Q. And it doesn't literally mean that St. Luke's is losing money on every patient, does it?

A. It does not do a patient-by-patient analysis, no." (Johnston, Tr. 5500, *in camera*).

For instance, in both 2009 and the first eight months of 2010, St. Luke's earned a profit (*i.e.*, revenues exceeded total costs) with every commercial health plan except {

}. (CCPFF ¶ 1208; PX00519 at 001 (2009 payor cost ratio spreadsheet), *in camera*). Even with { }, St. Luke's still earned a profit on outpatient cases. (RPFF ¶ 1798). By the end of 2010, St. Luke's was earning a profit with every commercial health plan, including { }. (CCPFF ¶ 1210). Furthermore, regardless of any overall losses, St. Luke's was at all times covering the direct costs of treating the patients of *all* commercial and government payors, and as a result experienced improvements in its bottom line when patient volume increased. (*See* Response to RPFF ¶ 1777).

1772. A negative earnings per adjusted discharge number meant that in the aggregate St. Luke's was not making money on patient care. (Johnston, Tr. 5322).

Response to Finding No. 1772

This proposed finding is inaccurate and misleading. St. Luke's was actually "making money" during the first eight months of 2010 because it had a positive operating cash flow. (*See* PX02129 at 002 (Ex. 1) (Hanley, Decl.)).

1773. {

} (Den Uyl, Tr. 6438, *in camera*).

Response to Finding No. 1773

Complaint Counsel has no specific response.

1774. {

} (Den Uyl, Tr. 6438).

Response to Finding No. 1774

Complaint Counsel has no specific response.

1775. {

} (Den Uyl, Tr. 6440, *in camera*).

Response to Finding No. 1775

Complaint Counsel has no specific response.

1776. {

} (Den Uyl, Tr. 6440, *in camera*).

Response to Finding No. 1776

Complaint Counsel has no specific response.

1777. {

} (Den Uyl, Tr. 6441-6442, *in camera*; RX-56 at 000010, *in camera*).

Response to Finding No. 1777

This proposed finding is incorrect and misleading to the extent it implies that St. Luke's was failing to cover both the direct and indirect costs of treating patients. During the first eight months of 2010, as well as all of 2009, St. Luke's contracts with all payors – including { } and government programs such as Medicare and Medicaid – reimbursed St. Luke's enough to cover all direct costs of treating patients, as well as pay for a significant portion of indirect costs. (*See* PX01951 at 039-040 (Den Uyl, Dep. at 150-154), *in camera*; PX01852 at 017 (¶ 25) (Dagen Rebuttal Report); PX00512 at 001 (Aug. 2010 year-to-date payor cost ratio spreadsheet), *in camera*; PX00519 at 001 (2009 payor cost ratio spreadsheet), *in camera*). As a result, St. Luke's was earning enough revenue in both 2009 and 2010 to pay for all costs directly associated with providing patient care – in other words, those costs that are more variable in nature (*e.g.*, drugs, food, etc.). (Dagen, Tr. 3189-3193, 3198-3199, 3239-3241, *in camera*; PX01852 at 017 (¶ 25) (Dagen Rebuttal Report)). In addition, the contributions St. Luke's made to indirect costs – which are more fixed in nature – had a positive impact on St. Luke's bottom line. (Response to RPFF ¶ 1783).

1778. { } (Den Uyl, Tr. 6474-6475, *in camera*; RX-56 at 000024, *in camera*).

Response to Finding No. 1778

This proposed finding is misleading and incomplete because it omits the fact that St. Luke's outpatient volume is substantially higher than its inpatient volume. During the first eight months of 2010, St. Luke's had: 7,817 acute inpatient admissions compared to 147,577 outpatient visits, and it performed 2,292 surgeries inpatient compared to 3,651 surgeries on an

outpatient basis. (PX02129 at 002 (Ex. 1) (Hanley, Decl.)). Further, under the direction of Mr. Wakeman, St. Luke's was increasing the proportion of revenue that it generates from outpatient services, with the goal to reach an outpatient ratio of 60%. (CCPFF ¶¶ 938-943).

1779. { } (Den Uyl, Tr. 6474-6475, *in camera*; RX-56 at 000024, *in camera*).

Response to Finding No. 1779

Complaint Counsel has no specific response.

1780. { } (Den Uyl, Tr. 6474-6475, *in camera*; RX-56 at 000024, *in camera*).

Response to Finding No. 1780

Complaint Counsel has no specific response.

1781. { } (Den Uyl, Tr. 6474-6475, *in camera*; RX-56 at 000024, *in camera*).

Response to Finding No. 1781

Complaint Counsel has no specific response.

1782. { } (Den Uyl, Tr. 6475-6475, *in camera*).

Response to Finding No. 1782

This proposed finding is incomplete and misleading because Mr. Den Uyl did not conclude that St. Luke's would "fail" or become insolvent absent the Acquisition, and he offered no expert opinion on how long St. Luke's could have survived as a standalone hospital. (CCPFF ¶¶ 1201-1202). Mr. Den Uyl did not even conclude that St. Luke's would continue to generate operating losses absent the Acquisition, instead testifying that it was "possible" that St. Luke's would have been a profitable standalone hospital. (CCPFF ¶ 1204).

1783. {

} (RX-34

(Dewey, IHT at 244, *in camera*)).

Response to Finding No. 1783

This proposed finding is incorrect. First, it is directly contradicted by St. Luke's financial performance in 2010, when St. Luke's experienced substantial improvements in its EBITDA, operating income, and overall cost coverage ratio, at a time when its patient volume increased but its reimbursement from payors remained largely the same. (Dagen. Tr. 3197-3199; *see also* PX01852 at 003 (Table 1) (Dagen Rebuttal Report) (showing year-over-year improvements in profitability); PX02129 at 002 (Ex. 1) (Hanley, Decl.) (showing year-over-year volume growth)). Second, Mr. Dagen concluded that the significant improvements in St. Luke's operating performance in 2010 compared to 2009 were "driven primarily by increases in volume." (Dagen. Tr. 3192-3193, 3197-3199). Because direct costs are variable in nature and indirect costs are more fixed, St. Luke's can fall short of covering its *total* costs but, as long as it covers its *direct* costs and makes some contribution to indirect costs, volume growth alone improves St. Luke's profitability (even without increases in rates). (Dagen, Tr. 3189-3193, 3198-3199, 3239-3242, *in camera* ("[a]s long as you're making a contribution to your indirect costs . . . it's beneficial to add the next patient"); PX01852 at 017 (¶ 25) (Dagen Rebuttal Report)). Mr. Dagen's pro forma analysis projecting St. Luke's financial performance in 2011 through 2013 confirms that volume growth could act as the primary driver for improved operating financial performance absent the Acquisition – even to the point of profitability by 2013. (*See* PX02147 at 036-042 (¶¶ 65-76) (Dagen Expert Report); PX01950 at 042-043 (Dagen, Dep. at 161-162), *in camera*).

This proposed finding is also unreliable and misrepresents Mr. Dewey's testimony. Its only support – which is the September 2010 investigational hearing testimony of David Dewey, who is not even a financial executive and who never testified in court – refers only to St. Luke's obstetrics service line and says nothing about St. Luke's hospital-wide costs and reimbursement. (*See* PX01909 at 062 (Dewey, IHT at 244, *in camera*); *see also* CCPFF ¶¶ 1585-1586).

1784. {

} (PX01018 at 003, *in camera*; Wakeman Tr. 2907-2908, *in camera*).

Response to Finding No. 1784

This proposed finding is incorrect. (Response to RPFF ¶ 1783).

1785. {

} (PX01018 at 002, *in camera*; Wakeman, Tr. 2904-2906, *in camera*).

Response to Finding No. 1785

Complaint Counsel has no specific response.

1786. {

} (PX01018 at 002, *in camera*; Wakeman, Tr. 2904-2906, *in camera*).

Response to Finding No. 1786

Complaint Counsel has no specific response.

1787. St. Luke's believed that its of lack of reimbursement, including from MCOs, was a leading cause of its poor operating financial performance. (RX-33 (Deacon, IHT at 76-77)).

Response to Finding No. 1787

This proposed finding is incomplete and misleading because it fails to account for the more relevant factors that influenced St. Luke's financial condition and operating performance: financial markets, strategic investments, and patient volume trends. The 2008 financial crisis had a significant impact on St. Luke's financial condition in 2008 and 2009. (PX02147 at 006, 021 (¶¶ 12-13, 41) (Dagen Expert Report)). For instance, one major cause of St. Luke's poor operating performance in 2009 was a significant increase in St. Luke's pension expense that resulted from the deterioration in the financial markets in 2008. (CCPFF ¶¶ 1064-1065). An increase of { } in St. Luke's pension expense in 2009 compared to 2008 was, in turn, a direct cause of St. Luke's higher operating losses in 2009 compared to 2008. (CCPFF ¶¶ 1064-1065). Mr. Oppenlander, St. Luke's CFO, wrote in 2009: "[t]ake out the effect of the pension plan, [and] the hospital is performing better than last year[.]" (PX01356 at 001 (Oppenlander May 2009 Email)). The decline in St. Luke's EBITDA and operating income in 2009 was also caused by an increase in expenses resulting from the execution of Mr. Wakeman's three year turnaround plan, which required certain growth-minded investments that would pay dividends over time. (CCPFF ¶ 1069).

Patient volume losses played a significant role in causing declines in St. Luke's EBITDA and operating income during the 2000s. (PX02147 at 019-021 (¶¶ 37-40) (Dagen Expert Report) (discussing how loss of Paramount and NWOCC precipitated operating performance declines in early and mid 2000s)). Similarly, volume *increases* – which were unaccompanied by any meaningful reimbursement rate increases – helped drive significant improvements in St. Luke's operating performance in 2010 compared to 2009. (Response to RPFF ¶ 1783). Mr. Dagen's pro forma analysis projecting St. Luke's financial performance for 2011 through 2013 confirms that volume growth would have continued to improve St. Luke's operating financial performance

absent the Acquisition – even in the absence of any material reimbursement rate increases. (*See* PX02147 at 036-042 (¶¶ 65-76) (Dagen Expert Report); PX01950 at 042-043 (Dagen, Dep. at 161-162), *in camera*).

This proposed finding is also unreliable because it is supported solely by the testimony of Doug Deacon, who is not even a financial executive and who never testified again in this matter after his September 2010 investigational hearing.

1788. {

} (Wakeman, Tr. 2942-2944, *in camera*; PX01283 at 002, *in camera*).

Response to Finding No. 1788

Complaint Counsel has no specific response.

1789. {

} (Wakeman, Tr. 2986-2987, *in camera*; PX01029, *in camera*).

Response to Finding No. 1789

Complaint Counsel has no specific response.

1790. {

}
(PX01029 at 007, *in camera*; Wakeman, Tr. 2988-2989, *in camera*; RX-37 (Machin, IHT at 53)).

Response to Finding No. 1790

Complaint Counsel has no specific response.

1791. {

} (Wakeman, Tr. 2998-2999, *in camera*).

Response to Finding No. 1791

Complaint Counsel has no specific response.

3. St. Luke's Largest MCOs Reimbursed It Below Its Costs

1792. {

} (RX-56 at 000010, *in camera*).

Response to Finding No. 1792

Complaint Counsel has no specific response.

1793. Prior to the joinder, St. Luke's received commercial reimbursement rates from MMO and Anthem that it understood was less than what other similar institutions were receiving for similar services rendered. (RX-16 (Bazeley, Dep. at 96-97)).

Response to Finding No. 1793

This proposed finding is unreliable and unfounded because its sole citation is hearsay testimony by a Board member who merely recited something a former St. Luke's executive, David Oppenlander, had told him. (*See* RX-16 at 25-26 (Bazeley, Dep. at 96-97) ("I just have to go on what I was told")). Neither Mr. Oppenlander nor Mr. Bazeley testified during trial.

a. MMO

1794. {

} (Wakeman, Tr. 2933, *in camera*; RX-56 at 000010, *in camera*).

Response to Finding No. 1794

Complaint Counsel has no specific response.

1795. { } (Wakeman, Tr. 2936, *in camera*).

Response to Finding No. 1795

Complaint Counsel has no specific response.

1796. {

} (RX-56 at 000010, *in camera*; Dagen Tr. 3394-3395, *in camera*).

Response to Finding No. 1796

This proposed finding is incomplete and misleading because, prior to the Acquisition, MMO's reimbursement to St. Luke's covered all **{*direct* costs}** of providing care to MMO members. (CCPFF ¶ 1209; *see also* Response to RPFF ¶ 1777). Further, during the last four months of 2010, St. Luke's earned sufficient revenue from MMO to cover the **{*total* costs}** of treating its members, despite reimbursement rates that were unchanged from their pre-Acquisition levels. (CCPFF ¶¶ 1210-1211; PX02385 at 002 (new MMO contract not effective until January 19, 2011), *in camera*).

1797. {

} (Den Uyl, Tr. 6474, *in camera*; RX-56 at 000023, *in camera*).

Response to Finding No. 1797

Complaint Counsel has no specific response.

1798. {

} (Den Uyl, Tr. 6474, *in camera*; RX-56 at 000023, *in camera*).

Response to Finding No. 1798

Complaint Counsel has no specific response.

1799. {

} (Den Uyl, Tr. 6474, *in camera*; RX-56 at 000023, *in camera*).

Response to Finding No. 1799

This proposed finding is misleading and incomplete because, during the last four months of 2010, St. Luke's earned sufficient revenue from MMO to cover the { } of treating its members, despite reimbursement rates that were unchanged from their pre-Acquisition levels.

(CCPFF ¶¶ 1210-1211; PX02385 at 002 (MMO contract effective January 19, 2011), *in camera*).

In other words, St. Luke's was { } when treating MMO patients.

1800. {

} (Pirc, Tr. 2339-2340, *in camera*; Wakeman, Tr. 2933-2934, *in camera*).

Response to Finding No. 1800

Complaint Counsel does not disagree.

1801. {

} (Guerin-Calvert, Tr. 7414-7415, *in camera*).

Response to Finding No. 1801

Complaint Counsel does not disagree.

1802. {

} (Guerin-Calvert, Tr. 7415-7416, *in camera*).

Response to Finding No. 1802

This proposed finding is incomplete and misleading. (Response to RPFF ¶ 1796).

1803. {

} (Pirc, Tr. 2339, 2353, *in camera*).

Response to Finding No. 1803

Complaint Counsel has no specific response.

1804. {

} (Pirc, Tr. 2340-2341, 2343-2344, *in camera*; PX02280 at 007, 013-015; PX02275, *in camera*).

Response to Finding No. 1804

This proposed finding is incomplete and misleading. (Response to RPFF ¶ 1796).

1805. {

} (RX-11 (Oppenlander, Dep. at 185, *in camera*)).

Response to Finding No. 1805

Complaint Counsel has no specific response.

1806. {
} (Pirc, Tr. 2346-2347, *in camera*).

Response to Finding No. 1806

If asserted as proof that St. Luke's was losing money when providing outpatient services to { } members, this proposed finding is incorrect and directly contradicted by Respondent's own proposed findings. (*See* RPFF ¶ 1798).

1807. {
} (PX02280 at 014; Guerin-Calvert, Tr. 7417-7418, *in camera*; Pirc, Tr. 2346, *in camera*).

Response to Finding No. 1807

Complaint Counsel has no specific response.

1808. {
} (PX02275; Guerin-Calvert, Tr. 7418-7419, *in camera*; Pirc, Tr. 2349-2350, *in camera*).

Response to Finding No. 1808

Complaint Counsel has no specific response.

1809. { } (Pirc, Tr. 2349-2350, *in camera*; Guerin-Calvert, Tr. 7421-7422, *in camera*).

Response to Finding No. 1809

Complaint Counsel has no specific response.

1810. {
} (Wakeman, Tr. 2934-2935, *in camera*).

Response to Finding No. 1810

Complaint Counsel has no specific response.

1811. { } (Wakeman, Tr. 2932-2935, *in camera*).

Response to Finding No. 1811

Complaint Counsel has no specific response.

1812. { } (Guerin-Calvert, Tr. 7420-7421, *in camera*; PX02275, *in camera*).

Response to Finding No. 1812

Complaint Counsel has no specific response.

1813. { } (Pirc, Tr. 2350-2351, *in camera*; PX02275, *in camera*).

Response to Finding No. 1813

Complaint Counsel has no specific response.

1814. { } (Guerin-Calvert, Tr. 7424, *in camera*; Pirc, Tr. 2350-2351, *in camera*).

Response to Finding No. 1814

Complaint Counsel has no specific response.

1815. } (Pirc, Tr. 2351-2352, *in camera*).

Response to Finding No. 1815

Complaint Counsel has no specific response.

1816. {

} (Guerin-Calvert, Tr. 7422-7423, *in camera*; Pirc, Tr. 2355-2356, *in camera*).

Response to Finding No. 1816

Complaint Counsel has no specific response.

1817. {

} (Pirc, Tr. 2354-2355, *in camera*; PX02284 at 001, *in camera*).

Response to Finding No. 1817

Complaint Counsel has no specific response.

1818. {

} (Pirc, Tr. 2355-2356, *in camera*).

Response to Finding No. 1818

Complaint Counsel has no specific response.

1819. {

} (Wakeman, Tr. 2975-2976, *in camera*; PX01583 at 001, *in camera*; PX01016 at 012-013, *in camera*; RX-37 (Machin, IHT at 127, *in camera*)).

Response to Finding No. 1819

Complaint Counsel has no specific response.

1820. Equilibrium occurs within a bargaining framework when both parties to the negotiation conclude that they are better off with the deal than without the deal. (Town, Tr. 3847).

Response to Finding No. 1820

Complaint Counsel does not disagree.

1821. {

} (Guerin-Calvert, Tr. 7423-7424, *in camera*).

Response to Finding No. 1821

This proposed finding is incomplete and misleading because the MMO-St. Luke's negotiations are also indicative of St. Luke's trying to negotiate a new and more favorable contract with MMO before the expiration of an existing contract. (*See* PX01852 at 018 (¶¶ 26) (Dagen Rebuttal Report)). As a result, these negotiations are poor indicators for what would have happened – but-for the Acquisition – during negotiations between MMO and St. Luke's in late 2010 as the contract neared its natural expiration. (*See* PX01852 at 018 (¶ 26) (Dagen Rebuttal Report)). Indeed, ordinary course documents and testimony suggest that MMO was in fact willing to { } with St. Luke's when their existing contract came up for renegotiation in late 2010. (*See* Pirc, Tr. 2234-2236, *in camera;* PX01852 at 018 (¶ 26) (Dagen Rebuttal Report)).

1822. { } (Guerin-Calvert, Tr. 7425-7426, *in camera*).

Response to Finding No. 1822

Complaint Counsel has no specific response.

b. Anthem

(i) St. Luke's Negotiated To Re-Enter Anthem's Network in 2008

1823. Anthem had terminated its contract with St. Luke's in 2005. (PX01022 at 010).

Response to Finding No. 1823

Complaint Counsel does not disagree.

1824. St. Luke's identified its lack of access to Anthem as a key challenge in 2008. (PX01352 at 022; Wakeman, Tr. 2809).

Response to Finding No. 1824

Complaint Counsel does not disagree.

1825. St. Luke's engaged in negotiations to get back into the Anthem network in 2008. (Wakeman, Tr. 2810-2811; Pugliese, Tr. 1610-1612, *in camera*).

Response to Finding No. 1825

Complaint Counsel does not disagree.

1826. Anthem would not allow St. Luke's back into its network until July 2009 and would not allow St. Luke's in the network unless St. Luke's agreed to a MFN clause in the contract before the State of Ohio passed a law making such MFN clauses illegal. (Pugliese, Tr. 1612-1615, *in camera*; Wakeman, Tr. 2810-2811; RX-1802 at 000002).

Response to Finding No. 1826

Complaint Counsel has no specific response.

1827. {

} (Pugliese, Tr. 1613-1615, *in camera*; PX02237 at 003, 010, *in camera*).

Response to Finding No. 1827

Complaint Counsel has no specific response.

1828. Mr. Wakeman, St. Luke's CEO, felt "miserable" at the time he signed the agreement with Anthem in 2008, but believed he needed to capitulate to Anthem's terms to serve the large portion of the community insured by Anthem. (Wakeman, Tr. 2810-2811).

Response to Finding No. 1828

This proposed finding is misleading and incorrect to the extent it implies that regaining access to the Anthem contract had a negative impact on St. Luke's financial health. Getting back into the Anthem provider network was a key growth goal in Mr. Wakeman's three year turnaround plan. (*See* PX01026 at 001-002 (St. Luke's Three-Year Plan); RPFF ¶ 1824). Mr. Wakeman testified that the new Anthem contract in July 2009 improved St. Luke's financial operating performance in 2010. (PX01920 at 022 (Wakeman, Dep. at 78-79), *in camera*). Respondent's expert, Mr. Den Uyl, similarly testified that the addition to Anthem's provider

network was a positive development for St. Luke's financial performance. (PX01951 at 033-034 (Den Uyl, Dep. at 128-130), *in camera*).

1829. { } (Pugliese Tr. 1614-1617, *in camera*).

Response to Finding No. 1829

Complaint Counsel has no specific response.

1830. { }(Pugliese, Tr. 1616, *in camera*).

Response to Finding No. 1830

Complaint Counsel has no specific response.

1831. { }(Pugliese, Tr. 1617, *in camera*; RX-968 at 000001-000002, *in camera*).

Response to Finding No. 1831

Complaint Counsel has no specific response.

1832. { } (Pugliese, Tr. 1617-1618, *in camera*).

Response to Finding No. 1832

Complaint Counsel has no specific response.

1833. { } (Pugliese, Tr. 1618, *in camera*). { } (Pugliese, Tr. 1618, *in camera*).

Response to Finding No. 1833

Complaint Counsel has no specific response.

1834. { } (Pugliese, Tr. 1618, *in camera*).

Response to Finding No. 1834

Complaint Counsel has no specific response.

1835. {

} (Pugliese, Tr. 1619-1620, *in camera*; PX02276 at 002, *in camera*).

Response to Finding No. 1835

Complaint Counsel has no specific response.

1836. {

} (Pugliese, Tr. 1620-1621, *in camera*; PX02408 at 001, *in camera*). {

(Pugliese, Tr. 1624, *in camera;* PX02408 at 001, *in camera*).

Response to Finding No. 1836

This proposed finding is contradicted by other testimony and ordinary course documents that suggest the rates under the Anthem contract were up for renegotiation in July of 2011, not July of 2012. (Wakeman, Tr. 2650, *in camera*; PX01016 at 013 (December 15, 2009, St. Luke's presentation to Board of Directors contemplates "July 1 [2011] implementation" of a new renegotiated agreement with Anthem), *in camera*).

1837. {

(Pugliese, Tr. 1624-1625, *in camera*; PX02408 at 001, *in camera*).

Response to Finding No. 1837

Complaint Counsel has no specific response.

1838. {

(Pugliese, Tr. 1624-1625, *in camera*).

Response to Finding No. 1838

This proposed finding is contradicted by other testimony and ordinary course documents that suggest Anthem rates were up for renegotiation as early as July 2011. (Response to RPFF ¶ 1836).

(ii) St. Luke's Determined Its Anthem Rates Did Not Cover Its Costs and Sought To Renegotiate

1839. { } (Pugliese, Tr. 1629, *in camera*; PX02382 at 003, *in camera*).

Response to Finding No. 1839

Complaint Counsel has no specific response.

1840. { } (Pugliese, Tr. 1631, 1639, *in camera*; PX02382 at 003, *in camera*; RX-965 at 000003, *in camera*).

Response to Finding No. 1840

Complaint Counsel has no specific response.

1841. { } (RX-848 at 000001; PX02382 at 001, *in camera*; PX02276 at 002, *in camera*; Pugliese, Tr. 1614-1615, 1619-1620, *in camera*).

Response to Finding No. 1841

This proposed finding is contradicted by other testimony and ordinary course documents that suggest Anthem rates were up for renegotiation as early as July 2011. (Response to RPFF ¶ 1836).

1842. { } (Pugliese, Tr. 1634-38, *in camera*; PX02382 at 003, *in camera*).

Response to Finding No. 1842

This proposed finding is misleading to the extent it implies St. Luke's reimbursement from Anthem was not beneficial to St. Luke's financial performance. Prior to the Acquisition, reimbursement from Anthem to St. Luke's exceeded the {

} of providing care to Anthem members. (PX00512 at 001 (August 2010 year-to-date payer cost ratio spreadsheet), *in camera*; PX00519 at 001 (2009 payer cost ratio spreadsheet), *in camera*; *see also* Den Uyl, Tr. 6597, *in camera*). In other words, St. Luke's was { } when it treated Anthem members.

1843. {
} (Pugliese, Tr. 1632-1633, *in camera*; PX02382 at 003, *in camera*; RX-965 at 000003, *in camera*).

Response to Finding No. 1843

Complaint Counsel has no specific response.

1844. {
} (Pugliese, Tr. 1633, *in camera*; PX02382 at 003, *in camera*).

Response to Finding No. 1844

Complaint Counsel has no specific response.

1845. {
} (Pugliese, Tr. 1633, *in camera*).

Response to Finding No. 1845

Complaint Counsel has no specific response.

1846. {
} (Pugliese, Tr. 1633, *in camera*).

Response to Finding No. 1846

This proposed finding is incorrect because Mr. Wakeman testified that {
}. (Wakeman, Tr. 2976, *in camera*). This

proposed finding cites to hearsay from an unreliable source. Mr. Pugliese's understanding of the MMO contract terms was based solely off of an *inference* that he made as the result of a conversation with a St. Luke's executive. (Pugliese, Tr. 1633, *in camera*). Indeed, Mr. Pugliese is an employee of Anthem – not MMO – and thus lacks firsthand knowledge of the terms of St. Luke's contract with MMO. (*See* CCPFF ¶¶ 1332-1340).

1847. { } (Pugliese, Tr. 1512, 1640, *in camera*; PX02382 at 001, *in camera*).

Response to Finding No. 1847

Complaint Counsel has no specific response.

1848. { }

(Pugliese, Tr. 1639-1640, *in camera*; RX-965 at 000003, *in camera*).

Response to Finding No. 1848

Complaint Counsel has no specific response.

1849. { } (Pugliese, Tr. 1640, *in camera*, RX-965 at 000003, *in camera*).

Response to Finding No. 1849

Complaint Counsel has no specific response.

1850. { } (Pugliese, Tr. 1640, *in camera*; RX-965 at 000003, *in camera*). { } (Pugliese, Tr. 1640, *in camera*; RX-965 at 000003, *in camera*).

Response to Finding No. 1850

Complaint Counsel has no specific response.

1851. { } (Pugliese, Tr. 1640-1641, *in camera*; RX-965 at 000003, *in camera*).

Response to Finding No. 1851

Complaint Counsel has no specific response.

1852. {
}
(Pugliese, Tr. 1641, *in camera*; RX-965 at 000003, *in camera*).

Response to Finding No. 1852

Complaint Counsel has no specific response.

1853. {
} (Pugliese, Tr. 1641, *in camera*; RX-965 at 000003, *in camera*).

Response to Finding No. 1853

Complaint Counsel has no specific response.

1854. {
} (Pugliese, Tr. 1642, *in camera*; RX-965 at 000002, *in camera*).

Response to Finding No. 1854

Complaint Counsel has no specific response.

1855. {
} (Pugliese, Tr. 1642, *in camera*; RX-965 at 000002, *in camera*).

Response to Finding No. 1855

Complaint Counsel has no specific response.

1856. {
} (Pugliese, Tr. 1643, *in camera;* RX-965 at 000002, *in camera*).

Response to Finding No. 1856

Complaint Counsel has no specific response.

1857. {
} (Pugliese Tr. 1509-1510, 1642-43, *in camera*; PX02382 at 001-002 *in camera*; RX-965 at 000002, *in camera*).

Response to Finding No. 1857

Complaint Counsel has no specific response.

1858. { } (Pugliese, Tr. 1510, *in camera*; PX02382 at 002, *in camera*).

Response to Finding No. 1858

Complaint Counsel has no specific response.

1859. { } (Pugliese, Tr. 1511, *in camera*); PX02382 at 001, *in camera*).

Response to Finding No. 1859

Complaint Counsel has no specific response.

1860. { } (Pugliese, Tr. 1643-1644, *in camera*).

Response to Finding No. 1860

Complaint Counsel has no specific response.

c. Aetna

1861. { } (RX-155 at 000001, *in camera*).

Response to Finding No. 1861

This proposed finding is inaccurate and misleading to the extent it implies that St. Luke's existing contract with Aetna in November 2009 did not already cover the costs of providing care to Aetna members. Indeed, in 2009, Aetna reimbursed St. Luke's sufficiently to cover the { } of treating Aetna members; in other words, the Aetna contract was { } for St. Luke's. (PX00519 at 001 (2009 payer cost ratio spreadsheet), *in camera*).

1862. {

} (Radzialowski, Tr. 834-835, *in camera*).

Response to Finding No. 1862

Complaint Counsel has no specific response.

d. United

1863. { } (Sheridan, Tr. 6638, *in camera*).

Response to Finding No. 1863

This proposed finding is vague and irrelevant because there is no indication what, if any, opinion or understanding United had of St. Luke's financial condition, nor is there any indication that United took any actions or made any decisions as a result of being aware of St. Luke's financial condition – indeed the cited testimony contains no such evidence. (*See* Sheridan, Tr. 6638, *in camera*).

1864. { } (Sheridan, Tr. 6638-6639, *in camera*).

Response to Finding No. 1864

This proposed finding is vague and irrelevant because there is no indication what, if any, opinion or understanding United had of St. Luke's financial condition, nor is there any indication that United took any actions or made any decisions as a result of being aware of St. Luke's financial condition – indeed the cited testimony contains no such evidence. (*See* Sheridan, Tr. 6638-6639, *in camera*).

1865. { } (Sheridan, Tr. 6643-6645, *in camera*; RX-1070 at 000044, *in camera*).

Response to Finding No. 1865

Complaint Counsel has no specific response.

1866. {
} (Sheridan, Tr. 6643, *in camera*; RX-1070 at 000043, *in camera*).

Response to Finding No. 1866

Complaint Counsel has no specific response.

1867. {
} (Sheridan, Tr. 6643, *in camera*).

Response to Finding No. 1867

Complaint Counsel has no specific response.

1868. {
} (Sheridan, Tr. 6646-6648, *in camera*; RX-920, *in camera*).

Response to Finding No. 1868

Complaint Counsel has no specific response.

1869. {
} (Sheridan, Tr. 6648-6651, *in camera*; RX-920, *in camera*).

