

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

In the matter of	)	
Evanston Northwestern Healthcare	)	Docket No. 9315
Corporation,	)	<b>Public Record</b>
	)	
	)	

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

**VOLUME X of XI**

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2150. Quantitative research in medicine is research that involves numbers and analysis of data describing multiple patients' experience. Qualitative data are data that cannot be easily summarized in numerical form. (Romano, Tr. 3011-12).

**Response to Finding No. 2150:**

Respondent has no specific response.

2151. In most areas, Dr. Chassin did not follow accepted standards of qualitative research. Dr. Chassin concedes that there are no empirical guides to compare quality of care at Highland Park Hospital before and after the merger. (Chassin, Tr. 5471). For example, Dr. Chassin's sampling strategy was not clearly described or justified and was not comprehensive. (Romano, Tr. 3013).

**Response to Finding No. 2151:**

This proposed finding is misleading, unsupported and grossly misstates the cited evidence. Dr. Chassin's testimony was limited to stating that he was not aware of published literature in the field of health services research that explains how to compare quality pre- and post-Merger; not that there were no empirical guides to make such comparisons. (Chassin, Tr. 5471). Further, the evidence showed that Dr. Chassin identified and selected interview participants to whom he asked a series of structured interview questions. (RFF ¶¶ 1206-1207). Dr. Romano, who did not conduct a comprehensive analysis of quality of care at the ENH hospitals, did not interview a single nurse, physician or hospital administrator in the course of his analysis. (Romano, Tr. 3244, 3247; RFF ¶ 1209). In addition, state departments of health or other professional associations or the Joint Commission do not use qualitative research methods in their assessments of hospital quality. (Chassin, Tr. 5169).

Finally, it would be nearly impossible to randomly select employees who worked at HPH during the pre-Merger period to interview. (Chassin, Tr. 5168). Random selection of interview participants is a qualitative research method, however, state departments of health and the Joint Commission do not use qualitative research methods. (Chassin, Tr. 5168-69). Instead, Dr.

Chassin used comparable interview methods to assess changes in quality from the pre- to post-Merger periods. (Chassin, Tr. 5168).

2152. Sampling strategy is the method used to select participants, who are the individuals from whom information is obtained. It is important for a sampling strategy to be comprehensive so that individuals who are chosen represent the breadth of experience within the organization. (Romano, Tr. 3014).

**Response to Finding No. 2152:**

Respondent has no specific response.

2153. Dr. Chassin's method was not comprehensive in that the sampling strategy focused largely on administrative, physician, and nursing leadership at ENH. There was very little effort to formally interview people actually in the front lines of providing care. (Romano, Tr. 3015). Also, some interviewees were not with Highland Park before the merger. (Chassin, Tr. 5165).

**Response to Finding No. 2153:**

This proposed finding is misleading and not supported by the evidence. The evidence showed that Dr. Chassin interviewed the clinicians, including nurses and physicians, who were directly responsible for the provision of care at HPH both before and after the Merger. (Chassin, Tr. 5194-95, 5233, 5240; RFF ¶ 1239). In addition, Dr. Chassin did seek out many individuals who were employed at HPH before the Merger, including, but not limited to, Dr. Scott Hansfield, a private practitioner and head of the department of obstetrics at HPH before the Merger, Drs. Michael Ankin, Jay Alexander, Bruce Harris, Leon Dragon, as well as nurses Heidi Krasner and Karen Mayer. (Chassin, Tr. 5194-95; 5233, 5240; RFF ¶ 1239).

2154. Dr. Chassin's sampling strategy was inadequate because there was no effort to seek out alternative views or individuals having contradictory opinions who might have a fundamentally different perspective from that of ENH leadership. (Romano, Tr. 3015).

**Response to Finding No. 2154:**

This proposed finding is misleading and inaccurate. Dr. Chassin actively sought out individuals who were present at HPH prior to the Merger to learn their views. (Chassin, Tr.



5161-62; RFF ¶ 1204). Dr. Chassin conducted 34 formal interviews of key physicians, nurses and administrative leaders who were present at HPH or Evanston Hospital either before or after the Merger or, in some cases, both. (Chassin, Tr. 5161-62; RFF ¶ 1204). For example, Dr. Chassin interviewed Dr. Hansfield. (Chassin, Tr. 5194-95). Additionally, Dr. Chassin sought out information from other sources, including at least a dozen deposition transcripts as well as the trial testimony of physicians and other witnesses, including Dr. Romano. (Chassin, Tr. 5161; RFF ¶ 1202). Finally, Dr. Romano made no effort to seek out the views of anyone, regardless of the views held, because he did not conduct interviews in the course of his quality assessment in this case and attended only one deposition. (Romano, Tr. 2993, 3247; RFF ¶ 1209).

2155. Dr. Chassin did 34 formal interviews during his visits to Highland Park Hospital. Typically one or two attorneys from Winston & Strawn were present during the interviews. Mr. Hillebrand, ENH's Chief Operating Officer, was also present for some of the early interviews. (Chassin, Tr. 5163).

**Response to Finding No. 2155:**

This proposed finding is inaccurate and misleading. The evidence showed that Hillebrand was present at only a couple of the early interviews conducted by Dr. Chassin. (Chassin, Tr. 5163). In addition, during the site visits to HPH, Dr. Chassin conducted informal interviews with people he met when there were no lawyers or administrators present. (Chassin, Tr. 5584; RFF ¶ 1206).

2156. Dr. Chassin's technique of interviewing an employee with a supervisor or an attorney for the employer present is highly problematic. A cardinal principle for any type of interview research is that the interviewee should be interviewed alone without the presence of supervisors or legal counsel. (Romano, Tr. 3015-16).

**Response to Finding No. 2156:**

This proposed finding is misleading and not supported by the evidence. This proposed finding does not cite to any evidence that demonstrates that the presence of counsel in any way

hindered Dr. Chassin's questions or the interviewees' responses. (Romano, Tr. 3015-16). In addition, the evidence showed that supervisors such as Hillebrand were present at only a couple of the 34 formal interviews that Dr. Chassin conducted. (Chassin, Tr. 5163). In addition, there is no evidence that any supervisor besides Mr. Hillebrand was present at any of the other interviews. (Chassin, Tr. 5163; Romano, Tr. 3015-16). In fact, the evidence shows that for all of the formal interviews, Dr. Chassin prepared a series of questions in advance of the interview and then led them through a set of structured questions during the interview. (Chassin, Tr. 5163; RFF ¶ 1207).

2157. The Joint Commission for the Accreditation of Healthcare Organizations uses a "tracer methodology" in its site visits of hospitals during the accreditation process. Dr. Chassin did not use this technique, which requires following the patient's course of treatment by the organization. (Romano, Tr. 3016-17).

**Response to Finding No. 2157:**

This proposed finding is misleading. The evidence showed that Dr. Chassin conducted 34 formal interviews as well as informal interviews of physicians and nursing personnel at HPH during two site visits. (Chassin, Tr. 5162-63). In addition, Dr. Romano did not employ the tracer methodology in the course of his analysis. (Romano, Tr. 3245-46).

2158. It is also preferable in qualitative research to have more than one researcher reviewing the same material because the process is so subjective. Dr. Chassin failed to do this. (Romano, Tr. 3017-18).

**Response to Finding No. 2158:**

This proposed finding grossly misstates the evidence. The evidence shows that Dr. Chassin did, in fact, employ the assistance of an additional researcher, Dr. Elizabeth Howell. (Chassin, Tr. 5160; RFF ¶ 1200). Dr. Howell, a board-certified obstetrician/gynecologist and a faculty member of the Department of Health Policy at Mount Sinai, was also present at all of the interviews that Dr. Chassin conducted. (Chassin, Tr. 5163; RFF ¶ 1200). Further, Dr. Howell

reviewed documents, performed literature searches, assisted with the interviews and helped to compile some of the data used in Dr. Chassin's analyses. (Chassin, Tr. 5160; RFF ¶ 1200).

2159. The evidence also indicates that Dr. Chassin did not seek out observations that might have contradicted or modified his analysis, or if he did, such evidence was not transferred from his written notes to his report. (Romano, Tr. 3018).

**Response to Finding No. 2159:**

This proposed finding is misleading and not supported by the evidence. Dr. Chassin sought out several individuals employed at HPH before the Merger, some of whom are no longer affiliated with ENH today. (Chassin, Tr. 5194-95; 5233, 5240; RFF ¶ 1239). Further, Dr. Romano did not seek out any observations – whether contradictory or complimentary – because he did not interview any physician or hospital administrator at any ENH hospital. (Romano, Tr. 3244, 3247; RFF ¶ 1209).

2160. Another way that Dr. Chassin's technique was inconsistent with qualitative research methods is that he did not include very much original evidence such as direct quotes from the individuals he interviewed. (Romano, Tr. 3019).

**Response to Finding No. 2160:**

This proposed finding is misleading and not supported by the evidence. The evidence showed that qualitative research methods – which are appropriate to use when there is very little knowledge about the field of study – were not appropriate to use in this case. (Chassin, Tr. 5166-68). Dr. Chassin, who is quite familiar with qualitative research methods, did not employ those methods in his analysis in this case because there was already quite a bit of information known about what constitutes high-quality care or well functioning hospital processes and, as a result, Dr. Chassin could collect data without relying on qualitative research methods. (Chassin, Tr. 5167-68). In addition, Dr. Chassin also relied on the trial testimony of witnesses and, thus, the ostensible absence of direct quotes is irrelevant. (Chassin, Tr. 5194).

Finally, state departments of health or other professional associations or the Joint Commission do not use qualitative research methods in their assessments of hospital quality.

(Chassin, Tr. 5169).

2161. Dr. Chassin's ability to evaluate the quality of care at Highland Park Hospital before the merger was limited by the methodology he selected which involved visiting the hospital and interviewing people in 2004 to try to understand what was happening with quality in 1998 or 1999; many of the people who provided care before the merger have moved to other positions or even other organizations. (Romano, Tr. 3021). For example, Mark Newton, the former Senior Vice President of Highland Park Hospital, was not interviewed. (Chassin, Tr. 5472).

**Response to Finding No. 2161:**

This proposed finding is misleading and not supported by the evidence. This proposed finding is misleading insofar as it implies that Dr. Chassin's methodology was limited to site visits and interviews. The methods that Dr. Chassin applied to his analyses in this case included: a review of clinical data from third-party registries; two site visits; interviews of physician and nursing staff and hospital administrators; a review of contemporaneous documents; and additional quantitative as well as qualitative data. (Chassin, Tr. 5159, 5164, 5192-93; RFF ¶¶ 1199, 1239). The evidence showed that Dr. Chassin interviewed numerous individuals who were employed at HPH prior to the Merger, including former employees of HPH – such as Dr. Scott Hansfield. (Chassin, Tr. 5194-95; 5233, 5240; RFF ¶ 1239). In addition, Dr. Chassin looked for and found consistency among sources and, for example, found evidence of inappropriate gynecologic surgery at HPH pre-Merger from the American College of Obstetricians and Gynecologists (“ACOG”) report as well as from site interviews. (Chassin, Tr. 5203; RFF ¶ 1210, 1255).

Further, the methods used by Dr. Chassin to conduct his assessment in the changes in quality at HPH after the Merger were entirely consistent with the methods used by Dr. Chassin when he was Commissioner of Health in the State of New York. (Chassin, Tr. 5190-91; RFF ¶

1209). For example, site interviews at hospitals are routinely conducted by JCAHO, state departments of health and professional organizations such as ACOG. (RFF ¶ 1209).

**REDACTED**

(RX 324 at ENHL PK 29689, *in camera*).

**REDACTED**

(Newton, Tr. 279, Newton, Tr. 512-

13, *in camera*). Finally, Dr. Romano did not interview any physicians or administrators, whether current or former employees of HPH or ENH, including Mark Newton, because he did not conduct any interviews in this case. (Romano, Tr. 2980; 3244, 3247; RFF ¶¶ 1209, 1334).

2162. The views of current ENH employees that Dr. Chassin would have talked to during his site visits may have had biased views. (Romano, Tr. 2980).

**Response to Finding No. 2162:**

This proposed finding is misleading and is not supported by the cited evidence. The cited evidence refers to Dr. Romano's stated reason that he did not conduct interviews; it does not support the statement that Dr. Chassin's interviewees had biased views. (Romano, Tr. 2980). Dr. Romano did not introduce any evidence that, in fact, the interviewees actually had biased views and, further, he made no effort to ascertain the views of any interview subjects because he did not interview a single physician or hospital administrator. (Romano, Tr. 2980; 3244, 3247; RFF ¶ 1209). In addition, for the reasons more fully discussed in RFF-Reply ¶ 2159, Dr. Chassin actively sought out individuals who were employed by HPH prior to the Merger. (Chassin, Tr. 5165-66, 5194-95; 5233, 5240; RFF ¶ 1239).

2163. No peer review technique used in health services research allows a researcher to go into an organization on one date and evaluate the organization's quality of care through site visits as of some date several years earlier. (Romano, Tr. 3021).

**Response to Finding No. 2163:**

This proposed finding is misleading and not supported by the evidence.

**REDACTED**

(RX 324

at ENHL PK 29699, *in camera*).

**REDACTED**

(RX 324 at ENHL

PK 29705-06, 29708, *in camera*). Site visits are routinely used by third parties in assessments of hospital quality. (Chassin, Tr. 5190-91; RFF ¶ 1209).

Finally, Dr. Romano did not conduct a site visit of any ENH hospital at any point during his analysis and, therefore, did not even attempt a peer review of Dr. Chassin's analysis as it related to his two site visits of HPH. (Romano, Tr. 3245).

**2. There Was No Significant Quality Improvement at Highland Park Hospital Due to the Merger<sup>18</sup>**

2164. There was no significant quality improvement at Highland Park Hospital due to the merger. (Romano, Tr. 3109-10, 3124, 3174-76, 3233-34; CX 405 at 2).

**REDACTED**

(Chassin, Tr. 5479-80;

Silver, Tr. 3831; Romano, Tr. 3142, 3151, 3159, *in camera*).

**Response to Finding No. 2164:**

This proposed finding is fundamentally inaccurate, misleading, misstates the cited evidence and ignores a wealth of record evidence to the contrary. Respondent objects to this proposed finding to the extent it is based on hearsay within hearsay and has not been specifically

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<sup>18</sup> For a discussion on the merger's effect on heart attack care, cardiac surgery and interventional cardiology on Highland Park Hospital and the ENH system, see CCFF 2060-2088, *in camera*.

<sup>19</sup> See CCFF 2174-2176, *in camera*.

admitted into evidence. (JX 1 ¶ 5). For example, neither Drs. Chassin nor Silver testified that any gradual improvements at HPH would have occurred without the Merger. (Chassin, Tr. 5479-80; Silver, Tr. 3831). In fact, the evidence showed that Dr. Chassin specifically found that ENH also made substantial improvements in quality in a number of clinical service areas after the Merger. (Chassin, Tr. 5138; RFF ¶ 1228). Most of those improvements required ENH to integrate its clinical and management systems and import or export its collaborative multidisciplinary culture to change the way clinical care was delivered at HPH. (Chassin, Tr. 5138-39; RFF ¶ 1228). The vast majority of those improvements could not have been achieved without a Merger. (Chassin, Tr. 5139; RFF ¶ 1228). Finally, there is substantial evidence of statistically significant improvements in quality of care at HPH because of the Merger including, but not limited to, dramatic and statistically significant improvements in the care of heart attack patients at HPH after the Merger. (Chassin, Tr. 5279-80 (*discussing* DX 8079); RFF ¶ 1495). For additional evidence concerning the improvements in quality of care at HPH because of the Merger, see RFF-Reply ¶¶ 2032, 2037. (Chassin, Tr. 5138-41, 5363-64; RFF ¶¶ 1228-1229, 2004, 2058).

**a. There Was No Significant Quality Improvement in Nursing Services at Highland Park Hospital Due to the Merger**

2165.

**REDACTED**

(Romano, Tr. 3136, *in camera*; CX 405 at 8; RX 924 at ENHLMN001411; RX 938 at ENHE F35 000317; RX 1347 at ENHL PK051851, *in camera*).

**Response to Finding No. 2165:**

This proposed finding is inaccurate and not supported by the evidence and, further, is duplicative of CCFF ¶ 2098. Respondent objects to this proposed finding to the extent it is based on hearsay within hearsay and has not been specifically admitted into evidence. (JX 1 ¶ 5). Dr.

Romano's conclusions with respect to the effect of the Merger on the quality of nursing services at HPH are not valid because conclusions on that issue cannot be drawn from patient satisfaction data or from the data he used to analyze AHRQ's PSIs. (Chassin, Tr. 5251; RFF ¶ 2276; RFF-Reply ¶¶ 2098-2101). Many of the PSIs that Dr. Romano used to assess nursing services were lacking in validity. (Chassin, Tr. 5251; RX 2010 at 19-22; RFF ¶ 2276). For example, Dr. Romano examined decubitus ulcer (e.g., pressure sores) rates, failure to rescue, selected infections due to medical care, and postoperative hip fracture rates to assess nursing care. (Romano, Tr. 3232-33; RX 2010 at 19-22). However, for the reasons more fully discussed at RFF-Reply ¶ 2107, decubitus ulcers, failure to rescue, and selected infections due to medical care are lacking in construct validity for processes of care. (Chassin, Tr. 5251; RX 2010 at 18-20; Romano, Tr. 6369 (*discussing* DX 7138 at 6)).

AHRQ's own guide to the PSIs notes that the published evidence shows that the indicator, decubitus ulcer, lacks validity for coding, which reflects how accurately the information about that complication was captured on a discharge abstract or Medicare claim. (RX 2010 at 18-19). In addition, that same indicator received a zero rating for construct validity for explicit and implicit processes, which meant that there was no published evidence regarding this domain of validity (referring to processes of care that can affect this outcome, decubitus ulcers). (RX 2010 at 18-19). Similarly, there is no published evidence for construct validity (implicit or explicit processes) for the failure to rescue indicator. (RX 2010 at 18-19; Romano, Tr. 6369). The indicator for selected infections due to medical care has no published evidence of validity for any of the domains of validity. (RX 2010 at 18-20). Thus, selected infections lacks validity for coding; construct explicit or implicit processes; or staffing (if valid, this measure shows that hospitals that increase the nursing hours per day should have fewer adverse events).



(RX 2010 at 18-20). Thus, for three out of the four AHRQ indicators that Dr. Romano used to assess nursing services at HPH and ENH, there is no published evidence of validity regarding these indicators and, further, for some there is evidence that the indicator actually lacks validity. (Chassin, Tr. 5251; RX 2010 at 18-20; Romano, Tr. 6369). The one remaining indicator, post-operative hip fracture, had some limited validity (i.e., based on one favorable study), but Dr. Romano himself noted that this event (post-operative hip fracture) is “extremely rare, so it’s really hard to draw conclusions from these findings.” (Romano, Tr. 3235).

Finally, Dr. Romano actually found evidence of improvement at HPH in three of these four nursing indicators including, pressure sores, selected infections due to medical care, and failure to rescue (Romano, Tr. 3232-5).

#### Pre-Merger

2166. Highland Park Hospital made improvements to its nursing culture before the merger as well as after the merger. (Chassin, Tr. 5479-80).

#### Response to Finding No. 2166:

This proposed finding is misleading and mischaracterizes the evidence on this issue. This proposed finding suggests that there were improvements in all areas of nursing at HPH pre-Merger, which is not supported by the cited evidence. Dr. Chassin’s testimony was that there were “some” improvements in nursing at HPH, but those improvements were limited to HPH’s labor and delivery service. (Chassin, Tr. 5479-80). Further, the evidence showed that the key elements of effective nursing were absent from HPH before the Merger. (Chassin, Tr. 5232; RFF ¶ 1344).

#### **REDACTED**

(Spaeth, Tr. 2247; O’Brien, Tr. 3533-34; Krasner, Tr. 3701-02; RX 442 at ENH RS 4660, *in camera*; RFF ¶¶ 1350-1351). Heidi Krasner, a nurse manager in HPH’s labor and delivery unit pre-Merger, confirmed that nurse vacancies and

inadequate compensation for nurses were problems pre-Merger. (Krasner, Tr. 3701-02, 3722; RFF ¶¶ 1351, 1354). Krasner could not cure any issues of compensation before the Merger. (Krasner, Tr. 3722; RFF ¶ 1354). Contemporaneous documents confirm that this statement was true for all of HPH nursing. (RX 450 at ENH DR 3478; RFF ¶ 1354).