Response to Finding No. 1869

This proposed finding is incomplete and misleading. In 2009, United reimbursed St. Luke's enough to cover all { } of treating United members. (PX00519 at 001 (2009 payor cost ratio spreadsheet), *in camera*). During the first eight months of 2010, St. Luke's contract with United was { }; in other words, United's reimbursement to St. Luke's covered the { } of treating United members. (*See* PX00512 at 001 (August 2010 year-to-date payor cost ratio spreadsheet), *in camera*); Den Uyl, Tr. 6597-6598, *in camera*).

1870. {
} (Sheridan, Tr. 6707-6708, *in camera*; RX-920, *in camera*).

Response to Finding No. 1870

Complaint Counsel has no specific response.

1871. {
}

(Sheridan, Tr. 6708, *in camera*; RX-920, *in camera*).

Response to Finding No. 1871

Complaint Counsel has no specific response.

e. FrontPath Was an Exception

1872. { } (Sandusky, Tr. 1386-1387, *in camera*; Guerin-Calvert, Tr. 7433-7434, *in camera*).

Response to Finding No. 1872

Complaint Counsel has no specific response.

1873. {

} (Sandusky, Tr. 1386-1388, *in camera*).

Response to Finding No. 1873

Complaint Counsel has no specific response.

1874. {
} (Sandusky, Tr. 1387-1388, *in camera*; RX-782 at 000001, *in camera*).

Response to Finding No. 1874

Complaint Counsel has no specific response.

1875. {

} (Sandusky, Tr. 1388, *in camera*).

Response to Finding No. 1875

Complaint Counsel has no specific response.

1876. {
} (Guerin-Calvert, Tr. 7433-7434, *in camera*).

Response to Finding No. 1876

This proposed finding is incomplete. St. Luke's new 2009 contract with Frontpath contained only a percent rate increase over the rates contained in the previous contract. (Guerin-Calvert, Tr. 7872-7873, *in camera*; see also CCPFF ¶ 1182).

C. St. Luke's Financial Condition Prior to the Joinder Was Not Improving

1. St. Luke's Financial Condition When CEO Dan Wakeman Arrived

1877. Mr. Wakeman took the position of President and CEO of St. Luke's Hospital and OhioCare Health System in February 2008. (PX01002 at 001).

Response to Finding No. 1877

Complaint Counsel has no specific response.

1878. St. Luke's was losing money from operations when Mr. Wakeman arrived. (Wakeman, Tr. 2770).

Response to Finding No. 1878

This proposed finding is incomplete and, as a result, misleading. After stating that St. Luke's lost money from patient care operations in 2007, Mr. Wakeman goes on to say that, "Overall, *bottom line was positive* because of the performance of the portfolio and the reserves." (Wakeman, Tr. 2770 (emphasis added)). In fact, St. Luke's was "blessed to have reserves[,]" (PX01274 at 001 (Wakeman May 2009 email), *in camera*), to cover the "long-term replacement, modernization and expansion of hospital facilities." (PX01275 at 047 (St. Luke's Credit Presentation)). In addition, at the time Mr. Wakeman arrived, St. Luke's had generated positive EBITDA every year since 2000. (PX02147 at 010 (Table 1) (Dagen Expert Report)). By the time of the Acquisition, St. Luke's had generated positive EBITDA in nine out of the last eleven years. (PX02147 at 010 (¶ 21) (Dagen Expert Report)).

1879. St. Luke's had previously conducted workforce reductions in 2006 as part of a plan to turn around St. Luke's. Approximately 80-100 individuals, mostly management, were let go. (Wakeman, Tr. 2771).

Response to Finding No. 1879

Complaint Counsel has no specific response.

1880. Prior to February 2008, St. Luke's Board had commissioned the NexTen study on the recommendation of Dave Dewey, Vice President of Business Development. This study showed that the number of physicians practicing at St. Luke's had decreased significantly prior to Mr. Wakeman's arrival. (Wakeman, Tr. 2738-2739).

Response to Finding No. 1880

Complaint Counsel does not disagree.

1881. Mr. Wakeman agreed with the approach of the NexTen study, but was disappointed that it had been undertaken so late. He believed that St. Luke's should have implemented a more directed effort to replace physicians it had lost. (Wakeman, Tr. 2739-2740).

Response to Finding No. 1881

Complaint Counsel has no specific response.

1882. From what he learned during his interviews for President and CEO of St. Luke's and OhioCare, Mr. Wakeman was concerned about the steady decline in activity, decline in revenues, and the exodus of medical staff without replacements. (Wakeman, Tr. 2741).

Response to Finding No. 1882

This proposed finding is incomplete and misleading. In fact, Mr. Wakeman took the job as President and CEO of St. Luke's because of the opportunity it presented and of St. Luke's "huge potential as an organization." (Wakeman, Tr. 2480-2481; PX01911 at 016 (Wakeman, IHT at 60), *in camera*). Mr. Wakeman testified that St. Luke's had huge potential "[b]ecause it sat in an optimal or better part of the community in the sense of growth and economic potential, was easily accessible off the freeways, and some of the information that was provided to me prior to coming on board showed a decline in activity and a corresponding decline in revenues." (Wakeman, Tr. 2481; *see also* Response to RPFF ¶ 1878). When Mr. Wakeman arrived at St.

Luke's, he believed a decline in activity and a decline in revenue created an opportunity for St. Luke's. (Wakeman, Tr. 2481; PX01911 at 017 (Wakeman, IHT at 61), *in camera* ("The decline in revenue, in itself, in an area where you have growth, means opportunity.")).

Mr. Wakeman also testified that before interviewing for the CEO position at St. Luke's, he was of the opinion that "St. Luke's was in a favorable location as it relates to economic conditions in the Northwest Ohio area . . . an area that had experienced some moderate growth over the period prior to 2008." (Wakeman, Tr. 2477). He also stated that "St. Luke's was well-known for their quality and service." (Wakeman, Tr. 2482). St. Luke's inpatient gross revenues (as a percentage of total revenues) upon Mr. Wakeman's arrival approached 70 percent. This was relatively high for a community hospital, which created an opportunity to drive profits through increasing higher-margin outpatient procedures. (Wakeman, Tr. 2744-2745).

Any decline in activity or revenues had been reversed by the time of the Acquisition. (CCPFF ¶¶ 898-988). In his last monthly report to St. Luke's board as an independent hospital, Mr. Wakeman wrote that, "activity was running hot all month." (PX00170 (Wakeman Aug. 2010 Monthly Report to St. Luke's Board of Directors)).

1883. St. Luke's inpatient gross revenues upon Mr. Wakeman's arrival approached 70 percent. This was relatively high for a community hospital. (Wakeman, Tr. 2744-2745).

Response to Finding No. 1883

Complaint Counsel does not disagree.

1884. Prior to joining St. Luke's, Mr. Wakeman was "befuddled" by why St. Luke's wasn't getting more activity. (Wakeman, Tr. 2769).

Response to Finding No. 1884

Complaint Counsel has no specific response.

1885. Before Mr. Wakeman formally joined St. Luke's, he attended a zoning meeting in Monclova in which Mercy Health Partners was seeking permission to build a medical

facility at 20A and Strayer Road, approximately a mile and a half from St. Luke's. (Wakeman, Tr. 2768).

Response to Finding No. 1885

Complaint Counsel has no specific response.

1886. Mr. Wakeman understood that Mercy planned to build a joint venture facility consisting of physician practices and a 35-37 bed specialty hospital at 20A and Strayer Road about a mile and a half from St. Luke's. (Wakeman, Tr. 2770).

Response to Finding No. 1886

Complaint Counsel has no specific response.

1887. Three key St. Luke's physician practices were in active negotiations with Mercy to participate in Mercy's 20A and Strayer project. Mr. Wakeman was very concerned by this, and prior to starting at St. Luke's, he met with two of the three practices to try to prevent their aligning with Mercy for the 20A and Strayer project. (Wakeman, Tr. 2769-2770, 2778-2779).

Response to Finding No. 1887

Complaint Counsel has no specific response.

1888. Mercy's 20A and Strayer plans were the most pressing issue faced by St. Luke's board at the time of Mr. Wakeman's arrival. (Wakeman, Tr. 2778).

Response to Finding No. 1888

Complaint Counsel has no specific response.

2. St. Luke's Three-Year Plan

1889. In the spring of 2008, after discussion with senior leaders, outside consultants, and the Board of Directors, Mr. Wakeman initiated a three-year plan to improve St. Luke's. (PX01010 at 001-004; Wakeman, Tr. 2812-2813).

Response to Finding No. 1889

Complaint Counsel has no specific response.

1890. St. Luke's had seen a significant drop in patient volume from 2000 to 2008. (PX01352 at 003-004; Wakeman, Tr. 2799-2800).

Response to Finding No. 1890

This proposed finding is incorrect and contradicted by another of Respondent's witnesses. According to Ms. Hanley, St. Luke's had 9,925 acute admissions, 119,626 outpatient visits, and 39,529 ER visits in 2000. (PX02129 at 002 (Ex. 1) (Hanley, Decl.)). By 2008, all of these figures had increased: 10,055 acute admissions, 148,271 outpatient visits, and 40,771 ER visits. (PX02129 at 002 (Ex. 1) (Hanley, Decl.)).

1891. Specifically, from 2000 to 2008, St. Luke's inpatient and OB discharges both dropped by 7 percent. (PX01352 at 003-004; Wakeman, Tr. 2799-2800).

Response to Finding No. 1891

This proposed finding is incorrect, incomplete, and misleading. Acute admissions (including both inpatient and OB) actually increased during this period. (*See* Response to RPFF ¶ 1890). In addition, this increase in patient visits led to an increase in St. Luke's total net revenue. In 2000, St. Luke's total net revenue was $104,662,000. (PX02129 at 002 (Ex. 1) (Hanley, Decl.)). By 2008, St. Luke's total net revenue had climbed to $135,433,000. (PX02129 at 002 (Ex. 1) (Hanley, Decl.)).

1892. From 2000 to 2008, the number of surgeries conducted on St. Luke's campus, including SurgiCare, had decreased by 24 percent. (PX01352 at 004; Wakeman, Tr. 2799-2800).

Response to Finding No. 1892

This proposed finding is incorrect, incomplete, and misleading. Outpatient visits to St. Luke's actually increased from 2000 to 2008. (*See* Response to RPFF ¶ 1890). The number of cases treated at Surgi+Care grew from the time Mr. Wakeman took over at St. Luke's until the time of the Acquisition. In 2007, Surgi+Care treated 2,507 patients, and by August 31, 2010, it had treated 3,179 patients (annualized to 4,769 cases for all of 2010). (PX01214 at 006 ("Surgi+Care Board of Manager's Meeting")). This translates into an increase of *over 50%* between 2007 and 2010.

1893. From 2005 to 2007, the number of cardiac catheterizations and cardiac surgeries performed at St. Luke's dropped dramatically, with declines of 53 percent decrease and 57 percent, respectively. (PX01352 at 004; Wakeman, Tr. 2799-2800).

Response to Finding No. 1893

Complaint Counsel has no specific response.

1894. In early 2008, Mr. Wakeman and St. Luke's senior leaders believed that St. Luke's continued poor performance would cause it to "go out of business" and "die slowly." (PX01111 at 004; Wakeman, Tr. 2792-2793).

Response to Finding No. 1894

This proposed finding is misleading and incomplete. By the time of the Acquisition, Mr. Wakeman had a much different impression of St. Luke's future. At the end of 2009, Mr. Wakeman told St. Luke's Board of Directors that the hospital would survive independently for at least three to seven years, and 2010 improvements in the equity markets and St. Luke's own financial performance would extend this timeframe even further. (*See* CCPFF ¶¶ 1071-1072). Mr. Wakeman's last words to an independent St. Luke's Board of Directors also reflect the positive turnaround that would have led to St. Luke's continued growth and survival. Increases in activity, volume, and patient satisfaction scores, combined with improvements in quality, service, expense control, and financial performance demonstrate that St. Luke's future was not, in fact, dire as this proposed finding suggests. (PX00170 (Wakeman Aug. 2010 Monthly report to St. Luke's Board of Directors); *see* CCPFF ¶¶ 987-988).

1895. When initiating the three-year plan, Mr. Wakeman believed that the primary issue that St. Luke's needed to address was its decline in activity and need for growth. (Wakeman, Tr. 2783).

Response to Finding No. 1895

Complaint Counsel does not disagree.

1896. One goal of the three-year plan was the physician strategy, employing additional physicians at St. Luke's. This was a continuation of the NexTen report that St. Luke's

board had approved in February 2007. (PX01010 at 001-002; Wakeman, Tr. 2801-2802, 2814-2815; Black, Tr. 5578).

Response to Finding No. 1896

Complaint Counsel does not disagree.

1897. A central component of St. Luke's physician strategy was to build up its primary care physician base. St. Luke's expected those primary care physicians would refer patients to specialists at St. Luke's. (Wakeman, Tr. 2802-2803).

Response to Finding No. 1897

Complaint Counsel does not disagree.

1898. Between January 2008 and June 2010, St. Luke's employed 23 new physicians, all but two in 2008 or 2009. (Den Uyl, Tr. 6478-6479; RX-56 at 000021, *in camera*).

Response to Finding No. 1898

Complaint Counsel does not disagree.

1899. The new physicians and physician practices acquired by St. Luke's lost money on an operational basis. In other words, the cost of paying for the physicians and their staff exceeded the revenue realized from the patients that they treated. (Den Uyl, Tr. 6479-6480, Wakeman, Tr. 2804).

Response to Finding No. 1899

This proposed finding is incomplete and misleading. St. Luke's pursued this strategy of employing new physicians and acquiring physician practices because it expected them to generate inpatient and outpatient revenue at St. Luke's. (Joint Stipulations of Law and Fact, JX00002A ¶ 42). In the ordinary course of its business, St. Luke's projected that employing physicians would generate a positive return on investment in the long term. (PX01080 at 003 ("Physician Strategy Investments")). Even according to Respondent's financial expert, Mr. Den Uyl, this strategy of employing physicians since 2008 led to increased revenue at St. Luke's. (Den Uyl, Tr. 6479; RX-56 at 21 (¶ 54) (Den Uyl Expert Report), *in camera*). Mr. Dagen

concluded that the physician strategy actually { } physician practice revenues between 2009 and 2010. (Dagen, Tr. 3410, *in camera*).

1900. St. Luke's timeframe for a pay-off on its physician practice acquisitions ranged from six years to even longer. (RX-11 (Oppenlander, Dep. at 112)).

Response to Finding No. 1900

Complaint Counsel has no specific response.

1901. St. Luke's physician practices incurred significant financial losses during the years leading up to the joinder: in 2008 St. Luke's employed physicians had an operating loss of about $2.5 million; in 2009 the loss increased to $4.5 million. By the time of the joinder, the total losses from St. Luke's physician practices from 2008-August 31, 2010 totaled about $11 million. (Den Uyl, Tr. 6480; RX-56 at 000022, *in camera*).

Response to Finding No. 1901

This proposed finding is misleading. St. Luke's physician practices were acquired to improve revenues at St. Luke's – which they did – in the period leading up to the Acquisition. (*See* Response to RPFF ¶ 1899). Employed physicians drive significant revenue to the hospital, which is not reflected in the physician practice subsidies, but *is* reflected in the hospital's overall financial performance. (Dagen, Tr. 3178). As Mr. Dagen testified, the acquisitions of physician practices "were investments into the future, and the results that they attained show that they were good investments and facilitated [St. Luke's] turnaround." (Dagen, Tr. 3185).

1902. Because 21 of the 23 physicians employed by St. Luke's as part of its physician strategy were employed during 2008 and 2009 any revenue growth that St. Luke's achieved as a result of increased admissions from the newly employed physicians would be more significant in 2008 and 2009 than in 2010. (Den Uyl, Tr. 6479).

Response to Finding No. 1902

This proposed finding is misleading. Mr. Den Uyl testified that he did not have an expert opinion on the revenue impact of physician acquisitions on St. Luke's. (Den Uyl, Tr. 6553-6554). In fact, the acquisition of physician practices is part of a long term strategy to increase revenue and volume at St. Luke's. (PX01952 at 025 (Brick, Dep. at 95); PX01080 at 003

("Physician Strategy Investments"); Dagen, Tr. 3185). As Mr. Dagen concluded, the physician strategy { } physician practice revenues between 2009 and 2010. (Dagen, Tr. 3410, *in camera*; *see* Response to RPFF ¶ 1899). Ordinary course documents from St. Luke's indicate that the physician employment strategy would have continued into 2011. (PX02147 at 033 (¶ 60) (Dagen Expert Report)).

1903. Employing physicians had both one time and recurring costs, including initial capitalization, insurance coverage, physician salaries, practice operational expenditures and capital expenditures, like the AllScripts EMR system. (Wakeman, Tr. 2803-2804, 2819-2820).

Response to Finding No. 1903

Complaint Counsel has no specific response.

1904. Another goal of the three-year plan was to convert all of St. Luke's patient rooms from double-bed to single-bed rooms to improve St. Luke's infection control, patient safety, and patient satisfaction. In addition, it was important for St. Luke's to make this conversion to stay competitive locally and keep up with national standards. (PX01010 at 003; Wakeman, Tr. 2815; Black, Tr. 5584-5585).

Response to Finding No. 1904

Complaint Counsel has no specific response.

1905. Another goal of the three-year plan was to achieve breakeven margins by the end of 2007 and then 2-4 percent margins for subsequent years. (PX01010 at 003; Wakeman, Tr. 2815-2816).

Response to Finding No. 1905

This proposed finding is unfounded and not supported by the cited exhibit. PX01010, Mr. Wakeman's three-year plan, was created in June 2008 and page 003 references the end of 2009, *not*, as the proposed finding indicates, 2007. (PX01010 at 003 (Wakeman Three-Year Plan)).

1906. Another goal of the three-year plan was to maintain St. Luke's "A" rating with Moody's in order to borrow money at low costs for capital expenditures. (PX01026 at 003; Wakeman, Tr. 2816).

Response to Finding No. 1906

Complaint Counsel does not disagree.

1907. Another goal of the three-year plan was to gain access to additional managed care plans, in particular Anthem and Paramount. (PX01010 at 001).

Response to Finding No. 1907

Complaint Counsel does not disagree.

1908. St. Luke's realized that to accomplish its three-year plan it would also need to make significant investments in its IT capabilities to keep up with the rest of the marketplace. (Wakeman, Tr. 2816-2817).

Response to Finding No. 1908

Complaint Counsel has no specific response.

1909. St. Luke's board monitored and questioned the costs of implementing St. Luke's three-year plan, including its physician strategy. (Wakeman, Tr. 2820-2822; PX01284). For example, one member of St. Luke's board expressed concern that St. Luke's was "burning through cash" as a result of its three-year plan. (PX01284; Wakeman, Tr. 2821-2822).

Response to Finding No. 1909

This proposed finding is incomplete, misleading, and contradicted by the cited exhibit. In fact, PX01284 is an email from St. Luke's then-CFO, Mr. Oppenlander, addressing a board member's concern. (PX01284 at 001 (Oppenlander Jul. 2008 Email)). Mr. Oppenlander writes, "At this point, we have not had to borrow money nor use any reserves in 2008, everything has been funded out of operations." (PX01284 at 001 (Oppenlander Jul. 2008 Email)). He goes on to say that, "If we are able to execute [a medical office building joint-venture] strategy, that should generate cash that we did not plan for and thus just about eliminate the need to spend reserves in 2008." (PX01284 at 001 (Oppenlander Jul. 2008 Email)). St. Luke's was "still cash flow positive[.]" (PX01284 at 001 (Oppenlander Jul. 2008 Email)). Mr. Oppenlander closed his

email by stating, "Since we are making investments in our revenue streams, I truly view the cash spend as investments [] in our future." (PX01284 at 001 (Oppenlander Jul. 2008 Email)).

1910. As part of the three year plan St. Luke's engaged in discussions with other providers in the Toledo area to develop win-win relationships. St. Luke's engaged in discussions with UTMC, Mercy, and ProMedica. (PX01010 at 001; Wakeman, Tr. 2822-2824; Black, Tr. 5587-5588).

Response to Finding No. 1910

Complaint Counsel has does not disagree.

3. Other Efforts To Improve St. Luke's

a. Capital Freeze

1911. In 2009, St. Luke's instituted a capital freeze, limiting capital expenditures to those that were necessary for safety and patient care. (Wakeman, Tr. 2842; RX-1226 at 000004; Black, Tr. 5610).

Response to Finding No. 1911

This finding is incomplete and misleading. Even during a "capital freeze" in 2008 and 2009, St. Luke's spent $7 million and $14 million on capital expeditures, respectively. (CCPFF ¶ 1051). In October 2009, Mr. Wakeman noted that the capital freeze had "melted down quickly" as he signed off on many 'big ticket" capital items. (Wakeman, Tr. 2575; PX01361 (Wakeman Oct. 2009 Email)). In 2010, St. Luke's capital expenditures fell to $5 million but only because St. Luke's was "waiting for the [Acquisition] to go through." (PX001951 at 063 (Den Uyl, Dep. at 246-247), *in camera*; Den Uyl, Tr. 6567, *in camera*).

1912. Previously, in the Fall of 2008, St. Luke's stopped capital expenditures so St. Luke's could make its $900,000 HCAP funding payments, which are funds paid into a pool by all hospitals to compensate certain hospitals based on the amount of care for the poor, such as Medicaid, or underinsured or noninsured individuals that they treat. (RX-844; Wakeman, Tr. 2828).

Response to Finding No. 1912

This proposed finding is incomplete and misleading. Mr. Oppenlander writes in RX-844 that St. Luke's has "to pay around 900K[,] then a few weeks later we get most of it back, then we pay another 900K again and then a few weeks later we get most of it back." (RX-844 (Oppenlander Sept. 2008 Email)). In fact, the actual charge was only $30,000 and this was the "first time in the last 5 years" that St. Luke's lost money due to HCAP funding payments." (RX-844 at 001 (Oppenlander Sept. 2008 email)).

1913. During the capital freeze, St. Luke's Vice Presidents did not propose capital requests to Mr. Wakeman "unless they were absolutely necessary replacements or a part of the strategic plan and had to be justified." (Wakeman, Tr. 2575-2576).

Response to Finding No. 1913

Complaint Counsel has no specific response.

1914. In October 2009, Mr. Wakeman expressed concern that St. Luke's was still spending too much on capital given its financial difficulties. CFO Dave Oppenlander assured him that recent capital purchases reflected bare bones essentials, only those necessary for serving patients. (PX01361; Wakeman, Tr. 2937-2939, *in camera*).

Response to Finding No. 1914

This proposed finding is incorrect and misleading. St. Luke's had the ability and was committed to financing capital projects beyond just "bare bones essentials." In 2008 and 2009, St. Luke's continued to spend millions of dollars in strategic investments, such as the acquisitions of physician practices and off-site imaging centers, as well as the implementation of EMR systems at physician practices. (Wakeman, Tr. 2575; PX01852 at 005-006 (¶ 8) (Dagen Rebuttal Report)).

1915. St. Luke's tried not to engage in cost cutting initiatives that would affect patient outcomes, core measures, or patient satisfaction. (Wakeman, Tr. 2614-2615).

Response to Finding No. 1915

Complaint Counsel does not disagree.

1916. {
}(Den Uyl, Tr. 6469-6470, *in camera*). {
} (Den Uyl, Tr. 6470-6471, *in camera*).

Response to Finding No. 1916

Complaint Counsel has no specific response.

1917. {
} (Den Uyl, Tr. 6470-6471, *in camera*).

Response to Finding No. 1917

This proposed finding is misleading. St. Luke's age of plant did not negatively impact its quality of care. (Dagen, Tr. 3399). In fact, St. Luke's quality of care was excellent and at or above other hosptials in the region. (Dagen, Tr. 3399). As Mr. Brick testified, age of plant depends on the type and timing of capital expenditures. (Brick, Tr. 3558-3559). Because St. Luke's was built in 1972 and its facilities were well-maintained, it would not be necessary to rebuild to lower the age of plant. (Brick, Tr. 3559). Even Respondent's financial expert, Mr. Den Uyl, testified that he did not analyze whether St. Luke's age of plant impacted patient care. (Den Uyl, Tr. 6577-6578, *in camera*).

1918. {
} (RX-56 at 000018, *in camera*).

Response to Finding No. 1918

This proposed finding is misleading. (*See* Response to RPFF ¶ 1917)

b. Wage and Benefit Reductions and Hiring Freeze

1919. Employee compensation is the largest expense item for hospitals and represents about 40 percent of St. Luke's total operating expenses. (Johnston, Tr. 5326).

Response to Finding No. 1919

Complaint Counsel has no specific response.

1920. In late 2008, St. Luke's began cutting back hours of its employees in an attempt to reduce operational expenses. (Black, Tr. 5598-5599).

Response to Finding No. 1920

Complaint Counsel has no specific response.

1921. St. Luke's also froze employee compensation in 2008, including step increases and merit pay increases, for all employees; at the time of the joinder, employees had not received pay increases for two years. (Johnston, Tr. 5317; Wakeman, Tr. 2841-2842; Black, Tr. 5608; RX-1226 at 000002-000003).

Response to Finding No. 1921

Complaint Counsel has no specific response.

1922. As an additional cost-cutting measure, St. Luke's had reduced the amount of earned time off that employees accrued and increased employees' premium contributions for their healthcare benefit. (Johnston, Tr. 5317; Black, Tr. 5609; RX-1226 at 000002-000003).

Response to Finding No. 1922

Complaint Counsel has no specific response.

1923. In 2009, all of St. Luke's executives took a 10 percent pay cut. (Johnston, Tr. 5317).

Response to Finding No. 1923

Complaint Counsel has no specific response.

1924. St. Luke's has access to published survey data on healthcare compensation at both the state and national levels. (Johnston, Tr. 5327).

Response to Finding No. 1924

Complaint Counsel does not disagree.

1925. Key clinical positions at St. Vincent and UTMC are unionized and compensation data for these positions is publicly available as a result. (Johnston, Tr. 5327).

Response to Finding No. 1925

Complaint Counsel has no specific response.

1926. During the period while St. Luke's salaries were frozen, other Lucas County hospitals were giving salary increases. (Johnston, Tr. 5327-5328).

Response to Finding No. 1926

This proposed finding is incomplete and misleading. While St. Luke's may have frozen salaries, it did not conduct layoffs. While other Lucas County hospitals may have been giving salary increases to some employees, they were reducing other employees' salary to zero through layoffs. (Wakeman, Tr. 2572; PX01274 at 001 (Wakeman May 2009 email), *in camera* ({ })). In fact, St. Luke's hired additional full-time employees during both calendar years 2009 and 2010. (Joint Stipulations of Law and Fact, JX00002A ¶¶ 44-45).

1927. There is a shortage in Lucas County of many key clinical positions, such as lab technicians, RNs, and pharmacists. (Johnston, Tr. 5328).

Response to Finding No. 1927

Complaint Counsel has no specific response.

1928. The fact that St. Luke's salaries were frozen while other Lucas County hospitals were giving pay increases created a situation where employees had the incentive and ability to leave St. Luke's to work for other Lucas County hospitals. (Johnston, Tr. 5328-5329).

Response to Finding No. 1928

This proposed finding is incomplete and misleading. Ms. Johnston described economic conditions in Lucas County where a lot of employers were struggling, and as such, "a higher percentage of [St. Luke's] employees . . . became the primary income earner." (Johnston, Tr. 5328-5329). As discussed above, St. Luke's was the only hospital in Lucas County not to conduct layoffs. (*See* Response to RPFF ¶ 1926). Ms. Johnston goes on to testify that the

stability of job security, compared with the potential for layoffs, would actually be viewed as a positive by employees compared to other hospitals in Lucas County. (Johnston, Tr. 5328-5329).

1929. Freezing salaries was a short-term strategy that could not continue, especially when no other Lucas County hospitals were freezing salaries at the same time. (Johnston, Tr. 5329).

Response to Finding No. 1929

Complaint Counsel has no specific response.

1930. When St. Luke's lifted its salary freeze, St. Luke's would face operating expenses that would increase at a greater percentage than previously, placing greater financial pressure on the organization. (Johnston, Tr. 5330).

Response to Finding No. 1930

Complaint Counsel has no specific response.

1931. St. Luke's also had a strategy of avoiding layoffs, but in the years immediately prior to the joinder it did not hire replacements as workers retired or left the organization. (Johnston, Tr. 5441-5442).

Response to Finding No. 1931

This proposed finding is incorrect. Indeed, St. Luke's replaced any employee if the position had a direct impact on the quality of patient care. (Wakeman, Tr. 2574). St. Luke's even hired additional full-time employees during both calendar years 2009 and 2010. (Joint Stipulations of Law and Fact, JX00002A ¶¶ 44-45).

1932. In February 2009, St. Luke's instituted a hiring freeze, going into a "highly oversighted mode" for hiring, restricting it to essential positions that affected patient care. (Wakeman, Tr. 2574, 2842; PX01597 at 001). St. Luke's hiring freeze continues to the present and was not part of St. Luke's three-year plan. (Wakeman, Tr. 2843-2844).

Response to Finding No. 1932

This proposed finding is misleading. (*See* Response to RPFF ¶ 1931). In addition, the number of full-time employees increased from 2008 to 2010. (PX01384 at 003 (St. Luke's Hospital FTE Reporting), *in camera*).

1933. During the hiring freeze, volume increased at St. Luke's so it generally did not make sense to conduct layoffs. Instead, St. Luke's cut pay, cut benefits, and froze pay. (Wakeman, Tr. 2573).

Response to Finding No. 1933

Complaint Counsel has no specific response.

1934. {

} (Den Uyl, Tr. 6468, *in camera*).

Response to Finding No. 1934

Complaint Counsel has no specific response.

1935. {

} (Den Uyl, Tr. 6468-6469, *in camera*).

Response to Finding No. 1935

Complaint Counsel has no specific response.

c. Freezing Defined Benefit Pension Plan

1936. On December 31, 2009, St. Luke's froze its employee defined benefit plan and shifted employees to a contribution plan. (Johnston, Tr. 5331; Arjani, Tr. 6730). This change resulted in cost savings for St. Luke's. (Wakeman, Tr. 2871).

Response to Finding No. 1936

Complaint Counsel does not disagree.

1937. Freezing a pension plan means that no new participants will be added to the plan; benefits only accrue to those people who are vested as of the date of the freezing of the plan. The pension benefit is also based on compensation as of that date; future compensation is not counted in calculating the plan's pension obligation or funding target. (Johnston, Tr. 5339; Arjani, Tr. 6730-6731).

Response to Finding No. 1937

Complaint Counsel has no specific response.