2167. In April 1998, Highland Park Hospital invited the American College of Obstetricians and Gynecologists (“ACOG”) to visit the hospital and review the Family Birthing Center. (Newton, Tr. 390-91; Krasner, Tr. 3752). Highland Park Hospital requested the site visit in response to a 1997 malpractice verdict involving a 1993 incident in the birthing center. (Krasner, Tr. 3733-34). The ACOG review team made many observations relating to nursing care. The ACOG review team was impressed with Highland Park Hospital’s “cohesive and comprehensive plan” to improve the quality of care in nursing. (RX 324 at ENHL PK 029765). The review team also found that despite working without a steady nursing leader of the Family Birthing Center before the hiring of Heidi Krasner, nurses at Highland Park Hospital functioned “fairly well.” (RX 324 at ENHL PK 029765)

**Response to Finding No. 2167:**

Respondent does not dispute that

**REDACTED**

(Chassin, Tr. 5221; RX 324 at ENHL PK 29708, *in camera*; RX 208 at ENHL PK 17285).

**REDACTED**

(Chassin, Tr. 5197-98; RX 324 at ENHL PK 29773, *in camera*).

**REDACTED**

(Chassin, Tr. 5197-98; RX 324 at ENHL PK 29773, *in camera*).

2168. ACOG commended Highland Park Hospital’s hiring of nursing leaders such as Heidi Krasner and Janet Stenske. (RX 324 at ENHL PK 029764-029765). The ACOG reviewer

team also complimented the Highland Park Hospital Family Birthing Center's cross-training program for its nurses. (RX 324 at ENHL PK 029769).

**Response to Finding No. 2168:**

This proposed finding is inaccurate, in part, and not supported by the evidence. The evidence showed that nurses were not well-trained at HPH before the Merger. (Krasner, Tr. 3703-05; RFF ¶ 1362). There were nurses without CPR certification, there was no nurse orientation program, there was no nurse training for delivering care to high-risk patients and nurses were not cross-trained. (Krasner, Tr. 3703-05; RFF ¶ 1362).

**REDACTED**

(RX 324 at ENHL PK 29774, *in camera*).

2169. The ACOG site visit to Highland Park Hospital resulted in a series of recommendations that the hospital began to address with follow-up actions. (Newton, Tr. 391; Spaeth, Tr. 2116; Krasner, Tr. 3753; CX 98 at 2). Heidi Krasner was involved in implementing some of the recommendations. Three of the ACOG recommendations that Heidi Krasner worked on included a review and revision of policies and procedures, increased fetal monitoring nurse education, and revision of documentation forms to improve nursing documentation. (Krasner, Tr. 3753-54).

**Response to Finding No. 2169:**

This proposed finding is misleading and not supported by the evidence. Further, as discussed more fully in RFF-Reply ¶ 2188,

**REDACTED**

(Chassin, Tr. 5197-98, 5200; RX 324 at ENHL PK 29773, 29754, *in camera*; RFF ¶¶ 1257, 1259, 1441; RFF-Reply ¶ 2188).

**REDACTED**

**REDACTED**

(CX 6265 at

ENHL PK 29812, *in camera*; RX 324 at ENHL PK 29709, *in camera*; RFF ¶¶ 1276-1292).

2170.

**REDACTED**

(Romano, Tr.

3155-56, *in camera*)

**REDACTED**

(Newton, Tr. 498, *in camera*).

**Response to Finding No. 2170:**

This proposed finding is misleading and not supported by the evidence. The evidence showed that the CHRPP review in 1999 had no physicians on the review team and it was a much more superficial review, and was carried out for very different purposes than the ACOG review. (Chassin, Tr. 5193-94; RFF ¶ 1266). Further, there were several problems identified in the 1998 ACOG review existing at HPH pre-Merger that were not addressed until after the Merger including, but not limited to, inadequate obstetrician coverage, ineffective department leadership, and ineffective discipline of physicians with significant problems with clinical and ethical judgment. (RFF ¶¶ 1267-1268, 1299-1303, 1317-1320, 1446-1457). For further discussion of the differences between 1998 ACOG review and 1999 CHRPP review, see RFF-Reply ¶ 2171.

2171.

**REDACTED**

(Newton,

Tr. 499, *in camera*).

**REDACTED**

(Newton, Tr. 499, *in camera*).

**Response to Finding No. 2171:**

Respondent has no specific response.

2172.

**REDACTED**

(CX 6265 at, e.g., 7, 9, 10, 16, *in camera*; Newton, Tr. 498-512, *in camera*).

**Response to Finding No. 2172:**

This proposed finding is misleading and not supported by the evidence. In contrast to the ACOG report, the CHRPP report was an attempt by the malpractice carrier to look at certain areas related to malpractice risk. (Chassin, Tr. 5193-94). There were no physicians on CHRPP's review team, and it was a much more superficial review carried out for very different purposes than the ACOG review. (Chassin, Tr. 5194; RFF ¶ 1266).

**REDACTED**

(RX 324 at ENHL PK 29696, *in camera*).

**REDACTED**

(RX 324 at ENHL PK

29695, *in camera*).

**REDACTED**

(RX 324 at ENHL PK 29695, *in camera*).

**REDACTED**

(CX 6265 at ENHL PK 29795, *in camera* (emphasis added); RFF ¶

1266).

**REDACTED**

(Chassin, Tr. 5197-98, 5200; RX 324 at ENHL PK 29773, 29754, *in camera*; RFF ¶¶ 1257, 1259, 1441; RFF-Reply ¶ 2188).

2173.

**REDACTED**

**REDACTED**

(See CCFF 2174-2176, 2199, *in camera* ).

**Response to Finding No. 2173:**

This proposed finding is misleading and not supported by the evidence. The evidence established that HPH nurses were not well-trained at HPH before the Merger. (RFF ¶¶ 1360-1367). For example, there were nurses without CPR certification, there was no nurse orientation program, there was no nurse training for delivering care to high-risk patients and nurses were not cross-trained. (Krasner, Tr. 3703-05). For a further discussion of the significant quality problems that persisted in HPH's labor and delivery service until after the Merger, see RFF-Reply ¶ 2170. (RFF ¶¶ 1267-1268, 1299-1303, 1317-1320, 1446-1457).

In addition, the evidence showed that ENH positively transformed the nursing service at HPH after the Merger. Nursing services improved through enhanced training, improvements in physician/nurse relationships, critical thinking and assessment skills, and improved safety. (Chassin, Tr. 5239-43; Ankin, Tr. 5070). For further discussion of the differences between 1998 ACOG review and 1999 CHRPP review, see RFF-Reply ¶ 2171.

2174.

**REDACTED**

(Romano, Tr. 3157, *in camera*; Newton, Tr. 509; CX 6265 at 18, *in camera*).

**REDACTED**

(CX 6265 at 25, *in camera*).

**Response to Finding No. 2174:**

This proposed finding is misleading and not supported by the evidence. While the CHRPP report acknowledged the existence of a chain of command policy at HPH, it did not comment on the degree to which HPH's chain of command policy was, in fact, implemented or working effectively such that it was actually protecting patients. (Chassin, Tr. 5602-03). ENH implemented a chain of command, under Dr. Silver's leadership, that addressed communication

issues between physicians and nurses. (Silver, Tr. 3809; RX 1416 at ENHL PK 54612-14). This was done in response to nursing concerns as well as some physicians' concerns that the chain of command was not clear-cut for some of the services provided. (Silver, Tr. 3810).

As discussed more fully in RFF-Reply ¶ 2171, the CHRPP report was a much less comprehensive review than the 1998 ACOG report. (Chassin, Tr. 5193-94; RFF ¶ 1266).

**REDACTED**

(Chassin, Tr. 5194; CX 6257 at ENHL PK 29795, *in camera*). For further discussion of the differences between 1998 ACOG review and 1999 CHRPP review, see RFF-Reply ¶ 2171.

2175. In connection with its site visit, CHRPP reported on several areas of strength at Highland Park Hospital relating to nursing including:

1.

**REDACTED**  
(CX 6265 at 19, *in camera*).

2.

**REDACTED** (CX 6265 at 21, *in camera*;  
Romano, Tr. 3158, *in camera*).

**REDACTED**  
(CX 6265 at 21, *in camera*).

**Response to Finding No. 2175:**

This proposed finding is misleading and not supported by the evidence. As discussed more fully in RFF-Reply ¶¶ 2170-2173, the 1999 CHRPP report, which did not include even a single physician on its review team, was a much less comprehensive review than the 1998 ACOG report. (Chassin, Tr. 5193-94).

**REDACTED**

**REDACTED**

(RX 657 at ENHL PK

29809, 29803, 29821, *in camera*; Krasner, Tr. 3717-19). “Gestaphobia” was a term that a physician at HPH used before the Merger as a reason to schedule an induction. (Krasner, Tr. 3719-20).

**REDACTED**

(RX 324 at ENHL PK

29774, *in camera*; RX 657 at ENHL PK 29803, *in camera*).

**REDACTED**

(Chassin, Tr.

5197-98, 5200; RX 324 at ENHL PK 29773, 29754, *in camera*; RFF ¶¶ 1257, 1259, 1441; RFF-Reply ¶ 2188). For a further discussion of the significant quality problems that persisted in HPH’s labor and delivery service until after the Merger, see RFF-Reply ¶¶ 2170, 2188. (RFF ¶¶ 1267-1268, 1299-1303, 1317-1320, 1446-1457).

2176.

**REDACTED**

(CX 6265 at 19, *in camera*, Krasner, Tr. 3877, *in camera*).

**REDACTED**

(Newton, Tr. 509, 513, *in camera*; O’Brien, Tr. 3672, *in camera*).

**Response to Finding No. 2176:**

Respondent does not dispute that

**REDACTED**

(CX 6525 at ENHL PK

29811, *in camera*). Today, however, the nursing resource team at HPH is larger than it was pre-Merger and, as a result there are more nurses to rotate among the nursing units within HPH and



among the ENH hospitals. (Krasner, Tr. 3275). As a result, there are no agency nurses in use at HPH today. (Krasner, Tr. 3725).

2177. Highland Park Hospital had a “high quality nursing staff” in the 1990s. (Newton, Tr. 383. *See also* Dragon, Tr. 4403). As of February 1, 1999, the registered nurse vacancy rate at Highland Park Hospital was only 6.17%. (CX 6264 at 1). **{Patient satisfaction with overall nursing care at Highland Park Hospital before the merger was comparable to peer hospitals.}** (Romano, Tr. 3136-37, *in camera*).

**Response to Finding No. 2177:**

This proposed finding is misleading and not supported by the evidence.

**REDACTED**

(Krasner, Tr. 3705-07; RX 324 at ENHL PK 29774, *in camera*; RFF ¶ 1344-1384). The significance of nursing problems in HPH’s pre-Merger labor and delivery service was that roughly a third of all admissions to HPH pre-Merger were admissions of women about to have a delivery. (Chassin, Tr. 5196). The problems with nursing in HPH’s pre-Merger labor and delivery unit paralleled nursing problems in other areas of the hospital. (Chassin, Tr. 5232-39).

In addition, there was no valid data concerning patient satisfaction at HPH with which to draw conclusions about satisfaction with nursing care. (Chassin, Tr. 5251; RFF ¶¶ 2254-2277).

2178. The ongoing quality improvement efforts in Highland Park Hospital’s overall and obstetrical nursing areas before the merger are exemplified by the hiring of Jane Stenske and Heidi Krasner both of whom were good leaders who implemented a number of improvements at Highland Park Hospital. (Krasner, Tr. 3721, 3746-3749) Both the problems and improvements in Highland Park Hospital’s nursing services continued post-merger. (Chassin, Tr. 5480-81).

**Response to Finding No. 2178:**

This proposed finding is, in part, misleading and not supported by the evidence. As discussed more fully in RFF-Reply ¶¶ 2188,

**REDACTED**

(Chassin, Tr. 5196-98, 5200-5204; RX 324 at ENHL PK 29773, 29754, *in camera*; RFF ¶¶ 1257, 1259, 1441). For example, the lack of an effective chain of command in labor and delivery – an identified leadership structure – was one of the biggest problems that was not solved until Dr. Silver was able to partner with Krasner to create an effective chain of command. (Chassin, Tr. 5602-03).

**Post-Merger**

2179.

**REDACTED** (Romano, Tr. 3233-34, *in camera*).

‡ (Romano, Tr. 3136, *in camera*).

**Response to Finding No. 2179:**

This proposed finding is misleading and not supported by the evidence. As discussed more fully in RFF-Reply ¶¶ 2098, 2100-2101, the methods that Dr. Romano used to assess nursing were lacking in validity. (RX 2010 at 18-19; Chassin, Tr. 5251). For example, AHRQ's own guide to the PSIs notes that the published evidence shows that the indicator, decubitus ulcer, lacks validity for coding, which reflects how accurately the information about that complication was captured on a discharge abstract or Medicare claim. (RX 2010 at 18-19; Chassin, Tr. 5251). Similarly, the failure to rescue indicator was also lacking in construct validity for processes of care. (RX 2010 at 18-19; RFF-Reply ¶ 2100). As discussed in RFF-Reply ¶¶ 2045, 2051, 2058-2059, 2061-2063, 2102, 2105-2006, the AHRQ indicators, based solely on administrative data,

are not a definitive source of information about quality of care. Rather, these indicators are intended to be used as a first-round screen of quality issues and thus require further investigation. (Chassin, Tr. 5251; RX 2010 at 19-22; RX 2007 at 26; RFF ¶ 2276; RFF-Reply ¶ 2165 (more fully discussing AHRQ's indicators relating to nursing services)).

2180.

**REDACTED**  
(CX 405 at 8; RX 924 at ENH MLN 001411; RX 900 at ENH GW 000528; RX 938 at ENHE F35 000317; RX 1347 at ENHL PK051851, *in camera*).

**Response to Finding No. 2180:**

This proposed finding is misleading. Respondent objects to this proposed finding to the extent it is based on hearsay within hearsay and has not been specifically admitted into evidence. (JX 1 ¶ 5). Several of the quality improvements that ENH put in place at HPH took time to accomplish. For example, the obstetric committee practice protocols, which included a communication protocol addressing nurse and physician communication, took substantial time to prepare. (Silver, Tr. 3865-66).

2181. Even six months after the merger in January 2000, Highland Park Hospital still had a high nursing vacancy rate of 11.4%. (RX 900 at ENH GW 000528).

**Response to Finding No. 2181:**

This proposed finding is misleading and not supported by the evidence. The evidence from numerous sources showed that pre-Merger HPH had a much higher nurse vacancy rate than post-Merger HPH, as high as 19%, and thus had to rely on agency and other temporary nurses. (RFF ¶¶ 1350-1353, 1355, 1358). ENH immediately provided several nurse pay increases to address high turnover and vacancy rates at HPH. (Krasner, Tr. 3721-22; O'Brien, Tr. 3535; RX 822 at ENH GW 296). ENH made market adjustments for nurses at the time of the Merger, and again in October of 2000. (O'Brien, Tr. 3535). In addition, the nursing resource team at HPH is larger than it was pre-Merger and, as a result there are more nurses to rotate among the nursing

units within HPH and among the ENH hospitals. (Krasner, Tr. 3275). As a result of improved nurse staffing at HPH today, there are currently no agency nurses in use at HPH. (Krasner, Tr. 3725; RFF-Reply ¶ 2176).

2182. Even after the merger, a Highland Park Hospital nurse, Linda Morris, noted in an August 2000 letter to Mark Neaman that the “environment is very negative and the nursing staff [is] very frustrated with staffing issues of professional and support staff.” (RX 924 at ENHLMN001411). She noted that she was not able to attend nursing orientation until almost a month after she started at Highland Park Hospital in June 2000, and there was no nursing orientation at Highland Park Hospital when she started there. (RX 924 at ENHLMN001411).

**Response to Finding No. 2182:**

This proposed finding is misleading and not supported by the evidence. The same evidence notes Linda Morris “admired the [Evanston Hospital’s] nurse’s professionalism and compassion, and wanted to be part of such an excellent organization.” (RX 924 at ENHL MN 1411). Further, Neaman’s response noted that one of ENH’s key goals was to change the perceived negative environment in nursing at HPH, and that doing so would require some time. (RX 924 at ENHL MN 1413). Neaman’s letter also noted several positives associated with HPH’s nursing service, including a newly hired nurse manager and excellent physician and nursing staff. (RX 924 at ENHL MN 1412). As discussed in RFF-Reply ¶ 2178, many of the changes to HPH’s nursing culture took substantial time to complete. (Chassin, Tr. 5602-03; Silver, Tr. 3865-66).

2183. There were problems with nursing turnover and high nursing vacancy rates at ENH after the merger; physicians were concerned about morale issues and how the nursing turnover would effect nursing staffing and quality of care provided to patients. (RX 938 at ENHE F35 000317).

**Response to Finding No. 2183:**

This proposed finding is misleading and not supported by the evidence. For example, ENH immediately provided several nurse pay increases to address high turnover and vacancy

rates at HPH. (Krasner, Tr. 3722; O'Brien, Tr. 3535; RX 822 at ENH GW 296; RFF-Reply ¶ 2181). ENH made market adjustments for nurses at the time of the Merger, and again in October of 2000. (O'Brien, Tr. 3535). The evidence showed that there was a nursing shortage as of September 2000, to which ENH responded by adjusting the wages and compensation of nursing staff. (RX 938 at ENHE F35 317).

2184.

**REDACTED**

RX 1347 at ENHL PK051851, *in camera*).

**Response to Finding No. 2184:**

This proposed finding is misleading and not supported by the evidence. Further, the evidence is undisputed that ENH implemented significant improvements to HPH's nursing service as a result of the Merger. (RFF ¶¶ 1385-1413; CX 405 at 8). For example, a 2003 memo to Mary O'Brien, President of HPH, regarding the state of inpatient nursing services at HPH details improvements in critical thinking and assessment skills, improved patient safety, reduced rates of patient misidentification and a series of other nursing improvements. (Chassin, Tr. 5242; RX 1445). Further, the cited evidence is actually an example of an organization engaging in self-critical assessments and ongoing efforts to identify areas of improvement, which are important characteristics associated with a well-functioning quality assurance program. (Chassin, Tr. 5219-20).

2185. Highland Park Hospital physicians complained in 2002, two years after the merger, that nursing staff was "understaffed and underachieving." (CX 405 at 8).

**Response to Finding No. 2185:**

This proposed finding is misleading and not supported by the evidence. Respondent objects to this proposed finding as it is based on hearsay within hearsay and has not been

specifically admitted into evidence. (JX 1 ¶ 5). The cited evidence, which consists of a single sentence, is not attributed to an identified source and is not corroborated by any other independent or objective data. (CX 405 at 8). Further, the substantial evidence is undisputed that ENH made substantial improvements to HPH's nursing service as a result of the Merger. (RFF ¶¶ 1385-1413).

**b. There Was No Significant Quality Improvement in Obstetrics and Gynecology at Highland Park Hospital Due to the Merger**

2186.

**REDACTED** (Krasner, Tr. 3748; Silver, Tr. 3929-31, *in camera*; O'Brien, Tr. 3672).

**Response to Finding No. 2186:**

This proposed finding is misleading and not supported by the evidence. For example, Dr. Romano found, using the JCAHO measure, that perineal tear rates (i.e., obstetric trauma) declined at ENH from the pre- and post-Merger periods significantly more than at ENH peer group hospitals. (Romano, Tr. 3397; RFF ¶ 1332). In addition,

**REDACTED**

Romano, Tr. 3228-29, *in camera*; RFF ¶ 1330).

**REDACTED**

(Romano, Tr. 3228, *in camera*; RFF ¶ 1330).

2187.

**REDACTED**

(Romano, Tr. 3188-89, 3224, 3226-28, 3230-32, *in camera*).

(Romano, Tr. 3127 (discussing DX 7033 at 19, *in camera*), *in camera*).

**Response to Finding No. 2186:**

This proposed finding is misleading and not supported by the evidence. For a discussion of the evidence related to statistically significant improvements in obstetrical care, see RFF-Reply ¶ 2186. For the reasons more fully discussed in RFF-Reply ¶¶ 2133-2143, Dr. Romano did not rely on any valid patient satisfaction data from which to draw valid conclusions about ob/gyn services at HPH. (Chassin, Tr. 5243, 5249-51; RFF ¶¶ 2248, 2251, 2254-2255).

Pre-Merger

2188. Prior to the merger, there were ongoing efforts at Highland Park Hospital to improve the quality of care in obstetrics. (Silver, Tr. 383; Chassin, Tr. 5498).