1938. After St. Luke's defined benefit pension plan was frozen, St. Luke's still had an obligation to make up the difference between the funding target, the present value of the plan's obligations, and the plan's assets. (Arjani, Tr. 6731).

Response to Finding No. 1938

Complaint Counsel has no specific response.

d. Shifting Patients to the SurgiCare Joint Venture

1939. In response to its financial challenges, St. Luke's encouraged surgeons, where possible to perform surgeries at SurgiCare, the joint venture outpatient center in which St. Luke's had a 50 percent interest. (Wakeman, Tr. 2876).

Response to Finding No. 1939

Complaint Counsel has no specific response.

1940. Because St. Luke's was a 50 percent owner of SurgiCare, St. Luke's would only receive half the margin on each case at SurgiCare. Nonetheless, because SurgiCare's MCO rates were higher than those of St. Luke's and its costs were lower as well, it was profitable for St. Luke's to shift patients to SurgiCare. Mr. Wakeman explained that "half of something positive is better than 100 percent of a total loss." (Wakeman, Tr. 2876).

Response to Finding No. 1940

This proposed finding is incomplete and misleading. Mr. Wakeman testified that "[b]ecause Surgi+Care is a freestanding outpatient surgery facility only, their costs for producing a case or a unit of service is significantly lower than the hospital's." (Wakeman, Tr. 2876). It is this cost structure, rather than reimbursement structure alone, that encouraged the shift from the hospital to outpatient facilities.

4. St. Luke's Financial Problems Continued Despite the Three-Year Plan

1941. Despite increasing utilization of the hospital after Mr. Wakeman's arrival, St. Luke's did not see an improvement in its bottom line. (RX-34 (Dewey, IHT at 183-185)). St. Luke's net patient service revenue had increased since 2007, but those revenues were still less than St. Luke's operating expenses. (PX1016 at 002, *in camera*; RX-11 (Oppenlander, Dep. at 176-177)).

Response to Finding No. 1941

This proposed finding is incomplete and inaccurate. St. Luke's had solid and improving financials by the time of the Acquisition. According to Mr. Den Uyl, during the first 8 months of

2010, St. Luke's "increased revenue and decreased cost." (RX-56 at 11 (¶ 30) (Den Uyl Expert Report), *in camera*; Den Uyl, Tr. 6593-6594, *in camera*). Mr. Dagen testified that St. Luke's experienced improvements in nearly all financial metrics. (Dagen, Tr. 3187). Operating cash flow margin, operating income margin, total net revenue, and patient volume all improved from 2009 to 2010. (*See* CCPFF ¶¶ 965-975). Furthermore, external conditions in the financial markets, rather than St. Luke's operating performance, were largely to blame for any disruption in St. Luke's financial performance. (CCPFF ¶¶ 1063-1070).

1942. St. Luke's did not achieve the financial goals of the three-year plan or any of the objective metrics that were outlined in those financial goals. (PX01010 at 003-004; Rupley, Tr. 1973; Wakeman, Tr. 3018-3019, *in camera*).

Response to Finding No. 1942

This proposed finding is incorrect and misleading. St. Luke's increased inpatient and outpatient net revenue, two specific goals in Mr. Wakeman's three-year plan. (CCPFF ¶¶ 910-913). Specifically, Mr. Wakeman mentions achieving a debt service coverage ratio of 2.0, but by the time of the Acquisition, St. Luke's debt service coverage ratio was 3.7. (PX01010 at 004 (Wakeman Three-Year Plan); PX02129 at 002 (Ex. 1) (Hanley, Decl.)). This finding also ignores the positive turnaround on many other financial metrics that St. Luke's had achieved by the time of the Acquisition. (*See* Response to RPFF ¶ 1941).

1943. St. Luke's did not accomplish the three-year plan goal of having "a break even margin by the end of 2009." (PX01010 at 003-004; Wakeman, Tr. 3018-3019, *in camera*).

Response to Finding No. 1943

Complaint Counsel has no specific response.

1944. St. Luke's did not even achieve a break even margin by the end of 2010. (PX01010 at 003-004; Wakeman, Tr. 3018-3019, *in camera*).

Response to Finding No. 1944

Complaint Counsel has no specific response.

1945. St. Luke's did not accomplish the three-year plan goal to "Maintain St. Luke's "A" rating with Moody's." (PX01010 at 003-004; Wakeman, Tr. 3018-3019, *in camera*).

Response to Finding No. 1945

Complaint Counsel has no specific response.

1946. St. Luke's did not accomplish the three-year plan goal to maintain a "Debt Service Coverage Ratio of 2.0." (PX01010 at 003-004; Wakeman, Tr. 3018-3019, *in camera*).

Response to Finding No. 1946

This proposed finding is incorrect. According to Ms. Hanley, St. Luke's debt service coverage ratio was 3.7 by the time of the Acquisition. (PX02129 at 002 (Ex. 1) (Hanley, Decl.)).

1947. St. Luke's did not accomplish the three-year plan goal to "Achieve an average age of plant consistent with Moody's "A" rated hospitals." (PX01010 at 003-004; Wakeman, Tr. 3018-3019, *in camera*).

Response to Finding No. 1947

Complaint Counsel has no specific response.

1948. St. Luke's did not accomplish the three-year plan goal of "[w]ithin three years, systematically convert all St. Luke's double-bed patient rooms to single-bed patient rooms." (PX01010 at 002; Wakeman, Tr. 3018-3019, *in camera*).

Response to Finding No. 1948

Complaint Counsel has no specific response.

1949. St. Luke's did not accomplish the three-year plan goal to "Establish two signature clinical service plans within 3 years: obstetrics and surgery." (PX01010 at 001; Wakeman, Tr. 3018-3019, *in camera*).

Response to Finding No. 1949

Complaint Counsel has no specific response.

1950. St. Luke's negative operating margin in the years prior to the joinder led to a very tight cash-on-hand situation, which caused it to withhold normally scheduled payments to vendors. (Johnston, Tr. 5316). St. Luke's average invoice statements require payments in 30 days; however, St. Luke's average term of payment was 53 days. (Wakeman, Tr. 2571).

Response to Finding No. 1950

This proposed finding is inaccurate. St. Luke's paid its bills on time, never missed a payment on its 2004 series bonds, and never missed a payment to its pensioners. (Wakeman, Tr. 2571; CCPFF ¶¶ 1006, 1034). According to Ms. Johnston, St. Luke's did not lose any prompt payment discounts either. (PX01926 at 024 (Johnston, Dep. at 88-89), *in* camera). Not only did St. Luke's not miss payments, St. Luke's high cash reserves put it in a comfortable position compared to comparable hospitals. St. Luke's cash-to-debt ratio was 412%, compared to an average of 102% for all Moody's-rated hospitals. (PX01372 at 002 (Moody's Rating Update: St. Luke's, Feb. 3, 2010); Brick, Tr. 3474). By the time of the Acquisition, St. Luke's had approximately $65 million in cash and investment balances. (*See* CCPFF ¶ 976). At the end of 2010, St. Luke's cash and investments had increased to approximately $70 million. (Joint Stipulations of Law and Fact, JX00002A ¶ 35).

1951. An accounts payable system typically includes payment parameters that seek to maximize cash flow, but after normal payment parameters were applied, St. Luke's could not fund all of its vendor checks due to its limited cash. (Johnston, Tr. 5322-5324).

Response to Finding No. 1951

This proposed finding is misleading. (*See* Response to RPFF ¶ 1950).

1952. As a result, St. Luke's would review the amount of outgoing checks each week and compare this against its target level of cash-on-hand after payroll. If the amount scheduled to go out each week would place St. Luke's cash-on-hand below the target level, then St. Luke's manually withheld these checks and did not mail them to vendors. (Johnston, Tr. 5324).

Response to Finding No. 1952

This proposed finding is misleading for two reasons. First, St. Luke's had substantial cash and investment balances prior to the Acquisition. (*See* Response to RPFF ¶ 1950). Second, Respondent relies solely on the testimony of Ms. Johnston for facts that occurred well before her arrival at St. Luke's in September 2010. (Johnston, Tr. 5421). Because she has no firsthand

knowledge of events and decisions made at St. Luke's prior to September 2010, her testimony is also unreliable.

1953. At the time of the joinder, St. Luke's target for cash-on-hand after payroll was $1.6 million dollars. (Johnston, Tr. 5323). By comparison, St. Luke's gross annual revenues were approximately $400 million. (Johnston, Tr. 5323).

Response to Finding No. 1953

Complaint Counsel has no specific response.

1954. Holding checks back manually is considered a poor internal control practice because it creates the risk of error or impropriety. (Johnston, Tr. 5324-5325). Holding back checks also leads to vendor frustration. (Johnston, Tr. 5325).

Response to Finding No. 1954

This proposed finding is misleading. There is no evidence that St. Luke's committed an error or impropriety in payments during this time. In addition, there is no evidence that any vendors were frustrated with St. Luke's during this time. Ms. Johnston's testimony is unreliable as she was not employed by St. Luke's during this time period. Finally, St. Luke's significant cash and investment reserves left it in an advantageous position compared to many similar hospitals. (*See* Response to RPFF ¶ 1950).

1955. {

} (Wakeman, Tr. 2920-2921, *in camera*).

Response to Finding No. 1955

This proposed finding is misleading. St. Luke's attained the Three-Year Plan's target number of core physicians by April 2010, a year ahead of schedule. (Wakeman, Tr. 2583-2584).

1956. In the three year period prior to the joinder, St. Luke's only experienced three or four months of positive operating performance from patient care. (Wakeman, Tr. 2604).

Response to Finding No. 1956

This proposed finding is incomplete and misleading. According to Mr. Den Uyl, during the first 8 months of 2010, St. Luke's "increased revenue and decreased cost." (RX-56 at 11 (¶ 30) (Den Uyl Expert Report), *in camera*; Den Uyl, Tr. 6593-6594, *in camera*). In the eight months leading up to the Acquisition in 2010, St. Luke's operating cash flow margin was positive 3.8%. (PX02129 at 002 (Ex. 1) (Hanley, Decl.)). St. Luke's total net patient revenues had increased 27% since 2007 to 2010. (*See* CCPFF ¶ 917). As Ms. Hanley testified, St. Luke's experienced a positive trend in patient revenue since 2008. (Hanley, Tr. 4701-4702). St. Luke's volume and occupancy had improved by the time of the Acquisition, (*See* CCPFF ¶¶ 945-963), as had St. Luke's operating cash flow and profitability. (*See* CCPFF ¶¶ 965-975). Mr. Wakeman's last words to St. Luke's Board of Directors in August 2010 tell the story of this positive operating performance:

- "[I]n the past three years . . . [w]e went from an organization with declining activity to near capacity." (PX00170 at 007).
- "[W]e have built our volume up to a point where we can produce an operating margin and keep our variable expenses under control." (PX00170 at 001).
- "Even with our increased activity, the patient satisfaction scores improved . . . ." (PX00170 at 004).
- "Our leadership status in quality, service and low cost stayed firmly in place." (PX00170 at 007).
- "In the past six months our financial performance has improved significantly. The volume increase and awareness of expense control were key." (PX00170 at 007).

1957. In August 2010, the last month before the joinder, St. Luke's "was able to squeeze out a $7,000 margin on $36 million revenue" running almost at full capacity. Mr. Wakeman believed this was "not impressive." (Wakeman, Tr. 2605; PX00170 at 001).

Response to Finding No. 1957

This proposed finding is incomplete. The next sentence in Mr. Wakeman's memo paints a different picture: "This positive margin confirms that we can run in the black if activity stays high." (PX00170 at 001 (Wakeman Aug. 2010 Monthly Board Report)). Mr. Wakeman closed his memo by saying, "The entire St. Luke's family has much to be proud of with the accomplishments in the past three years." (PX00170 at 007 (Wakeman Aug. 2010 Monthly Board Report)). St. Luke's increased activity would have led to more profitable months and continued the turnaround at St. Luke's. (*See* CCPFF ¶¶ 945-963, 965-975).

1958. The $7,000 operating margin on $36.7 million in gross revenue that St. Luke's attained in August 2010 incorporated two large, unusual additions to St. Luke's operating income that month: (1) a catch up payment for the University of Toledo faculty involved with the Family Medicine Residency; and (2) a tax credit from the State of Ohio as St. Luke's taxes had been over projected. (PX00170 at 001).

Response to Finding No. 1958

This proposed finding is misleading. Mr. Wakeman attributes the positive operating margin to high activity – not one-off payments as Respondent suggests. (*See* Response to RPFF ¶ 1957).

1959. Mr. Wakeman was not confident that the small positive operating margin in the month of August in 2010 reflected the operating margin for the remainder of the year: "There were many months that we had high capacity and lost money from operations due to the payor mix inside the organization and the services provided." (Wakeman, Tr. 2618-2619).

Response to Finding No. 1959

Complaint Counsel has no specific response.

1960. At the time of the joinder, St. Luke's was still not in a position to fund the capital needs of the organization through operations. (Wakeman, Tr. 2619).

Response to Finding No. 1960

This proposed finding is misleading. By the time of the Acquisition, operating cash flow margin was positive 3.8 percent. (PX02129 at 002 (Ex. 1) (Hanley, Decl.)). In other words,

during the first eight months of 2010, St. Luke's "produced [positive] cash from the operating revenue on operations." (Hanley, Tr. 4703). Mr. Oppenlander wrote in 2008 that physician practice acquisitions were all funded out of operations. (PX01284 at 001 (Oppenlander Jul. 2008 Email)). Finally, St. Luke's significant cash and investment balances enabled it to complete any high priority capital projects. (*See* CCPFF ¶¶ 976-981, 1071-1085).

1961. Prior to the joinder, Mr. Wakeman doubted that a stand-alone St. Luke's could be a significant competitor after 2011: "With healthcare reform and the stimulus bill going through that mandated meaningful use, the capital improvements that we needed to put into the organization because of our average age of plant, that now exceeded 16 years, and the private rooms we had to put in. All of those capital demands would have put us so far behind the eight-ball, we would have had a very difficult time competing in the long term after 2011 as an independent." (Wakeman, Tr. 2619-2620).

Response to Finding No. 1961

This proposed finding is inaccurate and is contradicted by other testimony from Mr. Wakeman as well as his own ordinary course statements. At the end of 2009, Mr. Wakeman told St. Luke's Board of Directors that St. Luke's would stay open as an independent hospital for at least three to seven years. (CCPFF ¶ 1071). By the time of the Acquisition, this timeframe would have been extended further given St. Luke's financial turnaround and improvements in the equity markets. (CCPFF ¶ 1072). In addition, Mr. Dagen, Complaint Counsel's financial expert, used a pro forma to conservatively forecast St. Luke's operating performance in the coming years. (CCPFF ¶ 1082). His analysis shows that St. Luke's would be able to continue operations and investments and "but for the acquisition [by ProMedica], St. Luke's would have been … a financially stable organization and able to compete in the marketplace." (CCPFF ¶¶ 1083-1084; Dagen, Tr. 3230-3231)

D. St. Luke's Board and Management Concluded that St. Luke's Could Not Survive as a Full Service, Stand-Alone Community Hospital

1962. The fact that St. Luke's was not making money, because of increasing expenses, despite staying busy, was a factor for members of St. Luke's board that precipitated the need to look for an affiliation partner. (RX-16 (Bazeley, Dep. at 50-51)).

Response to Finding No. 1962

Complaint Counsel has no specific response.

1963. {

} (PX01018 at 008, *in camera*).

Response to Finding No. 1963

This proposed finding is misleading and incomplete. Between the time of this assessment and the time of the Acquisition, St. Luke's had greatly improved its financial condition. (*See* CCPFF ¶¶ 898-988). St. Luke's had benefitted from improvements in operations due to Mr. Wakeman's three-year plan and in its reserves and investments due to improvements in the financial markets. (*See* CCPFF ¶¶ 906-944, 964-986). In 2009, St. Luke's had considered cutting service lines, but subsequently rejected this plan. (CCPFF ¶¶ 1058-1060). St. Luke's Board rejected service cuts, in part, because they found them to be distasteful. (CCPFF ¶ 1059). According to Mr. Wakeman, "St Luke's ultimately rejected drastic cuts in services and employees because they would have diminished the hospital's ability to serve the community and made it even less attractive to patients, employers, physicians and payors." (PX02102 at 008 (¶ 22) (Wakeman, Decl.)). St. Luke's financial condition ultimately improved to the point that these cuts were not necessary. (*See* CCPFF ¶¶ 898-988).

1964. {

} (Wakeman, Tr. 2909-2911, *in camera*; PX01018 at 008, *in camera*).

Response to Finding No. 1964

This proposed finding is misleading and incomplete. As discussed above, St. Luke's considered and rejected service line cuts in 2009. (Response to RPFF ¶ 1963; CCPFF ¶¶ 1058-1060). Further, there is no evidence that after August 2009, during the time leading up to the Acquisition, St. Luke's revisited the issue of eliminating service lines as a standalone hospital after clearly rejecting that option. (Response to RPFF ¶ 1963).

1965. { } (Wakeman, Tr. 2909-2910, *in camera*).

Response to Finding No. 1965

This proposed finding is incomplete and misleading. (*See* Response to RPFF ¶ 1963). And in fact, to the contrary, St. Luke's actually hired additional full-time employees during 2009 and 2010. (Joint Stipulations of Law and Fact, JX00002A ¶¶ 44-45).

1966. To survive independently, St. Luke's board determined that it would have to make significant changes to its employee base and services to resize the hospital commensurate with demands it was facing. (RX-34 (Dewey, IHT at 183-186)).

Response to Finding No. 1966

This proposed finding is misleading and incomplete. (*See* Response to RPFF ¶¶ 1963-1964). Mr. Dewey went on to say that St. Luke's management believed that cutting services "would be a disservice to the community" and "didn't feel that was the right thing for the community." (PX01909 at 048-049 (Dewey, IHT at 187-189), *in camera*).

1967. At about the same time, the initial indications of what healthcare reform legislation was going to require were coming to light, and St. Luke's concluded that meeting those requirements, such as a substantial capital investment IT, would require an organization beyond St. Luke's. (RX-34 (Dewey, IHT at 184-185)).

Response to Finding No. 1967

This proposed finding is directly contradicted by Respondent's documents and testimony. In fact, St. Luke's was well-positioned to take advantage of pending healthcare reform.

(PX01072 at 001 ("Key Messages from St. Luke' Hospital"); Wakeman, Tr. 2620-2621). Specifically, with respect to EMR, St. Luke's concluded that it would qualify for $6.3 million in federal subsidies to help fund its EMR system. (PX01281 at 012 (St. Luke's "Financial Pillar Challenge"); PX01503 at 001 (mid-2010 updated bid from EMR vendor), *in camera*). St. Luke's fully intended to implement EMR at the start of 2010, until joinder talks with ProMedica caused them to stop the process. (*See* Response to RPFF ¶ 1737).

1968. St. Luke's board also recognized that St. Luke's physical plant was aging and needed a number of improvements; and to maintain this asset that was serving the community, the St. Luke's board stated that St. Luke's management should try to find an affiliation partner. (RX-34 (Dewey, IHT at 184-185)).

Response to Finding No. 1968

Complaint Counsel has no specific response.

1969. { } (PX01018 at 008, *in camera*; Wakeman, Tr. 2910-2911, *in camera*).

Response to Finding No. 1969

This proposed finding is misleading. The service line cuts discussed in the proposed finding were not required for St. Luke's survival. (*See* Response to RPFF ¶¶ 1963-1964). Mr. Dagen concluded that St. Luke's positive trajectory in 2010 would have caused it to reach increasingly higher levels of EBITDA in the next several years, including positive EBITDA in 2011, 2012, and 2013. (PX02147 at 040-042 (¶¶ 72-74) (Dagen Expert Report)). The results of Mr. Dagen's analysis also confirm that, absent the Acquisition, St. Luke's would not only be able to avoid service cuts, but would be able to continue to make growth-minded investments, implement EMR, convert semi-private rooms to private rooms, eliminate its outstanding bond debt, and still have approximately $33 million in cash and reserves at the end of 2013. (Dagen, Tr. 3210-3214; PX02147 at 036 (¶ 65) (Dagen Expert Report)).

1970. {

} (PX01283 at 002, *in camera*; Wakeman, Tr. 2949-2950, *in camera*).

Response to Finding No. 1970

This proposed finding is incomplete and misleading. Mr. Wakeman made these statements after one disappointing month. (Wakeman, Tr. 2949, *in camera* ({

})). Soon after this month, St. Luke's started its financial turnaround leading to a positive trajectory by the time of the Acquisition, eleven months later. (*See* CCPFF ¶¶ 982-986).

1971. {

} (PX01283 at 002; Wakeman, Tr. 2951, *in camera*).

Response to Finding No. 1971

This proposed finding is incomplete. Mr. Wakeman also testified that the 2010 improvements in the equities markets and St. Luke's positive cash-flow operating margins would extend this timeframe even further. (Wakeman, Tr. 2626; PX01920 at 038 (Wakeman, Dep. at 144-145), *in camera*).

1972. {

} (Wakeman, Tr. 2965-2966, *in camera*).

Response to Finding No. 1972

Complaint Counsel has no specific response.

1973. St. Luke's CEO, Mr. Wakeman, did not agree with the St. Luke's board approach on November 4, 2009, as he believed it was not sufficiently focused to resolve St. Luke's serious financial problems. He believed that the November 4 board meeting "was an example of how large boards have an arduous time making difficult decisions. They are struggling with losses of $2 million per month and holding onto independence." (RX-880 at 000001; Wakeman, Tr. 2967, *in camera*).

Response to Finding No. 1973

Complaint Counsel has no specific response.

1974. After the November 4, 2009 board meeting, Mr. Wakeman believed that St. Luke's large financial losses and need for significant investments in, for example, an underpaid workforce, aging plant and equipment, and a new IT system, would eventually persuade the board to choose a joinder partner or make more aggressive service cuts. (RX-880 at 000001; Wakeman, Tr. 2967-2970, *in camera*).

Response to Finding No. 1974

Complaint Counsel has no specific response.

1975. {

}. (PX01583 at 001-002 *in camera*; Wakeman, Tr. 2977-2984, *in camera*).

Response to Finding No. 1975

Complaint Counsel has no specific response.

1976. {

} (PX01029 at 001, *in camera*).

Response to Finding No. 1976

Complaint Counsel has no specific response.

1977. {

} (Wakeman, Tr. 2984-2985, *in camera*).

Response to Finding No. 1977

This proposed finding is directly contradicted by Mr. Wakeman's contemporaneous records and testimony. In November 2009, Mr. Wakeman wrote: {

}

(PX01470 at 001 (Wakeman Nov. 2009 Email), *in camera*). Mr. Wakeman testified that such a rate increase would give St. Luke's the "breathing room" it needed. (Wakeman, Tr. 2648).

1978. {

} (PX01016 at 001, *in camera*).

Response to Finding No. 1978

Complaint Counsel has no specific response.

1979. {

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- } (PX01016 at 014, *in camera*; Wakeman, Tr. 2992, *in camera*).

Response to Finding No. 1979

This proposed finding is incomplete and misleading in that it ignores the numerous financial metrics by which St. Luke's performance and financial condition improved from December 2009 through the time of the Acquisition. (CCPFF ¶¶ 898-988).

1980. {

} (Wakeman, Tr. 2999-3000, *in camera*).

Response to Finding No. 1980

Complaint Counsel has no specific response.

E. Moody's and AMBAC's Independent Assessments of St Luke's Confirmed Its Financial Difficulty

1. Moody's Downgraded St. Luke's in November 2008 and in February 2010

1981. Moody's, the credit rating agency, downgraded St. Luke's Series 2004 revenue bonds by two grades in November 2008, from "A2" to "Baa1." (PX00379 at 001).

Response to Finding No. 1981

Complaint Counsel does not disagree.

1982. Moody's description of the challenges faced by St. Luke's in Moody's November 2008 downgrade report accurately reflected challenges faced by St. Luke's at that time. These challenges include: "significant operating loss of $7.9 million (-6.1 percent operating margin) in fiscal year 2007 and operating losses continued through ten months FY 2008, with an operating loss of $7.2 million (-6.3 percent operating margin.) Losses driven by inpatient surgical and cardiac volume declines, due in part to physician losses in fiscal year 2007; ongoing physician competition in cardiac services, and a weaker economy." (Wakeman, Tr. 2834; PX00379 at 001-002).

Response to Finding No. 1982

Complaint Counsel has no specific response.

1983. Moody's further downgraded St. Luke's on February 3, 2010 from Baa2 to Baa1. (PX00053 at 001).

Response to Finding No. 1983

Complaint Counsel does not disagree.

1984. { } (Wakeman, Tr. 3007, *in camera*).

Response to Finding No. 1984

The proposed finding is misleading. Mr. Brick, Complaint Counsel's bond-ratings expert, provided unrebutted testimony that the "Baa2" rating is considered a medium-grade rating, which places St. Luke's in the same category as 28% of all other rated-hospitals. (CCPFF ¶ 1017). Indeed, investors and the capital markets have an appetite for debt from issuers of medium grade risk. "Baa" rated hospitals and healthcare systems issued $2.6 billion in debt from January 2010 to January 2011. (CCPFF ¶ 1019).

1985. Moody's February 3, 2010 downgrade concluded that St. Luke's "outlook remains negative." (PX00053 at 001).

Response to Finding No. 1985

Complaint Counsel has no specific response.

1986. Moody's February 3, 2010 downgrade of St. Luke's highlighted that a challenge for St. Luke's was the "[t]hird consecutive year of large operating losses and an operating cash flow deficit posted for the first time through 11 months of FY 2009 (-9.8 percent operating margin and -2.0 percent operating cash flow.)" (PX00053 at 001).

Response to Finding No. 1986

Complaint Counsel has no specific response.

1987. Moody's February 3, 2010 downgrade of St. Luke's highlighted that a challenge for St. Luke's was "[c]urrently unfavorable commercial contracts and ongoing challenges with negotiating higher commercial reimbursement rates with SLH's two largest commercial payors, MMO and Anthem Blue Cross Blue Shield (who account for approximately 22 percent of SLH's gross revenues)." (PX00053 at 001).

Response to Finding No. 1987

Complaint Counsel has no specific response.

1988. Moody's February 3, 2010 downgrade of St. Luke's highlighted that another challenge for St. Luke's was the "[v]ery competitive market with the presence of a number of hospitals that are part of two larger and financially stronger systems, ProMedica Health System (Aa3-rated) and Mercy Health Partners (owned by A1-rated Catholic Health Partners)." (PX00053 at 001).

Response to Finding No. 1988

Complaint Counsel has no specific response.

1989. Moody's February 3, 2010 downgrade of St. Luke's highlighted that a further challenge for St. Luke's was the "[w]eak demographics in the primary service area that includes Toledo, OH is characterized by declining volume trends, high unemployment levels, and low median income levels." (PX00053 at 002).

Response to Finding No. 1989

Complaint Counsel has no specific response.

1990. Moody's February 3, 2010 downgrade of St. Luke's highlighted that a challenge for St. Luke's was the "[t]ransition in senior leadership with the recent resignation in December 2009 of the Chief Financial Officer (CFO) of six years." (PX00053 at 002).

Response to Finding No. 1990

Complaint Counsel has no specific response.

1991. Moody's February 3, 2010 downgrade concluded that St. Luke's "negative outlook." This means that there was a greater likelihood there would be a further downgrade than an upgrade in the future. (PX00053 at 001; Den Uyl, Tr. 6463, *in camera*).

Response to Finding No. 1991

This proposed finding is incorrect and misleading. In its last ratings update for an independent St. Luke's, Moody's also identified certain factors that "could change the rating - UP[,]" including: "[c]ontinued growth and stability of inpatient and outpatient volume trends; significantly improved and sustainable operating performance for multiple years; strengthening of debt coverage measures and liquidity balance; improved market share." (PX01372 at 003 (Moody's Rating Update: St. Luke's, Feb. 3, 2010)). As Mr. Wakeman testified, St. Luke's already had met several of the factors indicated by Moody's by the time of the Acquisition. (Wakeman, Tr. 3034-3036). As a result, St. Luke's recent financial turnaround produced results that likely would have led Moody's to upgrade St. Luke's credit rating. (PX02146 at 009-013 (¶¶ 15-20) (Brick Expert Report)). In addition, Respondent relies on the testimony of Mr. Den Uyl, when, in fact, Mr. Den Uyl testified that he did not analyze – and had no expert opinion on –

what credit rating St. Luke's would have received as a standalone entity going forward. (CCPFF ¶ 1030).

1992. At the time of the latest Moody's downgrade, St. Luke's level of bonds outstanding was fairly low. (Dagen, Tr. 3312).

Response to Finding No. 1992

Complaint Counsel does not disagree.

1993. {

} (Den Uyl, Tr. 6463-6464, *in camera*; RX-56 at 000019*, in camera*).

Response to Finding No. 1993

This proposed finding is incorrect and misleading. Again, Respondent's premise that Moody's was seriously concerned about St. Luke's is flawed. As Complaint Counsel's bond-rating expert, Mr. Brick, stated, "if Moody's is concerned about a hospital's financial viability, it will not hesitate to reduce that hospital's credit rating to speculative grade." (PX01854 at 002 (¶ 4) (Brick Rebuttal Report)). Had Moody's been concerned about St. Luke's ability to continue to thrive in its marketplace, Moody's would have downgraded St. Luke's to a "Ba" or lower credit rating, as Moody's had done with many hospitals in Massachusetts, New Jersey, and Ohio. (Brick, Tr. 3542-3543).

This finding also highlights the fact that St. Luke's low level of outstanding debt put it in a favorable position when compared to other hospitals. In 2009, St. Luke's cash-to-debt ratio was 412%, compared to 102% for all other Moody's-rate hospitals. (PX01372 at 004 (Moody's Rating Update: St. Luke's, Feb. 3, 2010)). As of August 31, 2010, St. Luke's had enough cash and investments on its financial statements to pay off all of its outstanding debt. (Joint Stipulations of Law and Fact, JX00002A ¶ 24; Response to RFA at ¶ 48).

2. St. Luke's Bond Default Was Only Resolved When ProMedica Agreed To Take Over St. Luke's Bond Obligations

a. AMBAC's Review of St. Luke's Bonds

1994. { } (Gordon, Tr. 6784, 6789, *in camera*).

Response to Finding No. 1994

Complaint Counsel does not disagree.

1995. AMBAC completed a credit analysis of St. Luke's bonds in late 2008 and early 2009 and downgraded St. Luke's credit from an A- to a BBB+ rating. (Gordon, Tr. 6791, *in camera*, 6792; 6799-6800; RX-177).

Response to Finding No. 1995

Complaint Counsel does not disagree.