**Response to Finding No. 2188:**

This proposed finding is misleading. While the cited testimony does acknowledge that there were efforts to improve the quality of care in obstetrics at HPH before the Merger, the cited evidence does not say whether quality in HPH's obstetrics service did, in fact, improve pre-Merger. Nor does this evidence purport to discuss the extent or efficacy of such alleged improvements. (Silver, Tr. 3831; Chassin, Tr. 5498). Further, there is substantial evidence of specific problems with HPH's quality of obstetrical care that persisted until the Merger – including, but not limited to,

**REDACTED**

(Chassin, Tr. 5197-98, 5200; RX 324 at ENHL PK 29773, 29754, *in camera*;

RFF ¶¶ 1257, 1259, *in camera*; RFF ¶ 1441).

**REDACTED**

(RX 324 at ENHL PK 29709, *in*

camera).

**REDACTED**

(RX 324 at ENHL PK 29710, *in camera*).

These characteristics of HPH's labor and delivery service pre-Merger, for example, the poor physician/nurse teamwork and communication directly relate to patient safety and constituted evidence of dysfunction. (Chassin, Tr. 5200; RFF ¶¶ 1259-1260).

2189. In the late 1990s, Highland Park Hospital had a good obstetrics program. The hospital had a "unique," renovated OB department and a comprehensive obstetrics program. Highland Park also had relationships with a perinatal network and advanced pediatric coverage. (Newton, Tr. 389). According to Dr. Silver, Chairman of ENH's OB/GYN Department, there were, prior to the merger, a number of good physicians in the Highland Park Hospital OB department. (Silver, Tr. 3831).

**Response to Finding No. 2189:**

This proposed finding is misleading and overlooks substantial evidence in the record to the contrary. The evidence cites to Newton, who was in a business role at HPH, was not a physician, and had no clinical responsibilities for any of the clinical areas evaluated by Dr. Chassin in this case. (Newton, Tr. 279, 512-13). The "unique" OB department did not affect the quality of patient care because Labor, Delivery, Recovery and Postpartum ("LDRP") does not affect quality of care. (Krasner, Tr. 3699; RFF ¶ 1238). It is a marketing tool that is simply a choice made by the hospital for a model of care. (Krasner, Tr. 3699). That said, it was not a good marketing tool at HPH as, for example, it did not increase birth volume at all at HPH. (Krasner, Tr. 3699-3700; RFF ¶ 1238).

The evidence – also discussed in RFF-Reply ¶¶ 2037, 2188 – documents that HPH had significant problems with its obstetrical service. For example,

**REDACTED**



**REDACTED**

(Chassin,

Tr. 5196; RX 324 at ENHL PK 29708-11, *in camera*; Silver, Tr. 3782; RFF ¶ 1249, *in camera*).

In fact, because HPH's Ob/Gyn leadership and department were not able to resolve internally the problems with the hospital's Ob/Gyn care pre-Merger, HPH asked ACOG to come to HPH and help implement the appropriate standards of care. (Spaeth, Tr. 2114-15, 2249).

**REDACTED**

(Chassin, Tr. 5221; RX 324 at ENHL PK 29708, *in camera*; RX 208 at ENHL PK 17285; RFF ¶ 1252, *in camera*).

**REDACTED**

**REDACTED**

(RFF ¶ 1439, *in camera*).

**REDACTED**

(Chassin, Tr. 5221; RX 324 at ENHL PK 29710, *in camera*). Thus, the overwhelming evidence established that HPH's obstetrical service was not functioning well before the Merger. (RFF ¶¶ 1439, 1441; RFF-Reply ¶ 2189).

2190. An outside consultant to ENH, Bain, described Highland Park Hospital's obstetric and neonatology facilities as "excellent" in a reported dated January 6, 2000, just days after the merger was consummated. (CX 1998 at 11).

**Response to Finding No. 2190:**

This proposed finding is misleading. The cited evidence does not specifically refer to both HPH's neonatology and obstetric facilities. (CX 1998 at 11).

**REDACTED**

**REDACTED**

(Chassin, Tr. 5192-94, 5106, 5159-60; RX 324 at ENHL PK 29708-11, *in camera*; Silver, Tr. 3782; RFF ¶ 1239).

2191.

**REDACTED**

511, *in camera*).

(Newton, Tr.

**REDACTED**

(Newton, Tr. 511, *in camera*).

**Response to Finding No. 2191:**

This proposed finding is misleading and not supported by the evidence.

**REDACTED**

(Chassin, Tr. 5585; RX

657 at ENHL PK 29812, *in camera*; RX 324 at ENHL PK 29709, *in camera*).

**REDACTED**

(RX 657 at ENHL PK 29812, *in camera*; Chassin, Tr. 5585; Romano, Tr. 3391; RFF ¶ 1287, *in camera*). The evidence showed that the obstetrician coverage provided pre-Merger by physicians who lived nearby HPH was inferior to the in-house coverage currently in place at that campus. (Silver, Tr. 3788; RFF ¶ 1286).

**REDACTED**

(RX 657 at ENHL PK 29809, *in camera*). The cited testimony of Newton, who was never responsible for the provision of clinical services at HPH's obstetrical unit, is uncorroborated. For example,

**REDACTED**

(Newton,

512-13, *in camera*; RX 324 at ENHL PK 29709, *in camera*; RFF ¶ 1289). Further, Newton was

in a business role at HPH, was not a physician, and had no clinical responsibilities for any of the clinical areas evaluated by Dr. Chassin in this case. (Newton, Tr. 279, 512-13).

The lack of available nighttime obstetrical coverage increases the risk of adverse outcomes, which, by definition, is a quality problem. (Chassin, Tr. 5586; RFF ¶ 1291). Dr. Romano conceded that the expansion of obstetrician coverage at HPH to include in-house coverage during the nighttime was a structural quality improvement. (Romano, Tr. 3252, 3389-90).

2192.

**REDACTED**

(Romano, Tr. 3132, *in camera*).

**Response to Finding No. 2192:**

For the reasons more fully discussed in RFF-Reply ¶ 2191, this proposed finding is inaccurate and not supported by the evidence. Further, the evidence showed that other hospitals in Lake County did not have an in-house obstetrician coverage program like the one ENH implemented at HPH. However, the fact that most community hospitals do not have in-house obstetrician coverage at night does not mean that such arrangements are desirable. (Silver, Tr. 3839-40).

**REDACTED**

(RX 324 at

ENHL PK 29709, *in camera*; RFF ¶ 1289).

2193. Before the merger, Dr. Silver did attend meetings at Highland Park Hospital to review high-risk cases related to the Illinois perinatal network, and he was not aware of any individual cases at Highland Park Hospital prior to the merger where there were deficiencies in the quality of care in the OB department. (Silver, Tr. 3832). He has never discovered any deficiencies, based on any data used by Highland Park Hospital prior to the merger to measure quality, at Highland Park Hospital's OB department prior to the merger. (Silver, Tr. 3832).

**Response to Finding No. 2193:**

This proposed finding is inaccurate, misleading and not supported by the evidence. Dr. Silver's testimony specifically identified problems with physician practice about which he was aware of prior to the Merger. For example, he identified problems with respect to the inappropriate practice of performing inductions for social reasons or patient convenience rather than medical necessity. (Silver, Tr. 3800-02; RFF ¶ 1275). Dr. Silver had been contacted by HPH's nursing staff, on at least one occasion, through the perinatal network about the practice of inappropriate inductions at HPH pre-Merger, but he had no authority to address that problem before the Merger. (Silver, Tr. 3801-02; RFF ¶ 1275).

2194. Evanston Hospital has "high-risk" obstetrics patients as well as a "high-risk" nursery. (Silver, Tr. 3771). Before the merger, Highland Park Hospital referred its high-risk obstetrics cases to Evanston Hospital. (Neaman, Tr. 1306-07, Silver, Tr. 3829). After the merger, the high-risk cases are still handled by Evanston Hospital rather than Highland Park Hospital. Highland Park Hospital does not have a specialty care nursery post-merger – the nursery continues to be located at Evanston Hospital. (Silver, Tr. 3829).

**Response to Finding No. 2194:**

This proposed finding is misleading and incomplete. There was never a formal affiliation or joint venture between Evanston Hospital and HPH pre-Merger. (Krasner, Tr. 3697; RFF ¶ 1248). The State of Illinois organizes perinatal care using central hospitals to care for high-risk obstetric patients. Pre-Merger, Evanston Hospital had a perinatal rating of Level III, and was designated by the state as a high-risk center, while HPH had a Level II designation. Therefore, as a result of state guidelines, HPH, as well as a number of other hospitals, referred their high-risk obstetric cases to Evanston Hospital pre-Merger, and they continue to do so today. (Silver, Tr. 3771, 3828-29).

2195. The ACOG report commended Highland Park Hospital's changes in nursing leadership before the merger, stating that such changes made it more likely for Highland Park

Hospital to establish a center of excellence for women's and children's services. (RX 324 at ENHL PK 029763).

**Response to Finding No. 2195:**

This proposed finding is misleading and incomplete.

**REDACTED**

(RX 324 at ENHL PK 29710, *in camera*). Further, the ACOG report also noted

**REDACTED**

(RX 324 at ENHL PK 29754, *in camera*; RFF ¶ 1258, *in camera*). The prospect of establishing a center of excellence for women's and children's services at HPH was a long-term goal, not a well-planned reality.

2196.

**REDACTED** (RX 365 at ENHRS003456, *in camera*).

**Response to Finding No. 2196:**

This proposed finding is incomplete.

**REDACTED**

**REDACTED**

(RX 365 at ENH RS 3456, *in camera*).

2197. Highland Park Hospital made many improvements in its obstetrics and gynecological department in a period of less than a year and a half, between May 1998 (the time of the ACOG visit) and September 1999 (the time of the CHRPP visit).

**REDACTED**

(CX 6265 at 20, *in camera*).

**Response to Finding No. 2197:**

This proposed finding is misleading and ignores record evidence. ACOG identified a plethora of items that needed to be improved in HPH's Ob/Gyn department pre-Merger. HPH made some headway in addressing several of these issues pre-Merger, but it did not make substantial progress on "many" of them.

**REDACTED**

(RX 6265 at

10-11, 19-26, *in camera*).

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**REDACTED**

} (CX 6265, *in camera*). Moreover, as noted in RFF-Reply ¶ 2321, the CHRPP report has a number of overall weaknesses.

2198.

**REDACTED** (Newton, Tr. 508-09, *in camera*).

**Response to Finding No. 2198:**

Respondent has no specific response to the first sentence of this proposed finding.

Respondents agree that HPH **REDACTED** (CCFF 2198, *in camera*).

The second statement in this proposed finding, however, is inaccurate.

**REDACTED** (Newton, Tr. 508-09, *in camera*).

2199.

**REDACTED** (CX 6265 at 25, *in camera*).

**Response to Finding No. 2199:**

This proposed finding is misleading.

**REDACTED**

} (CX 6265 at 24, *in camera*). To the contrary, the record evidence showed that many improvements were not made to the quality review process pre-Merger.

2200.

**REDACTED**

(Romano, Tr. 3133, *in camera*).

**Response to Finding No. 2200:**

This proposed finding is misleading and misstates the record evidence.

(Romano, Tr. 3133, *in camera*).

**REDACTED**

(Romano, Tr. 3451, *in camera*; RFF ¶ 1299, *in camera*). This hearing transcript is not part of the record and, therefore, cannot be relied on for the truth of the matters asserted therein.

2201. There is no literature yet on the link between ENH's preoperative review program and patient outcomes. It is also not possible to compare ENH's preoperative review program to any national benchmarks. (Silver, Tr. 3852).

**Response to Finding No. 2201:**

This proposed finding is incomplete. It is not possible to compare the preoperative review program to national benchmarks or to review literature on the topic because ENH's program is unique.

**REDACTED**

(Chassin, Tr. 3890, *in camera*).

Post-Merger

2202.

**REDACTED**

(Krasner, Tr. 3748; Silver, Tr. 3842, 3857-58; Silver, Tr. 3929, *in camera*; O'Brien, Tr. 3672).

**Response to Finding No. 2202:**

This proposed finding is incomplete, misleading and repetitive. (CCFF ¶ 2207). After the Merger, ENH sought a department chair for Ob/Gyn. Until a permanent chair was selected,



Dr. Rodney Hoxey, a reproductive endocrinologist, served as the interim chair. But because his practice did not focus on obstetrics, he did not have the clinical expertise with the department to institute the kind of changes that obstetrics needed. After a nationwide search, Dr. Silver was appointed as chair in the spring of 2001, and he immediately began to make a number of changes to Ob/Gyn and to correct some of the existing problems. (Silver, Tr. 3842-43; RFF-Reply ¶ 2207, 2237(2)). Moreover, a number of these changes could not have been implemented overnight and thus took years to achieve – including changes to the nursing culture, improving nurse/physician relationships and addressing nurse vacancy rates and hiring issues. (O'Brien, Tr. 3536-37; RFF ¶ 1387).

2203. After the merger, there continued to be nursing vacancies at Highland Park Hospital while Heidi Krasner was in the family birthing center. (Krasner, Tr. 3748). Highland Park Hospital still uses agency nurses after the merger. (O'Brien, Tr. 3672).

**Response to Finding No. 2203:**

This proposed finding is misleading to the extent it implies that nursing vacancies and the use of agency nurses continued at the same pre-Merger rates – they did not.

**REDACTED**

(O'Brien, Tr. 3672, *in camera*, RFF ¶ 1396; RX 1032 at ENH GW 471). As previously discussed, vacancy rates were an ongoing issue that could not be resolved overnight but, instead, were addressed over time. (RFF-Reply ¶ 2202).

**REDACTED**

(O'Brien, Tr. 3672, *in camera*; Krasner, Tr. 3694; RFF ¶¶ 1393, 1396).

2204. ENH claims that the institution of in-house physician coverage was a major improvement of the merger, but in fact, ENH operated the obstetrics and gynecology department at Highland Park Hospital from the time of the merger, January 1, 2000, until the summer of 2001 without in-house physician coverage. (Silver, Tr. 3841-42).

**Response to Finding No. 2204:**

This proposed finding is misleading. Institution of in-house physician coverage in the Ob/Gyn department *was* a major quality of care improvement of the Merger. (Chassin, Tr. 5204; RFF ¶ 1277). It did not occur until ENH located and hired a permanent Ob/Gyn department chair, Dr. Silver, who implemented the in-house coverage within three months of taking the chair position. (Silver, Tr. 3842-43; RFF-Reply ¶ 2202).

2205.

**REDACTED**

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(Silver, Tr.

3929-39, *in camera*; RX 2034, *in camera*).

**Response to Finding No. 2205:**

This proposed finding is grossly misleading and not supported by the evidence.

**REDACTED**

(Silver, Tr. 3836-37, *in camera*; RFF ¶ 1317, *in camera*).

**REDACTED**

(Silver, Tr. 3902-03; *in camera*).

**REDACTED**

(Silver, Tr. 3902-03; *in camera*).

**REDACTED**

(Silver, Tr.

3898-99, 3902, 3905; *in camera*).

**REDACTED**

**REDACTED**

(Silver, Tr. 3902, 3929; *in camera*).

1305; *in camera*).

**REDACTED**

(Silver, Tr. 3903-04, *in camera*; RX 2033 at ENHL PL 1305, *in camera*; RFF ¶¶ 1313-1315, *in camera*).

**REDACTED**

(RX 2034, *in camera*).

**REDACTED**

(Silver, Tr. 3908-10, *in camera*; RFF ¶ 1455, *in camera*).

**REDACTED**

(Chassin, Tr. 3906-07, *in camera*).

2206. Although Respondent claimed that it improved quality at HPH by eliminating the practice of performing D&C procedures (dilation and cutterage, or the surgical evacuation of miscarriages) in the emergency room, ENH allowed physicians to perform D&Cs in the emergency room at Highland Park Hospital from the time of the merger until after the Spring of 2001. (Silver, Tr. 3781, 3857-58). In addition, ENH allowed certain second trimester abortions to be performed in labor and delivery at Highland Park Hospital until at least the Spring of 2001. (Silver, Tr. 3857-58).

**Response to Finding No. 2206:**

This proposed finding is misleading to the extent it implies that ENH made a policy and procedure change to prohibit certain practices after the Merger and that physicians ignored those changes. In fact, the decision to change those practices occurred shortly after the arrival of, and at the suggestion of, Dr. Silver as department chair in the spring of 2001. (Silver, Tr. 3778, 3781, 3794-95, 3802, 3808; RFF ¶¶ 1301-1303).

2207. ENH's improvements to Highland Park Hospital's obstetrics and gynecology department did not take place until long after the merger. The critical pathways or protocols for OB were not even "published to the physicians," much less fully implemented, until between September of 2001 to May 2004. (Silver, Tr. 3845). A full-time chairperson was not installed at Highland Park Hospital until spring 2001. (Silver, Tr. 3841). In-house obstetrician coverage was not implemented until the summer of 2001. (Silver, Tr. 3842).

**Response to Finding No. 2207:**

This proposed finding is repetitive and misleading. (CCFF ¶ 2202). As discussed above, many of the improvements ENH instituted at HPH were long-term undertakings and not overnight fixes. (RFF-Reply ¶¶ 2202; 2204). Dr. Silver chaired the Obstetrics Practice Committee, which he formed shortly after his arrival, with developing protocols – a suggested set of procedures for physicians and caregivers in a particular subject area. (RFF ¶¶ 1304-1310). The Ob/Gyn critical pathways and protocols were two of the improvements that took time to develop; physician input had to be gathered, the pathway had to be drafted and then approved, and then it was released to physicians. (Silver, Tr. 3802-04). In addition, both of these are continually updated to reflect current knowledge and best practice. (RFF ¶ 1304). Immediately after the Merger, ENH had a full-time Ob/Gyn chair, Dr. David Cromer, who left shortly thereafter. To identify the best replacement candidate for the Ob/Gyn department chair position, ENH appointed an interim chair while conducting a nationwide search that lasted about nine months. Ultimately, Dr. Silver was appointed chair in the spring of 2001. (Silver, Tr. 3842-43).

2208.

**REDACTED**

(Neaman, Tr. 1401-02, *in camera*; CX 1033 at 1-2, *in camera*).

**Response to Finding No. 2208:**

This proposed finding is incomplete.

**REDACTED**

(Neaman, Tr. 1401, *in*

*camera*; CX 1033 at 1-2, *in camera*).

Further, the evidence showed that HPH had a patient die in its ED from a streptococcus infection before the Merger. (RX 462 at ENH RS 5485). The evidence also showed ongoing efforts by ENH to maintain quality improvement in the area of infection control and, in some areas of the hospital, ENH dramatically reduced the number of infections between 2001 and 2003. (RX 1769 at ENHL PK 5872).

- c. **There Was No Significant Improvement in Highland Park Hospital's Quality Assurance Activities Due to the Merger**

2209.

**REDACTED**

(Romano, Tr. 3159, *in camera*).

**Response to Finding No. 2209:**

This proposed finding is irrelevant, misleading and not supported by the evidence.

Whether or not there has been a nationwide trend in quality assurance ("QA") or quality improvement ("QI") does not change the fact that ENH corrected HPH's problems through the Merger. Pre-Merger, HPH's QA program had ineffective peer review of physicians and an inadequate process to discipline those physicians. (Chassin, Tr. 5210-11; RFF ¶ 1416). These structural issues with the QA program required the Merger to fix; they required the importation

of ENH's superior leadership structure and QA processes to HPH. (Chassin 5389-90; RFF ¶ 1417). Similarly, the pre-Merger QI program had indicators that were not valid quality measures and did not use data from sources outside HPH, there was a lack of benchmarking and use of best demonstrated practices, HPH used a simplistic and deficient care map process, and HPH's approach to improvement was extremely limited. (Chassin, Tr. 5253-54; RX 417 at ENHL PK 17694; RFF ¶¶ 1464-67).

In fact, the evidence showed that HPH's pre-Merger QI program had several, serious barriers to reforming its QI program. (RX 417 at ENHL PK 17695). There were problems with quality and with clinical practice at HPH pre-Merger, but much of it was below the view and focus of HPH's performance improvement program. (RX 417 at ENHL PK 17695). Specific weaknesses of HPH's QI program included: a lack of benchmarking and best demonstrated practice; a lack of specific focus on quality in daily operations; and a lack of consistent, measurable and meaningful results. (RX 417 at ENHL PK 17695). There were several barriers to serious clinical reform that included the limitations of HPH's pre-Merger hospital management; the limitations of physician practice (including subscale physician practice and failure to report errors); and a failure of leadership (including a lack of physician accountability), to name a few. (RX 417 at ENHL PK 17695-97).