1996. As part of this credit analysis of St. Luke's, AMBAC evaluated the Moody's and S&P's ratings for St. Luke's bonds and three years of financial metrics including admissions, net patient service revenue, operating margin, EBITDA margin, and debt coverage. (Gordon, Tr. 6792-6796, *in camera*; RX-177).

Response to Finding No. 1996

Complaint Counsel has no specific response.

1997. In its analysis, AMBAC highlighted that St. Luke's operating margin was negative { } (Gordon, Tr. 6796, *in camera*; RX-177).

Response to Finding No. 1997

Complaint Counsel has no specific response.

1998. AMBAC also noted that St. Luke's admissions were declining which { } (Gordon, Tr. 6795, *in camera*; RX-177).

Response to Finding No. 1998

This proposed finding is inaccurate. St. Luke's acute admissions had increased each year since 2007. (PX02129 at 002 (Ex. 1) (Hanley, Decl.)).

1999. Mr. Gordon recommended that St. Luke's rating be put on a downward trend, because {

} (Gordon, Tr. 6798, *in camera*; RX-177).

Response to Finding No. 1999

Complaint Counsel has no specific response.

2000. Mr. Gordon recommend the downward trend despite the fact that St. Luke's EBITDA margin and days cash on hand were{ } (Gordon, Tr. 6797-6799, *in camera*; RX-177).

Response to Finding No. 2000

Complaint Counsel has no specific response.

2001. In his review of the rating analysis, Mr. Gordon's supervisor downgraded St. Luke's to BBB+ and agreed with Mr. Gordon's downward trend recommendation. (Gordon, Tr. 6799-6800, *in camera*; RX-177).

Response to Finding No. 2001

Complaint Counsel has no specific response.

2002. {

} (Gordon, Tr. 6800-6801, *in camera*).

Response to Finding No. 2002

Complaint Counsel has no specific response.

2003. {

} (Gordon, Tr. 6804, *in camera*).

Response to Finding No. 2003

Complaint Counsel does not disagree.

2004. {

} (Gordon, Tr. 6805, *in camera*).

Response to Finding No. 2004

Complaint Counsel has no specific response.

b. St. Luke's Default

2005. {
} (Gordon, Tr. 6820, *in camera*).

Response to Finding No. 2005

This proposed finding is misleading. Although a "technical default" of a bond covenant occurred when St. Luke's debt service coverage ratio fell below 1.3, (PX01854 at 006 (¶10) (Brick Rebuttal Report); Gordon, Tr. 6848-6849, *in camera*), St. Luke's has not missed a payment on its Ambac-insured bonds. (Response to RFA at ¶ 47; Black, Tr. 5700). As a result, holders of St. Luke's bonds received every one of their regularly scheduled principal and interest payments in full and on time. (Gordon, Tr. 6850, *in camera*; Black, Tr. 5700). In addition, by the time of the Acquisition, St. Luke's debt service coverage ratio had improved to 3.7, well above the 1.3 level required by the 2004 Bond Series indenture. (CCPFF ¶ 1040).

Technical defaults as a result of a debt service coverage ratio violation were common during this period. As Mr. Gordon testified, from 2008 through 2010, {
} that he oversaw experienced technical defaults. (Gordon, Tr. 6851-6852, *in camera*). In fact, the parent company for Mercy, Catholic Health Partners, experienced a technical default in 2009, prompting Mr. Wakeman to note that "many groups are talking with their . . . [b]anks for waivers for [d]ebt service coverage [sic]." (PX01318 at 001 (Wakeman Jul. 2009 Email); PX01920 at 028 (Wakeman, Dep. at 103), *in camera*).

2006. {
}

(Gordon, Tr. 6808, *in camera*).

Response to Finding No. 2006

Complaint Counsel does not disagree.

2007. {

} (Gordon, Tr. 6808-6809, *in camera*).

Response to Finding No. 2007

Complaint Counsel has no specific response.

2008. St. Luke's bond covenants required that it maintain a debt service coverage ratio of 1.3 as of the end of any fiscal year. (RX-906 at 000001; PX01542 at 001).

Response to Finding No. 2008

Complaint Counsel does not disagree.

2009. St. Luke's informed AMBAC that for 2009 St. Luke's debt service coverage ratio would be *negative* 2.9. (PX02355 at 001; RX-182; Gordon, Tr. 6806-6809, *in camera*; RX-10 (Gordon, Dep. at 97)).

Response to Finding No. 2009

This proposed finding is inaccurate and contradicted by another of Respondent's own witnesses. According to Ms. Hanley, St. Luke's debt service coverage ratio was -2.0 at the end of 2009, not -2.9 as the finding suggests. (PX02129 at 002 (Ex. 1) (Hanley, Decl.)). By the time of the Acquisition, this figure had improved to 3.7. (PX02129 at 002 (Ex. 1) (Hanley, Decl.)).

2010. In December 2009, St. Luke's informed AMBAC that St. Luke's had also violated the debt service coverage ratio covenant for 2008. St. Luke's had failed to report that previously because it had calculated the 2008 ratio incorrectly. (PX02355 at 001; RX-182; Gordon Tr. 6806-6810; RX-10 (Gordon, Dep. at 97)).

Response to Finding No. 2010

Complaint Counsel has no specific response.

2011. St. Luke's informed AMBAC that its 2008 debt service coverage ratio was 0.5. (RX-10 (Gordon, Dep. at 97)).

Response to Finding No. 2011

Complaint Counsel has no specific response.

2012. St. Luke's operational shortfalls, not unrealized gains and losses, caused St. Luke's to violate its debt service coverage ratio bond covenant. (RX-11 (Oppenlander, Dep. at 168-169)).

Response to Finding No. 2012

This proposed finding is misleading to the extent it suggests that St. Luke's operational situation uniquely resulted in it violating its debt service coverage ratio bond covenant. In fact, this type of violation was very common during this period. (*See* Response to RPFF ¶ 2005). This type of violation was common during this period because of variable conditions in the financial markets. Realized gains and losses from financial market investments contributed to the debt service coverage ratio shortfall. (RX-11 at 000044 (Oppenlander, Dep. at 168-169), *in camera*). Both Mr. Wakeman and Ms. Johnston testified that the declining equity markets negatively impacted the debt service coverage ratio. (Wakeman, Tr. 2567; Johnston, Tr. 5455). In addition, St. Luke's financial statement pension liability – neither a cash expense nor directly caused by operational deficiencies – would have also contributed to the lower debt service coverage ratio during this time. (*See* CCPFF ¶¶ 993-1012). Understandably then, once the financial markets started to recover in 2010, so too did St. Luke's debt service coverage ratio. (PX02129 at 002 (Ex. 1) (Hanley, Decl.)).

2013. On December 23, 2009, St. Luke's filed a "Material Event Notice" formally notifying AMBAC, the bond insurer; the Huntington Bank, the trustee; and the City of Maumee, the issuing authority, that St. Luke's had violated its debt service coverage ratio covenants for 2008 and 2009. (RX-183 at 000004; Gordon, Tr. 6815-6816, *in camera*).

Response to Finding No. 2013

Complaint Counsel has no specific response.

2014. {

} (Gordon, Tr. 6811, *in camera*).

Response to Finding No. 2014

Complaint Counsel has no specific response.

2015. In December 2009, St. Luke's CFO also informed AMBAC that he would be resigning as of December 31, 2009. (PX2355 at 001-002; Gordon, Tr. 6812, *in camera*).

Response to Finding No. 2015

Complaint Counsel has no specific response.

2016. {
}(Gordon, Tr. 6812, *in camera*).

Response to Finding No. 2016

Complaint Counsel has no specific response.

2017. {
}

(Gordon, Tr. 6814, *in camera*).

Response to Finding No. 2017

Complaint Counsel has no specific response.

2018. {

} (Gordon, Tr. 6815, *in camera*).

Response to Finding No. 2018

Complaint Counsel has no specific response.

2019. In its December 23, 2009 "Material Event Notice," St. Luke's stated that its "plan to address its future covenant compliance is to attempt to negotiate new, or renegotiate existing contracts with its insurance carriers." And, St. Luke's stated that it "may explore other options, including but not limited to exploring an affiliation with another health system." These statements did not give AMBAC comfort that St. Luke's financial condition would improve. (RX-183 at 000004; Gordon, Tr. 6816-6817, *in camera*).

Response to Finding No. 2019

Complaint Counsel has no specific response.

2020. {

} (Gordon, Tr. 6819, *in camera*).

Response to Finding No. 2020

Complaint Counsel has no specific response.

2021. {

} (Gordon, Tr. 6820, *in camera*.)

Response to Finding No. 2021

This proposed finding is misleading and incorrect. AMBAC's only remedy in response to St. Luke's technical default may have been to require St. Luke's to retain an independent consultant to make recommendations for increasing its debt service coverage ratio. (Brick, Tr. 3468-3470; PX01854 at 006 (¶10) (Brick Rebuttal Report)). In fact, Mr. Gordon testified that {

} (Gordon, Tr. 6860, *in camera*).

2022. {

} (Gordon, Tr. 6821, *in camera*.)

Response to Finding No. 2022

Complaint Counsel does not disagree.

2023. {

} (Gordon, Tr. 6859, *in camera*).

Response to Finding No. 2023

The proposed finding is incomplete. St. Luke's large cash reserves may not have meant that AMBAC was at minimal risk, but it *did* mean that St. Luke's had the wherewithal to satisfy its AMBAC-insured debt obligations, if necessary. (Gordon, Tr. 6859, *in camera*).

2024. {

} (Den Uyl, Tr. 6465-6466).

Response to Finding No. 2024

This proposed finding is inaccurate. St. Luke's large cash reserves enabled it to pay off its outstanding bonds if necessary. Notes from a St. Luke's February 2010 Finance Committee meeting described the bond payments as "a car payment" and not a risk to St. Luke's because "we have [] enough cash to completely defease these." (PX01204 at 011 (St. Luke's Finance Committee Notes), *in camera*). Mr. Wakeman even testified that St. Luke's considered buying back its bonds in February 2009 using its cash reserves. (Wakeman, Tr. 2569).

2025. {

} (RX-181 at 000001, *in camera*; Gordon, Tr. 6822-6824, *in camera*).

Response to Finding No. 2025

This proposed finding is misleading and incorrect. As discussed above, AMBAC had no right to require St. Luke's to merge with anyone. AMBAC's sole remedy may have been to

require St. Luke's to hire an independent consultant to assist with improving its debt service coverage ratio – a metric that had improved by the time of the Acquisition. (*See* Response to RPFF ¶¶ 2005, 2021).

2026. {

} (RX-181 at 000001, *in camera*; Gordon, Tr. 6824-6825, *in camera*).

Response to Finding No. 2026

Complaint Counsel has no specific response.

2027. {

} (Gordon, Tr. 6825, *in camera*).

Response to Finding No. 2027

Complaint Counsel has no specific response.

2028. {

} (Gordon, Tr. 6825-6826, *in camera*).

Response to Finding No. 2028

Complaint Counsel has no specific response.

2029. {

} (RX-181 at 000001, *in camera*; Gordon, Tr. 6827, *in camera*).

Response to Finding No. 2029

Complaint Counsel has no specific response.

2030. {

} (RX-181 at 000002, *in camera*; Gordon, Tr. 6827, *in camera*).

Response to Finding No. 2030

This proposed finding is misleading and incorrect – the evidence has not shown that AMBAC had such rights under the indenture. (*See* Response to RPFF ¶ 2021).

2031. On March 11, 2010, AMBAC sent St. Luke's a formal notice of default. (RX-906 at 000001; Gordon, Tr. 6829-6830, *in camera*).

Response to Finding No. 2031

Complaint Counsel has no specific response.

2032. {

}

(Gordon, Tr. 6830, *in camera*).

Response to Finding No. 2032

Complaint Counsel has no specific response.

2033. {

} (Wakeman, Tr. 3009, *in camera*).

Response to Finding No. 2033

Complaint Counsel has no specific response.

2034. {

} (Wakeman, Tr. 3009, *in camera*).

Response to Finding No. 2034

This proposed finding is incorrect. It is possible that AMBAC's sole remedy was only to require St. Luke's to hire an independent consultant to assist with improving its debt service coverage ratio. (*See* Response to RPFF ¶ 2021).

2035. { } (RX-179 at 000001, *in camera*; Gordon, Tr. 6832, *in camera*).

Response to Finding No. 2035

Complaint Counsel has no specific response.

2036. {

}

(Gordon, Tr. 6832, *in camera*).

Response to Finding No. 2036

Complaint Counsel has no specific response.

2037. {

} (Gordon, Tr. 6832, *in camera*).

Response to Finding No. 2037

Complaint Counsel has no specific response.

2038. {

} (RX-179 at 000003, *in camera*; Gordon, Tr. 6832-6833, *in camera*).

Response to Finding No. 2038

This proposed finding is incomplete and misleading. Mr. Gordon testified that the {

} performed internally by Ambac concluded that St. Luke's was {

} (Gordon, Tr. 6864, *in camera*). Out of {

}, St. Luke's was placed in { }

(Gordon, Tr. 6864, *in camera*). One of the reasons Mr. Gordon gave for this classification was that { } (Gordon, Tr. 6865, *in camera*).

2039. {

} (RX-179 at 000003, *in camera*).

Response to Finding No. 2039

This proposed finding is incomplete, misleading, and irrelevant. The last financial statements that Mr. Gordon analyzed were for December 31, 2009 – ignoring any turnaround in 2010. (PX01934 at 037-038 (Gordon, Dep. at 139-144), *in camera*). Mr. Gordon did not know about St. Luke's financial rebound in 2010 at the time of his review. Mr. Gordon's review did not take into account St. Luke's 7.5% increase in inpatient volume, a metric he called {

} (PX00170 at 001 (Wakeman Aug. 2010 Monthly Board Report); PX01934 at 029 (Gordon, Dep. at 108), *in camera*). Mr. Gordon's review also did not take into account other factors identified by Mr. Gordon as relevant to his analysis – {

} – which had all improved by the time of the Acquisition. (PX01934 at 037-038 (Gordon, Dep. at 141-142), *in camera*).

2040. {

} (RX-179 at 000003, *in camera*.)

Response to Finding No. 2040

Complaint Counsel has no specific response.

2041. {

} (Gordon, Tr. 6835, *in camera;* RX-179 at 000003, *in camera*).

Response to Finding No. 2041

This proposed finding is inaccurate and misleading. AMBAC's analysis ignores St. Luke's 2010 turnaround. (*See* Response to RPFF ¶ 2039). Even at this time, AMBAC did not

rate St. Luke's (Gordon, Tr. 6864, *in camera*). In fact, there were

(Gordon, Tr. 6864-6865, *in camera*).

2042. {

} (Gordon, Tr. 6837-6838, *in camera*).

Response to Finding No. 2042

The proposed finding is irrelevant. Respondent has not shown that AMBAC's internal rating had any implication on St. Luke's operations or financial viability.

c. ProMedica Assumes Responsibility for St. Luke's Bonds To Resolve the Default

2043. On June 1, 2010, AMBAC, St. Luke's and ProMedica came to a Forbearance and Waiver Agreement to resolve St. Luke's debt covenant violation. (PX01542 at 001, Gordon, Tr. 6845-6855, *in camera*).

Response to Finding No. 2043

Complaint Counsel does not disagree.

2044. {

} (Den Uyl, Tr. 6466, *in camera*).

Response to Finding No. 2044

Complaint Counsel has no specific response.

2045. In the Forbearance and Waiver Agreement, AMBAC agreed to waive its remedies against St. Luke's upon a joinder between St. Luke's and ProMedica when ProMedica would become responsible for making payments on those bonds. If St. Luke's and ProMedica did not join then St. Luke's would be required to defease the complete balance of the bonds by the end of the year, December 31, 2010. The Agreement required St. Luke's to set up an irrevocable Escrow in case this defeasance would become necessary. (PX01542 at 003-004; Gordon, Tr. 6845-6855, *in camera*).

Response to Finding No. 2045

Complaint Counsel has no specific response.

2046. The Forbearance and Waiver Agreement also required St. Luke's to immediately pay $50,000 to AMBAC to cover legal and administrative costs associated with St. Luke's default. (PX01542 at 004).

Response to Finding No. 2046

Complaint Counsel has no specific response.

2047. And the Forbearance and Waiver Agreement required St. Luke's to maintain a cash to debt ratio of 2.5 while the joinder with ProMedica was still pending. (PX01542 at 004).

Response to Finding No. 2047

Complaint Counsel has no specific response.

2048. {

} (RX-1001, *in camera*; Gordon, Tr. 6843-6844, *in camera*).

Response to Finding No. 2048

This proposed finding is misleading. AMBAC may not have had the legal right to do anything more than require St. Luke's to hire a consultant to assist with improving its debt service coverage ratio. (*See* Response to RPFF ¶ 2021). This proposed finding also ignores the fact that Mr. Gordon did not review St. Luke's most recent financial turnaround before his last assessment. (*See* Response to RPFF ¶ 2039). Furthermore, Respondent relies on speculative testimony from Mr. Gordon, responding to a hypothetical of what AMBAC "might" have done if the Acquisition had not occurred. (Gordon, Tr. 6844, *in camera*).

d. Any Changes That Occurred In St. Luke's Financials In 2010 Would Likely Not Have Changed AMBAC's Assessment of St. Luke's Credit Risk

2049. {

} (Gordon, Tr. 6871, *in camera*).

Response to Finding No. 2049

This proposed finding is misleading and without foundation – Mr. Gordon never saw financial statements from 2010 demonstrating St. Luke's improved performance, and therefore was not in possession of the information required to make such an assessment. (*See* Response to RPFF ¶ 2039).

2050. {

} (Gordon, Tr. 6872-6873, *in camera*).

Response to Finding No. 2050

This proposed finding is misleading. Mr. Gordon testified in his deposition that net patient service revenue, {

} (PX01934 at 037 (Gordon, Dep. at 141), *in camera*). St. Luke's not only improved its net patient service revenue in 2010 but also its operating margin. (PX02129 at 002 (Ex. 1) (Hanley, Decl.)). Mr. Gordon also stated that increases in { } – all metrics that improved at St. Luke's in 2010 – were also important measures of a hospital's financial health. (*See* Response to RPFF ¶ 2039).

2051. {

} (Gordon, Tr. 6883, *in camera*).

Response to Finding No. 2051

This proposed finding is incomplete. Mr. Gordon testified that an improved operating income from 2009 to 2010 would have { }. (Gordon, Tr. 6869-6870, *in camera*). And indeed, St. Luke's operating income had improved in

2010: operating margin (reflecting operating income) improved from -10.3 percent in 2009 to -2.6 percent in 2010. (CCPFF ¶ 965).

F. Complaint Counsel's Financial Experts Mischaracterize St. Luke's Financial Condition

2052. Mr. Dagen did not compare St. Luke's operating margin to the operating margins for nonprofit urban hospitals with a bed size of 100 to 249 during the years 2007 to 2009. (Dagen, Tr. 3309).

Response to Finding No. 2052

Complaint Counsel has no specific response.

2053. Mr. Dagen did not compare St. Luke's operating margin to the operating margins of hospitals that received comparable bond ratings from Moody's during the time period 2007 up until the time of the joinder on September 1, 2010. (Dagen, Tr. 3310).

Response to Finding No. 2053

Complaint Counsel has no specific response.

2054. Mr. Dagen did not calculate the average age of plant for St. Luke's. (Dagen, Tr. 3321).

Response to Finding No. 2054

Complaint Counsel has no specific response.

2055. Mr. Dagen has not done any analysis to rebut Mr. Den Uyl's conclusion that St. Luke's average age of plant was higher than that of other hospitals that received comparable Moody's bond ratings to St. Luke's. (Dagen, Tr. 3322-3323).

Response to Finding No. 2055

This proposed finding is incorrect and mischaracterizes Mr. Dagen's testimony. Mr. Dagen testified that the age of plant metric is unreliable. (*See* Dagen, Tr. 3321; *see also* PX01950 at 020 (Dagen, Dep. at 71-73), *in camera*). To assess the condition of St. Luke's plant and equipment, Mr. Dagen instead relied on fact witness testimony, ordinary course documents, and a site visit. (Dagen, Tr. 3321; PX02147 at 014 (¶ 28) (Dagen Expert Report)).

2056. The only thing that Mr. Dagen did to determine the effect of additional Paramount revenue on St. Luke's financials in the period after the joinder was to compare the

percentage of revenue that St. Luke's obtained from Paramount before the joinder and compared it with the percentage of revenue that St. Luke's received from Paramount after the joinder. (Dagen, Tr. 3326).

Response to Finding No. 2056

This proposed finding is incorrect and mischaracterizes Mr. Dagen's testimony. Mr. Dagen also calculated how the increase in the proportion of revenue that St. Luke's received from Paramount members impacted St. Luke's net revenues and operating income during the last four months of 2010. (*See* Dagen, 3194-3196, 3243-3244, *in camera*). He found that only a small portion of St. Luke's revenue growth during the last four months of 2010 is attributable to St. Luke's admittance into the Paramount provider network. (Dagen, Tr. 3243-3244, *in camera* ("[t]he majority is due to growth unrelated to Paramount")).

2057. Mr. Dagen did not calculate how St. Luke's addition to the Paramount network affected its cost coverage ratio from 2009 to 2010, even though he may have had the data to do this analysis. (Dagen, Tr. 3331-3332).

Response to Finding No. 2057

Complaint Counsel has no specific response.

2058. Mr. Dagen did not calculate how St. Luke's addition to the Paramount network affected its number of patient days from 2009 to 2010. (Dagen, Tr. 3331-3332).

Response to Finding No. 2058

Complaint Counsel has no specific response.

2059. Mr. Dagen did not calculate how St. Luke's addition to the Paramount network affected its number of outpatient visits from 2009 to 2010. (Dagen, Tr. 3331-3332).

Response to Finding No. 2059

Complaint Counsel has no specific response.

2060. Mr. Dagen does not know if any expenses were shifted from St. Luke's to ProMedica as a result of the joinder. (Dagen, Tr. 3360).

Response to Finding No. 2060

This proposed finding is incomplete and mischaracterizes Mr. Dagen's testimony. Mr. Dagen stated that he analyzed Respondent's alleged cost savings in the last four months of 2010 in the context of conducting his efficiencies analysis and concluded that any actual savings were "minimal." (Dagen, Tr. 3358; *see also* CCPFF ¶¶ 779-895).

2061. Mr. Dagen's characterization of St. Luke's financial performance trends is misleading. As of the joinder date, St. Luke's had not reached profitability. In addition, Mr. Dagen ignored a number of cost items going forward. Also, even Mr. Dagen's own analysis would generate negative cash flow during the period he considered. (Den Uyl, Tr. 6484).

Response to Finding No. 2061

This proposed finding is incorrect: Mr. Dagen's pro forma analysis projects that, absent the Acquisition, St. Luke's would achieve positive and steadily improving operating cash flow (*i.e.*, EBITDA) in each year from 2011 to at least 2013. (Dagen, Tr. 3210-3211).

2062. In his conclusions regarding St. Luke's financials, Mr. Dagen relies heavily on the time period before 2007 going all the way back to 2000. (PX02147 at 005-006, 010, 012-013, 014-015, 019, 022-026; Dagen, Tr. 3156-3163).

Response to Finding No. 2062

This proposed finding is incorrect and misleading. Mr. Dagen's primary reason for assessing St. Luke's financial condition as far back as 2000 was to gain context and to inform his understanding as to the distortionary impacts that the 2008 financial crisis had on St. Luke's financial health prior to the Acquisition. (Dagen, Tr. 3156-3157 ("it's always better to have more information than less information"); *see* PX02147 at 021 (¶ 41) (Dagen Expert Report)). Mr. Dagen, however, focused primarily on the three years leading up to the Acquisition, which he deemed to be the "much more relevant time frame" for assessing St. Luke's financial health at the time of the Acquisition. (Dagen, Tr. 3157; *see also* Dagen, Tr. 3338 ("the most important time period is from 2008, when Dan Wakeman arrived, through 2010, when the joinder occurred")).

2063. {

} (RX-56 at 000030*, in camera*).

Response to Finding No. 2063

This proposed finding is misleading and mischaracterizes Mr. Dagen's analysis to the extent it implies that Mr. Dagen relied heavily on financial data going back ten years. (*See* Response to RPFF ¶ 2062).

2064. {

}

(RX-56 at 000028*, in camera*).

Response to Finding No. 2064

This proposed finding is misleading and mischaracterizes Mr. Dagen's analysis. Mr. Dagen gained valuable context by looking at financial data going back ten years, but he focused his analysis on the three years leading up to the Acquisition because he believed that financial data for recent time periods is more relevant to the analysis of St. Luke's financial condition. (*See* Response to RPFF ¶ 2062).

2065. Mr. Dagen's reliance of financial data going back more than ten years also is inconsistent with his own hearing testimony in which he admits that "the most important time period is from 2008 when Dan Wakeman arrived, through 2010 when the joinder occurred." (Dagen, Tr. 3338).

Response to Finding No. 2065

This proposed finding is misleading and mischaracterizes Mr. Dagen's testimony because Mr. Dagen agrees that financial data from the most recent three years prior to the Acquisition is the most important to his analysis of St. Luke's financial condition at the time of the Acquisition. (*See* Response to RPFF ¶ 2062).

2066. Mr. Dagen's reliance on St. Luke's positive EBITDA in nine of the previous eleven fiscal years, including 2011, to support his conclusion that St. Luke's was financially healthy at

the time of the joinder is misleading. (Den Uyl, Tr. 6484-6485; RX-56 at 000028*, in camera*).

Response to Finding No. 2066

This proposed finding is misleading and incorrect because the evidence demonstrates that EBITDA is used in the ordinary course by hospitals – including St. Luke's and ProMedica – to estimate the amount of cash that is generated by their operations. (*See* Response to RPFF ¶ 1628). Hospitals can use the cash generated from operations to reinvest in their facilities and equipment. (Dagen, Tr. 3154). As a result, St. Luke's positive cash flow from operations during the last decade contributed to St. Luke's ability to compete effectively in the Toledo market, expand services, and maintain a high quality of care. (PX02147 at 012-013 (¶ 25) (Dagen Expert Report).

2067. {

} (RX-56 at 000028*, in camera*).

Response to Finding No. 2067

This proposed finding is inaccurate and misleading. EBITDA is a commonly used proxy for operating cash flow, and including capital expenditures in a calculation of a company's cash flow is inappropriate and misleading. (*See* Response to RPFF ¶ 1628).

2068. {

} (RX-56 at 000028-000029*, in camera*).

Response to Finding No. 2068

This proposed finding is inaccurate and mischaracterizes Mr. Dagen's analysis because Mr. Dagen's expert report states clearly – and correctly – that St. Luke's EBITDA was positive $2.9 million during the full calendar year of 2010; Mr. Dagen never testified that St. Luke's (*i.e.*,

OhioCare) had positive EBITDA during the first eight months of 2010. (*See* PX02147 at 010 (¶ 21, Table 1) (Dagen Expert Report)).

2069. In his conclusions regarding St. Luke's financials, Mr. Dagen repeatedly relies on OhioCare's reserve balance on December 31, 2010, four months after the joinder. (PX02147 at 005-006, 013).

Response to Finding No. 2069

This proposed finding is incomplete and misleading because Mr. Dagen analyzed and considered St. Luke's reserve balance both as of the Acquisition date (August 31, 2010) as well as the end of 2010. (*See* Dagen, Tr. 3203-3204, 3325; PX01852 at 004-005 (¶¶ 6-7) (Dagen Rebuttal Report)).

2070. In his conclusions regarding St. Luke's financials, Mr. Dagen repeatedly relies on St. Luke's EBITDA as of December 31, 2010, four months after the joinder. (PX02147 at 005, 007-008, 010, 012-013; PX01852 at 002-003).

Response to Finding No. 2070

This proposed finding is incomplete and misleading because Mr. Dagen analyzed and considered St. Luke's EBITDA both as of the Acquisition date (August 31, 2010) as well as the end of 2010. (*See* Dagen, Tr. 3187, 3197-3198; PX01852 at 003-004 (¶ 4, Table 1) (Dagen Rebuttal Report)).

2071. In his conclusions regarding St. Luke's financials, Mr. Dagen relies on St. Luke's cost coverage ratio as of December 31, 2010, four months after the joinder. (PX01852 at 003).

Response to Finding No. 2071

This proposed finding is incomplete and misleading because Mr. Dagen analyzed and considered St. Luke's cost coverage ratio both as of the Acquisition date (August 31, 2010) as well as the end of 2010. (*See* Dagen, Tr. 3187, 3197-3198; PX01852 at 003-004 (¶ 4, Table 1) (Dagen Rebuttal Report)).

2072. {

} (RX-56 at 000029, *in camera*).

Response to Finding No. 2072

This proposed finding is inaccurate and against the weight of the evidence to the extent it implies that any and all post-Acquisition performance of St. Luke's reserve fund would not have occurred but-for the Acquisition. Mr. Dagen's $70 million figure was reached only after appropriately removing post-Acquisition gains in the reserve fund that could be attributed to the Acquisition, as contrasted with the increase in St. Luke's reserves that occurred as a result of improvements in the financial markets during the last four months of 2010. (*See* PX02147 at 013 (¶ 26 n.22) (Dagen Expert Report); Dagen, Tr. 3323-3325). As a result, $70 million represents what St. Luke's reserve fund level likely would have been as of December 31, 2010 absent the Acquisition. (Dagen, Tr. 3323-3325).

This proposed finding is also incorrect and against the weight of the evidence to the extent it implies that "restricted" funds contained in St. Luke's reserves are unavailable for the same purposes as "unrestricted funds." Ordinary course documents, fact witness testimony, and even Mr. Den Uyl's own admissions, all indicate that most – if not all – of St. Luke's "restricted" funds can be used for the same purposes as the "unrestricted" funds. (CCPFF ¶¶ 1228-1229; *see also* Dagen, Tr. 3342-3343).

2073. Mr. Dagen's reliance on financial data from after August 31, 2010 is inappropriate because after the joinder St. Luke's financially benefitted from the relationship with ProMedica. For example, St. Luke's joined the Paramount network and achieved certain cost savings as a result of the joinder including becoming part of ProMedica's insurance plan, reducing supply costs, and heart center savings. (RX-56 at 000031, *in camera*; Den Uyl, Tr. 6491-6492).

Response to Finding No. 2073

This proposed finding is misleading and incorrect because Mr. Dagen's analysis of St. Luke's financial performance post-Acquisition appropriately controlled for and eliminated the distortionary effects of any benefits that St. Luke's enjoyed as a result of the Acquisition. (*See* Responses to RPFF ¶¶ 1615, 2056). In contrast, Mr. Den Uyl – the sole citation provided for this proposed finding – alluded to several ways that the Acquisition benefitted St. Luke's financial health, but nowhere in the record did he *quantify* such savings. (*See* RX-56 at 000031 (¶ 76) (Den Uyl Expert Report), *in camera*; Den Uyl, Tr. 6491-6492).

2074. For his financial analysis of St. Luke's, Mr. Dagen assumes that St. Luke's could access the entirety of its reserve funds including its restricted reserves to fund its operations despite testimony to the contrary by St. Luke's executives. (Dagen, Tr. 3339-3344).

Response to Finding No. 2074

This proposed finding is against the weight of the evidence. (Response to RPFF ¶ 2072).

2075. St. Luke's "would not have realized if they were on their own" the cost savings that St. Luke's received as a result of the joinder (Den Uyl, Tr. 6492-6493).

Response to Finding No. 2075

This proposed finding is inaccurate because Mr. Dagen's efficiencies analysis revealed that many of the cost savings alleged by Mr. Den Uyl could have been achieved absent the Acquisition. (*See* Dagen, Tr. 3289-3291, 3359, *in camera*; *see also* CCPFF ¶¶ 844-867). In contrast, neither Ms. Guerin-Calvert nor Mr. Den Uyl conducted an efficiencies analysis; as a result, neither of them can offer an expert opinion on the merger-specificity of any cost savings that Respondent alleges resulted from the Acquisition. (*See* CCPFF ¶¶ 784-785).

2076. {

}(RX-56 at 000029, *in camera*).

Response to Finding No. 2076

Complaint Counsel has no specific response.

2077. {

} (RX-56 at 000031, *in camera*).

Response to Finding No. 2077

This proposed finding is misleading and inaccurate because St. Luke's never actually implemented freezes on capital expenditures or new hiring. (*See* CCPFF ¶¶ 1046-1047, 1051-1053).

2078. {

} (RX-56 at 000036, *in camera*).

Response to Finding No. 2078

This proposed finding is incorrect to the extent it implies that St. Luke's revenue growth leading up to the Acquisition would have not been sustainable for a standalone St. Luke's after August 31, 2010. St. Luke's ordinary course documents and fact witness testimony indicate that a standalone St. Luke's would have continued to implement and benefit from revenue-generating growth strategies (*e.g.,* physician acquisitions, increasing outpatient volume), as well as experience additional patient growth from Anthem members. (*See* PX01852 at 009-010 (¶ 12) (Dagen Rebuttal Report); *see also* RPFF ¶ 938, 943). St. Luke's actual growth since the Acquisition has confirmed that St. Luke's would have continued its upward revenue trend even without the Acquisition. (*See* Response to CCPF ¶ 2056).

2079. {

} (RX-56 at 000036, *in camera*).

Response to Finding No. 2079

Complaint Counsel has no specific response.

2080. {

} (RX-56 at 000036, *in camera*).

Response to Finding No. 2080

Complaint Counsel has no specific response.

2081. {

}

(RX-56 at 000036, *in camera*).

Response to Finding No. 2081

Complaint Counsel has no specific response.

2082. Mr. Dagen assumed that MMO would increase St. Luke's contract rates in 2011 despite the fact that St. Luke's tried unsuccessfully to negotiate higher rates from MMO in late 2009. (Dagen, Tr. 3349).

Response to Finding No. 2082

Complaint Counsel has no specific response.

2083. Mr. Dagen assumed that Anthem would increase St. Luke's contract rates in June 2011 despite the fact that Anthem's contract did not expire until July 2012, and St. Luke's attempted unsuccessfully to negotiate higher rates from Anthem in late 2009. (Dagen, Tr. 3349-3353).

Response to Finding No. 2083

This proposed finding is contradicted by other testimony and ordinary course documents that suggest Anthem rates were up for renegotiation as early as July 2011. (Response to RPFF ¶ 1836).

2084. Mr. Dagen's projections assume that operating expenses would only grow by 3 percent over the 2010 expenses for the years 2011 to 2013. This assumption is inappropriate. (Dagen, Tr. 3361; RX-56 at 000037-000038, *in camera*; Den Uyl, Tr. 6487-6491).

Response to Finding No. 2084

This proposed finding is incorrect. A 3 percent operating expense growth rate is appropriate – and, if anything, conservative – for purposes of projecting a standalone St. Luke's

operating performance in 2011 through 2013 because it is based on both historical expenses as well as projections of future expenses done by St. Luke's executives in the ordinary course of business. (*See* PX01852 at 023-025 (¶¶ 33-35) (Dagen Rebuttal Report); Dagen, Tr. 3202-3203, 3205).

2085. Mr. Dagen's 3 percent operating expense growth projection relies on a St. Luke's document that assumes the joinder occurs and reflects efficiencies from the joinder. (RX-56 at 000037, *in camera*; Den Uyl, Tr. 6487–6488).

Response to Finding No. 2085

This proposed finding is incorrect and misleading. (*See* Response to RPFF ¶ 2086).

2086. {

}

(Dagen, Tr. 3363-3369, *in camera*; PX0395 at 003, *in camera*).

Response to Finding No. 2086

This proposed finding is incorrect to the extent it implies St. Luke's could not have achieved many of the cost savings contained in this document on its own absent the Acquisition. Mr. Dagen's extensive efficiencies analysis showed that St. Luke's could have unilaterally accomplished many of the alleged post-Acquisition savings. (Dagen, Tr. 3262-3270, *in camera*; *see also* PX02147 at 071-074, 076 (¶¶ 132-133, 138-140, 147) (Dagen Expert Report)). Further, Mr. Dagen's analysis revealed that there were also assumptions used when creating PX00395 that would cause it to project expenses that are *higher* than what St. Luke's would actually face as a standalone hospital. (Dagen, Tr. 3371, *in camera*).

This proposed finding is also misleading and incomplete because it ignores another ordinary course document that Mr. Dagen relied upon to corroborate the 3% expense growth rate

used in his pro forma analysis. (*See* Dagen, Tr. 3372-3373, *in camera*; *see also* PX01852 at 023-024 (¶ 33) (Dagen Rebuttal Report); *see also* PX01590 at 021, *in camera*).

2087. {

}(Dagen, Tr. 3371-3373, *in camera*; PX01590 at 001-023, *in camera*).

Response to Finding No. 2087

This proposed finding is incorrect and misleading. (*See* Response to RPFF ¶ 2086).

2088. {

} (Dagen, Tr. 3373, *in camera*).

Response to Finding No. 2088

This proposed finding is misleading and incomplete because Respondent never called the authors of PX01590 or PX00395 to the witness stand. Further, Respondent did not put a single fact witness on the stand to testify about what St. Luke's expense growth rate would have been in 2011 – or any future year – absent the Acquisition. Mr. Dagen considered historical expenses and ultimately relied on *several* ordinary course documents that all corroborated his use of a 3 percent expense growth rate assumption. (*See* PX01852 at 023-024 (¶ 33) (Dagen Rebuttal Report); Dagen, Tr. 3202-3203, 3205).

2089. The St. Luke's document on which Dagen relies for his 3 percent operating expense growth projection is for St. Luke's only, although Mr. Dagen's model is for the entire OhioCare system. (Den Uyl, Tr. 6487–6489; RX-56 at 000037, *in camera*).

Response to Finding No. 2089

Complaint Counsel has no specific response.

2090. If Mr. Dagen had been consistent with the growth methodology he used to establish his inpatient and outpatient revenue growth rate, his assumed operating expense growth rate would have been 5 percent rather than 3 percent. (Den Uyl, Tr. 6489-6490; RX-56 at 000037, *in camera*).

Response to Finding No. 2090

This proposed finding is inaccurate to the extent it implies an inconsistency in Mr. Dagen's process for estimating expense and revenue growth rates for a standalone St. Luke's in 2011 through 2013. In reality, Mr. Dagen applied a holistic approach to projecting expenses and revenues that in both instances involved considering a combination of historical performance, ordinary course evidence, and fact witness testimony. (*See* PX01852 at 023-024 (¶ 33) (Dagen Rebuttal Report); *see also* Dagen, Tr. 3202-3203, 3205). In the case of operating expenses, recent historical growth rates standing alone were not a reliable predictor of St. Luke's future expense growth rates because anomalous and non-recurring events had increased St. Luke's expenses to abnormally high levels in 2009. (*See* PX01852 at 024-025 (¶¶ 34-35) (Dagen Rebuttal Report); *see also* Dagen, Tr. 3379-3380, *in camera*).

Further, this proposed finding is unsupported because there is not a single ordinary course document in the record that projected a 5% or higher expense growth rate at a standalone St. Luke's in 2011, 2012, or 2013. (*See* Dagen, Tr. 3218; *see also* PX01951 at 067 (Den Uyl, Dep. at 264), *in camera*).

2091. {

} (Dagen, Tr. 3377-3378, *in camera*).

Response to Finding No. 2091

This proposed finding is misleading and unfounded because there is not a single ordinary course document in the record that projected a 5% or higher expense growth rate at a standalone St. Luke's. (*See* Dagen, Tr. 3218; *see also* PX01951 at 067 (Den Uyl, Dep. at 264), *in camera*).

2092. {

} (Dagen, Tr. 3378, *in camera*).

Response to Finding No. 2092

This proposed finding is misleading and unfounded because there is not a single ordinary course document in the record that projected a 5% or higher expense growth rate at a standalone St. Luke's. (*See* Dagen, Tr. 3218; *see also* PX01951 at 067 (Den Uyl, Dep. at 264), *in camera*).

2093. {

} (RX-56 at 000037, *in camera*; Dagen, Tr. 3409-3410, *in camera*).

Response to Finding No. 2093

This proposed finding is misleading and unfounded because there is not a single ordinary course document in the record that projected a 5% or higher expense growth rate at a standalone St. Luke's. (*See* Dagen, Tr. 3218; *see also* PX01951 at 067 (Den Uyl, Dep. at 264), *in camera*).

2094. {

} (Dagen, Tr. 3409-3410, *in camera*).

Response to Finding No. 2094

This proposed finding is inaccurate to the extent it implies an inconsistency in Mr. Dagen's process for estimating expense and revenue growth rates for a standalone St. Luke's in 2011 through 2013. (*See* Response to RPFF ¶ 2090).

2095. The Hospital and Related Services portion of the Medical Care Consumer Price Index increased at a rate of approximately 6.8 percent over the 2007 through 2010 time period, during which Mr. Dagen assumes a 3 percent expense growth rate for OhioCare. (Den Uyl, Tr. 6490-6491; RX-56 at 000037, *in camera*).

Response to Finding No. 2095

Complaint Counsel has no specific response.

2096. {

} (RX-56 at 000033-000034, 000038, *in camera*).

Response to Finding No. 2096

This proposed finding is incorrect because it relies on a flawed analysis by Mr. Den Uyl. In the cited expert report, Mr. Den Uyl relies on a document that he claims represents CRC's actual performance from September 1, 2010 through December 31, 2010. (RX-56 at 000038, *in camera*). On its face, however, this document actually depicts CRC's performance through only the first day of December, and not the last day of December as Mr. Den Uyl concludes. (*See* RX-1283 at 001 (handwritten note denotes date range of "9/1/2010 – 12/1/2010"), *in camera*). As a result, this proposed finding

2097. Mr. Dagen assumed that restricted funds would be available for use for the purpose of his analysis. In reality, St. Luke's trustee restricted funds are specifically designated for debt service coverage and professional liability insurance purposes and are not available for ordinary and routine use. (Den Uyl, Tr. 6493-6494; RX-56 at 000038, *in camera*).

Response to Finding No. 2097

This proposed finding is incorrect and against the weight of the evidence because the restricted funds in St. Luke's reserves could be made available for ordinary and routine use if necessary. (*See* Response to RPFF ¶ 2072).

2098. Mr. Dagen's assumptions regarding St. Luke's EMR capital expenditures and associated subsidies are flawed, because they captured all the EMR related subsidies, but have not accounted for the necessary costs to obtain those subsidies. (Den Uyl, Tr. 6495; RX-56 at 000039-000040, *in camera*).

Response to Finding No. 2098

This proposed finding is incorrect because Mr. Dagen based his pro forma assumptions on ordinary course documents that precisely detailed St. Luke's timing, costs, and incentive payments if it began implementing EMR even as late as 2011. (*See* PX01496 at 003; PX01502 at 001; PX01503 at 001, *in camera*; *see also* PX01852 at 021-022 (¶ 31 n. 56) (Dagen Rebuttal Report)).

2099. {

} (RX-56 at 000039-000040, *in camera*).

Response to Finding No. 2099

Complaint Counsel has no specific response.

2100. {

} (RX-56 at 000039-000040, *in camera*).

Response to Finding No. 2100

This proposed finding is misleading and inaccurate because St. Luke's could have begun implementing EMR in early 2011 and still satisfied the meaningful use timeline in order to receive all available federal ARRA incentive payments on time. (*See* Response to RPFF ¶ 1732).

2101. {

} (RX-56 at 000040, *in camera*).

Response to Finding No. 2101

This proposed finding is incorrect and misleading because any such operational costs – which appear to be exaggerated in the first place – are already accounted for in Mr. Dagen's pro forma analysis. (PX01852 at 021-022 (¶ 31) (Dagen Rebuttal Report)).

2102. Mr. Dagen's projection assumes capital expenditures that are significantly below St. Luke's historical average capital expenditures. Mr. Dagen assumed capital expenditures of only $4.9 million, $8.2 million, and $9.1 million in 2011, 2012, and 2013 respectively. However, St. Luke's historical capital expenditures averaged $11.3 million annually. (RX-56 at 000040, *in camera*; PX02147 at 014-015).

Response to Finding No. 2102

This proposed finding is incorrect. Mr. Dagen's pro forma analysis assumes that St. Luke's will spend $14.5 million on capital expenditures in 2011, $11.4 million in 2012, and $11.7 million in 2013, all at or above St. Luke's historical average. (*See* PX01852 at 023 (Table

4) (Dagen Rebuttal Report)). Mr. Dagen's capital expenditure assumptions are based on fact witness testimony and ordinary course capital budgeting performed by St. Luke's, and they encompass all of St. Luke's expected capital needs, including EMR, private rooms, and routine maintenance. (*See* PX01852 at 020-022 (¶¶ 29-32) (Dagen Rebuttal Report); *see also* Dagen, Tr. 3210-3211).

2103. The fact that Mr. Dagen assumes capital expenditures that are significantly below St. Luke's historical average capital expenditures is particularly problematic because St. Luke's has just come off a period where it reduced its capital expenditures in both 2009 and 2010. To project a continued low amount, therefore, understates what the hospital will need. (Den Uyl, Tr. 6495-6496).

Response to Finding No. 2103

This proposed finding is incorrect and misleading. (*See* Response to RPFF ¶ 2102).

2104. {
} (RX-56 at 000040, *in camera*).

Response to Finding No. 2104

This proposed finding is incorrect because Mr. Dagen assumed in his pro forma analysis that St. Luke's would fund, if necessary, the $1.8 million in allegedly deferred capital projects. (Dagen, Tr. 3211).

2105. Mr. Dagen's analysis is incorrect as it relatesto capital expenditures that St. Luke's will need going forward. St. Luke's will have to spend money on routine capital expenditures, on the private bed conversions, and on a new EMR system. In addition, St. Luke's had deferred a number of capital expenditures. (Den Uyl, Tr. 6498-6501).

Response to Finding No. 2105

This proposed finding is incorrect because it misrepresents Mr. Dagen's analysis and conclusions. (*See* Response to RPFF ¶ 2102).

2106. Mr. Dagen assumed an 8 percent return for St. Luke's investment portfolio reserves. This assumption is quite aggressive. (PX02147 at 039; RX-56 at 000041, *in camera*).

Response to Finding No. 2106

This proposed finding is contradicted by the weight of the evidence to the extent it implies that an 8 percent assumption is unreasonably high. Mr. Dagen used an 8 percent assumption in his pro forma analysis because that is the figure St. Luke's uses in its ordinary course to project the expected return on its investments. (*See* PX01060 at 007 (St. Luke's February 2010 Pension Actuarial Valuation Report), *in camera*; PX02147 at 039 (¶ 70) (Dagen Expert Report)). In addition, Neville Arjani, ProMedica's actuary, testified that 8 percent is a reasonable assumption and that it is in line with industry standards. (PX01943 at 022-024 (Arjani, Dep. at 81-89)).

2107. { } (RX-56 at 000041, *in camera*).

Response to Finding No. 2107

Complaint Counsel has no specific response.

2108. { } (RX-56 at 000041, *in camera*).

Response to Finding No. 2108

Complaint Counsel has no specific response.

2109. If one adjusted Mr. Dagen's model by adding in cash outlays that St. Luke's needed to make but are unaccounted for by his model, then St. Luke's unrestricted reserves would be $14.46 million at the end of 2011, $3.768 million at the end of 2012, and *negative* $4.610 million at the end of 2013. (Den Uyl, Tr. 6500-6502; RX-56 at 000042, *in camera*).

Response to Finding No. 2109

This proposed finding is misleading because Mr. Den Uyl admitted that, despite including these figures in his expert report, he has not concluded that St. Luke's reserve fund was, in fact, likely to be depleted by 2012 – or even 2013 – absent the Acquisition. (Den Uyl, Tr. 6588-6589, *in camera*).

2110. If one further adjusted Mr. Dagen's model to assume a 5 percent increase in annual operating cost, rather than Mr. Dagen's 3 percent assumption, then St. Luke's unrestricted reserves would be $10.805 million at the end of 2011, *negative* $7.489 million at the end of 2012, and *negative* $27.728 million at the end of 2013. (Den Uyl, Tr. 6502-6503; RX-56 at 000042-000043, *in camera*).

Response to Finding No. 2110

This proposed finding is misleading and unsupported because there is not a single ordinary course document in the record that projected a 5% or higher expense growth rate at a standalone St. Luke's. (*See* Dagen, Tr. 3218; *see also* PX01951 at 067 (Den Uyl, Dep. at 264), *in camera*). Further, Mr. Den Uyl admitted that, despite including these figures in his expert report, he has not concluded that St. Luke's reserve fund was, in fact, likely to be depleted by 2012 – or even 2013 – absent the Acquisition. (Den Uyl, Tr. 6588-6589, *in camera*).

2111. {

} (Dagen, Tr. 3411-3413, *in camera*).

Response to Finding No. 2111

This proposed finding is misleading and incomplete because Mr. Dagen concluded that St. Luke's was "turning around their operations" during the first eight months of 2010 on the basis that it was experiencing significant improvements in essentially "all . . . financial metrics," including: EBITDA, overall cost coverage ratio, patient days, inpatient days, and outpatient visits. (Dagen, Tr. 3187).

V. The Joinder Creates Pro-Competitive Benefits and Forcing ProMedica To Divest St. Luke's Would Harm St. Luke's and the Community

A. The Joinder Has Improved St. Luke's Financial Condition

2112. St. Luke's has benefitted by becoming part of a larger system, such as utilizing corporate infrastructure overhead services. (Hanley, Tr. 4681).

Response to Finding No. 2112

Complaint Counsel has no specific response.

2113. The infusion of capital into St. Luke's has increased the benefits to the community by allowing St. Luke's to remain as an ongoing hospital. (Guerin-Calvert, Tr. 7551-7552).

Response to Finding No. 2113

This proposed finding is inaccurate and misleading because the full weight of the evidence demonstrates that, absent the Acquisition, St. Luke's could have continued to operate as a full-service and high-quality hospital. (*See* PX02147 at 041-043 (¶¶ 74-79)). At the end of 2009, for instance, Mr. Wakeman informed St. Luke's Board of Directors that the hospital could survive independently for at least three to seven years, and 2010 improvements in the equity markets and St. Luke's operating performance would extend this timeframe even further. (*See* CCPFF ¶¶ 1071-1072).

2114. It also allows St. Luke's to make improvements to the hospital that benefit patients such as converting semi-private rooms to private rooms and investment in technology. (Guerin-Calvert, Tr. 7569-7570).

Response to Finding No. 2114

This proposed finding is misleading because St. Luke's had the financial resources – $65 million in cash and investments as of August 31, 2010 – to comfortably fund these projects as a standalone hospital. (*See* Response to RPFF ¶ 1630). Further, in late 2009, St. Luke's had already committed to going ahead with a massive overhaul and upgrade of its information technology systems, before merger talks with ProMedica stalled those plans. (*See* CCPFF ¶ 821). Additionally, St. Luke's could have made any necessary private rooms and information technology improvements with another partner, such as UTMC. (*See* CCPFF ¶¶ 845-854).

1. ProMedica Has Infused St. Luke's with Needed Capital

2115. As part of the joinder, ProMedica has contributed $5 million to the St. Luke's Foundation. (Hanley, Tr. 4679; Johnston, Tr. 5375). ProMedica has also committed to contribute $30 million over three years to St. Luke's Hospital. (Johnston, Tr. 5375).

Response to Finding No. 2115

Complaint Counsel has no specific response.

2116. { } (RX-31 (Akenberger, Dep. at 39-40, *in camera*)).

Response to Finding No. 2116

Complaint Counsel has no specific response.

2117. ProMedica's $10 million allocation of strategic capital to St. Luke's for 2011 was based upon the obligation ProMedica made to invest $30 million dollars into St. Luke's over a three-year period. (RX-31 (Akenberger, Dep. at 41, *in camera*); Hanley, Tr. 4679; Johnston, Tr. 5375).

Response to Finding No. 2117

Complaint Counsel has no specific response.

2118. { } (RX-31 (Akenberger, Dep. at 41, *in camera*)).

Response to Finding No. 2118

Complaint Counsel has no specific response.

2119. { } (RX-31 (Akenberger, Dep. at 40-41, *in camera*)).

Response to Finding No. 2119

Complaint Counsel has no specific response.

2120. ProMedica defines routine capital expenditures as capital that is currently being in service with the various facilities and will need to be replaced; examples of routine capital expenditures include replacement of medical imaging machines like CT scanners and replacement of carpeting in a facility. (RX-31 (Akenberger, Dep. at 30)).

Response to Finding No. 2120

Complaint Counsel has no specific response.

2121. Routine capital is capital that needs to be replaced because its useful life is no longer operating at an appropriate level. (RX-31 (Akenberger, Dep. at 34)).

Response to Finding No. 2121

Complaint Counsel has no specific response.

2122. ProMedica defines strategic capital expenditures asreflecting investments that it is making in the community to provide support for ProMedica's strategic plan to meet patient and quality needs, employee needs, and financial needs. (RX-31 (Akenberger, Dep. at 34)).

Response to Finding No. 2122

Complaint Counsel has no specific response.

2123. Strategic capital would be something that would require new investment of capital towards a new service, expansion of a service, or new technology. (RX-31 (Akenberger, Dep. at 34)).

Response to Finding No. 2123

Complaint Counsel has no specific response.

2124. {

} (RX-31 (Akenberger, Dep. at 68, *in camera*)).

Response to Finding No. 2124

Complaint Counsel has no specific response.

2125. The influx of capital that ProMedica provided to St. Luke's allowed St. Luke's to start planning for and implementing strategic capital projects such as private room expansion, facility renovations, and IT upgrades relating to meaningful-use compliance. (Johnston, Tr. 5372).

Response to Finding No. 2125

This proposed finding is misleading to the extent it implies that St. Luke's could not make these improvements as an independent hospital or with a partner other than ProMedica. (*See* Response to RPFF ¶ 2114).

2126. Prof. Town agrees that consumers may benefit from additional money ProMedica has allocated to St. Luke's. (Town, Tr. 4366-4367, 4374).

Response to Finding No. 2126

Complaint Counsel has no specific response.

2127. ProMedica would not invest in St. Luke's without the joinder. (Town, Tr. 4374; RX-1855 at 000024, *in camera*).

Response to Finding No. 2127

Complaint Counsel has no specific response.

2128. {

} (RX-1856 at 000027, *in camera*).

Response to Finding No. 2128

This proposed finding is unfounded and incorrect. It cites no ordinary course documents, deposition testimony, or trial testimony as support. Instead, this proposed finding relies solely on a self-serving and made-for-litigation narrative that Respondent submitted in response to a Civil Investigative Demand from the FTC. In contrast, the full weight of the evidence demonstrates that a standalone St. Luke's would have had ample resources to continue investing in its facilities, infrastructure, and employees. (*See* Response to RPFF ¶ 1630). Further, St. Luke's could have attained most of the cost savings that Respondent alleges may result from the Acquisition if it were acquired by an alternative purchaser, such as UTMC. (*See* Gold, Tr. 245-247; *see also* CCPFF ¶¶ 845-854).

2129. {

} (RX-1855 at 000024, *in camera*).

Response to Finding No. 2129

This proposed finding is unfounded and incorrect. It cites no ordinary course documents, deposition testimony, or trial testimony for its support. Instead, this proposed finding relies

solely on a self-serving and made-for-litigation narrative that Respondent submitted in response to a Civil Investigative Demand from the FTC. In contrast, the full weight of the evidence demonstrates that a standalone St. Luke's had ample resources to make the required cash contributions to its pension, pay off its bonds, and fund the implementation of an EMR system. (*See* PX02147 at 041-042 (¶¶ 74-75) (Dagen Expert Report)).

2130. {

} (RX-1855 at 000025, *in camera*).

Response to Finding No. 2130

This proposed finding is unfounded and incorrect. It cites no ordinary course documents, deposition testimony, or trial testimony for its support. Instead, this proposed finding relies solely on a self-serving and made-for-litigation narrative that Respondent submitted in response to a Civil Investigative Demand from the FTC. In contrast, the full weight of the evidence demonstrates that a standalone St. Luke's could continue to operate as a full-service and high-quality hospital without having to reduce its level of care or services. (*See* PX02147 at 041-043 (¶¶ 74-79) (Dagen Expert Report)).

2. St. Luke's Became Part of ProMedica's Obligated Group

2131. Effective at closing, ProMedica brought St. Luke's into its Obligated Group. (Hanley, Tr. 4513; Johnston, Tr. 5372).

Response to Finding No. 2131

Complaint Counsel does not disagree.

2132. Subsequently, AMBAC granted a waiver to St. Luke's, which required that ProMedica's Obligated Group replace St. Luke's on the bond note. (Hanley, Tr. 4677; RX-907).

Response to Finding No. 2132

Complaint Counsel has no specific response.

2133. Additionally, on September 28, 2010, Moody's upgraded St. Luke's bond rating because St. Luke's joined ProMedica's Obligated Group and took on its bond rating. (Hanley, Tr. 4676; RX-350 at 000001).

Response to Finding No. 2133

Complaint Counsel has no specific response.

3. ProMedica Absorbed St. Luke's Pension Liability

2134. Since the joinder, ProMedica has helped fund contributions to St. Luke's pension plan. (Hanley, Tr. 4678).

Response to Finding No. 2134

This proposed finding is contradicted by the testimony of Neville Arjani, ProMedica's actuary, who testified that St. Luke's – not ProMedica – made a { } cash contribution into its pension plan in March of 2011. (Arjani, Tr. 6761-6762, *in camera*). Respondent's own proposed finding states that "*St. Luke's* made the required $5 million contribution to its defined benefit pension plan prior to March 31, 2011." (RPFF ¶ 1683 (emphasis added)).

2135. { } (Johnston, Tr. 5409*, in camera*).

Response to Finding No. 2135

Complaint Counsel has no specific response.

2136. { } (Johnston, Tr. 5409, *in camera*).

Response to Finding No. 2136

This proposed finding is unfounded and misleading to the extent it implies that St. Luke's had a philosophy prior to the Acquisition – or that it would have one absent the Acquisition – that did not strive to maintain a pension fund that was 100% funded. Ms. Johnston draws no such conclusion in her testimony about St. Luke's practices, nor does she discuss what actions

St. Luke's would have taken with respect to its pension fund absent the Acquisition. (*See* Johnston, Tr. 5409, *in camera*). Even if such an opinion were implicit in her testimony, Ms. Johnston would be an unreliable source because she never worked a single day for a standalone St. Luke's, nor would she absent the Acquisition. (*See* Johnston, Tr. 5303, 5306, 5527).

This proposed finding is also incorrect and misleading to the extent it implies that St. Luke's would not be capable of refunding its pension fund back to a 100% funded status absent the Acquisition. In fact, St. Luke's had ample financial resources to do so. (*See* PX02147 at 041-042 (¶¶ 74-75) (Dagen Expert Report)).

4. The Joinder Has Already Allowed St. Luke's To Reduce Some of Its Costs

2137. St. Luke's was not large enough to fund a captive insurance plan or be a part of a captive insurance plan on its own. (Wakeman, Tr. 2838).

Response to Finding No. 2137

Complaint Counsel has no specific response.

2138. Following the joinder, St. Luke's has saved about $500,000 in malpractice insurance from becoming part of ProMedica's captive insurance company. (Hanley, Tr. 4680).

Response to Finding No. 2138

This proposed finding is contradicted by Mr. Dagen's conclusion that the alleged insurance savings are unsubstantiated and largely achievable by St. Luke's as a standalone hospital. (Dagen, Tr. 3359; *see also* PX02147 at 073-074 (¶¶ 138-140) (Dagen Expert Report)).

2139. Additionally, moving St. Luke's into ProMedica's captive insurance company had the effect of freeing up over $8 million in cash that remains unencumbered on St. Luke's balance sheet. (Hanley, Tr. 4680).

Response to Finding No. 2139

This proposed finding is incorrect and misleading to the extent it implies that the Acquisition was necessary in order for St. Luke's to free up the restricted funds in its reserves.

Mr. Den Uyl, Respondent's financial expert, admitted that St. Luke's could have reclassified at least $7 million of its restricted funds into unrestricted funds absent the Acquisition. (PX01951 at 047-048 (Den Uyl, Dep. at 183-184, 186-187), *in camera*; *see also* CCPFF ¶¶ 1228-1229).

2140. {

} (Wakeman, Tr. 3023-3025, *in camera*).

Response to Finding No. 2140

This proposed finding is incorrect to the extent it implies the Acquisition was necessary for St. Luke's to achieve these back-office savings. Mr. Dagen analyzed Respondent's alleged efficiencies and concluded that the back-office savings often involved actions that St. Luke's could have taken unilaterally as a standalone hospital, or otherwise attained through an Acquisition by an alternative partner. (PX02147 at 076-077, 083 (¶¶ 147, 163) (Dagen Expert Report)). Dr. Gold testified, for instance, that a UTMC-St. Luke's affiliation could generate efficiencies in "back-of-the-house functions" such as "finance, information technology, human resources services, and many others," as well as promote "consolidation of clinical services." (Gold, Tr. 245-246).

5. The Joinder Has Given St. Luke's Increased Revenues from Paramount Members

2141. Following the joinder, St. Luke's became a participating provider in Paramount, and its volume of Paramount patients has increased significantly since then. (Hanley, Tr. 4678-4679; Johnston, Tr. 5375, 5382; Wakeman, Tr. 3023-3025, *in camera*).