2210. Prior to the merger, Highland Park Hospital had a system in place to keep track of the quality of care at the hospital. (Spaeth, Tr. 2090). The medical staff at Highland Park Hospital prior to the merger was fairly interested in improving the quality of care at the hospital. (Spaeth, Tr. 2095).

**REDACTED**

(Romano, Tr. 3142, *in camera*; CX 6296 at 10-22, *in camera*).

Highland Park Hospital would also discipline problematic physicians before the merger. (Newton, Tr. 381-383).

**REDACTED**

(See, e.g., CX 464 at 2-3, *in camera*).

**Response to Finding No. 2210:**

Respondent has no specific response to the first statement in this proposed finding.

However, the rest of the statements are inaccurate and misstate the record evidence. The HPH medical staff's "interest" in improving quality of care is irrelevant in the absence of action implementing that interest.

**REDACTED** (Chassin, Tr. 5211; RX 417 at ENHL PK 17695-96; RX 251 at ENHL PK 17839, *in camera*; RFF ¶ 1422, *in camera*; RFF-Reply ¶ 2212).

**REDACTED**

(Romano, Tr. 3142; Harris, Tr. 4421-22, *in camera*; RX 365 at ENH RS 3454, *in camera*). Further, HPH determined there was a "huge under reporting of adverse events" which was an "educational, political, and system problem." (RX 417 at ENHL PK 17695; RFF ¶ 1421). And even when adverse events were reported, HPH lacked a systematic method to examine them and determine ways to prevent them from recurring. (Chassin, Tr. 5211; RX 417 at ENHL PK 17695; RFF ¶¶ 1421-1422).

For the reasons more fully discussed in RFF-Reply ¶ 2209, HPH had serious weaknesses in its QI program pre-Merger including: a lack of benchmarking and best demonstrated practice; a lack of specific focus on quality in daily operations; and, a lack of consistent, measurable and meaningful results. (RX 417 at ENHL PK 17695). For example, a failure of leadership (including a lack of physician accountability) was identified as but one of several barriers at HPH pre-Merger that prevent meaningful clinical reform. (RX 417 at ENHL PK 17695-97).

Finally, this proposed finding improperly relies on Newton's testimony as to QA issues. Newton did not oversee, or have any responsibility for, the quality of clinical services at HPH.

(Spaeth, Tr. 2282-83, 2285; Newton, Tr. 279). HPH had serious problems with physician discipline pre-Merger, particularly in the Ob/Gyn department. (Chassin, Tr. 5206-07; RFF ¶ 1441). The record evidence identifies inappropriate practices and physician misbehavior pre-Merger that was not dealt with by HPH, as well as a culture that prevented physicians from taking effective disciplinary action. (Chassin, Tr. 5217-18; RX 417 at ENHL PK 17696-97; RFF ¶ 1436).

**REDACTED**

(Chassin, Tr. 5225; RX 2033, *in camera*; RX 2034 at ENHL PL 1301, *in camera*; RFF ¶ 1446). ENH worked quickly to address quality problems, but as with so many other improvements, they could not fix the QA issues overnight. Rather, over time, ENH exported its organizational culture, which encouraged the reporting of hospital errors, and this resulted in a positive change at HPH in the reporting of errors. (Chassin, Tr. 5227-28; RFF ¶ 1444).

Pre-Merger

2211.

**REDACTED**

(Romano, Tr. 3145, *in camera*).

Response to Finding No. 2211:

Respondent has no specific response.

2212.

3142, *in camera*).

**REDACTED**

(Romano, Tr.

6296 at 3-6, *in camera*).

(Romano, Tr. 3146, *in camera*; CX

*camera*; CX 6296 at 3-6, *in camera*).

**REDACTED**

(Romano, Tr. 3151, *in*



**Response to Finding No. 2212:**

This proposed finding is duplicative and is not supported by the evidence. (CCFF ¶ 2210).

**REDACTED**

(Chassin, Tr. 5221-22; RX 2006 at 103; Harris, Tr. 4418-19, *in camera*; RX 365 at ENH RS 3454, *in camera*; RFF ¶ 1437; Romano, Tr. 3142, *in camera*; RFF-Reply ¶ 2213). Since the root cause analysis was required by JCAHO, it does not speak to the strengths or weaknesses of HPH's per-Merger QA program. (Chassin, Tr. 5620-21; RFF ¶ 1437).

**REDACTED**

(Harris, Tr. 4421, *in camera*; RX 365 at ENH RS 3454).

**REDACTED**

(Chassin, Tr. 5222-23; RX 324 at ENHL PK 29713, *in camera*; RX 284 at ENHL PK 26594; RFF 1423). For example,

**REDACTED**

(RX 324 at ENHL PK 29714, *in camera* (emphasis added)). Another example occurred

**REDACTED**

(RX 1772 at ENHL PK 17957, *in camera*; RFF ¶ 1423).

**REDACTED**

(Chassin, Tr. 5211, 5223; RX 417 at ENHL PK 17695-96; RX 251 at ENHL PK 17839, *in camera*; RFF ¶¶ 1422, 1428).

2213.

**REDACTED**

*See, e.g.,* RX 346 at ENHL

PK 024709, *in camera*).

**REDACTED**

(RX 414 at ENHL PK 039155, 039164, *in camera*).

**Response to Finding No. 2213:**

This proposed finding is misleading.

**REDACTED**

(Harris, Tr. 4421, *in camera*, RFF ¶ 1438; RX 346 at ENHL

PK 24709, *in camera*). HPH had weak, ineffective, and non-systematic QA and QI programs pre-Merger. (Chassin, Tr. 5210-11, 5220, 5253-54; RFF ¶¶ 1416, 1464; RX 417 at ENHL PK 17694-95; RFF-Reply ¶¶ 2209, 2212). As more fully discussed in RFF-Reply ¶ 2212,

**REDACTED**

(Chassin, Tr. 5222-23; RX 324 at ENHL PK

29713-14, *in camera*; RX 284 at ENHL PK 26594; RFF ¶ 1423, *in camera*).

2214. Before the merger, Highland Park Hospital undertook an internal program to examine and improve quality. (RX 417 at ENHL PK 017693). Through this program, Highland Park Hospital self-identified problems in the quality of care it provided to patients and process to improve quality. (RX 417 at ENHL PK 017694-017697).

**Response to Finding No. 2214:**

This proposed finding is incomplete and misleading insofar as it implies that HPH made any actual progress at improving the problems identified in the cited evidence. For the reasons more fully discussed in RFF-Reply ¶¶ 2209-2210, there were several barriers to serious clinical reform that included the limitations of HPH's pre-Merger hospital management; the limitations of physician practice (including subscale physician practice and failure to report errors); and a failure of leadership (including a lack of physician accountability), to name a few. (RX 417 at ENHL PK 17695-97; RFF-Reply ¶¶ 2209-2210).

2215. Highland Park Hospital, analyzed the quality of care it provided and actively sought to improve the quality of its services. (RX 178 at ENHL PK 015618-015621).

**REDACTED**

(RX 204 at ENHL PK 031140, *in camera*).

**Response to Finding No. 2215:**

This proposed finding is misleading and inaccurate.

**REDACTED**

(RX 178 at ENHL PK

15618; RX 204 at ENHL PK 31140, *in camera*).

**REDACTED**

(RX 204 at ENHL PK 31140, *in camera*). Finally, there is

substantial evidence that HPH was not proactive in discussing its adverse events. For example, there was no discussion of the 1993 malpractice case in the department of obstetrics when it occurred and there was

**REDACTED**

(Chassin, Tr. 5221; RX 324 at ENHL PK 29710, 29714, *in camera*

(emphasis added); RFF-Reply ¶¶ 2213).

2216. The 1999-2002 Strategic Plan for Highland Park Hospital included attention to providing documented and measurable outcomes of quality that exceeded those of the competition. This would be accomplished by creation of additional clinical pathways and changing the way care was provided. (Newton, Tr. 331-32; CX 1868 at 12).

**Response to Finding No. 2216:**

This proposed finding is incomplete and misleading. While the 1999-2002 Plan did include attention to providing documented and measurable outcomes of quality, these were being implemented as a method to differentiate the HPH organization in terms of marketing. In fact,

that strategy was developed “with the goal to increase market share” of the hospital, it had nothing to do with improving quality or QA systems. (Newton, Tr. 331-32; CX 1868 at 12). Further, Complaint Counsel has not cited a contemporaneous document that indicates HPH was planning to implement clinical pathways and was changing the way care was provided. Instead, this proposed finding is based on the unreliable testimony of Newton, who is testifying solely based on memory as to what HPH would have done. (Newton, Tr. 331-32). Moreover, Complaint Counsel relies on the testimony of Newton with respect to quality issues, yet Newton did not oversee or have any responsibility for the quality of clinical services at HPH. (Spaeth, Tr. 2282-83, 2285; Newton, Tr. 279-80; RFF-Reply ¶ 2216).

2217. Highland Park Hospital reviewed outliers before the merger, which are cases that lie outside the norm for a particular illness. Highland Park Hospital also looked at partial negative outcomes which is where expectation of the patient’s recovery was not 100%. In these instances, the hospital looked at “pieces of the care that was rendered” in order to determine if the physician provided the proper care. (Spaeth, Tr. 2092).

**Response to Finding No. 2217:**

This proposed finding is irrelevant and taken out of context. The testimony reflects a description of the general “quality and the strength of Highland Park Hospital before the merger,” not a description of the QA process specifically. (Spaeth, Tr. 2090-92).

2218. Before the merger, Highland Park Hospital kept track of quality of care through case reviews by physicians. These reviews identified problem cases that might end up with the hospital mentoring the physician. The hospital also looked at cases over time as to trends with regard to possible outcomes. (Spaeth, Tr. 2090-91).

**Response to Finding No. 2218:**

This proposed finding is incomplete. The cases reviewed by physicians were identified and chosen for review by management rather than physicians, and, in part, were reviewed as a way to gather trend information. (Spaeth, Tr. 2090-91). Finally, there is substantial evidence that HPH was not proactive in its case reviews of adverse events.

**REDACTED**

(Chassin, Tr. 5221; RX 324 at ENHL PK 29710, 29714, *in camera* (emphasis added); RFF-Reply ¶¶ 2212-2213).

2219. At Highland Park Hospital prior to the merger, the board of directors would credential and re-credential physicians based upon the recommendation of the medical executive committee and the department chairmen. Prior to the merger, there was also a committee in place that had Board members and members of the medical staff leadership that would look at quality issues and peer review issues. (Newton, Tr. 381).

**Response to Finding No. 2219:**

Respondent has no response to this proposed finding except to the extent it implies there was one committee that looked at quality and peer review issues. The cited testimony is as follows: “There was a committee structure in place that had board members and members of the medical staff leadership that would be involved in looking at quality issues and peer review issues.” (Newton, Tr. 381). The evidence showed that, after the Merger, ENH introduced a periodic re-credentialing process in which HPH physicians underwent a review of their practices under which they were required to meet the credentialing requirements that have been established to maintain clinical privileges by the appropriate department chairman. (Chassin, Tr. 5226; Neaman, Tr. 1354; RX 651 at ENH MN 1536). After the Merger, several physicians at HPH were not granted re-appointment during the periodic re-credentialing process because of their failures to respond while on call. (Chassin, Tr. 5227).

2220. At Highland Park Hospital prior to the merger, there was also a Vice President of the medical staff administration who would work with department chairmen “to make sure they effectively conducted their professional responsibilities.” (Newton, Tr. 381). At Highland Park Hospital during the 1990s, there were disciplinary actions taken against physicians practicing at Highland Park. Such actions included reduction of privileges, suspension of privileges, or removal from staff. (Newton, Tr. 382-83).

**Response to Finding No. 2220:**

Respondent has no specific response to the first sentence in this proposed finding. As to the second assertion, it is misleading and repetitive. As stated above, Newton had no responsibility for quality of clinical services at HPH. (RFF-Reply ¶ 2210). His testimony on these disciplinary actions was an estimation based on pure speculation, at best. He could not recall the exact number of disciplinary actions, nor could he recall specific penalties, only scenarios of what was likely to have happened in such actions. (Newton, Tr. 382-83; RFF-Reply ¶ 22 (discussing the ineffectiveness of pre-Merger physician discipline at HPH)). Further, there was substantial evidence of pre-Merger physician misconduct, some of which was egregious, that went unaddressed until after the Merger. (RFF ¶¶ 1441-1446, 1452-1453). For example, {

**REDACTED**, (Chassin, Tr. 5225; RX 2033, *in camera*; RX 2034, *in camera*).

; (RX 2034 at ENHL PL 1301, *in camera*).

2221. In the late 1990s, Highland Park Hospital had a specific quality assurance program for its obstetrics department that included a set of processes by the medical staff (peer review, chart review, re-credentialing), reviews through the neonatal network, reviews through CHRPP's standard elements program, and an internal program that looked at any "sentinel events." (Newton, Tr. 392). There were ongoing efforts at Highland Park Hospital before the merger to improve the quality of care in the OB/Gyn department. (Silver, Tr. 3831).

**Response to Finding No. 2221:**

This proposed finding is misleading and not supported by the evidence.

**REDACTED**

(Newton, Tr. 512-13, *in camera*).

**REDACTED**

(RFF ¶¶

1249, 1259, 1269, *in camera*; RFF ¶¶ 1275, 1416; Silver, Tr. 3798-99; Chassin, Tr. 5196; RX 324 at ENHL PK 29708-11, *in camera*).

The pre-Merger quality assurance program at HPH was inadequate with respect to both physician discipline and adverse event reviews, which are the primary components of hospital quality assurance programs. (Chassin, Tr. 5210-11 RX 417 at ENHL PK 17695; RFF ¶¶ 1415-1416). HPH had a very weak structure within each of the clinical departments for performing effective peer review and identifying problem physicians, and it lacked an adequate process to discipline those physicians. (Chassin, Tr. 5210-11).

The perinatal network did not provide effective peer-review by physicians outside HPH. For example, Dr. Silver had no authority for the conduct of physicians at HPH before the Merger, notwithstanding the perinatal network. (RFF ¶ 1275).

**REDACTED**

(RX 324 at ENHL PK 29714, *in camera*

(emphasis added)).

This proposed finding fails to identify any specific evidence from the record of what the alleged ongoing efforts at improvement in HPH's OB/Gyn department were pre-Merger, the extent of such efforts, or the outcome of such efforts.

**REDACTED**

(RFF ¶¶

1276-1300, 1301-1303, 1441-1446, 1449, 1452-1453; Romano, Tr. 3450, *in camera*).

**REDACTED**

(Romano, Tr.

3450, *in camera*).

2222. Information obtained through Highland Park Hospital's quality assurance efforts in the obstetrics department would be distributed to the joint conference committee of the medical staff and to the hospital's board of directors. This information would not be ignored but would be addressed. (Newton, Tr. 392-93).

**Response to Finding No. 2222:**

Respondent has no specific response to the first sentence. The second sentence is inaccurate and misstates the record evidence. The record is replete with examples of HPH's failure to address QA issues in Ob/Gyn pre-Merger, including

**REDACTED**

(Chassin, Tr. 5197-98, 5200; RX 324 at ENHL PK 29773, 29754, *in camera*;

RFF ¶¶ 1257, 1259, 1441; 1450-1456). Furthermore, this proposed finding again relies solely on the testimony of Newton, who had no responsibility for the quality of clinical services at HPH.

(RFF-Reply ¶ 2216).

2223.

**REDACTED**

(Romano, Tr. 3154, *in*

*camera*).

**REDACTED**

(Romano, Tr. 3155, *in camera*).



**Response to Finding No. 2223:**

This proposed finding is misleading to the extent it implies that

**REDACTED**

(Chassin, Tr. 5221; RX 324 at ENHL PK 29708, *in camera*; RX 208 at ENHL PK 17285; RFF ¶ 1252, *in camera*; RFF-Reply ¶ 2248).

2224.

**REDACTED**

(Romano, Tr. 3155, *in camera*).

**REDACTED**

*camera*).

(Romano, Tr. 3155-56, *in*

**Response to Finding No. 2224:**

This proposed finding is unsupported by record evidence and is duplicative of CCF ¶¶ 2170, 2173. Complaint Counsel merely cites Dr. Romano's bald assertion to support this proposed finding that ACOG recommendations were discussed in HPH's relevant committees. It does not cite any contemporaneous documents. The second statement of this proposed finding is repetitive. (RFF-Reply ¶ 2222, 2321). Further, there were several problems identified in the 1998 ACOG review and that existed at HPH pre-Merger that were not addressed until after the Merger including, but not limited to: inadequate obstetrician coverage; the exertion of effective department leadership; and effective discipline of physicians with significant problems with clinical and ethical judgment. (RFF ¶¶ 1267-1268, 1299-1303, 1317-1320, 1446-1457). For further discussion of the differences between 1998 ACOG review and 1999 CHRPP review, see RFF-Reply ¶ 2171.

2225. Up until the time of the merger in 2000, the various clinical departments of medicine at Highland Park Hospital selected their chairmen from among private practitioners on the medical staff. Highland Park Hospital's practice of choosing its clinical department chairmen from among the private practitioners on the medical staff did not present a problem for assuring quality of care. (Newton, Tr. 379-80).

**Response to Finding No. 2225:**

This proposed finding is false to the extent it asserts there were no problems with selecting private practitioners as chairmen of the clinical departments at HPH.

**REDACTED**

(Chassin, Tr. 5218; RX 324 at ENHL PK 29708, *in camera*; RFF ¶ 1433, *in camera*).

**REDACTED**

(Chassin, Tr. 5219; RX 324 at ENHL PK 29713, *in camera*; RFF ¶ 1432).

**REDACTED**

(Spaeth, Tr. 2252; Chassin, Tr. 5218-19; RX 324 at ENHL PK 29708, *in camera*; RFF ¶ 1433). And third, because the physicians in leadership roles practiced at other hospitals, HPH sometimes had trouble finding physicians to accept positions as department chairman. (Spaeth, Tr. 2251-52; RFF ¶ 1434).

2226. It does not make any difference to quality of care if a hospital chooses its department chairmen from among private practitioners who are on the medical staff, or directly employs the chairmen, because physicians are professionals who go through a peer review process. (Newton, Tr. 380). Most community hospitals have elected officers, and JCAHO has not taken a position that elected medical staff officers are adverse to quality. (Spaeth, Tr. 2315).

**Response to Finding No. 2226:**

This proposed finding is false, as to the first assertion. This aspect of this proposed finding relies solely on the testimony of Newton, who had no responsibility for quality of clinical services at HPH and was not qualified to offer such an expert opinion. (RFF-Reply ¶ 2216). With the change to a national search and selection process instituted by ENH at HPH post-Merger, HPH department chairmen are no longer confronted with the conflicts-of-interest facing the private practicing physician leaders at HPH before the Merger. (Chassin, Tr. 5391; Spaeth, Tr. 2252-53; RFF ¶ 1443). This policy change impacted quality of care. The second assertion in this proposed finding is irrelevant. Simply because JCAHO has not taken a position on the impact on quality of elected versus appointed officers is not evidence that there is not an adverse impact from the use of an elected officers.

2227.

**REDACTED** (Romano, Tr. 3142, 3151, 3159, *in camera*).

**Response to Finding No. 2227:**

This proposed finding is irrelevant and inaccurate.

**REDACTED** (Romano, Tr. 3449-50, *in camera*; RFF ¶ 1419, *in camera*).

**REDACTED** (Chassin, Tr. 5228; RX 889 at ENHL PK 16485, *in camera*; RFF ¶ 1445).

**REDACTED** (Chassin, Tr. 5229-30; RX 889 at ENHL PK 16485, *in camera*; RFF ¶ 1445). Further, there is ample evidence that HPH faced serious

barriers to clinical reform pre-Merger, such as limitations of hospital administration; subscale physician practice; and physicians who failed to report errors or question practice, to name but a few examples of HPH's pre-Merger weaknesses that hindered quality improvement efforts. (RX 417 at ENHL PK 17695-96). The evidence showed that Illinois ranked 47th among all 50 states in the 1998-1999 period and only 46th place in 2000-2001 for healthcare quality, which was rather poor. (Romano, Tr. 3001).

**REDACTED**

(Chassin, Tr. 5279-80 (*discussing* DX 8079); RX 2043; RFF ¶ 1495; RFF ¶¶ 1496-1504, *in camera*).

**REDACTED**

(Chassin, Tr. 5279-80 (*discussing* DX 8079); RX 2043; RFF ¶ 1495; RFF ¶¶ 1496-1504, *in camera*).