Response to Finding No. 2141

This proposed finding is incorrect and misleading to the extent it implies that St. Luke's could not become a member of the Paramount provider network absent the Acquisition. Prior to the Acquisition, St. Luke's executives expressed an interest in having access to the Paramount provider network, but it was ProMedica's own executives who decided not to enter into an

agreement. (*See* CCPFF ¶¶ 865-866). As a result, any financial benefits that St. Luke's enjoyed from being permitted to join the Paramount provider network are not merger-specific because they could have been accomplished absent the Acquisition. (*See* Dagen, Tr. 3289-3290, *in camera*; PX02147 at 080-081 (¶ 158) (Dagen Expert Report)).

2142. { } (Wakeman, Tr. 3023-3025, *in camera*; Johnston, Tr. 5513, *in camera*).

Response to Finding No. 2142

Complaint Counsel has no specific response.

2143. St. Luke's addition to the Paramount network was one reason St. Luke's financial performance improved after its joinder with ProMedica. (Dagen, Tr. 3329).

Response to Finding No. 2143

Complaint Counsel has no specific response.

2144. Mr. Dagen estimates that St. Luke's addition to the Paramount network increased St. Luke's revenues in 2010 as compared to 2009 by about 23 percent. (Dagen, Tr. 3330).

Response to Finding No. 2144

This proposed finding is incorrect and misstates Mr. Dagen's analysis. Mr. Dagen estimated that Paramount accounted for only 23 percent *of the total increase* in St. Luke's revenues during the *last four months of 2010*. (*See* Dagen, Tr. 3243-3244, 3330, *in camera*). In contrast to what the proposed finding claims, Mr. Dagen did not compare Paramount volume in 2009 and 2010, and he did not conclude that St. Luke's revenues improved by 23 percent in 2010 due to its addition to the Paramount network.

2145. Mr. Dagen estimates that St. Luke's addition to the Paramount network increased St. Luke's EBITDA in 2010 as compared to 2009 by about 23 percent. (Dagen, Tr. 3330).

Response to Finding No. 2145

This proposed finding is incorrect and misstates Mr. Dagen's analysis. Mr. Dagen estimated that Paramount accounted for only 23 percent *of the total increase* in St. Luke's EBITDA during the *last four months of 2010*. (*See* Dagen, Tr. 3243-3244, 3330, *in camera*). In contrast to what the proposed finding claims, Mr. Dagen did not compare Paramount volume in 2009 and 2010, and he did not conclude that St. Luke's EBITDA improved by 23 percent in 2010 due to its addition to the Paramount network.

6. The Joinder Will Allow ProMedica and St. Luke's To Realize Additional Efficiencies

2146. { } (Hanley, Tr. 4619-4621, *in camera*; PX00421 at 010-011, *in camera*).

Response to Finding No. 2146

Complaint Counsel has no specific response.

2147. { } (Hanley, Tr. 4625, *in camera*; Oostra Tr. 5868, *in camera*).

Response to Finding No. 2147

Complaint Counsel has no specific response.

2148. { } (Hanley, Tr. 4648, *in camera*).

Response to Finding No. 2148

Complaint Counsel has no specific response.

2149. { } (Hanley, Tr. 4651, *in camera*).

Response to Finding No. 2149

Complaint Counsel has no specific response.

2150. {

}

(Hanley, Tr. 4650, *in camera*; PX00020 at 004, *in camera*).

Response to Finding No. 2150

This proposed finding is unfounded and incorrect to the extent it implies that any of the efficiencies alleged in the Compass Lexecon report are cognizable and merger-specific under the *Merger Guidelines*. Mr. Dagen conducted a *Merger Guidelines* analysis of Respondent's alleged efficiencies and concluded that nearly all "should not be credited by the Court because they either are not actual efficiencies, do not require the joinder to be accomplished, or are speculative and unsubstantiated." (PX02147 at 005 (¶ 10) (Dagen Expert Report)). In contrast, neither of Respondent's expert witnesses conducted an analysis or offered an opinion on whether the alleged efficiencies are cognizable under the *Merger Guidelines*, despite both being qualified to do so. (CCPFF ¶¶ 784-785). Further, a key fact witness that Respondent relied upon to substantiate its efficiencies claims, Gary Akenberger, never testified live in this court. (CCPFF ¶¶ 783-784).

2151. {

}

(Hanley, Tr. 4652, *in camera*).

Response to Finding No. 2151

Complaint Counsel has no specific response.

2152. {

} (Hanley, Tr. 4652-4653, *in camera*).

Response to Finding No. 2152

Complaint Counsel has no specific response.

2153. {

} (Hanley, Tr. 4728, *in camera*).

Response to Finding No. 2153

Complaint Counsel has no specific response.

2154. Since the closing of the joinder on August 31, 2010, ProMedica and St. Luke's have established a steering committee that has charged approximately 20 integration teams to further develop the efficiencies opportunities summarized in the Compass Lexecon report and identify new opportunities not identified for the Compass Lexecon report. (RX-31 (Akenberger, Dep. at 97-98)).

Response to Finding No. 2154

Complaint Counsel has no specific response.

B. The Joinder Enhances St. Luke's Ability To Respond to Healthcare Reform

2155. {

}

(RX-1858 at 000017-000018, *in camera*).

Response to Finding No. 2155

This proposed finding is unfounded. It cites no ordinary course documents, deposition testimony, or trial testimony for its support. Instead, this proposed finding relies solely on a self-serving and made-for-litigation Interrogatory response submitted by Respondent to the FTC.

2156. ProMedica believes that St. Luke's has allocated part of its initial capital contribution of $10 million toward investment to become compliant for "meaningful use." (Hanley, Tr. 4679). {

} (RX-31 (Akenberger, Dep. at 175, *in camera*)).

Response to Finding No. 2156

This proposed finding is against the weight of the evidence. Mr. Perron, St. Luke's Computer Information Systems Director, testified that ProMedica will not start implementing EMR at St. Luke's until 2012 at the earliest (compared to St. Luke's original plan, prior to merger talks with ProMedica, to begin implementing EMR in early 2010). (PX01928 at 037

(Perron, Dep. at 139), *in camera*; *see* Response to RPFF ¶ 1737). Mr. Perron testified that, as a result, he was "[u]nsure" whether ProMedica can implement EMR at St. Luke's in time to take advantage of all federal ARRA financial incentives. (PX01928 at 037 (Perron, Dep. at 139), *in camera*; *see also* PX01912 at 068 (Akenberger, IHT at 262-263), *in camera*).

2157. St. Luke's has begun planning with ProMedica for implementation of "meaningful use" requirements. (Johnston, Tr. 5380-5381). St. Luke's is beginning implementation of clinical documentation, medical administration and bar-coding systems. (Johnston, Tr. 5381).

Response to Finding No. 2157

Complaint Counsel has no specific response.

2158. {

} (RX-1858 at 000016, *in camera*).

Response to Finding No. 2158

This proposed finding is unfounded because it cites no ordinary course documents, deposition testimony, or trial testimony for its support. Instead, this proposed finding relies solely on a self-serving and made-for-litigation Interrogatory response submitted by Respondent to the FTC.

2159. ProMedica has also provided approximately 55 individual employees who have assisted with the "meaningful use" conversion process. (Johnston, Tr. 5380).

Response to Finding No. 2159

Complaint Counsel has no specific response.

2160. St. Luke's expects that, based on the progress seen so far on the "meaningful use" IT project, St. Luke's will now be able to meet deadlines required by healthcare reform legislation. (Johnston, Tr. 5381).

Response to Finding No. 2160

This proposed finding is incomplete because testimony from ProMedica and St. Luke's executives indicates that St. Luke's may not qualify for all federal incentive payments if it follows ProMedica's current implementation schedule. St. Luke's Computer Information Systems Director testified that ProMedica does not intend to start implementing EMR at St. Luke's until 2012; as a result, he was "[u]nsure" whether St. Luke's will qualify for all available federal financial incentives. (PX01928 at 037 (Perron, Dep. at 139), *in camera*). ProMedica's Senior Vice President of Finance, Mr. Akenberger, also testified that ProMedica does not intend to implement EMR at St. Luke's until 2012. (PX01912 at 068 (Akenberger, IHT at 262-263), *in camera*).

This proposed finding is also misleading and inaccurate to the extent it implies that, absent the Acquisition, St. Luke's would not have implemented EMR in time to meet deadlines required by healthcare reform legislation. To the contrary, before merger talks with ProMedica sidelined the plans, St. Luke's was preparing to begin implementing EMR in early 2010 and intended to finish in time to not only meet the deadlines required by healthcare reform legislation but also in time to receive all available federal ARRA incentive payments. (*See* Responses to RPFF ¶¶ 1732, 1737).

C. The Joinder Allows ProMedica and St. Luke's To Consolidate Clinical Services To Lower Costs, To Improve Quality, and To Optimize Facilities

2161. {

} (PX02105 at 013, *in camera*).

Response to Finding No. 2161

This proposed finding is misleading, unreliable, and contradicted by evidence in the record. The cost savings projected in the Compass Lexicon efficiencies analysis have been shown to be speculative, and were created without input from key St. Luke's employees. Further, Respondent has not provided any substantial additional evidence to support the findings of the efficiencies report. (*See* CCPFF ¶¶ 788-794).

1. Navigant Consulting's Clinical Service Line Consolidation Recommendations

2162. { } (Shook, Tr. 1110, *in camera*).

Response to Finding No. 2162

Complaint Counsel has no specific response.

2163. ProMedica retained Navigant Consulting, Inc. ("Navigant") in mid-2010 to conduct a clinical integration study to determine how best to deploy services across the ProMedica system following the joinder with St. Luke's. (Nolan, Tr. 6253, 6263; Hanley, Tr. 4670, *in camera*).

Response to Finding No. 2163

Complaint Counsel has no specific response.

2164. The project required Navigant to review the Toledo metropolitan marketplace, determine current and projected future healthcare needs in that market, and develop a set of recommendations as to the best distribution of services across ProMedica's facilities to meet community needs. (Nolan, Tr. 6254).

Response to Finding No. 2164

This proposed finding is unsupported by the cited testimony. Mr. Nolan does not mention determining the current or projected future healthcare needs of the Toledo marketplace. (Nolan, Tr. 6254).

2165. Clinical integration describes the process when two organizations join together and combine their clinical capabilities in the optimal manner to provide high-quality and cost-effective healthcare. (Nolan, Tr. 6254-6255).

Response to Finding No. 2165

Complaint Counsel has no specific response.

2166. {

} (Nolan, Tr. 6328, *in camera*).

Response to Finding No. 2166

Complaint Counsel has no specific response.

2167. When making clinical integration recommendations, Navigant considers the market demographics and population projections, physical plants and facilities, anticipated healthcare-related legislation, and emerging community needs. (Nolan, Tr. 6255-6256).

Response to Finding No. 2167

Complaint Counsel has no specific response.

2168. Navigant believes that benefits of clinical integration include operational efficiencies, economies of scale, the seamless flow of information across the system, better access and affordability for patients, staffing efficiencies, and higher quality from achieving a critical mass of volume of particular services. (Nolan, Tr. 6257-6260).

Response to Finding No. 2168

Complaint Counsel has no specific response.

2169. Likewise, Mercy believes that the volume or frequency of procedures has an effect on quality such that the more a hospital, physician, or nurse does something, the more proficient they will become at that particular task. (Shook, Tr. 959).

Response to Finding No. 2169

This proposed finding mischaracterizes the cited testimony. Mr. Shook does not suggest that the more cases a hospital has, the more proficient a hospital will be at a procedure. He simply states that a hospital must "see a reasonable amount of cases in order to maintain your proficiency." (Shook, Tr. 959).

2170. Navigant believes that independent community hospitals face an increasingly competitive and resource-constrained environment and struggle to gain economies of scale or efficiencies. (Nolan, Tr. 6261).

Response to Finding No. 2170

This proposed finding is incomplete and overly broad. Mr. Nolan also testified that he personally knows of community hospitals with good financial performance and excellent quality of care. (Nolan, Tr. 6368-6369).

2171. Navigant also believes that independent community hospitals tend to lack capital resources to provide new medical technology. (Nolan, Tr. 6261-6262).

Response to Finding No. 2171

This proposed finding is incomplete and misleading. Mr. Nolan also testified that he personally knows of community hospitals with good financial performance and excellent quality of care. (Nolan, Tr. 6368-6369).

2172. Navigant perceives St. Luke's to be similar to other independent, community hospitals it has studied in terms of its competitive environment and financial challenges. (Nolan, Tr. 6262-6263).

Response to Finding No. 2172

Complaint Counsel has no specific response.

2173. {

} (Hanley, Tr. 4670, *in camera*).

Response to Finding No. 2173

Complaint Counsel has no specific response.

2174. {

} (Nolan, Tr. 6268-6270, *in camera*).

Response to Finding No. 2174

Complaint Counsel has no specific response.

2175. { } (Nolan, Tr. 6284, *in camera*; PX00479 at 001, *in camera*).

Response to Finding No. 2175

Complaint Counsel does not disagree.

2176. {

} (Nolan, Tr. 6286-6288, *in camera*; PX00479 at 007-008, *in camera*).

Response to Finding No. 2176

Complaint Counsel has no specific response.

2177. {

} (Nolan, Tr. 6289, *in camera*).

Response to Finding No. 2177

Complaint Counsel has no specific response.

2178. {

}

(Nolan, Tr. 6291-6292; PX00479 at 009, *in camera*).

Response to Finding No. 2178

Complaint Counsel does not disagree that this is what Navigant recommended. However, Complaint Counsel notes that Navigant's study primarily addresses relocating existing ProMedica services to existing ProMedica facilities, without explaining what role, if any, the Acquisition plays in facilitating such consolidations. (PX00396 at 008-010 ("Clinical Integration Strategy" Executive Summary), *in camera*). Kevin Nolan, the lead consultant on the project,

testified that most of Navigant's recommendations have little to no impact on St. Luke's services. (PX01946 at 019-021 (Nolan, Dep. at 67-75)).

2179. {

} (Nolan, Tr. 6284-6285, *in camera*; PX00479 at 006, *in camera*).

Response to Finding No. 2179

Complaint Counsel has no specific response.

2180. {

} (PX00479 at 006, *in camera*; Hanley, Tr. 4670-4671, *in camera*).

Response to Finding No. 2180

Complaint Counsel has no specific response.

2181. {

} (Nolan, Tr. 6301-6302, *in camera*).

Response to Finding No. 2181

Complaint Counsel has no specific response.

2182. {

} (Nolan, Tr. 6302-6303, *in camera*; Hanley, Tr. 4672, *in camera*).

Response to Finding No. 2182

Complaint Counsel has no specific response.

2183. {

} (Nolan, Tr. 6303, *in camera*).

Response to Finding No. 2183

Complaint Counsel has no specific response.

2184. {

} (Nolan, Tr. 6295, 6304, *in camera*).

Response to Finding No. 2184

Complaint Counsel has no specific response.

2185. {

} (Nolan, Tr. 6304, *in camera*).

Response to Finding No. 2185

Complaint Counsel has no specific response.

2186. {

} (Hanley, Tr. 4672, *in camera*).

Response to Finding No. 2186

Complaint Counsel has no specific response.

2187. {

} (Nolan, Tr. 6305, *in camera*).

Response to Finding No. 2187

This proposed finding is misleading to the extent that it implies this is a benefit of the Acquisition. St. Luke's inpatient rehabilitation center was a high-quality, low-cost alternative to ProMedica prior to the Acquisition. Consolidating inpatient rehabilitation at Flower is not a benefit. Instead, closing St. Luke's inpatient rehabilitation center has resulted in decreased competition, increased cost to patients that would have gone to St. Luke's, and increased travel time and inconvenience for patients who live closer to St. Luke's than Flower. (CCPFF ¶¶ 826-828).

2188. {

} (Nolan, Tr. 6296, *in camera*).

Response to Finding No. 2188

Complaint Counsel has no specific response.

2189. { } (Nolan, Tr. 6296, *in camera*).

Response to Finding No. 2189

Complaint Counsel has no specific response.

2190. {

} (Nolan, Tr. 6305-6306, *in camera*).

Response to Finding No. 2190

This proposed finding is irrelevant and misleading to the extent that it implies this is a benefit of the Acquisition. As Mr. Nolan admitted, inpatient psychiatry at St. Luke's was a *de minimis* service prior to the Acquisition. (Nolan, Tr. 6328-6329). Any benefit that ProMedica may realize from this consolidation is not merger specific and could have been accomplished without the Acquisition.

2191. {

} (Nolan, Tr. 6307, *in camera*).

Response to Finding No. 2191

Complaint Counsel has no specific response.

2192. {

} (PX00479 at 010, *in camera*).

Response to Finding No. 2192

Complaint Counsel has no specific response.

2193. {

} (Nolan, Tr. 6293, *in camera*; PX00479 at 010, *in camera*).

Response to Finding No. 2193

This proposed finding is misleading to the extent if suggest that implementing these recommendations can only be accomplished as a result of the Acquisition. Most of Navigant's recommendations focused on relocating services within ProMedica's legacy hospitals and were not facilitated by or related to the Acquisition. (*See* Response to RPFF ¶ 2178).

2194. {

} (Nolan, Tr. 6293-6294, *in camera*; PX00479 at 010, *in camera*).

Response to Finding No. 2194

Complaint Counsel has no specific response.

2195. {

} (Nolan, Tr. 6295, *in camera*; PX00479 at 010, *in camera*).

Response to Finding No. 2195

This proposed finding is irrelevant. This is the same role that Bay Park served prior to the Acquisition. (*See* RPFF ¶¶ 84, 88).

2196. {

} (Nolan, Tr. 6295, *in camera*; PX00479 at 010, *in camera*).

Response to Finding No. 2196

This proposed finding is irrelevant. This is the same role that ProMedica envisioned for Wildwood without the Acquisition. (*See* RPFF ¶89).

2197. {

} (Nolan, Tr. 6297-6298, *in camera*; PX00479 at 010, *in camera*).

Response to Finding No. 2197

Complaint Counsel has no specific response.

2198. {

} (Nolan, Tr. 6298-6299, *in camera*).

Response to Finding No. 2198

This proposed finding is misleading to the extent that it implies that this is a benefit of the Acquisition. In fact, eliminating open heart procedures at St. Luke's will result in increased travel time for patients that would have gone to St. Luke's or will have to be transferred from St. Luke's. (*See* CCPFF ¶¶ 830-831). Additionally, Dr. Gbur, an independent physician who performs interventional cardiology procedures at St. Luke's, testified that closing the open heart program at St. Luke's would affect his ability to do cardiac interventions at St. Luke's, resulting in his patients having to travel farther for those proceedures. (Gbur, Tr. 3112-3113). Consolidating open heart procedures at TTH will also likely result in a cost increase to patients and MCOs. (*See* CCPFF ¶ 825).

2199. {

} (RX-31 (Akenberger, Dep. at 131-132, *in camera*)).

Response to Finding No. 2199

Complaint Counsel has no specific response.

2200. Cardiac physicians believe that a hospital needs about 180 cardiac cases a year to break even. (RX-26 (Riordan, Dep. at 59)).

Response to Finding No. 2200

Complaint Counsel has no specific response.

2201. Prior to the joinder, St. Luke's had about 150 cardiac cases a year and had been unable to raise it above that number. (RX-26 (Riordan, Dep. at 60)).

Response to Finding No. 2201

Complaint Counsel has no specific response.

2202. {

} (Nolan, Tr. 6299, *in camera*).

Response to Finding No. 2202

Complaint Counsel has no specific response.

2203. {

} (Nolan, Tr. 6299-6300, *in camera*).

Response to Finding No. 2203

This proposed finding is misleading and inconsistent with other Navigant testimony. On one hand, Navigant found St. Luke's inpatient psychiatry service to be *de minimis* with approximately 0.1 patients per day. (Nolan, Tr. 6328-6329). In fact, St. Luke's has no inpatient psychiatric beds. (*See* CCPFF ¶ 813). On the other hand, Navigant asserts that closing St. Luke's inpatient psychiatry service would create benefits such as freeing space for OB expansion and creating private rooms. These two findings are inconsistent with each other.

2204. {

} (Nolan, Tr. 6300, *in camera*).

Response to Finding No. 2204

Complaint Counsel does not disagree.

2205. {

} (Nolan, Tr. 6300, *in camera*).

Response to Finding No. 2205

This proposed finding is misleading. St. Luke's had *de minimis* psychiatry patients and did not have inpatient psychiatry beds, so moving that service to Flower would have no effect on St. Luke's capacity for private room conversion. (*See* Response to RPFF 2203).

2206. {

} (RX-31 (Akenberger, Dep. at 123, *in camera*)).

Response to Finding No. 2206

Complaint Counsel has no specific response.

2207. {

} (Nolan, Tr. 6318, *in camera*).

Response to Finding No. 2207

Complaint Counsel has no specific response.

2208. {

} (Nolan, Tr. 6315-6316, *in camera*).

Response to Finding No. 2208

Complaint Counsel has no specific response.

2209. {

} (Nolan, Tr. 6316-6317, *in camera*).

Response to Finding No. 2209

Complaint Counsel has no specific response.

2210. {

} (Nolan, Tr. 6317, *in camera*).

Response to Finding No. 2210

Complaint Counsel has no specific response.

2211. {

} (Nolan, Tr. 6319, *in camera*).

Response to Finding No. 2211

Complaint Counsel has no specific response.

2212. {

} (Nolan, Tr. 6319-6320, *in camera*).

Response to Finding No. 2212

Complaint Counsel has no specific response.

2213. { } (Nolan, Tr. 6320, *in camera*).

Response to Finding No. 2213

Complaint Counsel has no specific response.

2214. {

} (Nolan, Tr. 6321-6322, *in camera*).

Response to Finding No. 2214

This proposed finding is misleading. Navigant's clinical integration study primarily addresses relocating existing ProMedica services to existing ProMedica facilities, without explaining what role, if any, the Acquisition plays in facilitating such consolidations. (PX00396 at 008-010 ("Clinical Integration Strategy" Executive Summary), *in camera*). Kevin Nolan, the lead consultant on the project, testified that most of Navigant's recommendations have little to no impact on St. Luke's services. (PX01946 at 019-021 (Nolan, Dep. at 67-75)). Additionally, the reduction in competition in the market caused by the Acquisition is likely to increase costs to patients and MCOs, rather than facilitate consumer benefits. (*See* CCPFF ¶ 825).

2215. {

} (PX01221 at 018, *in camera*).

Response to Finding No. 2215

This proposed finding is misleading and overstates the evidence. Coronary Artery Bypass Grafts is the only service line identified where ProMedica may achieve an inpatient volume threshold when combined with St. Luke's. (PX01221 at 18, *in camera*). Additionally, the increases in volume as a result of a decrease in competition in the market will likely lead to an increase in cost to patients and MCOs. (*See* CCPFF ¶ 825).

2216. {

} (Nolan, Tr. 6322, *in camera*).

Response to Finding No. 2216

Complaint Counsel has no specific response.

2217. {

} (Nolan, Tr. 6322, *in camera*).

Response to Finding No. 2217

This proposed finding is unreliable and without foundation to the extent that Navigant is making these claims without ever reviewing detailed financial information for St. Luke's. (PX01946 at 044 (Nolan, Tr. at 169); Nolan, Tr. 6375-6376, *in camera*). Mr. Nolan testified that he only reviewed St. Luke's financials from a "30,000-foot level." (PX01946 at 044 (Nolan, Tr. at 169-170).

2218. {

}

(Nolan, Tr. 6355-6356, *in camera*).

Response to Finding No. 2218

This proposed finding is incomplete and misleading to the extent that it implies that this efficiencies estimate is merger specific. The $3.4 million in asserted efficiencies is for the entire clinical integration. (PX01946 at 023 (Nolan, Dep. at 84-85); Nolan, Tr. 6354-6355, *in camera*). However, most of the clinical integration projects and recommendations do not even involve St. Luke's. (*See* Response to RPFF ¶ 2214). Navigant did no independent analysis to determine the reasonableness of ProMedica's estimate. Navigant only "had some discussions with [ProMedica] in terms of what some of their assumptions were." (Nolan, Tr. 6355-6356, *in camera*). Additionally, the cost of the clinical integration is $74 million. (PX01946 at 034 (Nolan, Dep. at 128)).

2219. {

} (Hanley, Tr. 4814, *in camera*).

Response to Finding No. 2219

This proposed finding is misleading. Higher volume programs do not always have higher quality. (*See* CCPFF ¶¶ 669-682, 693-702 (St. Luke's quality was higher than TTH)). Additionally, ProMedica charges more for services than St. Luke's does, so to the extent that services are moved from St. Luke's to ProMedica hospitals, there will be a cost increase to patients and MCOs. (CCPFF ¶ 825).

2220. {

} (Hanley, Tr. 4748, *in camera*).

Response to Finding No. 2220

Complaint Counsel has not specific response.

2221. {

} (RX-1855 at 000028, *in camera*).

Response to Finding No. 2221

This proposed finding is misleading and without foundation. The sole source for this proposed finding is ProMedica's response to the Civil Investigative Demand issued by the Federal Trade Commission in this case. The responses contained within are self-serving and made for litigation. Further, most cost savings allegedly associated with the Acquisition are either speculative or not merger-specific. (*See* Response to RPFF ¶¶ 2161, 2178). Also, cost avoidances are often the result of a decrease in competition and can be harmful to consumers. (See CCPFF ¶ 801).

2. Consolidating Some Clinical Services with ProMedica Has Already Allowed St. Luke's To Increase Its Capacity and Its Proportion of Private Rooms

2222. {

} (Nolan, Tr. 6276-6277, *in camera*; PX01216 at 025, *in camera*).

Response to Finding No. 2222

This proposed finding is incomplete and misleading to the extent that it implies private rooms are the industry norm for Lucas County, or that St. Luke's percentage of private rooms is substantially lower than other hospital in Lucas County. TTH and Flower also had low percentages of private rooms. (Nolan, Tr. 6377; Response to RPFF ¶ 1757).

2223. {

} (Nolan, Tr. 6282, *in camera*; PX01215 at 003, *in camera*).

Response to Finding No. 2223

This proposed finding is misleading to the extent it suggests that any of the claimed "issues" could not have been addressed by St. Luke's absent the Acquisition. St. Luke's had a

large reserve fund for capital projects and had minimal outstanding debt. (See CCPFF ¶¶ 32, 977, 980).

2224. {

.}

(RX-1855 at 000025-000026, *in camera*).

Response to Finding No. 2224

This proposed finding is misleading and without foundation. The sole source for this proposed finding is ProMedica's response to the Civil Investigative Demand issued by the Federal Trade Commission in this case. The responses contained within are self-serving and made for litigation. Further, ProMedica could have accomplished most, if not all, of these claimed efficiencies with its three legacy hospitals, and without the Acquisition. (*See* Response to RPFF ¶ 2178).

2225. {

} (RX-1856 at 000026, *in camera*).

Response to Finding No. 2225

This proposed finding is incomplete, misleading, and without foundation. The sole source for this proposed finding is St. Luke's response to the Civil Investigative Demand issued by the Federal Trade Commission in this case. The responses contained within are self-serving and made for litigation. Further, the proposed finding omits the important fact that consolidating inpatient rehabilitation away from St. Luke's causes an increase in cost to patients and MCOs, because ProMedica charges more than St. Luke's for such services. (CCPFF ¶ 828).

2226. {

} (PX02105 at 011, *in camera*; Hanley, Tr. 4681).

Response to Finding No. 2226

Complain Counsel has no specific response.

2227. {

} (RX-31 (Akenberger, Dep. at 106, *in camera*)).

Response to Finding No. 2227

Complain Counsel has no specific response.

2228. {

} (RX-31 (Akenberger, Dep. at 107-108, *in camera*)).

Response to Finding No. 2228

Complain Counsel has no specific response.

2229. {

} (RX-31 (Akenberger, Dep. at 108, *in camera*)).

Response to Finding No. 2229

Complain Counsel has no specific response.

2230. {

} (Wakeman, Tr. 3025-3026, *in camera*).

Response to Finding No. 2230

Complain Counsel has no specific response.

2231. {

} (RX-31 (Akenberger, Dep. at 111, *in camera*)).

Response to Finding No. 2231

This proposed finding is misleading and incomplete. Consolidating St. Luke's inpatient rehabilitation center into Flower will result in a $1 million increase in cost to patients and MCOs due to ProMedica charging higher prices than St. Luke's for these services. (CCPFF ¶ 828).

2232. As a result of adding new beds in the previous inpatient rehabilitation unit, St. Luke's has been able to reduce its ER diversions virtually to zero. (Johnston, Tr. 5374).

Response to Finding No. 2232

This proposed finding is misleading. This claimed efficiency is not merger specific. St. Luke's could have closed the program and added beds, or otherwise made adjustments or reallocated utilization across departments, without the Acquisition. (*See* CCPFF ¶ 1079).

2233. As a stand-alone hospital, St. Luke's is limited in its ability to turn semi-private rooms to private rooms, even though it has more beds available than it is using. (Guerin-Calvert, Tr. 7287).

Response to Finding No. 2233

This proposed finding is inaccurate and misleading. St. Luke's had ample capital reserves to complete this project, and considered it to be a high priority. (CCPFF ¶1079; Response to RPFF ¶ 1741). This finding also is misleading to the extent that it implies St. Luke's will be more equipped to complete this project after the Acquisition. ProMedica's CEO testified that ProMedica is "making no investment at St. Luke's at this point for private rooms," absent the small number of private rooms created in St. Luke's former inpatient rehabilitation space. (Oostra, Tr. 5907, *in camera*).

2234. In addition, given its deteriorating financial condition, if St. Luke's cannot take advantage of its excess capacity and reposition itself by converting semi-private rooms to private rooms, it will fall behind its competitors. (Guerin-Calvert, Tr. 7288-7289).

Response to Finding No. 2234

This finding is inaccurate. St. Luke's had the capital reserves to complete this project, and considered it to be a high priority. (CCPFF ¶1079; Response to RPFF ¶ 1741). Additionally, St. Luke's is not at a competitive disadvantage due to its percentage of private rooms, as private rooms are not an industry standard in Lucas County and numerous Lucas County hospitals have semiprivate rooms. (Response to RPFF ¶ 1757; 2222).

2235. With the benefit of capital it received from ProMedica, St. Luke's plans to add 17 additional private rooms. (Johnston, Tr. 5372, 5376-5377).

Response to Finding No. 2235

This proposed finding is inaccurate. ProMedica's CEO testified that ProMedica is "making no investment at St. Luke's at this point for private rooms," absent the small number of private rooms created in St. Luke's former inpatient rehabilitation space. (Oostra, Tr. 5907, *in camera*).

2236. The project budget for the additional 17 private rooms is $3 million. (Johnston, Tr. 5377).

Response to Finding No. 2236

Complaint Counsel has no specific response.

2237. The private room conversion will convert existing non-patient space within St. Luke's into new private patient rooms. (Johnston, Tr. 5377).

Response to Finding No. 2237

Complaint Counsel has no specific response.

2238. Converting semi-private rooms to private rooms is a less expensive alternative than new construction, but would make St. Luke's bed capacity situation worse because this approach would reduce the overall bed capacity of the hospital. (Johnston, Tr. 5378-5379).

Response to Finding No. 2238

Complaint Counsel has no specific response.

2239. Converting non-patient spaces into new private rooms is the least expensive way to add new private rooms without reducing overall bed capacity. (Johnston, Tr. 5377-5379).

Response to Finding No. 2239

Complaint Counsel has no specific response.

2240. Prof. Town agrees that private rooms would be a benefit to St. Luke's patient base. (Town, Tr. 4365-4366).

Response to Finding No. 2240

This proposed finding is misleading. The line of questioning relates only to postpartum rooms and includes several other capital projects. Professor Town responds that all of the projects, taken as a whole, "may" improve quality compared to not completing any of them. (Town, Tr. 4365-4366).

3. The Joinder Gives St. Luke's Access to ProMedica's Quality Programs and Systems

2241. Each of ProMedica's hospitals, as well as Paramount and PPG, has its own quality council. (PX01930 (Reiter, Dep. at 19)).

Response to Finding No. 2241

Complaint Counsel has no specific response.

2242. ProMedica also has service line and institute quality councils for the cancer institute, the orthopedic institute, the heart and vascular institute, and a fourth related to critical care services. (PX01930 (Reiter, Dep. at 22-23)).

Response to Finding No. 2242

Complaint Counsel has no specific response.

2243. ProMedica's corporate quality department provides quality report cards to measure how each hospital and business unit is doing based on valid quality metrics. (PX01930 (Reiter, Dep. at 19-20)).

Response to Finding No. 2243

This proposed finding is misleading. The current report cards in evidence were based on proposed rules for the new CMS attainment model. The final rules were released in May 2011,

and are very different from the proposed models. Therefore the results of the report cards in evidence are unreliable. Additionally, Mr. Wakeman believed there was a reporting error when he first saw the report cards because the methodology for determining the quality scores was vastly different than how quality scores were determined previously. (*See* Response to RPFF ¶¶ 1462, 1464).

2244. ProMedica compares its performance with and sets its goals in comparison to national quality scores and best practices, as well as local and regional hospitals. (RX-25 (Reiter, Dep. at 100)). In that way, ProMedica tracks the quality performance of each of its business units. (PX01930 (Reiter, Dep. at 20)).

Response to Finding No. 2244

Complaint Counsel has no specific response.

2245. The eICU is a computerized telemonitoring system that allows ProMedica to monitor all of its ICU beds across the system from a central control tower. (PX01930 (Reiter, Dep. at 24)).

Response to Finding No. 2245

Complaint Counsel has no specific response.

2246. {

} (PX00605 at 004, *in camera*).

Response to Finding No. 2246

Complaint Counsel has no specific response.

2247. ProMedica implemented eICU to achieve better critical care quality scores. (PX01930 (Reiter, Dep. at 180)).

Response to Finding No. 2247

Complaint Counsel has no specific response.

2248. Smart pumps are computerized infusion pumps that allow for medication to be infused into the body through veins, like an IV. (RX-25 (Reiter, Dep. at 65)).

Response to Finding No. 2248

Complaint Counsel has no specific response.

2249. Unlike normal IVs, smart pumps are computerized allowing the hospital staff to set safe limits for drug doses and alerting the staff if the dosing exceeds those limits. (RX-25 (Reiter, Dep. at 65)).

Response to Finding No. 2249

Complaint Counsel has no specific response.

2250. ProMedica believes that smart pumps improve quality of care by reducing medication errors. (RX-25 (Reiter, Dep. at 65)).

Response to Finding No. 2250

Complaint Counsel has no specific response.

2251. St. Luke's did not have smart pumps or the eICU before the joinder. (RX-25 (Reiter, Dep. at 66); PX01930 (Reiter, Dep. at 180-181)).

Response to Finding No. 2251

This proposed finding is misleading to the extent that it implies that using smart pumps at St. Luke's is a merger-specific benefit of the Acquisition. St. Luke's was planning to acquire smart pumps before the Acquisition. They had already obtained quoted prices, and were determining how to integrate the smart pumps into their electronic medical records system. (PX01850 at 074 (¶108) (Town Rebuttal Report)). Additionally, there is no indication that the Acquisition has helped St. Luke's implement eICU, because even after the Acquisition, St. Luke's is required to pay for all of the equipment and system upgrades itself. (PX01850 at 074 (¶108) (Town Rebuttal Report)).

2252. In the early joinder discussions, ProMedica identified the eICU as a potential benefit that St. Luke's would realize from joining the ProMedica system. (PX01930 (Reiter, Dep. at 181)).

Response to Finding No. 2252

This proposed finding is misleading. eICU is a program that St. Luke's would have implemented itself, and the Acquisition has not helped St. Luke's implement the program

because St. Luke's is required to pay for all of the equipment and system upgrades itself. (PX01850 at 074 (¶108) (Town Rebuttal Report)).

2253. { } (Johnston, Tr. 5412-5413, *in camera*).

Response to Finding No. 2253

This proposed finding is misleading to the extent that it implies this is a merger specific benefit. Prior to the Acquisition, St. Luke's was already looking into obtaining infusion pumps, also known as smart pumps. (*See* Response to RPFF ¶ 2251). Additionally, a stand-alone St. Luke's likely could have obtained discounts by purchasing smart pumps through a purchasing organization like Voluntary Hospitals of America, which St. Luke's used to reduce cost during its supply chain initiative. (PX01909 at 0049 (Dewey, IHT at 189), *in camera*; PX01933 at 23, 028 (Oppenlander, Dep. at 82-84, 102-103), *in camera*).

2254. Following the joinder, ProMedica began the process of bringing St. Luke's into its system-wide quality efforts. (PX01930 (Reiter, Dep. at 56)).

Response to Finding No. 2254

This proposed finding is misleading to the extent that it implies that quality at St. Luke's will improve due to the Acquisition. ProMedica's CEO testified that ProMedica's quality program "needed to catch up" and that ProMedica employees were "very confused" by ProMedica's quality meetings. (*See* CCPFF ¶¶ 689-690). Additionally, ProMedica hospital had poor quality scores, and prior to the Acquisition St. Luke's had concerns about ProMedica bringing down the quality scores at St. Luke's. (*See* CCPFF ¶¶ 669-692).

2255. For example, ProMedica took steps to bring St. Luke's into its patient safety council, which includes the safety officers from all of ProMedica's provider organizations. (PX01930 (Reiter, Dep. at 57)). ProMedica also involved St. Luke's in its best practice standardization initiatives. (PX01930 (Reiter, Dep. at 57)).

Response to Finding No. 2255

This proposed finding is misleading to the extent it implies that ProMedica's best practice standardization initiatives are superior to the best practices at St. Luke's. Evidence shows that some of ProMedica's best practices are out-dated and not on-par with the practices at St. Luke's. (PX01611 at 001 (St. Luke's V.P. of Patient Care, Konwinski, email regarding glucose best practice); PX01610 at 001-003 (Konwinski emails regarding insulin orders)). ProMedica's own employees have described ProMedica's quality programs as complicated, difficult to understand, and outright confusing. (*See* CCPFF ¶¶ 689-690). Additionally, ProMedica's hospitals had poor quality scores and, as a result, St. Luke's had concerns prior to the Acquisition about ProMedica bringing down the quality scores at St. Luke's. (*See* CCPFF ¶¶ 669-692).

D. Other Joinder Benefits

2256. {

} (RX-1855 at 000024, *in camera*).

Response to Finding No. 2256

This proposed finding is unfounded. It cites no ordinary course documents, deposition testimony, or trial testimony for its support. Instead, this proposed finding relies solely on a self-serving and made-for-litigation narrative that Respondent submitted in response to a Civil Investigative Demand from the FTC.

2257. {

} RX-1855 at 000029, *in camera*).

Response to Finding No. 2257

This proposed finding is unfounded. It cites no ordinary course documents, deposition testimony, or trial testimony for its support. Instead, this proposed finding relies solely on a self-

serving and made-for-litigation narrative that Respondent submitted in response to a Civil Investigative Demand from the FTC.

This proposed finding is also misleading to the extent it implies that members of the community are not opposed to the Acquisition. In fact, numerous local employers and physicians testified that they are concerned the Acquisition will result in higher rates, lower quality, or other anticompetitive harm. (*See, e.g.*, CCPFF ¶¶ 639, 641, 630-632).

2258. Becoming part of ProMedica has improved St. Luke's employee morale as employees feel more secure being part of a financially stable organization. (Johnston, Tr. 5373).

Response to Finding No. 2258

Complaint Counsel has no specific response.

2259. St. Luke's employees received a 1 percent pay increase on January 1, 2011. (Johnston Tr. 5373). St. Luke's employees received a second 1 percent pay increase in July 2011. (Johnston, Tr. 5373).

Response to Finding No. 2259

Complaint Counsel has no specific response.

2260. In June 2011, all employees received a one-time financial thank-you. Full-time employees received $200; part-time employees received $100; and contingent employees received $25. (Johnston, Tr. 5373).

Response to Finding No. 2260

Complaint Counsel has no specific response.

2261. In the past, as its patient volumes increased before the joinder, St. Luke's was forced to place many of the nursing staff on mandatory call. (Johnston, Tr. 5365).

Response to Finding No. 2261

Complaint Counsel has no specific response.

2262. Mandatory call means a nurse was on call beyond their normal hours of work and in most cases being on call meant that the nurses were called in and required to work overtime. (Johnston, Tr. 5365).

Response to Finding No. 2262

Complaint Counsel has no specific response.

2263. Being part of ProMedica enables St. Luke's to tap into the ProMedica staffing pool to help ramp up staffing at its facilities. (Johnston, Tr. 5373-5374). St. Luke's has been able to use ProMedica's nurse staffing pool and reduce the number of units that have mandatory call duty. (Johnston, Tr. 5387).

Response to Finding No. 2263

Complaint Counsel has no specific response.

2264. St. Luke's has been able to utilize the services of ProMedica's physician recruiters to help with physician recruitment. (Johnston Tr. 5374).

Response to Finding No. 2264

Complaint Counsel has no specific response.

2265. Since the joinder, ProMedica's recruiters have assisted three of St. Luke's physician groups with their recruitment efforts. (Johnston, Tr. 5386). ProMedica's recruiters have already helped recruit certified registered nurse anesthetists for St. Luke's anesthesiology group. (Johnston, Tr. 5386).

Response to Finding No. 2265

Complaint Counsel has no specific response.

2266. Through ProMedica's partnership with the University of Toledo, all full-time employees will receive free tuition to any undergraduate or graduate program. Part-time employees will receive 50 percent tuition. (Johnston, Tr. 5374).

Response to Finding No. 2266

Complaint Counsel has no specific response.

2267. St. Luke's has improved its cash-on-hand after payroll from $1.6 million at the time of the joinder to a current total of between $3 and $7 million. (Johnston, Tr. 5380).

Response to Finding No. 2267

Complaint Counsel has no specific response.

2268. St. Luke's has been able to pool its investments with the ProMedica investment pool and reduce investment fees. (Johnston, Tr. 5373).

Response to Finding No. 2268

Complaint Counsel has no specific response.

2269. { } (Johnston, Tr. 5495-5497, *in camera*). { } (Johnston, Tr. 5497, *in camera*).

Response to Finding No. 2269

This proposed finding is misleading and incorrect to the extent it implies that St. Luke's could not have funded these projects absent the Acquisition. At the time of the Acquisition, St. Luke's had $65 million in cash and investments, compared to a total estimated cost of less than $1.8 million to complete all of the allegedly deferred projects identified in this proposed finding. (Response to RPFF ¶ 1688).

2270. { } (Johnston, Tr. 5496-5497, *in camera*).

Response to Finding No. 2270

Complaint Counsel has no specific response.

PROPOSED CONCLUSIONS OF LAW

I. Complaint Counsel Has the Ultimate Burden of Persuasion as to Each Element of Its Section 7 Claim

1. Complaint Counsel alleges that the joinder (the "joinder") between ProMedica Health System, Inc. ("ProMedica") and St. Luke's Hospital ("St. Luke's") violates Section 7 of the Clayton Act, as amended, 15 U.S.C. § 18. Compl. ¶¶ 39-40.

Response to Proposed Conclusion of Law No. 1:

No specific response.

2. Clayton Act Section 7 only prohibits an entity from acquiring "the whole or any part" of a business' stock or assets if the effect of the acquisition "may be substantially to lessen competition, or tend to create a monopoly." *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1109 (N.D. Cal. 2004) (citing 15 U.S.C. § 18)).

Response to Proposed Conclusion of Law No. 2:

No specific response.

3. An analysis of a Section 7 claim requires a determination of (1) the product market in which to assess the transaction, (2) the geographic market in which to assess the transaction, and (3) the transaction's probable effect on competition in the product and geographic markets. *FTC v. Staples, Inc*., 970 F. Supp. 1066, 1072 (D.D.C. 1997).

Response to Proposed Conclusion of Law No. 3:

This proposed conclusion of law is correct. It should be noted, however, that the U.S. DOJ and FTC *Horizontal Merger Guidelines* (2010) observe that some analytical tools to assess competitive effects do not rely on market definition and that direct evidence of competitive effects can reduce the role of inferences from market definition alone. *See Merger Guidelines* at § 4.

4. Complaint Counsel bears the burden of proving every element of its Section 7 claim by a preponderance of the evidence. *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1109 (N.D. Cal. 2004).

Response to Proposed Conclusion of Law No. 4:

No specific response.

5. To prevail on a Section 7 claim, Complaint Counsel must show that there is a reasonable probability that the transaction will result in a substantial lessening of competition in the future. *United States v. Long Island Jewish Med. Ctr*., 983 F. Supp. 121, 135 (E.D.N.Y. 1997). To meet this burden, Complaint Counsel cannot simply demonstrate some likely impact on competition; instead, Complaint Counsel "has the burden of showing that the acquisition is reasonably likely to have 'demonstrable and substantial anticompetitive effects.'" *New York v. Kraft Gen. Foods, Inc*., 926 F. Supp. 321, 358 (S.D.N.Y. 1995) (quoting *United States v. Atl. Richfield Co*., 297 F. Supp. 1061, 1066 (S.D.N.Y. 1969); *see also FTC v. Tenet Health Care Corp*., 186 F.3d 1045, 1051 (8th Cir. 1999) ("Section 7 deals in probabilities, not ephemeral possibilities.").

Response to Proposed Conclusion of Law No. 5:

This proposed conclusion of law is incomplete. To establish a Section 7 claim, Complaint Counsel "need not show that the challenged merger or acquisition *will* lessen competition, but only that the loss of competition is a 'sufficiently probable and imminent' result of the merger or acquisition." *FTC v. CCC Holdings*, 605 F. Supp. 2d 26, 35 (D.D.C. 2009) (citations omitted).

6. If an analysis of the parties' market shares and the market concentration creates a presumption that the joinder of ProMedica and St. Luke's will have anticompetitive effects, ProMedica may rebut that presumption by showing "that the market share statistics give an inaccurate account of the merger's probable effects on competition in the relevant market." *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1110 (N.D. Cal. 2004). Rebuttal evidence may also include factors relating to competition in the relevant market or the competitive or financial weakness of the acquired company. *United States v. Baker Hughes Inc*., 908 F.2d 981, 983, 985 (D.C. Cir. 1990). If ProMedica successfully rebuts the presumption, then the burden shifts back to Complaint Counsel to produce "additional evidence of anticompetitive effects." *Id*. at 1110. At all times, however, the ultimate burden of persuasion remains with Complaint Counsel. *Id*. at 983.

Response to Proposed Conclusion of Law No. 6:

This proposed conclusion of law is incomplete. Complaint Counsel can also establish a *prima facie* case with qualitative and other evidence demonstrating that anticompetitive effects are likely. *In re Polypore Int'l, Inc.*, No. 9327, 2010 FTC LEXIS 97, at *25-26 (FTC Dec. 13,

2010) (citing *In re Chicago Bridge & Iron Co*., 138 F.T.C. 1024, 1053 (2005) (Comm'n Dec.) and *Merger Guidelines*). The stronger the *prima facie* case, the greater Respondent's burden of production is on rebuttal. *Id*. at *26 (citing *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 725 (D.C. Cir. 2001); *United States v. Baker Hughes*, 908 F.2d 981, 991 (D.C. Cir. 1990)). Furthermore, pursuant to Commission Rule 3.43(a), "the proponent of any factual proposition shall be required to sustain the burden of proof with respect thereto." 16 C.F.R. § 3.43(a) (2011).

II. Complaint Counsel Did Not Meet Its Burden of Proving Proper Relevant Markets in Which To Analyze the Effects of the Joinder

7. Complaint Counsel must prove by a preponderance of the evidence that an acquisition is reasonably likely to cause anticompetitive effects in a proven relevant market. *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1109 (N.D. Cal. 2004); *see also United States v. Penn-Olin Chem. Co*., 378 U.S. 158, 171 (1964). Complaint Counsel "bear[] the burden of proof and persuasion in defining the relevant market." *United States v. SunGard Data Sys*., 172 F. Supp. 2d 172, 182-83 (D.D.C. 2001); *see also FTC v. Lundbeck, Inc*., No. 10-3458, slip op. at 4 (8th Cir. Aug. 19, 2011). If Complaint Counsel does not properly define a relevant market, their case fails. *United States v. Long Island Jewish Med. Ctr*., 983 F. Supp. 121, 140 (E.D.N.Y. 1997); *Bathke v. Casey's Gen. Stores, Inc*., 64 F.3d 340, 345 (8th Cir. 1995) ("Antitrust claims often rise or fall on the definition of the relevant market.").

Response to Proposed Conclusion of Law No. 7:

This proposed conclusion of law is incomplete. Complaint Counsel must establish a relevant market by the preponderance of the evidence. *New York v. Kraft Gen. Foods*, 926 F. Supp. 321, 358 (S.D.N.Y. 1995). Further, as noted above, the most recent *Merger Guidelines* note that direct evidence of competitive effects can reduce the role of inferences from market definition alone. *See Merger Guidelines* at § 4.

8. The Complaint alleges two relevant product markets: 1) "general acute care inpatient services sold to commercial health plans, which encompasses a broad cluster of basic medical and surgical diagnostic and treatment services that include an overnight hospital stay, such as emergency services, internal medicine, and minor surgeries," and 2) "inpatient obstetrical services," which includes "hospital services provided for labor and delivery of newborns." Compl. ¶¶ 12, 14.

Response to Proposed Conclusion of Law No. 8:

No specific response.

9. A relevant product market consists of "products that have reasonable interchangeability for the purposes for which they are produced – price, use and qualities considered." *United States v. E.I. Du Pont de Nemours*, 351 U.S. 377, 404 (1956). Products are reasonably interchangeable if consumers treat them as "acceptable substitutes." *FTC v. Cardinal Health, Inc*., 12 F. Supp. 2d 34, 46 (D.D.C. 1998). A relevant product may consist of a cluster of products, even if the individual products within the cluster are not substitutes between themselves. *See, e.g.*, *FTC v. Staples, Inc*., 970 F. Supp. 1066, 1074 (D.D.C. 1997); *JBL Enters., Inc. v. Jhirmack Enters., Inc.*, 698 F.2d 1011, 1016 (9th Cir. 1983).

Response to Proposed Conclusion of Law No. 9:

This proposed conclusion of law is incomplete. The rationale for the use of cluster markets is analytical convenience where the "market share and entry conditions are similar for each" product or service included in the cluster. *Emigra Group v. Fragomen, Del Rey, Bernsen & Loewy, LLP*, 612 F. Supp. 2d 330, 353 (S.D.N.Y. 2009) (citing Jonathan B. Baker, *Market Definition: An Analytical Overview*, 74 ANTITRUST L.J. 129, 157-59 (2007)); *see also FTC v. ProMedica Health Sys.*, No. 3:11CV47, 2011 U.S. Dist. LEXIS 33434, at *23, *146 (N.D. Ohio March 29, 2011). The literature also supports this rationale specifically in the context of hospitals. *See* Jonathan B. Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, 51 LAW & CONTEMP. PROBS. 93, 138-40 (1988) (explaining that, consistent with Supreme Court precedent, acute inpatient services cluster market is appropriate "solely for descriptive and analytic convenience in situations where it will not be misleading").

The rationale adopted in *JBL Enterprises v. Jhirmack Enterprises*, cited by Respondent, is inapposite here and not supported by any evidence. 698 F.2d 1011, 1016-17 (9th Cir. 1983) (holding that full cluster of goods significantly differed from and appealed to buyers on different

basis than individual products). The court in *Staples* did not offer a rationale for the use of cluster markets or indeed even use the term. *FTC v. Staples, Inc*., 970 F. Supp. 1066, 1074 (D.D.C. 1997).

10. In hospital merger cases, federal courts, the FTC, and the DOJ have agreed that the proper market in which to analyze the competitive effects of a hospital merger is the market for general "acute care inpatient hospital services." The same is true in this case. *See In re Evanston Nw. Healthcare Corp*., 2007 FTC LEXIS 210, at *149 (F.T.C. Aug. 6, 2007).

Response to Proposed Conclusion of Law No. 10:

No specific response.

11. Consistent with past precedent, this Court concludes that general acute-care inpatient services, inclusive of inpatient obstetrical services, constitute a proper relevant market in which to analyze the competitive effects of St. Luke's joinder with ProMedica. *See e.g., In re Evanston Nw. Healthcare Corp*., 2007 FTC LEXIS 210, at *149 (F.T.C. Aug. 6, 2007); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 139 (E.D.N.Y. 1997); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1290-91 (W.D. Mich. 1996).

Response to Proposed Conclusion of Law No. 11:

This proposed conclusion of law is incorrect. The evidence and case law support the existence of two relevant markets in which it is appropriate to analyze the competitive effects of the Acquisition: inpatient general acute-care services ("GAC") and inpatient obstetrical services ("OB"). *See ProMedica*, 2011 U.S. Dist. LEXIS 33434, at *23-25 (finding inpatient general acute-care services market and a narrower inpatient obstetrical services market); *FTC v. Butterworth Health Corp.*, 946 F. Supp. at 1285, 1291 (W.D. Mich. 1996) (finding separate markets with different market participants for general acute care inpatient hospital services and for primary care inpatient hospital services); *see also United States v. Rockford Mem'l Corp*., 898 F.2d at 1278, 1284 (7th Cir. 1990) (Posner, J.) ("services are not in the same product market merely because they have a common provider"); *cf.*, *Morgenstern v. Wilson*, 29 F.3d 1291, 1296 (8th Cir. 1994) (Section 2 case defining relevant market as "adult cardiac surgery"); *Defiance*

Hosp. v. Fauster-Cameron, Inc., 344 F. Supp. 2d 1097, 1109 (N.D. Ohio 2004) (finding narrower market of anesthesia services in Section 2 case where, *inter alia*, only certain providers performed the service); *Little Rock Cardiology Clinic v. Baptist Health*, 573 F. Supp. 2d 1125, 1140-41 (E.D. Ark. 2008; CC Post-Tr. Br. at 6-21). Because competitive conditions, including entry conditions and the number of competitors, differ meaningfully in the OB market, it would be misleading and inappropriate to include OB services as part of the cluster of general acute-care services for purposes of analyzing the Acquisition's competitive effects.

No court has ever held that a general acute-care inpatient services market is the only correct product market in which to analyze competitive effects in hospital merger cases. Indeed, even courts adopting the GAC market have differed in the details of its application, based on the facts of the case. *See, e.g, Butterworth*, 946 F. Supp. 1285 (two market definitions, each with different market participants and geographic markets)*; United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121 (E.D.N.Y. 1997) (analyzed tertiary services as separate market)*; FTC v. Tenet Health Care Corp.*, 17 F. Supp. 2d 937 (E.D. Mo. 1998) (excluding tertiary services from GAC market)*; California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109 (N.D. Cal. 2001) (including tertiary services where both parties offered them).

12. The Complaint alleges a separate relevant market of inpatient obstetrical services. Compl. ¶¶ 12, 14. In prior hospital merger cases, courts have included inpatient obstetrical services in the general acute care inpatient services market. RPF 1024. *See California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1119 (N.D. Cal. 2001) (explaining that "[w]hile the treatments offered to patients within this cluster of services are not substitutes for one another (for example, one cannot substitute a tonsillectomy for heart bypass surgery), the services and resources that hospitals provide tend to be similar across a wide range of primary, secondary, and tertiary inpatient services. Accordingly, courts have consistently recognized the cluster of services comprising acute inpatient services as the appropriate product market in hospital merger cases.").

Response to Proposed Conclusion of Law No. 12:

This proposed conclusion of law is incorrect. Respondent grossly inflates the significance of *Sutter*. The parties in that case agreed that "acute inpatient care" was the appropriate market. *Sutter Health Sys.*, 130 F. Supp. 2d at 1119. The *Sutter* court did not address whether a separate relevant product market would be necessary if the market participants and market shares were dramatically different for specific inpatient services. Neither party argued that a separate product market was appropriate. The court certainly did not hold that inpatient obstetrical services must always be included in a general acute care inpatient services market. *Id.*

The rationale for the cluster market cited in *Sutter* is also inapposite, for it would warrant the inclusion of tertiary and quaternary services, and possibly outpatient, physician and other ancillary services, that even Respondent agrees do not belong in an appropriately defined inpatient general acute-care services market.

13. This Court concludes that Complaint Counsel's claims regarding the alleged market for inpatient obstetrical services must fail because they have not met their burden of proving that a narrower market for inpatient obstetrical services exists. *See FTC v. Arch Coal, Inc*., 329 F. Supp. 2d 109, 122 (D.D.C. 2004) ("The burden … is squarely on plaintiffs to establish that [the service at issue] is a separate relevant market."); *United States v. SunGard Data Sys*., 172 F. Supp. 2d 172, 182-83 (D.D.C. 2001); *United States v. Long Island Jewish Med. Ctr*., 983 F. Supp. 121, 140 (E.D.N.Y. 1997); *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1172 (N.D. Cal. 2004).

Response to Proposed Conclusion of Law No. 13:

This proposed conclusion of law is incorrect. Complaint Counsel have met their burden of establishing an inpatient obstetrical services market. (*See* CC Post-Tr. Br. at 16-21; CCPFF ¶¶ 199-207).

14. Complaint Counsel also have the burden of proving the relevant geographic market by a preponderance of the evidence. *United States v. Conn. Nat'l Bank*, 418 U.S. 656, 669 (1974); *United States v. SunGard Data Sys*., 172 F. Supp. 2d 172, 182-83 (D.D.C. 2001). To meet that burden, Complaint Counsel must present evidence on "where consumers of hospital services could practicably turn for alternative services should the merger be

consummated and prices become anticompetitive." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1052-53 (8th Cir. 1999). The relevant geographic market must "correspond to the commercial realities of the industry and be economically significant." *Brown Shoe Co. v. United States*, 370 U.S. 294, 336-37 (1962). Therefore, to sustain its burden, Complaint Counsel must present evidence on "where consumers could practicably go, not on where they actually go." *Tenet*, 186 F.3d at 1052; *FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir. 1995).

Response to Proposed Conclusion of Law No. 14:

No specific response.

15. This Court concludes that the relevant geographic market in which to analyze the effects of the St. Luke's joinder with ProMedica is Lucas County, Ohio. *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1290 ("A properly defined market includes potential suppliers who can readily offer consumers a suitable alternative to defendants' services.").

Response to Proposed Conclusion of Law No. 15:

No specific response.

III. Complaint Counsel Did Not Meet Its Burden of Demonstrating That The Joinder of ProMedica and St. Luke's Will Enable ProMedica To Raise Rates Above Competitive Levels in Either Alleged Relevant Market

16. Clayton Act Section 7 requires Complaint Counsel to demonstrate that as a result of the joinder, there is a "reasonable probability" of a substantial lessening of competition in the future for general acute care inpatient services, or inpatient obstetrical services, in Lucas County. *See United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 135 (E.D.N.Y. 1997). Complaint Counsel must show that a predicted post-joinder price increase is not "totally speculative," and to make this showing, Complaint Counsel must demonstrate that the prices that have resulted or will result from the joinder exceed competitive levels, not just that they may be higher than they were before the joinder. *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 143 (E.D.N.Y. 1997).

Response to Proposed Conclusion of Law No. 16:

This proposed conclusion of law is incorrect. *Long Island Jewish Medical Center* stated only that plaintiffs must demonstrate that the merged entity will be able to raise prices "above competitive levels." 983 F. Supp. at 143. But, in its competitive effects analysis, the court assumed that current prices were at "competitive levels," such that evidence that prices would be higher than they were before the joinder would, in fact, establish a Section 7 violation. Courts

generally rely on current prices as the presumptively "competitive price" in antitrust cases. (IIA Phillip Areeda & Herbert Hovenkamp, Antitrust Law ¶ 537b (3d ed. 2010); *CF Indus. v. Surface Transp. Bd.*, 255 F.3d 816 (D.C. Cir. 2001)). No court has ever concluded that although a merger will result in higher prices, the merger is legal because the prices are not "supracompetitive."

A. Market Concentration Statistics Do Not Accurately Portray Competitive Dynamics

17. Calculating market shares and market concentration does not end the analysis of whether a transaction is likely to substantially lessen competition. *FTC v. CCC Holdings, Inc.*, 605 F. Supp. 2d 26, 46 (D.D.C. 2009). The Supreme Court has cautioned that "statistics concerning market share and concentration are not conclusive indicators of anticompetitive effects." *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 130 (D.D.C. 2004) (citing *United States v. General Dynamics Corp.*, 415 U.S. 486, 498 (1974). Courts recognize that "determining the existence of or threat of anticompetitive effects has not stopped at a calculation of market shares" and, therefore, "a finding of market shares and consideration of [the presumption created by market shares] should not end the court's inquiry." *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1111 (N.D. Cal. 2004); *see also United States v. Baker Hughes Inc.*, 908 F.2d 981, 992 (D.C. Cir. 1990) (noting "The Herfindahl-Hirschman Index cannot guarantee litigation victories").

Response to Proposed Conclusion of Law No. 17:

No specific response.