2228. Even after the merger, physicians at Highland Park Hospital complained of lack of communication regarding policy, ineffective leadership, and no representation in ENH. (CX 405 at 2) They also complained about the Quality Control committee being moved out of Highland Park Hospital after the merger. (CX 405 at 6).

**Response to Finding No. 2228:**

This proposed finding is incomplete and misleading. Respondent objects to this proposed finding as it is based on hearsay within hearsay and has not been specifically admitted into evidence. (JX 1 ¶ 5). The cited evidence is not attributed to an identified source and is not

corroborated by any other independent or objective data. (CX 405 at 8). Further, this proposed finding fails to mention that the only physicians interviewed on these issues were independent physicians, most of whom split their time between HPH and other hospitals. (CX 405 at 1). Finally, the evidence established that HPH's chain of command pre-Merger was deficient and rarely utilized. (RFF ¶¶ 1265, 1267). It was not until after the Merger that HPH's chain of command was improved by, for example, the introduction of a formal, written obstetric committee protocol on the chain of command which was effectively utilized post-Merger. (RFF ¶¶ 1306-1307).

2229.

**REDACTED**

(CX 464 at 2, *in camera*).

**REDACTED**

(CX 464 at 3, *in camera*)

**Response to Finding No. 2229:**

This proposed finding is incomplete.

**REDACTED**

, (CX 464 at 2-3, *in camera*).

2230. As of February 2004, Mark Neaman, ENH's CEO, was still addressing organizational and leadership problems in its Cardiology Department resulting in a "toxic" and dysfunctional environment in the department that had existed for years without ever being fixed. These problems had become an issue in ENH's attempts to keep Dr. Vtopka at ENH. (CX 773 at 1). Dr. Vtopka was a cardiac surgeon at ENH who subsequently left ENH to start a new program of his own. (Rosengart, Tr. 4441).

**Response to Finding No. 2230:**

This finding is misleading, incomplete and mischaracterizes the evidence. Dr. Vtopka had *two* concerns about HPH that factored into his decision to leave; the first was economic security and the second was the environment in the cardiology group. (CX 773). In addition, regardless of Dr. Vtopka's decision to leave, Neaman believed the "organizational/leadership

matters” needed to be resolved quickly, but that the changes would not occur overnight. (CX 773).

2231. Prior to the merger, cardiologists practicing at ENH agreed that operations at Evanston Hospital needed improvement. (Neaman, Tr. 1177 (discussing CX 1998 at 22)). Also, the performance of the cath lab at ENH was poor versus ENH’s key competitors and needed improvement. (Neaman, Tr. 1177-78 (discussing CX 1998 at 24)).

**Response to Finding No. 2231:**

This proposed finding is irrelevant and misleading. Respondent objects to this proposed finding to the extent that it is based on hearsay within hearsay and has not been specifically admitted into evidence. (JX 1 ¶ 5). Complaint Counsel is attempting to make use of hearsay testimony simply by having a witness read CX 1998 at 22 into the record. The cited evidence is not attributed to an identified source and is not corroborated by any other independent or objective data. (CX 405 at 8).

**REDACTED**

(RX 1083 at ENHE TR 931; RX 343 at ENHL PL 9740, *in camera*).

**REDACTED**

(RX 343 at ENHL PL 9740, *in camera*). Finally, the undisputed evidence is that Evanston Hospital’s performance in the area of caring for heart attack patients, both before and

after the Merger, remained superior to all hospitals in the State of Illinois with respect to the use of aspirin and beta blockers. (RX 2043).

**d. There Was No Significant Improvement in Highland Park Hospital's Quality Improvement Activities Due to the Merger**

2232.

**REDACTED**

(Romano,

Tr. 3168-70, *in camera*; Krasner, Tr. 3746-48; O'Brien, Tr. 3561-62; RX 284 at ENHL PK 026595-96).

**Response to Finding No. 2232:**

This proposed finding is false. ENH made major improvements in HPH's QI program after the Merger by exporting its unique program to HPH, a process that dramatically improved the quality of patient care at HPH. (Chassin, Tr. 5257-58; Ankin, Tr. 5055; RFF ¶¶ 1462-1463).

**REDACTED**

(Romano, Tr. 3451-52, *in camera*; RFF ¶ 1462).

**Pre-Merger**

2233. There were ongoing quality improvement efforts at Highland Park Hospital prior to the merger. (Krasner, Tr. 3746-48; RX 284 at ENHL PK 026595-026596). Before the merger, Highland Park Hospital's quality improvement activities included a drive toward clinical best practices through the use of guidelines on care or care maps. (O'Brien, Tr. 3562).

**Response to Finding No. 2233:**

This proposed finding is false, misleading and incomplete. There were ongoing efforts as discussed in this proposed finding, but they were unsuccessful. While HPH recognized some of the limitations in its QI program toward the end of the pre-Merger period, there is no evidence that HPH actually improved its QI process before the Merger. (Chassin, Tr. 5256; RX 417 at ENHL PK 17695; RFF ¶ 1468). Care maps were an attempt to reduce length of stay and to track global outcomes; the goal of care maps was to make care more efficient. (RFF-Reply ¶ 2240).

2234.

**REDACTED**  
(RX 253 at ENHL PK 031272-031273, 031283, *in camera*).

**Response to Finding No. 2234:**

This proposed finding is false.

**REDACTED**

(RX 253 at ENHL PK

31272-73, 31283, *in camera*). The record evidence demonstrated that HPH's QI program routinely did not identify areas of concern. (RFF-Reply ¶¶ 2209-2210, 2212, 2215). The evidence also showed that HPH's pre-Merger quality improvement program faced numerous barriers to meaningful quality reform. (RX 417 at ENHL PK 17695-97).

Finally, there is substantial evidence that HPH was not proactive in discussing its adverse events. For example, there was no discussion of the 1993 malpractice case in the department of obstetrics when it occurred, and there was

**REDACTED** . (Chassin, Tr. 5221; RX 324 at ENHL PK 29710, 29714, *in camera* (emphasis added); RFF-Reply ¶¶ 2212-2213).

2235.

**REDACTED**

(RX 442 at ENH RS 004658, *in camera*).

**Response to Finding No. 2235:**

This proposed finding is misleading.

**REDACTED**

(RX 442 at ENH RS 4658, *in camera*). The evidence showed that HPH's pre-Merger quality improvement program faced numerous barriers to meaningful quality reform,



including a lack of knowledge of best demonstrated practices as well as substandard physician practice and an inability to report errors. (RX 417 at ENHL PK 17695-97).

2236. Before the merger, Highland Park Hospital looked at quality indicators such as the length of time in the operating room and the time spent by a patient in the cath lab. Highland Park Hospital also tracked Press Ganey scores prior to the merger. (Spaeth, Tr. 2092-94).

**Response to Finding No. 2236:**

Respondent has no specific response to the first sentence of this proposed finding. The second sentence, however, is incomplete. For the reasons stated in RFF-Reply ¶¶ 2133-34, Dr. Romano did not rely on any reliable patient satisfaction data from which meaningful conclusions could be drawn. (Chassin, Tr. 5243, 5249-51).

2237. There were ongoing quality improvement efforts prior to the merger especially in Highland Park Hospital's obstetrics and nursing areas:

1. In 1997, Highland Park Hospital hired Jane Stenske as vice president of nursing, who was a good hire for Highland Park Hospital, supportive of nursing at Highland Park Hospital, and a good leader at the hospital prior to the merger. (Krasner, Tr. 3746-47). Ms. Stenske instituted a 24 hour/day seven days per week nursing on-call program before the merger. (Krasner, Tr. 3746).

**Response to Finding No. 2237(1):**

Respondent has no specific response.

2. In 1997, Highland Park Hospital also hired Heidi Krasner as the clinical nurse manager in the Family Birthing Center to improve nursing in the birthing center. (Krasner, Tr. 3691, 3747). Ms. Krasner did a good job and accomplished quite a bit prior to the merger while working at Highland Park Hospital. (Krasner, Tr. 3747).

**Response to Finding No. 2237(2):**

This proposed finding is repetitive, incomplete and mischaracterizes the cited testimony. (CCFF ¶ 2223). Krasner testified that she was not satisfied with what she had been doing at HPH pre-Merger in terms of making progress in problem areas, and that there was still quite a bit to accomplish. (Krasner, Tr. 3747). For example, Krasner was unable to change the

nurse/physician relationships or find the support of a strong physician leader until after the Merger and the arrival of Dr. Silver as chair of Ob/Gyn. (Chassin, Tr. 5207; RFF ¶ 1299). In addition, she testified that she had hoped HPH would improve from 1997-2000 with her continued efforts in terms of physician relationships, but that it did not. (Krasner, Tr. 3747).

3. Before the merger, Ms. Krasner successfully filled most of the nursing vacancies in the Family Birthing Center. (Krasner, Tr. 3721, 3748). Ms. Krasner also began to cross-train nurses, trained nurses to scrub in the operating room, and provided training programs to build the nursing staff's clinical competence. (Krasner, 3721, 3748-49).

**Response to Finding No. 2237(3):**

This proposed finding is misleading with respect to the nurse vacancy issue. Krasner was unable to fill nursing vacancies before the Merger due to compensation issues. HPH did not have the salaries or benefits packages to compete in the market, and Krasner was unable to fix these issues pre-Merger. This was true for all of HPH nursing, not just in the Family Birthing Center. (Krasner, Tr. 3722; RFF ¶¶ 1353-1354; RX 450 at ENH DR 3478). In addition, HPH faced high turnover rates in nursing, which produced continual vacancies that were a problem at HPH. (Krasner, Tr. 3702, 3721-22, 3755; RFF ¶¶ 1357-1358).

2238. One aspect of ENH's claims of quality improvement are its "critical pathways."

**REDACTED**

(Romano, Tr. 3166, *in camera*). A critical care pathway is a "map" of a suggested course of action for a specific disease or a specific problem. Its use is not mandated, but is developed as a best practices technique. (Ankin, Tr. 5054-55). Critical pathways are always being revised. (O'Brien, Tr. 3561-62).

**Response to Finding No. 2238:**

Respondent has no specific response, except to the use of "claims of quality improvements." This aspect of this proposed finding is misleading. Critical pathways were

absolutely a post-Merger quality improvement designed to improve patient outcomes made at HPH by ENH. (Chassin, Tr. 5257; RFF ¶ 1475).

2239.

**REDACTED**

(Romano, Tr. 3168, *in camera*).

**Response to Finding No. 2239:**

This proposed finding is misleading to the extent it asserts that care maps were comparable to critical pathways – they are not. As described in RFF-Reply ¶ 2240, HPH’s care maps were different in both design and purpose from ENH’s critical pathways. Further, after the Merger, ENH implemented 57 critical pathways at HPH. (Chassin, Tr. 5257-58; RX 869; RX 1775; RX 1776; RX 1683).

2240. There is no evidence that ENH’s critical pathways are better than the care maps used by Highland Park Hospital before the merger. (O’Brien, Tr. 3560-62).

**Response to Finding No. 2240:**

This proposed finding is false. **REDACTED**

(Chassin, Tr. 5255; RX 216, *in camera*). Those care maps lacked valid process measures of quality and did not result from a multidisciplinary process that included physicians and nurses developing a best approach to patient care. (Chassin, Tr. 5255-56; RFF ¶ 1467). The pre-Merger HPH care maps were very simplistic and deficient as a means of improving care. (RFF ¶¶ 1464, 1467).

Alternatively, critical pathways contain numerous process measures of quality designed to improve patient outcomes, and many best practices from other sources, to generate a proactive approach to quality improvement. (Chassin, Tr. 5257; RFF ¶ 1475). Critical pathways also contain information that was lacking in the HPH care maps, including a variance-tracking tool, a

physician ordering sheet, a documentation tool and an educational piece with options delineated for physicians. (RX 869; RFF ¶ 1480).

2241. Even before the merger, Highland Park improved upon its care maps and was creating new ones. (CX 95 at 3).

**Response to Finding No. 2241:**

This proposed finding is misleading. The evidence showed that HPH's care maps were simplistic and lacked valid process measures of care. (RFF ¶¶ 1464, 1467). The evidence further showed that, soon after the Merger, the number of critical pathways that ENH implemented at HPH exceeded 50. (Chassin, Tr. 5257-58; RX 869; RX 1775; RX 1776; RX 1683).

2242.

**REDACTED**

(Romano, Tr. 3168, *in camera*).

**Response to Finding No. 2242:**

This proposed finding is false. Pre-Merger HPH tracked length of stay, cost per case, global mortality and, sometimes, global rates of complication with respect to its care maps. In contrast, Evanston Hospital tracked similar data, but it also tracked valid process measures of quality, which is the best method to monitor improvement. (Chassin, Tr. 5258). Dr. Chassin did not compare the data on care maps and critical pathways pre- and post-Merger because length of stay and cost per case are not related to quality of care, so such a comparison would not have told him anything about changes in the quality of care at HPH after the Merger. (Chassin, Tr. 5258-59).

2243.

**REDACTED**

(Romano, Tr. 3169, *in camera*).

**Response to Finding No. 2243:**

This proposed finding is repetitive and false. (RFF-Reply ¶ 2242). Pre-Merger HPH tracked length of stay, cost per case, global mortality and, sometimes, global rates of complication with respect to its care maps. In contrast, Evanston Hospital tracked similar data, but it also tracked valid process measures of quality, which is the best method to monitor improvement. (Chassin, Tr. 5258). Dr. Chassin did not compare the data on care maps and critical pathways pre- and post-Merger because length of stay and cost per case are not related to quality of care, so such a comparison would not have told him anything about changes in the quality of care at HPH after the Merger. (Chassin, Tr. 5258-59).

2244.

**REDACTED**

(Romano, Tr. 3169, *in camera*).

**Response to Finding No. 2244:**

This proposed finding is irrelevant, repetitive and false. (RFF-Reply ¶ 2242-2243). Pre-Merger HPH tracked length of stay, cost per case, global mortality and, sometimes, global rates of complication with respect to its care maps. In contrast, Evanston Hospital tracked similar data, but it also tracked valid process measures of quality, which is the best method to monitor improvement. (Chassin, Tr. 5258). Dr. Chassin did not compare the data on care maps and critical pathways pre- and post-Merger because length of stay and cost per case are not related to quality of care, so such a comparison would not have told him anything about changes in the quality of care at HPH after the Merger. (Chassin, Tr. 5258-59).

2245.

Post-Merger

**REDACTED**

(Romano, Tr. 3170, *in camera*).

**Response to Finding No. 2245:**

This proposed finding is misleading.

**REDACTED**

(Romano, Tr. 3170, *in camera*). Further, the absence of evidence of an event does not allow one to conclude that an event did or did not happen.

2246. In practice, the reviews are mixed on what critical pathways can accomplish in obstetrics and gynecology. For example, a typical delivery pathway may not be helpful with a heterogeneous patient mix. Complicating factors in patients may delay the various steps of a pathway from being implemented. (Silver, Tr. 3839).

**Response to Finding No. 2246:**

Respondent has no specific response.

2247. Implementation of a majority of ENH critical pathways was not complete until August 2002, more than two years after the merger, with 14 of those 33 pathways not implemented until between October 2001 and August 2002. (RX 1357 at ENHE F42 021021).

**Response to Finding No. 2247:**

This proposed finding is misleading and not supported by the evidence. At the time of the Merger, Evanston Hospital had 57 multidisciplinary critical pathways. Evanston Hospital immediately formulated a detailed plan for rolling out the pathways in a way that would teach HPH its multidisciplinary model of QI, including a strategy for identifying interdisciplinary team members, educating staff and establishing a support system for implementation. (Chassin, Tr. 5257-58; RX 869; RX 1775; RX 1776; RX 1683; RFF ¶ 1477). The first of ENH's critical pathways were implemented at HPH as early as March 2000. (RX 889 at ENHL PK 16483).

Between January 2000 and October 2001, ENH implemented 15 new pathways and, by August 2002, ENH introduced a total of 33 new critical pathways to HPH. (RX 1357 at ENHE F42 21020-21; RFF ¶ 1478). As explained in more detail at RFF-Reply ¶ 2207, critical pathways require a significant amount of time to develop and implement.

2248. While HPH requested a site visit from ACOG before the merger to aid its quality improvement efforts in obstetrics and gynecology, ENH has not requested an ACOG site visit for HPH after the merger. (Krasner, Tr. 3752).

**Response to Finding No. 2248:**

This proposed finding is incomplete.

**REDACTED**

(Chassin, Tr. 5221; RX 324 at ENHL PK 29708, *in camera*; RX 208 at ENHL PK 17285; RFF ¶ 1252). HPH's Ob/Gyn leadership and department were unable to resolve internally the problems with the hospital's Ob/Gyn care, so HPH asked ACOG experts to come to HPH and help implement the appropriate standards of care. (Spaeth, Tr. 2114-15, 2249; RFF ¶ 1251).

**e. There Was No Significant Quality Improvement in Laboratory Medicine and Pathology Services Due to the Merger**

2249. There is no evidence that the quality of laboratory and pathology services at Highland Park Hospital improved because of the merger. (Victor, Tr. 3642-44).

**Response to Finding No. 2249:**

This proposed finding is inaccurate and ignores the record evidence. The record evidence showed that there were improvements in the Immediate Response or "Stat" Laboratory within HPH ("HPH Lab") to equipment, personnel, environmental controls, access to subspecialist pathologists, turn-around times for lab results, and policies and procedures, as a result of the Merger. (Chassin, Tr. 5350-53; RFF ¶¶ 1792, 1795-1796, 1827-1841, 1854-1862)

2250. Prior to the merger, Highland Park Hospital and Lake Forest Hospital operated a lab called Consolidated Medical Laboratories (“CML”) as a joint venture. (Victor, Tr. 3638-39). CML had a main lab located at Lake Bluff and an immediate response lab at each hospital. (Victor, Tr. 3639). After the merger, ENH converted the laboratory at Highland Park Hospital to a full-service lab. (Victor, Tr. 3640-41).

**Response to Finding No. 2250:**

Respondent has no specific response.

2251. An immediate response lab just does “stat” testing, which is testing that must be performed immediately. (Victor, Tr. 3639-40). For situations that are not urgent, a lab specimen can safely be sent off-site for testing. (Victor, Tr. 3640).

**Response to Finding No. 2251:**

Respondent has no specific response.

2252. Before the merger, there were two separate hospitals that each had an interest in the performance of Consolidated Medical Laboratories. (Victor, Tr. 3640).

**Response to Finding No. 2252:**

Respondent has no specific response.

2253. Prior to the time that ENH took over the management of the lab at Highland Park Hospital, Dr. Victor, the Chairman of the Clinical Pathology Department at ENH, had not been to Highland Park Hospital’s lab to assess its quality. (Victor, Tr. 3642).

**Response to Finding No. 2253:**

This proposed finding ignores record evidence. Dr. Victor testified that he had visited the HPH Lab before June 1, 2000. (Victor, Tr. 3601).

2254. Dr. Victor had no statistics to back up any claim that turnaround time at the lab at Highland Park Hospital was longer before June 1, 2000, that it was after that date. He also had no statistics to show to what extent there were mislabeled specimens at the Highland Park Hospital lab prior to June 1, 2000. Dr. Victor’s overall view of quality improvement at Highland Park Hospital’s lab after June 1, 2000, was not based upon any statistics or studies. (Victor, Tr. 3643-44).



**Response to Finding No. 2254:**

This proposed finding is false to the extent it alleges Dr. Victor's view was not based on any studies. Dr. Victor's view of post-Merger quality improvement at the HPH lab was informed by a study conducted under his direction at the time of the Merger of the services provided by the HPH lab. (O'Brien, Tr. 3507).

**f. There Was No Significant Quality Improvement in Oncology at Highland Park Hospital Due to the Merger**

2255.

**REDACTED**  
(Dragon, Tr. 4406; O'Brien, Tr. 3565, 3568-69; Romano, Tr. 3097-98, *in camera*).

**REDACTED**  
(Romano, Tr. 3097, *in camera*; Dragon, Tr. 4390-91).

**Response to Finding No. 2255:**

This proposed finding is false and misstates Dr. Leon Dragon's, the head of the Kellogg Cancer Care Center, testimony. Pre-merger HPH patients could not get the same services available post-Merger at the Kellogg Cancer Care Center.