18. Based on its findings, this Court concludes that the "structure, history, and probable future" of the general acute care inpatient services market show that Complaint Counsel's market shares are not indicative of likely anticompetitive effects from the joinder. *United States v. General Dynamics Corp.*, 415 U.S. 486, 498 (1974). Therefore, a presumption based on market concentration statistics that the joinder will lead to anticompetitive effects does not satisfy Complaint Counsel's burden of proof to establish a violation of Clayton Act Section 7. Relying solely on market shares to analyze competitive effects is "especially problematic" when the transaction involves differentiated products, such as inpatient general acute care services. *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1122 (N.D. Cal. 2004); *see also Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1410-12 (7th Cir. 1995) (It is "always treacherous to try to infer monopoly power from a high rate of return" in a market of differentiated products because "the difference may reflect higher quality more costly to provide"). Particularly with differentiated products, there is no automatic correlation between market share and price. *See Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1410-12 (7th Cir. 1995). Where market shares are not an accurate predictor of future

competitive effects, they are no substitute for a rigorous analysis of actual market dynamics. *See United States v. Baker Hughes Inc*., 908 F.2d 981, 983-85 (D.C. Cir. 1990).

Response to Proposed Conclusion of Law No. 18:

This proposed conclusion of law is incorrect. Respondent's unsupported claim that "a presumption [of anticompetitive harm] based on market concentration statistics . . . does not satisfy Complaint Counsel's burden of proof" ignores Respondent's burden to produce credible rebuttal evidence, even if the presumption of harm was established by market concentration statistics alone. (*See* RPCL ¶ 6; CCPCL ¶¶ 12-15). Otherwise, Complaint Counsel prevails on its *prima facie* case. (*Id*.).

Further, the high market shares and significant increases in concentration are consistent with and supported by a large body of evidence from numerous sources, all of which indicates that the Acquisition will, in fact, lead to substantial anticompetitive harm in two relevant markets. (*See* CC Post-Tr. Br. at 36-78; CCPFF ¶¶ 315-702).

B. Complaint Counsel Have Failed To Produce Evidence that the Joinder Resulted or Will Result in Anticompetitive Effects in their Alleged Relevant Markets

19. "Analysis of the likely competitive effects of a merger requires [a determination] of…the transaction's probable effect on competition in the relevant product and geographic markets." *FTC v. Arch Coal, Inc*., 329 F. Supp. 2d 109, 117 (D.D.C. 2004). Complaint Counsel cannot "simply [make] conclusory allegations that…the merger will significantly limit competition without any evidence." *Advocacy Org. v. Mercy Health Servs.*, 987 F. Supp. 967, 974 (E.D. Mich. 1997). Rather, they must show "anticompetitive effects…that will result from the merger." *Advocacy Org. v. Mercy Health Servs.*, 987 F. Supp. 967, 974 (E.D. Mich. 1997).

Response to Proposed Conclusion of Law No. 19:

No specific response.

20. An economic expert's econometric analysis must reflect competitive realities; if the expert's opinion "is not supported by sufficient facts to validate it in the eyes of the law . . . it cannot support a decision." *United States v. General Dynamics Corp*., 415 U.S. 486, 498 (1974); *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045 n.13 (8th Cir. 1999); *see*

FTC v. CCC Holdings, Inc., 605 F. Supp. 2d 26, 70-72 (D.D.C. 2009) (dismissing an expert's model because "the data and predictions cannot reasonably be confirmed by the evidence."). Because general acute care inpatient services are differentiated products, factors such as cost, quality, underestimation of the increase in inflation or cost escalation, and the duration of a contract can cause differences in competing hospitals' prices. *See Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1412 (7th Cir. 1995) (noting that quality can affect prices). *See Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 242 (1993). Indeed, the *Brooke Group* court ruled that "when indisputable record facts contradict or otherwise render the [expert's] opinion unreasonable, it cannot support a jury's verdict." *Brooke Group*, 509 U.S. at 242.

Response to Proposed Conclusion of Law No. 20:

No specific response except that there is no evidence to support that cost, quality, or competitively-benign factors can explain ProMedica's significantly higher prices in Lucas County. (*See* CC Post-Tr. Br. at 51-52; PX01850 at 057-059 (¶¶ 89-90) (Town Rebuttal Expert Report), *in camera*).

21. Likewise, this Court concludes the Complaint Counsel's economic expert's econometric analysis "is not supported by sufficient facts to validate it in the eyes of the law," because it does not accurately reflect the actual competitive dynamics in the general acute care inpatient services market. Therefore, "it cannot support a decision." *United States v. General Dynamics Corp*., 415 U.S. 486, 498 (1974); *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045 n.13 (8th Cir. 1999).

Response to Proposed Conclusion of Law No. 21:

This proposed conclusion of law is incorrect. Professor Town's econometric analysis is supported by hundreds of hours of testimony of numerous market participants, including health plans, employers and physicians, third-party documents, data, and the merging parties' own documents. (*See* CC Post-Tr. Br. at 28-104; CCPFF at ¶¶ 273-1236).

22. Complaint Counsel's failure to present any evidence of anticompetitive effects in its alleged inpatient obstetrical services market is fatal to their case as to that alleged relevant market. *See United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1172 (N.D. Cal. 2004); *Menasha Corp. v. News Am. Mktg. In-Store, Inc*., 354 F.3d 661, 664-65 (7th Cir. 2004) (holding that conclusory reasoning does not replace the need for actual economic analysis).

Response to Proposed Conclusion of Law No. 22:

This proposed conclusion of law is incorrect. The competitive effects analysis and the supporting evidence confirming ProMedica's significant increase in leverage and the likelihood of increased rates applies equally to the OB and GAC markets. (*See* Town, Tr. 4454-4456 (explaining that bargaining analysis applies equally to OB market). Furthermore, Complaint Counsel has provided additional evidence specifically pertaining to anticompetitive effects in the OB market. (*See, e.g.,* CCPFF ¶¶ 229-233, 314, 324-325, 337, 364, 425, 428, 432, 435, 479, 482-483, 507-508, 701-702, 708, 732-750). Finally, Professor Town's merger simulation predicting significant price increases applies to both the GAC and OB markets. (Town, Tr. 4468-4469).

C. The Joinder Will Neither Enhance ProMedica's Market Power Nor Enable It To Increase Rates for General Acute Care Inpatient or Inpatient Obstetrical Services above Competitive Levels

23. Complaint Counsel must show that the joinder gives ProMedica the ability to raise prices above a competitive level. *See, e.g.*, *See United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1170 (N.D. Cal. 2004). Particularly because the joinder has been consummated, this Court concludes that evidence of actual competitive effects, pre- and post-joinder, should be given substantial weight in this analysis. *See United States v. Archer-Daniels-Midland Co.*, 781 F. Supp. 1400, 1421 (S.D. Iowa 1991); *Lektro-Vend Corp. v. Vendo Co.,* 660 F.2d 255, 276 (7th Cir. 1981); *Lektro-Vend*, 660 F.2d at 276 (stating "post-acquisition evidence favorable to a defendant can be an important indicator of the probability of anticompetitive effects where the evidence is such that it could not reflect deliberate manipulation by the merged companies temporarily to avoid anti-competitive activity").

Response to Proposed Conclusion of Law No. 23:

This proposed conclusion of law is incorrect. Post-acquisition evidence that is even *arguably* subject to manipulation by the defendant is, as is clearly the case here, entitled to little or no weight. *Chicago Bridge & Iron Co. v. FTC*, 534 F.3d 410, 435 (5th Cir. 2008); *see also Hosp. Corp. of Am. v. FTC*, 807 F.2d 1381, 1384 (7th Cir. 1986) (Posner, J.); *In re Polypore Int'l*

Inc., No. 9327, 2010 FTC LEXIS 17, at *620 (March 1, 2010) (Chappell, A.L.J.). The two cases cited by Respondent, in which courts accorded some consideration to post-acquisition evidence, involved evidence that clearly could not have been manipulated by the defendant. *See Lektro-Vend Corp. v. The Vendo Co.*, 660 F. 2d 255, 276 (7th Cir. 1981) (relying on precipitous decline in defendant's post-acquisition market share); *United States v. Archer-Daniels-Midland Co.*, 781 F. Supp. 1400, 1423 (S.D. Iowa 1991) (relying on post-acquisition industry-wide trends).

24. In differentiated markets, the merged firm may be able to raise prices unilaterally if customers accounting for a "significant fraction" of the merged firms' sales view the merging parties as their first and second choices for the product, and if, in response to a price increase, rival sellers likely would not "replace any localized competition lost through the merger by repositioning their product lines." *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1123 (N.D. Cal. 2004); *In re Evanston Nw. Healthcare Corp.*, 2007 FTC LEXIS 210, at *158-59 (F.T.C. Aug. 6, 2007).

Response to Proposed Conclusion of Law No. 24:

No specific response.

25. Because ProMedica and St. Luke's are not close substitutes and because Mercy and UTMC are ready alternatives that can constrain ProMedica's pricing, this Court concludes that the joinder will not affect ProMedica's bargaining leverage. *See Oracle*, 331 F. Supp. 2d at 1172 (finding plaintiffs failed to prove unilateral effects as a result of the merger because they failed to prove that there were a significant number of customers who regarded the merging companies as first and second choices); *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1129-32 (N.D. Cal. 2001) (using diversion analysis to support finding that patients would turn to other hospitals in the face of a price increase).

Response to Proposed Conclusion of Law No. 25:

This proposed conclusion of law is incorrect. Complaint Counsel has established that ProMedica and St. Luke's were close substitutes, that Mercy and UTMC have not constrained and will not constrain ProMedica's pricing, and that the Acquisition will increase ProMedica's bargaining leverage substantially. (*See* CC Post-Tr. Br. at 36-60; CCPFF ¶¶ 315-628).

26. Merging parties are constrained from increasing prices to supracompetitive levels if other firms can enter the relevant markets. *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 149 (E.D.N.Y. 1997). Entry can occur if new firms enter the relevant markets, or if existing firms expand their current capacity or "expand into new regions of

the market." *FTC v. Cardinal Health, Inc*., 12 F. Supp. 2d 34, 55 (D.D.C. 1998). *See also United States v. Baker Hughes Inc*., 908 F.2d 981, 989 n.8 (D.C. Cir. 1990). Indeed, in *Baker Hughes*, the court noted the presence of existing companies "poised for future expansion" in the relevant markets to support its conclusion that the merger would not likely cause anticompetitive effects. 908 F.2d at 988-89. *See also In re Evanston Nw. Healthcare Corp*., 2007 FTC LEXIS 210, at *159 (F.T.C. Aug. 6, 2007) (quoting IV Phillip E. Areeda, Herbert Hovenkamp & John L. Solow, *Antitrust Law* ¶ 914a at 67 (2d ed. 2006) ("The degree to which a merger in a product-differentiated market might facilitate a unilateral price increase depends on . . . the relative inability of other firms to redesign their products to make them close to the output of the merging firms.")). Even perceived entry or expansion can constrain a possible anticompetitive price increase. *See Baker Hughes*, 908 F.2d at 988.

Response to Proposed Conclusion of Law No. 26:

This proposed conclusion of law is incomplete and incorrect. To put forth an entry defense, Respondent bears the burden to "provide evidence that the likelihood of entry reaches a threshold ranging from 'reasonable probability' to 'certainty.'" *Chicago Bridge*, 534 F.3d at 430, n.10; *see also* CCPCL ¶¶ 39-42 (explaining requirements that entry be "timely, likely, and sufficient").

Respondent's reliance on on *Baker Hughes* is misplaced. Courts and treatises have sharply criticized and declined to adopt the "threat of entry" holding in *Baker Hughes*. *See Chicago Bridge*, 534 F. 3d at 430, n.10 ("*Baker Hughes'* conclusion that a mere threat of entry is sufficient to constrain anti-competitive effects has been criticized, and we will not adopt it here.") (citing cases and treatises).

27. Declining demand for a product or service can increase competition and constrain that product's or service's price. *United States v. Rockford Mem'l*, 717 F. Supp. 1251, 1283-84 (N.D. Ill. 1989) (noting that demand for inpatient care in northern Illinois hospitals had decreased due to "[t]he advent of outpatient services, cost containment and managed healthcare…. In turn, this has led the acute inpatient care market to become more price sensitive and competitive as hospitals attempt to attract steady sources of inpatients through lower prices.").

Response to Proposed Conclusion of Law No. 27:

No specific response except that Respondent has produced no evidence relied upon in *Rockford* and there is no evidence in the record that the markets in Lucas County, GAC and OB, are increasingly price sensitive.

28. The ability of even a few patients to switch to other hospitals for care is a key factor that can constrain any potential price increase by a merging hospital. *FTC v. Tenet Health Care Corp.*, 186 F. 3d 1045, 1054 (8th Cir., 1999) (finding that a switch of a small percentage of patients could render any potential price increase unprofitable); *see also California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109 (N.D. Cal. 2001) (using actual physician overlapping privileges data to counter managed care organizations' testimony that patients would not switch hospitals in the face of a price increase).

Response to Proposed Conclusion of Law No. 28:

This proposed conclusion of law is incorrect. Respondent grossly misstates and exaggerates the holdings of *Tenet* and *Sutter*, which neither suggest that their factual findings should be generalized to other hospital cases, nor describe the referenced findings as a "key factor" in their decision. *Tenet* found only that, based on the facts of that case, plaintiffs' geographic market was refuted by "the proximity of many patients to other hospitals in other towns, coupled with the compelling and essentially unrefuted [critical-loss analysis showing] that the switch to another provider by a small percentage of patients would constrain a price increase[.]" *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999). *Sutter*, also addressing the relevant geographic market, briefly addressed physician admitting privileges in its opinion, noting the relative weakness of plaintiffs' evidence in that case on the issue. *Sutter*, 130 F. Supp. 2d at 1131.

29. The physical closeness of all the hospitals in Lucas County also affects the competitive dynamics of the market. *See FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1053 (8th Cir. 1999) (finding the fact that over 22 percent of residents in the "most important zip codes" already use hospitals outside the proposed geographic market is a "check on the exercise of market power by the hospitals within the service area"). Courts have routinely dismissed testimony that location is a deterrent to patients switching hospitals when the testimony is based on anecdotal statements from MCOs and employers. *See Tenet*, 186 F.3d at 1054 (testimony of third party MCOs that they would be forced to

accept price increases from the merged entity because patients insist on going to hospital closest to home was "suspect."); *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1131 (N.D. Cal. 2001) ("Informal, off-the-cuff remarks and anecdotal evidence concerning the marketplace are no substitute for solid economic evidence.") (quoting *FTC v. Freeman Hosp.*, 911 F. Supp. 1213, 1220 (W.D. Mo. 1995). This Court concludes that the distances between the Lucas County hospitals is a "check on the exercise of market power" by ProMedica and St. Luke's. *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1053 (8th Cir. 1999)

Response to Proposed Conclusion of Law No. 29:

This proposed conclusion of law is incorrect. The location of the hospitals within Lucas County is relevant to the competitive effects analysis because the proximity of ProMedica hospitals and St. Luke's in southwest Lucas County is a key factor that contributes to the close competition between them and leads to the competitive harm. (*See* CC Post-Tr. Br. at 38 (explaining that some hospitals within a geographic market will be closer substitutes than others)). The cases cited by Respondent address the proper analysis and evidence required to establish a geographic market, which is not in dispute in this case. *See Tenet*, 186 F.3d 1045 (8th Cir. 1999) (dismissing case for failure to establish geographic market); *Sutter*, 130 F. Supp. 2d 1109 (N.D. Cal. 2001) (same); *FTC v. Freeman Hosp.*, 911 F. Supp. 1213, 1220 (W.D. Mo. 1995) (same).

Respondent also misstates the holding of *Tenet*. In *Tenet*, the court was skeptical of the health plans' testimony that they would not steer their members to other hospitals to defeat a rate increase where the evidence established that they *could* do so. *Tenet*, 186 F.3d at 1054 ("the evidence shows that . . . buyers can and do resist price increases[.]"). In fact, the parties had stipulated that the health plans at issue had "a very significant, if not determinative, effect on patients' selection of hospitals." *FTC v. Tenet Healthcare Corp.*, 17 F. Supp. 2d 937, 940 (E.D. Mo. 1998), *rev'd on other grounds,* 186 F.3d 1045 (8th Cir. 1999). The evidence in this case

demonstrates the opposite – that health plans cannot steer patients to defeat a price increase.

(*See* CC Post-Tr. Br. at 70-74; CCPFF at ¶¶ 539-592).

30. In light of the fact that this Court has previously found that rivals to ProMedica and St. Luke's are "poised for future expansion," declining demand will increase competition, and the fact that only a few patients need to switch to other hospitals which are nearby to constrain a price increase, this Court concludes that the joinder is not reasonably likely to cause anticompetitive effects. *See e.g.*, *United States v. Baker Hughes Inc*., 908 F.2d 981, 988-89 (D.C. Cir. 1990); *United States v. Rockford Mem'l*, 717 F. Supp. 1251, 1283-84 (N.D. Ill. 1989); *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999); *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109 (N.D. Cal. 2001).

Response to Proposed Conclusion of Law No. 30:

This proposed conclusion of law is incorrect. Complaint Counsel refers to its responses to Respondent's Proposed Conclusions of Law ¶¶ 26-29.

31. In this matter several managed care organizations and employers testified during trial. However, testimony from industry participants is inherently suspect, particularly when the testimony is from large, sophisticated buyers. *See FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999) (stating that MCOs' testimony that they would unhesitatingly accept a price increase was contrary to their economic interests and, therefore suspect). The *Tenet* court noted that "large, sophisticated third-party buyers can and do resist price increases." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999). Moreover, large, sophisticated buyers – who have years of experience and access to information including their own insureds' historical utilization of hospitals in the market, hospital costs and revenues, and coordination of benefits – are expected to substantiate their apprehensions that the joinder would raise prices to an anticompetitive level. *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1131 (N.D. Cal. 2004). Otherwise, the testimony of market participants speaks only to current customer perceptions and habits, but does not address what customers would do in the event of a price increase. *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999). *See also FTC v. Arch Coal, Inc*., 329 F. Supp. 2d 109, 145-46 (D.D.C. 2004) (noting that many cases and antitrust authorities "do not accord great weight to the subjective views of customers in the market," and stating that the concern expressed by the customers at issue "is little more than a truism of economics: a decrease in the number of suppliers *may* lead to a decrease in the level of competition in the market.") (emphasis added).

Response to Proposed Conclusion of Law No. 31:

This proposed conclusion of law is incorrect. In *Oracle*, the court explicitly noted that "[i]f backed by credible and convincing testimony [about what customers could or could not do

to avoid a price increase] or testimony presented by economic experts, customer testimony . . . can put a human perspective . . . on the injury to competition that plaintiffs allege." *United States v. Oracle,* 331 F. Supp. 2d 1098, 1131 (N.D. Cal. 2004). Respondent relies on cases in which the court disregarded customer testimony, because it was "rote," conclusory, or did not stand up to patently contradictory evidence. *Id.* (observing customer witnesses testified "with a kind of rote"); *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109 (D.D.C. 2004) (noting customers testified to little more than anxiety that fewer suppliers would lead to higher prices); *Tenet*, 186 F.3d 1045 (holding testimony that health plans would not resist price increases suspect where evidence showed that they could and it was in their economic self-interest to do so). Such criticisms do not apply here.

Respondent again misstates the holding of *Tenet*. In *Tenet*, the court was skeptical of the health plans' testimony where the evidence flatly contradicted their claims. *Tenet*, 186 F.3d at 1054 ("*the evidence shows* that . . . buyers can and do resist price increases.") (emphasis added). In contrast, customer testimony in this matter is consistent with, and supported by, a large body of evidence in the record.

32. This Court concludes that the subjective testimony of managed care organizations and employers offers the Court no probative evidence of post-joinder anticompetitive effects, and the Court disregards it. *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 146 (D.D.C. 2004) (discrediting testimony of customers because they lack expertise to opine on what will happen in the market in the future); *see also FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999) (dismissing testimony of market participants that failed to show where consumers could practicably go for inpatient hospital services).

Response to Proposed Conclusion of Law No. 32:

This proposed conclusion of law is incorrect. Complaint Counsel refers to its reponse to Respondent's Proposed Conclusion of Law ¶ 31.

IV. Absent the Joinder, St. Luke's Competitive Significance Would Decrease

33. As part of the Court's examination of the likely competitive effects of the joinder, it must consider what St. Luke's competitive strength and capability would have been absent the joinder. *See, e.g. United States v. Int'l Harvester, Co.*, 564 F.2d. 769, 773-76 (7th Cir. 1997) (holding that the district court properly considered the defendant seller's financial weakness and resultant weakness as a competitor in the context of ruling that a merger did not violate Section 7 of the Clayton Act); *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 155-57 (D.D.C. 2004) (seller's "weak competitive status remains relevant to…whether substantial anticompetitive effects are likely from the transaction.").

Response to Proposed Conclusion of Law No. 33:

This proposed conclusion of law is incomplete. The so-called flailing-firm defense requires a "substantial showing that the acquired firm's weakness, which cannot be resolved by any competitive means, would cause that firm's market share to reduce to a level that would undermine the government's *prima facie* case." *Tenet*, 17 F. Supp. 2d at 947 (citing *Univ. Health*, 938 F.2d at 1221). But the "more compelling the *prima facie* case, the more evidence the defendant must present to rebut it successfully." *Arch Coal*, 329 F. Supp. 2d at 129 (quoting *Baker Hughes*, 908 F.2d at 991). "[F]inancial weakness . . . is probably the weakest ground of all for justifying a merger [and it] certainly cannot be the primary justification of a merger." *Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324, 1339, 1441 (7th Cir. 1981)); *see also FTC v. Warner Commc'ns, Inc.*, 742 F.2d 1156, 1164-65 (9th Cir. 1984). Courts have strongly disfavored "a weak company defense" because it "would expand the failing company doctrine, a defense which has strict limits." *Warner Commc'ns*, 742 F.2d at 1164 (internal quotations omitted). (*See also* CCPCL ¶¶ 47-50).

34. The District Court's analysis in *Arch Coal* exemplifies the type of analysis this Court applied. *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004). There, the court assessed the acquired entity's poor financial condition in determining that the FTC's claims of its competitive significance were "far overstated." *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 155-57 (D.D.C. 2004). For example, the court found the acquired entity "consistently lost money" and ruled that a "company with a positive EBITDA but a negative net income is not sustainable for the long term." *FTC v. Arch Coal*, 329 F.

Supp. 2d 109, 155 (D.D.C. 2004). Importantly, the court noted that even though the failing firm defense did not apply, the acquired entity's "weak competitive status remains relevant to an examination of whether substantial anticompetitive effects are likely from a transaction." *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004). The evidence there showed that the acquired entity was struggling financially and would be a stronger competitor as a result of the acquisition than it would have been without. *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004). The court considered all this evidence before ultimately concluding that the FTC had failed to establish that the merger at issue there would likely result in anticompetitive effects. *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004).

Response to Proposed Conclusion of Law No. 34:

This proposed conclusion of law is incorrect. *Arch Coal* could not be more different from the facts of this case. Specifically, the transaction at issue in *Arch Coal* "just barely" raised a presumption of harm, leading to a "marginal" and "weak" *prima facie* case. 329 F. Supp. 2d at 128, 158. The struggling coal-mining firm literally was in a state of irreversible decline because of the depletion of its coal reserves. *Id.* at 127. The financial condition of the "flailing firm" was also uniquely dire because of its reliance on depleting natural resources. *Id.* at 155. The firm had consistently lost money since its inception and could no longer obtain financing, even in the junk-bond markets. *Id.* at 155-56. Furthermore, in *Arch Coal*, "the prospects for identifying and securing another buyer [were] dim," even after the flailing firm had hired an investment-banking firm that "engaged in a comprehensive search for a buyer" for three years and "contacted [] every potential purchaser worldwide." 329 F. Supp. 2d at 156-57. Such facts bear no resemblance to this case, and thus Respondent's reliance on *Arch Coal* is misplaced.

35. As part of the Court's overall charge to evaluate the "structure, history, and probable future" of the general acute care inpatient hospital services market, it has also examined St. Luke's future competitive state within the context of the health care industry and rapid changes occurring within it. *United States v. General Dynamics Corp.*, 415 U.S. 486, 498 (1974).

Response to Proposed Conclusion of Law No. 35:

No specific response.

36. This Court has evaluated St. Luke's deteriorating financial condition as part of its determination of whether anticompetitive effects will likely result from the joinder. *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 155-57 (D.D.C. 2004). This Court concludes that Complaint Counsel have "far overstated" St. Luke's competitive significance and that its joinder with ProMedica is not reasonably like to result in substantial anticompetitive effects because of St. Luke's sustained weak competitive status. *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004).

Response to Proposed Conclusion of Law No. 36:

This proposed conclusion of law is incorrect. Respondent produced no evidence demonstrating that St. Luke's increasing market shares would suddenly plummet from 11.5% to 2% or less in GAC and from 9.3% to 1.3% or less in OB. In fact, St. Luke's market shares were increasing (at ProMedica's expense) at the time of the Acquisiton. (*See* CC Post-Tr. Br. at 89-93; CCPCL ¶ 47). As such, Respondent's defense fails.

V. The Joinder Has Resulted In And Will Continue To Yield Meaningful Procompetitive Benefits For The Community

37. The court in *Arch Coal* considered evidence that the seller as part of a joined entity "will be a stronger competitive force in a post-merger market than [the seller] has been or will be if no merger occurs" in holding that the merger was not anticompetitive. *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004). Similarly, in *International Harvester*, the Seventh Circuit found that the district court had properly considered the fact that the merger agreement "substantially improved [the defendant seller's] financial, operating, and competitive position" in affirming that the agreement did not violate the antirust laws. *United States v. Int'l Harvester, Co.*, 564 F.2d. 769, 777 (7th Cir. 1997).

Response to Proposed Conclusion of Law No. 38:

No specific response.

38. Evidence of qualitative and quantitative benefits to consumers of healthcare services in Toledo is recognized as relevant to a defense to a government challenge to a merger. *See FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1053-54 (8th Cir. 1999) (noting improved quality as a benefit of the merger); *In re Evanston Nw. Healthcare Corp*., 2007 FTC 210, at *225-28 (F.T.C. Aug. 6, 2007) (reviewing respondents' proposed efficiencies).

Response to Proposed Conclusion of Law No. 38:

No specific response.

39. Evidence of efficiencies may be introduced to rebut a plaintiff's *prima facie* case. *FTC v. Heinz Co.*, 246 F.3d 708, 720 (D.C. Cir. 2001); *United States v. Baker Hughes Inc*., 908 F.2d 981, 982-3 (D.C. Cir. 1990). The Eleventh Circuit has held that "a defendant may rebut the government's prima facie case with evidence showing that the intended merger would create significant efficiencies in the relevant market." *FTC v. Univ. Health, Inc*., 938 F.2d 1206, 1222-23 (11th Cir. 1991) (holding that a defendant could overcome a presumption that the proposed acquisition would lessen competition by demonstrating that the acquisition would result in significant efficiencies to benefit consumers). Courts, therefore, should consider "evidence of enhanced efficiency in the context of the competitive effects of the merger." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999). Further, in the hospital merger context, evidence may show that "a hospital that is larger and more efficient … will provide better medical care than either of those hospitals could separately." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999). Efficiencies are particularly compelling in the health care industry where hospitals face significant challenges to meet the demands of new health care legislation, and regulatory reforms are changing the competitive landscape such that "a merger deemed anticompetitive today, could be considered procompetitive tomorrow." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054-55 (8th Cir. 1999) (citing *United States v. Mercy Health Servs*., 107 F.3d 632, 637 (8th Cir. 1997)). For example, in *Tenet*, the Eighth Circuit criticized the district court for not "properly evaluat[ing] evolving market forces in the rapidly-changing healthcare market." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1055 (8th Cir. 1999).

Response to Proposed Conclusion of Law No. 39:

This proposed conclusion of law is incomplete. To make out a valid efficiencies defense, Respondent must prove the Acquisition results in "significant economies and that these economies ultimately would benefit competition and, hence, consumers." *Univ. Health*, 938 F.2d at 1223; *see also Butterworth*, 946 F. Supp. at 1300. Respondent's "proof of extraordinary efficiencies" must be "more than mere speculation and promises about post-merger behavior." *Heinz Co.*, 246 F.3d at 720-21; *see also Univ. Health*, 938 F.2d at 1223 ("defendant [cannot] overcome a presumption of illegality based solely on speculative, self-serving assertions"); *Staples*, 970 F. Supp. at 1089. Under the *Merger Guidelines*, efficiencies must be merger-specific, substantiated, and of such a character and magnitude that the transaction is not likely to be anticompetitive. *Merger Guidelines* § 10.

40. In light of its previous findings that St. Luke's has benefitted from the joinder, this Court concludes that the joinder will mean that St. Luke's "will be a stronger competitive force" than without the joinder, making anticompetitive effects unlikely. *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004). This Court also concludes that the St. Luke's joinder with ProMedica may create significant efficiencies that will benefit the community they serve if allowed to proceed. *FTC v. Univ. Health, Inc*., 938 F.2d 1206, 1222-23 (11th Cir. 1991).

Response to Proposed Conclusion of Law No. 40:

No specific response except that Respondent has failed to articulate significant merger-specific, well-substantiated and cognizable efficiencies. (*See* CCPFF ¶¶ 779-895).

41. Accordingly, this Court concludes Complaint Counsel have not met their burden of providing a Clayton Act Section 7 violation and will issue an order dismissing the Complaint with prejudice and entering judgment in favor of Respondent.

Response to Proposed Conclusion of Law No. 41:

This proposed conclusion of law is incorrect. ProMedica's acquisition of St. Luke's substantially lessens competition in two relevant markets in violation of Clayton Act Section 7. Respondent has not rebutted the presumption of competition harm or proved any valid defenses. As such, a remedy requiring Respondent to divest St. Luke's is the necessary and appropriate remedy.

Respectfully submitted,

s/ Matthew J. Reilly

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Dated: September 30, 2011

Counsel Supporting the Complaint

CERTIFICATE OF SERVICE

I hereby certify that on September 30, 2011, I filed the foregoing document electronically using the FTC's E-Filing System, which will send notification of such filing to:

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I also certify that on September 30, 2011, I delivered via electronic mail and hand delivery a copy of the foregoing document to:

The Honorable D. Michael Chappell
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I further certify that on September 30, 2011, I delivered via electronic mail a copy of the foregoing to:

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CERTIFICATE FOR ELECTRONIC FILING

I certify that the electronic copy sent to the Secretary of the Commission is a true and correct copy of the paper original and that I possess a paper original of the signed document that is available for review by the parties or the adjudicator.

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