**REDACTED**

(Romano, Tr. 3098, *in camera*). This centralization of services was not available at HPH pre-Merger. Dr. Dragon testified that he did not have patient satisfaction data or quality of life studies that compared the quality of life pre- and post-Merger. (Dragon, Tr. 4406). However, the absence of hard data indicating that quality of life improved does not mean one can conclude that quality of life did not improve. Instead, Dr. Dragon relied on his personal observations and his 27 years of experience in the oncology field. (Dragon, Tr. 4303, 4407). In the same vein, O'Brien was cross-examined as to whether patient outcomes changed at HPH pre-

and post-Merger; not as to whether these changes led to any improvements. (O'Brien, Tr. 3565, 3568-69).

2256. The Kellogg Cancer Care Center at Highland Park Hospital is an outpatient facility. (Dragon, Tr. 4405).

**REDACTED**

(Romano, Tr. 3097-98, *in camera*).

**REDACTED**

(Romano, Tr. 3097-98, *in camera*).

**REDACTED**

(Romano, Tr. 3097, *in camera*).

**Response to Finding No. 2256:**

This proposed finding is inaccurate, incomplete and misleading. The quality of care in HPH's oncology services absolutely improved with the extension of the Kellogg Cancer Care Center to HPH. (Chassin, Tr. 5369-70).

**REDACTED**

(Dragon, Tr. 4352; Romano, Tr. 3097, *in camera*).

**REDACTED**

(Romano, Tr. 3098, *in camera*;

Dragon, Tr. 4356).

2257.

**REDACTED**

(Romano, Tr. 3098, *in camera* ).

**Response to Finding No. 2257:**

This proposed finding is inaccurate and incomplete.

**REDACTED**

**REDACTED**

.} (Romano, Tr. 3103, *in*

*camera*). Notably, the Kellogg Cancer Care Center is an outpatient facility. (Dragon, Tr. 4405).

2258.

**REDACTED**

(Romano, Tr. 3097, *in camera*).

**Response to Finding No. 2258:**

This proposed finding is misleading and not supported by testimony. Before the Merger, all but one of the clinical trials were pulled from HPH. (Dragon, Tr. 4329-4332).

2259. Dr. Dragon is the medical director of the Kellogg Cancer Care Center at Highland Park Hospital, a position he has held since December 2002. (Dragon, Tr. 4306). Dr. Dragon was in private practice when he first became credentialed to practice at Highland Park Hospital in 1999. (Dragon, Tr. 4304).

**Response to Finding No. 2259:**

Respondent has no specific response.

2260. After Dr. Dragon became director of the Kellogg Cancer Care Center in December 2002, the Center moved into the office space that Dr. Dragon had been using for his private practice, which was located in the medical office building across the street from Highland Park Hospital. (Dragon, Tr. 4389). It was not until February 2005 that the Kellogg Cancer Care Center moved to its present location. (Dragon, Tr. 4390).

**Response to Finding No. 2260:**

This proposed finding is incomplete. The Kellogg Cancer Care Center was actually first brought on-site at HPH in June or July of 2000, when it occupied space on the second floor of the hospital. (Dragon, Tr. 4404).

2261. Dr. Dragon's patients, before the merger, could obtain complementary services such as counseling, dietary services, pharmacy services, and psycho-social services in the Highland Park area. These services are those that are predominantly used in conjunction with the provision of Dr. Dragon's services after the merger. (Dragon, Tr. 4390-91).

**Response to Finding No. 2261:**

This proposed finding misstates Dr. Dragon's testimony. The complementary services Complaint Counsel identified are predominantly used in conjunction with Dr. Dragon's provision of outpatient services. (Dragon, Tr. 4391).

2262. Patient outcome measures for oncology include survival rates, symptom management, and quality of life. ENH as an institution does not look at these measures on a regular basis. (Dragon, Tr. 4397-98). Dr. Dragon had no measurements beyond his own personal observations to compare quality of life before 2002 with quality of life after 2002. (Dragon, Tr. 4406).

**Response to Finding No. 2262:**

Respondent has no specific response.

2263. Mary O'Brien, President of Highland Park Hospital, did not know how bringing the Kellogg Cancer Care Center to Highland Park Hospital impacted patient outcomes for cancer care. (O'Brien, Tr. 3565). She was also unaware of what the patient outcomes for cancer care were at Highland Park Hospital before the merger. (O'Brien, Tr. 3568).

**Response to Finding No. 2263:**

This proposed finding is irrelevant. Drs. Dragon and Chassin both identified the specific areas in which patient care was improved in oncology through the introduction of the Kellogg Cancer Care Center at HPH, for example, by making available multidisciplinary academic oncology center that combines both medical oncology, radiation therapy and breast cancer centers. (Dragon, Tr. 4343-44; Neaman, Tr. 1352; Spaeth, Tr. 2276). Patients are cared for by a team consisting of the physician oncologist, nurse, pharmacist, psychologist, social worker, and nutritionist. (Chassin, Tr. 5369; RFF ¶¶ 1769-1770). Finally, the introduction of the Kellogg Cancer Care Center and subsequent implementation of state-of-the-art diagnostic and treatment equipment unquestionably improved patient care for oncology patients at HPH. (RFF ¶¶ 1785-1789).

g. **There Was No Significant Quality Improvement in Emergency Care at Highland Park Hospital Due to the Merger**

2264.

**REDACTED**

(Harris, Tr. 4283-84;

Romano, Tr. 3109-10, *in camera*).

**Response to Finding No. 2264:**

This proposed finding is misleading and inaccurate. Complaint Counsel, on cross-examination of Dr. Harris, simply inquired as to his knowledge of the existence of data or discussions with respect to several specific measures, which are addressed later in Complaint Counsel's findings. (Harris, Tr. 4283-84; CCF ¶ 2272).

**REDACTED**

(Romano, Tr. 3109-10, *in*

*camera*). One quarter of data is insufficient to draw conclusions as to patient satisfaction with emergency services. (Romano, Tr. 3364-65; Chassin, Tr. 5337).

2265.

**REDACTED**

(Romano, Tr. 3109-10, *in camera*). Highland Park Hospital already had a good emergency department before the merger. (Harris, Tr. 4264-67, 4271).

**Response to Finding No. 2265:**

The first sentence in this proposed finding is misleading and incomplete.

**REDACTED**

(Romano, Tr.

3109-10, *in camera*; Romano Tr. 3364-65; Chassin, Tr. 5337). More importantly, Dr. Romano testified that he was unable to determine whether changes in patient satisfaction with respect to the ED were significant. (Romano, Tr. 3364-65). And finally, over 80% of HPH's ED patients are outpatients. Yet, the Press Ganey data Dr. Romano examined only included *inpatient*

surveys. (Romano, Tr. 3365; Harris, Tr. 4213). Dr. Harris did not testify that pre-Merger HPH had a “good” ED. He testified that HPH made several improvements before the Merger. He did testify, however, as to the problems the pre-Merger HPH ED faced and the additional improvements that needed to be made. (RFF ¶¶ 1872-1877).

2266. Before the merger, quality in the Highland Park Hospital emergency department was monitored to make sure it was at a level the department felt was acceptable for its internal standards and any area-wide standards. (Harris, Tr. 4209).

**Response to Finding No. 2266:**

Respondent has no specific response.

2267. Prior to the merger, Highland Park Hospital had a formal QA/QI program which measured the quality of care offered at Highland Park Hospital’s emergency room. The emergency room had a variety of indicators to monitor performance. (Harris, Tr. 4264-65).

**Response to Finding No. 2267:**

This proposed finding is incomplete. In addition to using formal indicators to monitor QA/QI performance in the ED pre-Merger, physicians also relied on their personal observations. (Harris, Tr. 4265).

2268. One indicator of Highland Park Hospital’s emergency room pre-merger QI program was turn-around time, which is the time from when the patient comes into the door until the time the patient leaves, is transferred, or admitted. (Harris, Tr. 4266).

**Response to Finding No. 2268:**

Respondent has no specific response.

2269. Highland Park Hospital made improvements to the emergency room pre-merger. For example, around 1995 or 1996, the Highland Park Hospital emergency department instituted changes to expedite the treatment of patients with minor injuries and illness. This was the fast-track program. The fast-track program reduced the turn-around time for patients. (Harris, Tr. 4266). Implementing the fast-track program pre-merger and adding physician assistants to the emergency department in 1997 were significant improvements to the department. (Harris, Tr. 4267).

**Response to Finding No. 2269:**

This proposed finding is misleading to the extent it implies that the pre-Merger fast-track program was the same as the post-Merger program. Substantial improvements to the equipment, personnel, and physical space were made to the HPH fast-track program post-Merger. These improvements enhanced the quality of care in the ED. (Chassin, Tr. 5333-34; Harris, Tr. 4249-50).

2270. Highland Park Hospital implemented fast-track procedures prior to the merger partially as a result of survey responses received from Press Ganey. The Press Ganey survey was "one more piece of information" used to make decisions. (Harris, Tr. 4270). Prior to the merger, Highland Park Hospital also streamlined the X-ray procedure in the emergency department, also partially as a result of survey responses received from Press Ganey. (Harris, Tr. 4270-71.)

**Response to Finding No. 2270:**

Respondent has no specific response.

2271. Even before the merger, there were times when Highland Park Hospital would have more than one physician present in the emergency room. (Harris, Tr. 4277).

**Response to Finding No. 2271:**

This proposed finding is misleading, incomplete and mischaracterizes the trial testimony. Before the Merger, if there were two physicians present in the emergency room it was due to pure happenstance. For example, a physician could arrive early before his or her shift began. Two physicians were never scheduled to be in the emergency room at the same time. (Harris, Tr. 4230, 4277).

2272. Dr. Harris did not see or was not aware of any:

1. Studies that compared clinical outcomes of patients who used the Highland Park Hospital emergency room prior to the renovations with the clinical outcomes after the renovation. (Harris, Tr. 4283).

**Response to Finding No. 2272(1):**

This proposed finding is incomplete. Dr. Harris went on to state that there are not many outcome studies in emergency medicine to be used in making such comparisons. (Harris, Tr. 4283).

2. Data that compared Highland Park Hospital's emergency room pre-merger and post-merger turn-around times, the turn-around times of fast-track patients, or the amount of time it took a patient to get an EKG. (Harris, Tr. 4283-84).

**Response to Finding No. 2272(2):**

Respondent has no specific response.

3. Instance in which a patient transferred from Highland Park Hospital prior to the merger had a worse clinical outcome because of the transfer. (Harris, Tr. 4287-88).

**Response to Finding No. 2272(3):**

This proposed finding is incomplete, not supported by the testimony and mischaracterizes trial testimony. Dr. Harris was unaware of whether a patient transferred from HPH to another hospital prior to the Merger had a worse clinical outcome as a result of the Merger because he did not follow that patient to the next hospital. (Harris, Tr. 4288).

**h. There Was No Significant Quality Improvement in Intensive Care at Highland Park Hospital Due to the Merger**

2273. There is little evidence showing that the ENH's merger with Highland Park Hospital has improved the quality of intensive care at Highland Park Hospital. (Ankin, Tr. 5091-92).

**Response to Finding No. 2273:**

This proposed finding is false and ignores record evidence to the contrary. As a result of the Merger, the number of care paths at HPH increased. Available data indicated that patient outcomes improved as a result of the implementation of the intensivist program at HPH. Specifically, data show that mortality decreased. (Ankin, Tr. 5091-92; Chassin Tr., 5328;



O'Brien, Tr. 3528-29). Further, Dr. Romano conceded that the addition of intensivists at HPH was likely to improve patient outcomes, reduce mortality in the ICU and lead to improvements in quality of care. (RFF ¶ 1713).

2274. Dr. Ankin is the President of Pulmonary Physicians of the North Shore. (Ankin, Tr. 5033). Pulmonary Physicians of the North Shore is the physician group that contracted with ENH to provide intensivist coverage at Highland Park Hospital after the merger. (Ankin, Tr. 5103-04). Dr. Ankin considers himself to be an intensivist although he is not certified as one. (Ankin, Tr. 5038).

**Response to Finding No. 2274:**

Respondent has no specific response to the first two sentences in this proposed finding. The third sentence is misleading and incomplete. Dr. Ankin was board-certified in internal medicine and pulmonary medicine. (Ankin, Tr. 5033). Intensivists did not exist at the time of his graduation. If Dr. Ankin were to return today to Northwestern University, the medical school he attended, and take the same course of study and training program that he took back when he was a medical student, he would be board-certified today as a pulmonology and critical care specialist. (Ankin, Tr. 5038).

2275. An intensivist is a physician who focuses his practice on the care of critically ill or injured individuals. (Ankin, Tr. 5035).

**Response to Finding No. 2275:**

Respondent has no specific response.

2276. Prior to the merger, Highland Park Hospital had a physician at the hospital during nighttime and weekend hours who would evaluate patients in the ICU and talk to the attending physician. (Ankin, Tr. 5058).

**Response to Finding No. 2276:**

This proposed finding is incomplete. Before the Merger, HPH hired a fellow from the University of Chicago who was still in training. He was paid by the hospital to moonlight at

night and on the weekends. (Ankin, Tr. 5058). Prior to the Merger,

**REDACTED**

**(RFF ¶ 1679).**

2277. Dr. Ankin did not try to determine how much, if at all, mortality rates have improved for Highland Park Hospital since the intensivist program was implemented in 2001. (Ankin, Tr. 5091). In addition, Peggy King, a Senior Vice President at ENH and quality coordinator, did not approach Dr. Ankin about ascertaining how outcomes at Highland Park Hospital changed since the merger. (Ankin, Tr. 5091-92).

**Response to Finding No. 2277:**

Respondent has no specific response to the first statement. The evidence showed that Dr. Ankin was aware that intensivist programs have been shown to decrease mortality. (Ankin, Tr. 5039). The second statement is irrelevant.

**REDACTED**

**(RX**

1481 at ENHL PK 21124, *in camera*).

2278. ENH operated the Highland Park Hospital intensive care unit without intensivists from January 2000 until the spring of 2001. (Ankin, Tr. 5078-79). It also did not start an intensivist program at Glenbrook Hospital until the same time it implemented the program at Highland Park Hospital. (Ankin, Tr. 5085). ENH implemented the intensivist program only after it was recommended, in 2001, by a national organization. (RX 1097 at ENHL PK 016335). (See CCF 2393).

**Response to Finding No. 2278:**

Respondent has no specific response to the first sentence in this proposed finding. The second and third assertions are false and ignore record evidence. ENH implemented an intensivist program at Evanston and Glenbrook Hospitals in approximately 1995, well before the Leapfrog Group recommended such a program around 2001. (Ankin, Tr. 5040, 5083; RX 989 at ENHL MO 7123). In 2001, ENH extended the intensivist program to HPH. (Ankin, Tr. 5085; RX 1097 at ENHL PK 16335). The evidence thus clearly established that ENH implemented intensivist programs at both Evanston and Glenbrook Hospitals years before the Leapfrog

Group's recommendation in 2001, and at HPH soon after the Merger. (Ankin, Tr. 5040, 5083; RX 989 at ENHL MO 7123).

**i. There Was No Significant Quality Improvement in Pharmacy Services at Highland Park Hospital Due to the Merger**

2279.

**REDACTED**

(Kent, Tr. 4936; RX 1326 at ENHE JG 015738, *in camera*; CX 1034 at 10; Romano, Tr. 3181, *in camera*).

**Response to Finding No. 2279:**

This proposed finding is wholly unsupported by the evidence and is misleading. ENH directly improved pharmacy services and the quality of care of those services through the addition of 24-hour a day pharmacists, pharmacist participation in rounds, and the installation of Pyxis. (Chassin, Tr. 5355-56; RFF ¶¶ 1950-1953, 1992-1998). With respect to its drug distribution system, the evidence showed that ENH substantially decreased the time it took to administer the first dose of an antibiotic to inpatients from 170 minutes pre-Epic to 93 minutes post-Epic in June 2004. (RX 1750 ENHL SK 575).

In addition, the evidence established that medication error rates substantially declined at ENH as a whole between 2002 and 2004, following the implementation of Epic at the ENH hospitals. (RX 1750 at ENHL SK 577; RFF-Reply ¶ 2282). Finally, the evidence showed that ENH improved its compliance with the Institute of Safe Medication Practices ("ISMP") medication safety recommendations, most notably at HPH's pharmacy services. (Kent, Tr. 4876; RFF ¶ 1992-1998).

2280. Medication error rates are one of the things that ENH's pharmacy department looks at to evaluate its pharmacy services. (Kent, Tr. 4878-79).

**Response to Finding No. 2280:**

This proposed finding is misleading. ENH monitors medication error rates, but not always to evaluate specific services. (Kent, Tr. 4878-79).

2281.

**REDACTED**

(Romano, Tr. 3181, *in camera*; CX 1034 at 10).

**Response to Finding No. 2281:**

This proposed finding is misleading and incomplete. Medication error rates cannot be used as a determinant of outcome or quality or medication safety because the reported events only reflect a small number of the actual events that occur. (Kent, Tr. 4939). Instead, people are encouraged to report medication errors, which are used to identify trends in types of medication errors. So if there is an increase in the number of errors reported, that is a positive thing because it means that people are reporting more errors and the hospital is able to uncover problems. (Kent, Tr. 4929-40).

**REDACTED**

(Romano, Tr. 3181, *in camera*). Finally, the evidence established that medication error rates have substantially declined at ENH as a whole between 2002 and 2004, following the implementation of Epic at the ENH hospitals. (RX 1750 at ENHL SK 577; RFF-Reply ¶ 2282).  
2282.

**REDACTED**

(Kent, Tr. 4936, *in camera*; RX 1326 at ENHE JG 015738, *in camera*).

**Response to Finding No. 2282:**

The first sentence in this proposed finding is not supported by the evidence and is misleading to the extent it attempts to define medication events as the combination of medication

errors and adverse drug events, and to the extent it implies that ENH's performance index is only comprised of medication errors and adverse drug events. (Kent, Tr. 4936). The second sentence of this proposed finding is directly contradicted by the record evidence, which is that HPH's rate of medication events stayed substantially the same, not that they increased. (Kent, Tr. 4879-80). In addition, the record evidence is that ENH's rate of medication errors – including errors of omission, dose given at the wrong time, or to the wrong patient – all decreased from 2002 to 2004 after the first full year of Epic's implementation. (RX 1750 at ENHL SK 577). Significantly, the cited evidence, for RX 1326 at ENHE JG 15738, includes data only through the first quarter of 2002. (RX 1326 at ENHE JG 15738). The more up-to-date evidence established that the rates of medication errors have, in fact, decreased for ENH as a whole from 2002 to 2004. (RX 1750 at ENHL SK 577).

**j. There Was No Significant Quality Improvement in Psychiatric Care at Highland Park Hospital Due to the Merger**

2283.

**REDACTED**

(Romano, Tr. 3115-16, *in camera*).

**Response to Finding No. 2283:**

This proposed finding is false. ENH improved the quality of care in HPH's psychiatric services after the Merger through all of the changes it made, in particular through the rationalization of the patient populations, the ability to offer a wider variety of treatment options and programs, and the addition of a crisis management team. (Chassin, Tr. 5347; RFF ¶ 2186).

2284.

**REDACTED**

(Romano, Tr. 3115, *in camera*).

**Response to Finding No. 2284:**

Respondent has no specific response to the first assertion in this proposed finding. The second assertion is misleading. **REDACTED**

(Romano, Tr. 3115-16, *in camera*).

2285.

**REDACTED**  
(Romano, Tr. 3116-17, *in camera*).

**Response to Finding No. 2285:**

This proposed finding is misleading and inaccurate. One would not expect to see an improvement in patient satisfaction at Evanston Hospital as a result of the post-Merger segregation, significant or other, in the Press Ganey data Dr. Romano evaluated, because the data measured different services offered by different programs – the pre-Merger combined adult and adolescent unit compared to the completely separate adult and adolescent post-Merger units. (Chassin, Tr. 5349).

- k. **The Merger Did Not Significantly Improve the Quality of Care at Highland Park Hospital Because of the So-Called Clinical “Rationalization”**

2286.

**REDACTED**  
(Romano, Tr. 3174-76, *in camera*).

**Response to Finding No. 2286:**

This proposed finding is false. Before the Merger, several services at Evanston Hospital had reached the limit of that campus’ capacity. The rationalization of resources freed up

capacity by moving various services from Evanston Hospital to HPH, thus improving the quality of care at both campuses. (Neaman, Tr. 1323; Hillebrand, Tr. 1798; RFF ¶ 292).

For example, if patients needed to be relocated because of operating room overcrowding, the Merger created clinical efficiencies to address this situation. (RFF ¶ 293). Other clinical services, such as reproductive endocrinology and psychiatric services, also benefited from centralizing the resources of the multiple hospitals after the Merger. (Newton, Tr. 451-52; Chassin, Tr. 5339; RFF ¶ 2172). The Merger was expected to create potential synergies in clinical areas such as behavioral health, home health, skilled nursing and pediatrics. (RX 518 at ENH GW 2066; RFF ¶ 294).

2287.

**REDACTED**

(Romano, Tr. 3174, *in camera*).

**Response to Finding No. 2287:**

This proposed finding is misleading and not supported by the evidence. As more fully discussed in RFF-Reply ¶¶ 2081-2083,

**REDACTED**

(Rosengart, Tr. 4502-

05; RX 1411 at ENHL PK 51288, *in camera*; RFF ¶ 1623, 1643, *in camera*).

2288.

**REDACTED**

(Romano, Tr.

3174-75, *in camera*).

**Response to Finding No. 2288:**

This proposed finding is misleading and is not supported by the evidence. The evidence showed that the ENH cardiac surgery program functions as a single program with combined volumes that exceed 500 cases annually. (Rosengart, Tr. 4452-53; RFF ¶¶ 1598-1599; RFF-Reply ¶ 2083). The ENH surgeons perform cardiac surgery at multiple sites and, as a result, individual surgeon volume was increased by the Merger with the extension of cardiac surgery to the HPH campus. (Rosengart, Tr. 4460; RFF ¶¶ 1594, 1598-99). For example, Dr. Rosengart performed 100 cardiac surgeries at HPH last year and close to another 100 at Evanston Hospital. (Rosengart, Tr. 4460).

Finally, as is more fully discussed in RFF-Reply ¶¶ 2081-2083, the volume-outcome relationship is only true on average.

**REDACTED**

(Rosengart, Tr.

4502-05; RX 1411 at ENHL PK 51288, *in camera*; RFF ¶¶ 1623, 1643, *in camera*).

2289.

**REDACTED**

(Romano, Tr. 3176, *in camera*).

**Response to Finding No. 2289:**

This proposed finding is misleading and not supported by the cited evidence.

**REDACTED**

(Romano, Tr. 3176, *in camera*). For the reasons more fully discussed in RFF-Reply ¶ 2112, administrative data are flawed and lack sufficient clinical detail.



(Chassin, Tr. 5176-77; RFF ¶¶ 2225, 2229-2236). Thus, Dr. Romano's analysis of rationalization is unreliable.

**I. There Was No Significant Quality Improvement at Highland Park Hospital by Virtue of Academic Affiliation**

2290.

**REDACTED**

(Romano, Tr. 3124-25, *in camera*).

**Response to Finding No. 2290:**

This proposed finding is false. The quality of care improved at HPH post-Merger as a result of the upgrade in physician skills, the access to academic and teaching practices, and the integration and rotation of medical staffs. (Chassin, Tr. 5373-74, 5377; RFF ¶¶ 2148-2149).

2291.

**REDACTED**

(Romano, Tr. 3118, *in camera*).

**Response to Finding No. 2291:**

This proposed finding is false. For purposes of her pricing analysis Dr. Noether identified a group of Chicago-area academic hospitals using industry recognized criteria including: breadth of service, bed size and teaching intensity. (RFF ¶ 1066). Post-Merger, the ENH system, which included HPH, met all three of these criteria. (RX 1912 at 60). In addition, when HPH joined ENH, it enjoyed the benefits of ENH's affiliation with Northwestern University Medical School. (O'Brien, Tr. 3542).

2292.

**REDACTED**

(Romano, Tr. 3124, *in camera*).

**Response to Finding No. 2292:**

This proposed finding is not supported by the evidence and is misleading. The evidence showed that after the Merger, a number of HPH physicians became meaningfully involved in teaching activities at Evanston Hospital. (O'Brien, Tr. 3539; RFF ¶¶ 2163-2164). These academic instructors rotate between Evanston Hospital, Glenbrook Hospital and HPH. (O'Brien, Tr. 3541). For example, pathologists at HPH are responsible for teaching residents at Evanston Hospital. (Victor, Tr. 3589-90). Pathologists at HPH also give didactic lectures – lectures that are focused on a specific topic – to the residents at Evanston Hospital. (Victor, Tr. 3589-90). Since ENH brought its family medicine program to HPH after the Merger, the HPH family medicine program has included residents from Northwestern University. (O'Brien, Tr. 3539; Chassin, Tr. 5380). The participation of these residents in formal academic programs in family medicine at HPH is a quality improvement. (Chassin, Tr. 5380). In addition to traditional teaching opportunities, ENH physicians are now able to participate in grand rounds, which involve the bedside teaching of residents, that are run at Evanston Hospital. (Harris, Tr. 4253). For example, there are grand rounds for all physicians every Thursday in the Department of Ob/Gyn. (Silver, Tr. 3767).

The upgrade in physician skills and the access to academic practice are structural changes that improved the quality of the HPH staff. (Chassin, Tr. 5377). As a result of the integration of the medical staffs and the academic focus that ENH brought to HPH, the quality of care improved at HPH. (Chassin, Tr. 5373).

2293.

.....  
(*in camera*).

**REDACTED**

(Romano, Tr. 3118,

; (Romano, Tr. 3124, *in camera*).

**REDACTED**

**Response to Finding No. 2293:**

This proposed finding is duplicative of CCFE ¶ 2103. Further, this proposed finding is misleading and not supported by the evidence. As more fully discussed in RFF-Reply ¶ 2103, Respondent set forth substantial evidence of the benefits of improved access to academic activities involving residents and medical students at Evanston Hospital and how, for example, the integration of the clinical staffs provided HPH physicians the opportunity to upgrade their skills by becoming part of an academic enterprise that challenged them to teach residents, participate in more educational conferences, and keep up with the latest developments in healthcare. (Chassin, Tr. 5373-74; Silver, Tr. 3818). The evidence showed that HPH physicians from, for example, Ob/Gyn; pathology, radiology, emergency medicine, cardiology, cardiac surgery and anesthesiology, rotate through all three campuses. (Silver, Tr. 3765-66, 3819; RFF ¶ 2150). The upgrade in physician skills and the access to academic practice are structural changes that improved the quality of the HPH staff. (Chassin, Tr. 5377). As a result of the integration of the medical staffs and the academic focus that ENH brought to HPH, the quality of care improved at HPH. (Chassin, Tr. 5373-74).

**C. The Quality Changes Are Not Merger Specific Because Highland Park, on Its Own Or with Others, Could Have Achieved the Same Quality Changes**

2294. The quality changes are not merger specific because Highland Park Hospital could have achieved the same quality changes on its own or through another affiliation. (CX 92 at 3, 12, 20; CX 541 at 1; CX 545 at 3; CX 98 at 1-2).

**Response to Finding No. 2193:**

This proposed finding is false. Before the Merger, HPH did not have the plans or the capacity to implement the quality changes that occurred after the Merger. Nor could HPH have achieved these improvements through a joint venture. (Chassin, Tr. 5390-93; RFF ¶ 2448). For example, a cardiac surgery program run through an affiliation or joint venture would have been

of significantly lesser quality, similar to those programs operating today at Weiss Hospital or Swedish Covenant Hospital. (Chassin, Tr. 5392-93; RFF ¶ 2460). Further, HPH lacked the financial capacity to make such changes before the Merger. (Neaman, Tr. 1353; RFF ¶ 2452).

**1. Highland Park Hospital Was Already a Good Hospital Before the Merger**

2295. Highland Park Hospital was already a good hospital before the merger that, pre-merger, added new clinical services and made improvements. (Newton, Tr. 292, 293, 376, 377, 388; CX 2415 at 2-9; CX 1052 at 4-5; CX 98 at 2; CX 96 at 1; Spaeth, Tr. 2102-05, 2110-11, 2113-17, 2120-22; Ballengee, Tr. 185). Prior to the merger, both Highland Park Hospital and Evanston Hospital were pretty good hospitals. (Ballengee, Tr. 160).

**Response to Finding No. 2295:**

This proposed finding is inaccurate and misleading. HPH was a good *community* hospital before the Merger, and nothing more. According to Spaeth the hospital tried to add new clinical services and make improvements, but these efforts proved to be largely useless. (Spaeth, Tr. 2245-46, 2285-86).

**REDACTED**

(Newton, Tr. 471; Newton

Tr, 512-13, *in camera*; Spaeth, Tr. 2282-83; RFF-Reply ¶ 2216). This proposed finding is further misleading because it attempts to equate pre-Merger Evanston Hospital with pre-Merger HPH. But there is no possible comparison between Evanston Hospital, a tertiary academic hospital and HPH, a struggling community hospital. (RFF ¶¶ 30-49).

2296. Mr. Newton stated that even before the merger Highland Park Hospital wanted to be recognized by the consuming public as maintaining a high level of quality due to the pressure to be included in health plan networks. (Newton, Tr. 303-05). If a hospital had a “poor image of quality” among enrollees, that perception would be transmitted back to the health plans. (Newton, Tr. 304-05).

**Response to Finding No. 2296:**

This proposed finding is irrelevant. HPH’s pre-Merger goals have no bearing on the issues presented in this case. The evidence showed that HPH had serious quality and financial

problems that were overcome as a result of the Merger. (RFF ¶¶ 272-294, 1226-27). Further, Newton did not oversee or have any responsibility for the quality of clinical services at HPH. (RFF-Reply ¶ 2216).

2297. JCAHO is the Joint Commission for the Accreditation of Healthcare Organizations, which is the entity responsible for accrediting hospitals and certain other types of healthcare organizations in the U.S. (Romano, Tr. 2969).

**Response to Finding No. 2297:**

Respondent has no specific response.

2298. Quality at Highland Park Hospital from 1977 to 1985 (Ms. Ballengee's time at the hospital) was good. (Ballengee, Tr. 185-86). Highland Park Hospital did very well with its JCAHO evaluations from 1977 to 1985. During this time period, the hospital never failed to pass JCAHO standards. (Ballengee, Tr. 151-52).

**Response to Finding No. 2298:**

This proposed finding is irrelevant; it discusses quality at HPH 20 years ago.

2299. The quality of care at Highland Park Hospital up until the year 2000 was "very good, if not excellent." (Newton, Tr. 376). The hospital was well-respected in the community and considered by many to be one of the "finest community hospitals in the country." (Newton, Tr. 301; *see also* Spaeth, Tr. 2095). There was never a time between 1988 and 2000 (Mr. Newton's time at the hospital) when Highland Park Hospital did not have JCAHO accreditation. (Newton, Tr. 386).

**Response to Finding No. 2299:**

This proposed finding is false. Before the Merger, the quality of care at HPH was certainly not excellent, much less good.

**REDACTED**

(Chassin 5138, 5191-92, 5196, 5210-11;

Spaeth, Tr. 2249; Silver, Tr. 3782; RX 324 at ENHL PK 29708-11, *in camera*; RX 417 at ENHL PK 17695; RFF ¶¶ 1226, 1416; RFF ¶ 1249, *in camera*). Moreover, Newton did not oversee or have any responsibility for the quality of clinical services at HPH. (Reply-RFF ¶ 2216).

2300. In its accreditation process, JCAHO looks at about 1200 very specific aspects of hospital activities that are called elements of performance. (Chassin, Tr. 5156-57). Roughly 75% of JCAHO's elements of performance are structural in nature, and the remaining 25% are process measures. (Chassin, Tr. 5157).

**Response to Finding No. 2300:**

Respondent has no specific response.

2301. In 1999, Highland Park Hospital received a preliminary JCAHO accreditation score of 95, an exceptional outcome. (Neaman, Tr. 1198; Newton, Tr. 388; Spaeth, Tr. 2122; CX 96 at 1; CX 2304 at 3). Neele Stearns, the Chairman of the Board of Highland Park Hospital, also characterized the 95 score as exceptional in his report to the Highland Park Hospital Board. (CX 96 at 1; Spaeth, Tr. 2149).

**Response to Finding No. 2301:**

This proposed finding is misleading and ignores record evidence. A score of 95 is not an exceptional outcome. It is quite common for hospitals to receive JCAHO scores around 95. For instance, in 1999, Chicago Hospitals generally received JCAHO scores in the mid-90s. (Spaeth, Tr. 2122, 2148-49; Chassin, Tr. 5158; RFF ¶ 1521). In fact, in part as a result of the frequency of scores in the mid-90s, JCAHO revised its accreditation process by eliminating the scheduling of visits in advance. (Chassin, Tr. 5158).

2302.

**REDACTED**

(RX 412 at ENHL PK 017794, *in camera*)

**Response to Finding No. 2302:**

Respondent has no specific response.

2303. ENH received a preliminary score of 94 on the JCAHO preliminary report for its 1999 survey. (Neaman, Tr. 1231; CX 871 at 4). ENH's final JCAHO score as of February 2000 was 95. (Neaman, Tr. 1198; CX 6 at 5). ENH's CEO, Mark Neaman, considers a JCAHO score of 95 to be exceptional. (Neaman, Tr. 1198).

**Response to Finding No. 2303:**

Respondent has no specific response to the first two sentences in this proposed finding.

The last sentence in this proposed finding is irrelevant and incomplete. Neaman also testified

that, while a hospital could achieve a score of 95, there could still be contingencies or other major concerns that JCAHO had with a hospital that would not be reflected in such a score.

(Neaman, Tr. 1198-99; RFF-Reply ¶ 2301).

2304. ENH considers the four most significant entities that measure quality of care at hospitals to be JCAHO, Medicare, Press Ganey, and Leapfrog. (Neaman, Tr. 1226). Among these four, ENH places most significance on the JCAHO analysis. (Neaman, Tr. 1227).

**Response to Finding No. 2304:**

This proposed finding mischaracterizes the cited testimony. Significance is placed on JCAHO because accreditation is a hospital requirement, not because it is a quality measure in and of itself. (Neaman, Tr. 1226-27).

2305. Most hospitals in the country use JCAHO scores to look at quality of care. (Spaeth, Tr. 2154).

**Response to Finding No. 2305:**

This proposed finding is irrelevant. Joint Commission accreditation is a necessary requirement for getting Medicare payments. (Neaman, Tr. 1367; Spaeth, Tr. 2154; RX 545 at ENH JH 11578). Joint Commission accreditation is a minimum standard. (Holt-Darcy, Tr. 1421). Additionally, some MCOs have followed the government and require Joint Commission accreditation before doing business with a provider. (Neaman, Tr. 1367; Spaeth, Tr. 2154).

2306. In 1996, before the merger, Highland Park Hospital scored a 93 out of 100 on a JCAHO survey. (RX 178 at ENHL PK 015620)

**Response to Finding No. 2306:**

Respondent has no specific response.

2307. The community of Highland Park and the other communities surrounding Highland Park Hospital respected the hospital and saw value in the hospital. (Neaman, Tr. 1228-29; CX 874 at 5 (February 23, 1999, Evanston board meeting minutes reflecting that “Highland Park is a strong community hospital”)).

**Response to Finding No. 2307:**

This proposed finding mischaracterizes the cited testimony. Neaman *believed* that people in the HPH community respected HPH and saw value in it. (Neaman, Tr. 1228-29). In any event, ENH's pre-Merger due diligence revealed that the perception that HPH was a "strong community hospital" was not accurate. (CX 6304 at 4-5 (Livingston, Dep.)).

2308. Highland Park Hospital was recognized by patients before the merger as rendering more sophisticated medical care than the average community hospital. (Spaeth, Tr. 2095). Many people before the merger viewed Highland Park Hospital as a high quality institution rendering high quality care. (Spaeth, Tr. 2098).

**Response to Finding No. 2308:**

This proposed finding is directly contradicted by testimony. Before the Merger, the HPH community did not view HPH as a high quality community hospital. Instead, many members of the HPH community went to Northwestern Memorial, the University of Chicago, Loyola, Rush University Medical Center, or the Mayo Clinic because HPH could not satisfy their health care needs. Further, HPH physicians would refer their patients away from HPH for a number of healthcare services. (Spaeth, Tr. 2246; RFF ¶ 43).

2309. Ronald Spaeth is employed by ENH as the President of the Evanston Northwestern Healthcare Foundation. He formerly served as the Chief Executive Officer of Highland Park Hospital from 1983 up to and including the time of the merger. (Spaeth, Tr. 2235-36). Mr. Spaeth agrees that Highland Park Hospital "was a good community hospital" before the merger (Spaeth, Tr. 2095).

**Response to Finding No. 2309:**

Respondent has no specific response.

2310. Other clinical administrators employed by or affiliated with ENH also agree that Highland Park Hospital was a good hospital before the merger. For example, Dr. Dragon, Medical Director of the Kellogg Cancer Care Center at Highland Park Hospital, agrees that Highland Park Hospital was a "good quality community institution" before the merger. (Dragon, Tr. 4402-03). Similarly, Dr. Ankin, who provides the intensivist coverage at Highland Park Hospital through his group, Pulmonary Physicians of the



North Shore, agrees that before the merger, Highland Park Hospital was a good hospital. (Ankin, Tr. 5087-88).

**Response to Finding No. 2310:**

Respondent has no specific response.

2311. Prior to the merger, Highland Park Hospital sought to recruit the best physicians, to render the most effective experience for a patient, to have the best outcomes for its patients, and to have the highest quality at the hospital. (Spaeth, Tr. 2089).

**Response to Finding No. 2311:**

This proposed finding is incomplete and inaccurate. Prior to the Merger, HPH was able to recruit a single physician from a university setting, Dr. Dragon, and was only able to recruit and hire a few primary care physicians and one or two radiologists and oncologists. (RFF ¶ 2171). Prior to the Merger, HPH could not recruit subspecialty physicians to the hospital. (RFF ¶ 2170).

2312. Both Mark Neaman and Ronald Spaeth agree that prior to the merger, Highland Park Hospital had good doctors on staff. (Neaman, Tr. 1228; Spaeth, Tr. 2239). One of the things that attracted ENH to Highland Park before the merger was that the doctors had very strong and positive relationships with the community. (Neaman, Tr. 1228-29).

**Response to Finding No. 2312:**

This proposed finding is incomplete.

**REDACTED**

(RFF ¶¶ 1425-1427, 1450-1456, *in camera*).

2313. The medical staff at Highland Park Hospital before the merger was an excellent medical staff, consisting of a very good group of primary care physicians and a very excellent group of specialists, including medical oncologists. (Dragon, Tr. 4315).

**Response to Finding No. 2313:**

This proposed finding is misleading. (RFF-Reply ¶ 2312). Pre-Merger HPH lacked specialist coverage in oncology, pathology and radiation/radiology medicine. (Dragon, Tr. 4315-17; Chassin, Tr. 5352, 5362; RFF ¶¶ 1723, 1815, 2142; RFF-Reply ¶ 2314).

2314. Approximately 85% to 90% of the physicians on staff at Highland Park Hospital prior to the merger were board certified in their area of medical specialty. (Newton, Tr. 377). The hospital had a quality medical staff with significant coverage over a range of about 45 specialties. (Newton, Tr. 320).

**Response to Finding No. 2314:**

This proposed finding is inaccurate to the extent it states HPH had significant specialist coverage. There were significant holes in pre-Merger HPH's specialist coverage, including a lack of oncology, pathology and radiation/radiology specialists. (Dragon, Tr. 4315-17; Chassin, Tr. 5352, 5362; RFF ¶¶ 1723, 1815, 2142).

2315. Before the merger, the Highland Park Hospital medical staff would elect a chairman of each department, and the staff as a whole would elect a medical staff leader on an annual basis, although some terms were for two years. (Spaeth, Tr. 2250-51).

**Response to Finding No. 2315:**

Respondent has no specific response.

2316. The physicians elected to leadership roles at Highland Park Hospital before the merger were not employed by the hospital, but were voluntary physicians on the medical staff. (Spaeth, Tr. 2251). Prior to the merger, Highland Park Hospital paid a stipend to its clinical department chairmen. (Spaeth, Tr. 2080). The role of the department chairmen was revised, and they became salaried by Highland Park Hospital effective in 1999. (CX 95 at 3; CX 98 at 5; CX 99 at 3).

**Response to Finding No. 2316:**

Respondent has no specific response to the first sentence of this proposed finding. The remaining sentences are not supported by the evidence. As of February 1999, there is no evidence that HPH's department heads were, in fact paid. (CX 95 at 3; CX 98 at 5; CX 99 at 3).

**REDACTED**

(RX 324 at ENHL PK 29708, *in camera*).

2317. Highland Park Hospital had a high quality nursing staff in the 1990s. It was not dysfunctional. (Newton, Tr. 383). The hospital also had an outstanding group of nurses who were oncology nursing certified to provide chemotherapy. (Dragon, Tr. 4403).



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**Response to Finding No. 2317:**

This proposed finding is unsupported by the evidence and is misleading. The evidence showed that HPH had a poor quality nursing staff pre-Merger.

**REDACTED**

(Chassin, Tr. 5197, 5232, 5235; RFF ¶¶ 1257-1259, *in camera*; RFF ¶¶ 1344-1348, 2456; RX 324, *in camera*; RX 925 at ENHL PK 51687). These problems were evident in a number of hospital departments, in particular, in Ob/Gyn.

2318. In 1997, Highland Park Hospital received the Lincoln Award, which is given for quality improvement. The award required a site visit to the hospital. (Spaeth, Tr. 2103-04; CX 2415 at 4). Highland Park Hospital was one of only five hospitals in Illinois to receive the Lincoln Award and the hospital planned to seek even higher levels of recognition within the program. (CX 2415 at 4; CX 2056 at 3; Spaeth, Tr. 2103).

**Response to Finding No. 2318:**

This proposed finding is incomplete and misleading. The Lincoln Award has different levels – gold, silver and bronze. Gold indicates a hospital has met all of the criteria, silver indicates a hospital has made significant progress, and bronze recognizes a hospital that has just begun the process of implementing steps to meet the criteria. O'Brien, a former examiner for the Lincoln Award, did not consider HPH's 1997 receipt of the Lincoln award a "win" because HPH only received the bronze level, which did not even require a site visit. (O'Brien, Tr. 3542-43).

2319. Although Highland Park Hospital received a deficiency letter from the Department of Health and Human Services in 1999, the deficiencies referred to the hospital's physical facilities, not to the quality of the medical staff or to the hospital's patient outcomes. (Hillebrand, Tr. 1775). Highland Park Hospital began correcting the facility deficiencies noted by the Department of Health and Human Services before the merger. (Spaeth, Tr. 2229; CX 1720 at 306). The total cost of repairing the deficiencies was approximately \$922,000. (RX 1379 at ENH JG 011545. *See also* CX 1720 at 12 (\$750,000 and \$1,000,000)).

**Response to Finding No. 2319:**

Respondent has no specific response to the first two sentences of this proposed finding. But the final sentence, which purports to address the total cost of repairing the deficiencies, is inaccurate. ENH and HPH each spent roughly \$1 million to correct the deficiencies identified in the Illinois Department of Public Health (“IDPH”) letter. (Hillebrand, Tr. 1771; RFF ¶ 1535). Further, ENH learned that it would cost an additional \$14.77 million to correct critical and priority upgrades to the physical plant at HPH that were identified in a 1999 due diligence architectural survey. (Chassin, Tr. 5285-87; Neaman, Tr. 1336; RFF ¶¶ 1514, 1540-41; RX 635 at ENH JH 4002, 4013, 4016).

2320. Health plans considered Highland Park Hospital to have good quality before the merger.

(Mendonsa, Tr. 529, *in camera*). PHCS considered Highland Park to be a good hospital before the merger. (Ballengee, Tr. 166). Highland Park Hospital also met the quality requirements of One Health prior to the merger. (Neary, Tr. 625).

**Response to Finding No. 2320:**

This proposed finding is not supported by the cited evidence. First, the witnesses relied upon in this proposed finding do not have any reliable clinical expertise. (Neary, Tr. 630; Mendonsa, Tr. 475-78). Ballengee has not evaluated the quality of hospitals in over 20 years. (Ballengee, Tr. 149-50). At trial, Ballengee demonstrated that she was not aware of the current services offered by HPH. (Ballengee, Tr. 201-03).

**REDACTED**

(Mendonsa, Tr. 529, *in camera*).

(Mendonsa, Tr. 538, *in camera* (‘

**REDACTED**

’).

The testimony of Ballengee relied upon by Complaint Counsel simply does not support the proposition for which it is cited. Ballengee did not characterize HPH as a “good hospital.” (Ballengee, Tr. 166). This proposed finding is misleading with respect to One Health. The only requirement One Health maintained for its hospitals was mere licensure by Medicare and the State of Illinois. (Neary, Tr. 625). Both of these measures are bare minimum standards. (RFF ¶ 1519).

**REDACTED**

(RFF ¶¶

1519-1533; RFF ¶ 1534, *in camera*).

2321. In 1996, before the merger Highland Park Hospital received a positive review from the Chicago Hospital Risk Pooling Program (CHRPP) in CHRPP’s risk management program. (RX 147 at ENHL PK 015803) At that time, Highland Park Hospital also experienced positive outcomes in hip injury patients. (RX 147 at ENHL PK 015804). In 1996, Highland Park Hospital also reached the “99<sup>th</sup> percentile” in measurements of inpatient satisfaction. (RX 147 at ENHL PK 015805).

**Response to Finding No. 2321:**

This proposed finding is false and misleading. First, the cited evidence does not actually identify what clinical area of HPH CHRPP reviewed in 1996. (RX 147 at ENHL PK 015803).

**REDACTED**

(CX 6265 ENHL PK 2975, *in*

*camera*). The only support Complaint Counsel cites for its hip injury assertion is one phrase in the February 15, 1996 meeting minutes of HPH, which seems to indicate that the Total Hip improvement team had a “positive impact on complications.” (RX 147 at ENHL 15804).

**REDACTED**

(Romano, Tr. 3235, *in camera*; RFF-

Reply ¶ 2165).

With respect to this proposed finding that HPH reached the 99th percentile in measurements of inpatient satisfaction, the cited minutes do not even identify what instrument was used to measure such patient satisfaction. Accordingly, this proposed finding is unreliable. In any event, HPH only reached that percentile in January and December. (RX 147 at ENHL PK 15805). In addition, Complaint Counsel cite no independent or objective data to corroborate this information.

Finally, CHRPP was an attempt by a malpractice carrier to look at particular areas with respect to malpractice risk. It is an insurance review and should not be seen as carrying the weight of ACOG, the preeminent body in the field. The CHRPP review is not done by physicians. (Chassin, Tr. 5193-94; RFF ¶ 1266).

2322.

**REDACTED**  
at ENHL PK 017847, *in camera*).

(RX 413

**Response to Finding No. 2322:**

This proposed finding is misleading and mischaracterizes the evidence.

**REDACTED**

(RX 413 at ENHL PK 17846, *in camera*).

2323. At the time of the merger, Mr. Stearns believed that HPH was an attractive candidate for other hospitals for acquisition or purchase or merger. (CX 6305 at 12 (Stearns Dep.)).

**Response to Finding No. 2323:**

This proposed finding is misleading because it fails to explain that pre-Merger HPH suffered from numerous financial and quality problems and because it fails to explain the lengthy



search process pre-Merger HPH went through to find an appropriate merger partner before Evanston Hospital emerged as the only viable candidate. (RFF-Reply ¶¶ 369-372).

**a. Highland Park Hospital Offered Leading Edge and Innovative Clinical Programs Before the Merger**

2324. Highland Park Hospital offered leading edge and innovative clinical programs before the merger. (Newton, Tr. 291-92, 339, 415; Dragon, Tr. 4403, 4399; CX 1863 at 10; CX 2415 at 2-4; CX 1052 at 4-5; CX 98 at 2. See CX 413 at 7 (“HPH has over the last several years brought leading edge and innovative clinical services to residents of Lake County.”)).

**Response to Finding No. 2324:**

This proposed finding is false. The evidence cited by Complaint Counsel in CX 413 is in a section entitled “Community Perception.” Pre-Merger HPH provided clinical programs in keeping with its status as a community hospital; there was nothing particularly innovative about such services. HPH was a good *community* hospital before the Merger, and nothing more. According to Spaeth, the hospital tried to add new clinical services and make improvements, but these efforts proved to be largely useless. (Spaeth, Tr. 2245-46, 2285-86, 2312; RFF-Reply ¶ 2295).

2325.

**REDACTED**

(Romano, Tr. 3172, *in camera*).

**Response to Finding No. 2325:**

This proposed finding is misleading and not supported by the evidence.

**REDACTED**

(RFF ¶ 1446, *in camera*). In addition, the evidence showed that patients at HPH after the Merger have much improved access to new, high-quality services including, for example, cardiac surgery and interventional cardiology. (Chassin, Tr. 5289, 5307-08; RFF ¶¶

1565, 1661-1664; RFF-Reply ¶ 2087). Dr. Romano conceded that the opening of the cardiac surgery program at HPH improved quality of care because, for example, it improved access to CABG procedures to residents of Lake County and reduced geographic disparities within the Chicago Metropolitan Statistical Area. (Romano, Tr. 3275; RFF ¶ 1566). Thus, Dr. Romano's testimony stands as an admission that patients at HPH have improved access to a new domain of care after the Merger.

2326. From the early 1990s up until the time of the merger, Highland Park Hospital created "Centers of Excellence" by which it would focus on certain clinical functions for which Highland Park Hospital would be particularly distinguished. (Newton, Tr. 291-92). Highland Park Hospital created Centers of Excellence in oncology, reproductive endocrinology, breast cancer, and women's health. (Newton, Tr. 292).

**Response to Finding No. 2326:**

This proposed finding is false. Pre-merger HPH did establish centers, but not Centers of Excellence. (Spaeth, Tr. 2286). This proposed finding relies solely on Newton, who did not offer credible testimony. (RFF-Reply ¶ 2216).

2327. Before the merger, Highland Park Hospital offered particularly strong services in reproductive endocrinology and the Breast Center, which was a multi-disciplinary program in breast cancer. (Newton, Tr. 377). Before the merger, patients at risk for breast disease were followed by a cancer specialist at Highland Park Hospital's Breast Center, which still exists today at Highland Park Hospital. (O'Brien, Tr. 3568; CX 98 at 2).

**Response to Finding No. 2327:**

Respondent has no specific response.

2328. Prior to the merger in 1998, Highland Park Hospital offered women considered at risk for breast cancer the opportunity to participate in a national clinical cancer trial called STAR (Study of Tamoxifen and Raloxifene). (Spaeth, Tr. 2086; CX 699 at 5-6).

**Response to Finding No. 2328:**

This proposed finding is misleading. HPH's pre-Merger oncology program consisted of a handful of oncologists providing primary oncological care who participated in very little cancer

research and no academic research. (Spaeth, Tr. 2294). Nor did HPH's physicians participate in Northwestern Memorial's research protocols pre-Merger. (Spaeth, Tr. 2311; RFF ¶¶ 1750-1789).

2329. The women's health program included of education, creation of new facilities, recruitment of physicians, and the expansion of clinical services. The program also involved creation of one of the first concepts approved by the State of Illinois for single-room maternity care. (Newton, Tr. 292-93). The concept called for labor, delivery, recovery, and post-partum ("LDRP") activities to take place within one room. (Newton, Tr. 293; Spaeth 2115-16). The LDRP unit was one of Highland Park Hospital's pre-merger innovations in the women's health program. (Newton, Tr. 293).

**Response to Finding No. 2329:**

This proposed finding is misleading and irrelevant because, by the time the Merger was consummated, HPH suffered from significant problems in its Ob/Gyn department. (RFF ¶¶ 1223-1292). Labor, Delivery, Recovery and Postpartum ("LDRP") was a marketing tool and did not affect the quality of care at HPH. The use of LDRP did not increase birth volume at HPH. (Krasner, Tr. 3699-700; RFF ¶ 1238).

2330. Before the merger, Highland Park Hospital had recruited one of the only 400 physicians in the country with special qualifications in reproductive endocrinology. As a result, Highland Park Hospital's fertility center was one of the top ten fertility programs in the country, as measured by clinical pregnancy rates. (Newton, Tr. 376-77; CX 2415 at 3 ("one of the premiere IVF programs in the Midwest")).

**Response to Finding No. 2330:**

This proposed finding is misleading. In general, HPH had difficulty recruiting physicians because its community hospital environment did not offer academic and research opportunities and did not offer a high complexity of cases. (Spaeth, Tr. 2247).

2331. In the late 1990s, Highland Park Hospital had a "very good" obstetrics program. The hospital had a unique, renovated OB department and a comprehensive obstetrics program. Highland Park also had relationships with a perinatal network and advanced pediatric coverage. (Newton, Tr. 389). Dr. Silver, Chairman of ENH's OB/GYN Department, agrees that prior to the merger, there were a number of good physicians in the Highland Park Hospital OB department. (Silver, Tr. 3831).

**Response to Finding No. 2331:**

This proposed finding is false, misleading and unsupported by the weight of the evidence. HPH's Ob/Gyn services suffered from serious quality problems pre-Merger, including inadequate coverage by obstetricians on labor and delivery, lack of effective obstetrical leadership, inadequate nursing skills and lack of nursing accountability, very poor physician-nurse teamwork, inappropriate gynecologic surgery and a very weak QA program. (Chassin, Tr. 5191, 5196; Spaeth, Tr. 2249; Silver, Tr. 3782; RFF ¶¶ 1233, 1249). Ob/Gyn was a particular concern because about one third of all HPH admissions pre-Merger were women about to deliver a baby. (Chassin, Tr. 5196; RFF ¶ 1250). As explained previously, the perinatal program was a state requirement. (RFF-Reply ¶ 2194).

2332. Before the merger, Highland Park Hospital had a relationship with Children's Memorial Hospital in which Children's provided 24-hour advanced pediatric care through its neonatologists on-site at Highland Park. (Newton, Tr. 339, 415; Spaeth, Tr. 2123; CX 699 at 6).

**Response to Finding No. 2332:**

This proposed finding is misleading. Children's Memorial Hospital's subspecialists infrequently performed surgery at HPH because they preferred to operate at Children's Memorial Hospital. (Spaeth, Tr. 2090-2291).

**REDACTED**

(RX 988; RX 989, *in camera*).

2333. The Intensive Care Unit at Highland Park Hospital in the late 1990s was a modern unit that was managed by independent physicians, with no problems with nurse staffing. (Newton, Tr. 393). Prior to the merger, Highland Park Hospital had physicians providing 24-hour critical care who had board certification in critical care, internal medicine, and pulmonology. (Newton, Tr. 394; Spaeth, Tr. 2117). Highland Park Hospital had

intensivists who were available in both their offices and through hospital rounds for an hour or two a day at the hospital. (Spaeth, Tr. 2278).

**Response to Finding No. 2333:**

This proposed finding is false and misleading. HPH did not have an intensivist program before the Merger. (Ankin, Tr. 5045; Spaeth, Tr. 2278; Newton, Tr. 470-71; RFF ¶ 1677).

Physician coverage of the Intensive Care Unit (“ICU”) before the Merger meant that the attending physician came to the ICU, saw only his or her own patients, finished rounds and returned to his or her office. (Ankin, Tr. 5046; RFF ¶ 1679). Further,

**REDACTED**

(Ankin, Tr. 5046; RX

989 at ENHL MO 7123, *in camera*).

**REDACTED**

(Ankin, Tr. 5047-48; RFF ¶ 1680, *in*

*camera*).

2334. The Emergency Department at Highland Park Hospital in the late 1990s was “very good” with staffing provided by an independent physician group. Prior to the merger, the Emergency Department served as a resource hospital that trained paramedics in Lake County and northern Cook County. (Newton, Tr. 394-95).

**Response to Finding No. 2334:**

This proposed finding is misleading and inaccurate. In addition to facility and equipment problems, HPH’s ED suffered from a variety of quality issues before the Merger, including a lack of double physician coverage and an inadequate fast track program. (Harris, Tr. 4230, 4247; RFF ¶¶ 1878, 1887).

2335. In the late 1990s, the Emergency Department at Highland Park Hospital was a Level II trauma institution and was equal to or better than Highland Park’s peer hospitals. (Newton, Tr. 394-95; Spaeth, Tr. 2082, 2116-17).

**Response to Finding No. 2335:**

This finding is vague, misleading and unhelpful. In particular, this proposed finding does not further explain what it means by “equal to or better than peer hospitals” – *i.e.*, equal to or better than in what respect?

2336. Before the merger, Highland Park Hospital’s Department of Radiation Medicine had a linear accelerator and was staffed by a physician group from Northwestern Memorial Hospital and Northwestern Medical School. (Newton, Tr. 399. *See also* CX 699 at 24; O’Brien, Tr. 3491, 3493 (When Ms. O’Brien assessed Highland Park Hospital’s radiology department in 2000, HPH had two CT scanners, while Glenbrook Hospital had one. (O’Brien, Tr. 3493).

**Response to Finding No. 2336:**

This proposed finding is incomplete. The linear accelerator was purchased in the mid-1980’s and owned by an independent practice. ENH had to pay to have it removed after the Merger because it had no value whatsoever. (O’Brien, Tr. 3499-501; Newton, Tr. 469; RFF ¶¶ 1743, 2130-2131). The linear accelerator was two generations beyond modern equipment at the time, and below what a typical community hospital would have had at that time. (Dragon, Tr. 4336-37; RFF ¶ 1744). Moreover, physicians did not send their patients to HPH for radiology services pre-Merger because the equipment was so antiquated. (Chassin, Tr. 5362-63; RFF ¶ 2131). Finally, while HPH did have two CT scanners, it performed fewer radiology exams than Glenbrook Hospital even though Glenbrook Hospital only had one scanner. (O’Brien, Tr. 3492-93; RFF ¶ 2132).

2337. Before the merger, the Highland Park Hospital radiology department had a full array of diagnostic and therapeutic capabilities, including CT, MRI, and ultrasound. In addition, there were radiologists who had special qualifications in mammography. The quality of the equipment was exceptional. (Newton, Tr. 399).

**Response to Finding No. 2337:**

This proposed finding is inaccurate. Pre-Merger HPH had considerable problems with its radiology equipment, which had limited radiation capacity. (RFF-Reply ¶¶ 2336, 2343).

Notably, HPH did not own any equipment dedicated to treating oncology patients. (Dragon, Tr. 4333-34; RFF ¶ 1743). For instance, ENH also added two new CT scanners in HPH's radiology department.. (RFF ¶ 2133). ENH had to pay to have it removed because it had no value whatsoever. (O'Brien, Tr. 3499-501; RFF ¶¶ 2130-2131). Moreover, physicians did not send their patients to HPH for radiology services pre-Merger because the equipment was so antiquated. (Chassin, Tr. 5362-63; RFF ¶ 2131). Another important post-Merger change in the radiology department at HPH was the addition of subspecialty radiologists. (RFF ¶ 2143).

2338. Before the merger, Dr. Leon Dragon, who is now the Director of the Kellogg Cancer Care Center at Highland Park Hospital, served on the medical staff of Highland Park Hospital. (Spaeth, Tr. 2084). Highland Park Hospital had a "tumor board" before the merger relating to cancer care activities whose members discussed cases in a collaborative manner. There also was a cancer committee at the hospital. (Spaeth, Tr. 2120-21; Dragon, Tr. 4403).

**Response to Finding No. 2338:**

Respondent has no specific response.

2339. Before the merger, Highland Park had received a certificate of approval from the commission on cancer of the American College of Surgeons. (CX 699 at 6, 24).

**Response to Finding No. 2339:**

This proposed finding is incomplete. HPH received the certificate of approval from the American College of Surgeons for its designation as a Community Hospital Comprehensive Cancer Program. (CX 699 at 6).

2340. Prior to the merger, Highland Park Hospital had an institutional review board ("IRB") and clinical oncology trials were done through the hospital IRB protocols, including trials relating to the Eastern Cooperative Oncology Group ("ECOG") and the National Surgical Adjuvant Breast Program. (Dragon, Tr. 4399-400; Newton, Tr. 419-20).

**Response to Finding No. 2340:**

This proposed finding is misleading. The group cooperative trials were removed from HPH before the Merger, leaving HPH with only one clinical research trial. (Dragon, Tr. 4328-30, 4332, 4399-400; RFF ¶¶ 1740-1741).

2341. Prior to the merger, Highland Park Hospital had a relationship with the Robert H. Lurie Comprehensive Cancer Center of Northwestern University that connected Highland Park with the National Cancer Network, an alliance of sixteen of the nation's leading cancer centers. (Spaeth, Tr. 2086; CX 699 at 5).

**Response to Finding No. 2341:**

This proposed finding is inaccurate and misleading. Pre-Merger HPH's oncology program consisted of a handful of oncologists providing primary oncological care who participated in very little cancer research and no academic research. (Spaeth, Tr. 2294). Nor did HPH physicians participate in Northwestern Memorial's research protocols before the Merger. (Spaeth, Tr. 2311; RFF ¶¶ 1750-1789).

2342. Prior to the merger, the hospital also had radiation oncology, another component of an oncology program, in place. (Newton, Tr. 420).

**Response to Finding No. 2342:**

This proposed finding is misleading and inaccurate. Pre-Merger radiation oncology at HPH involved antiquated equipment with limited radiation capacity, no radiology imaging system, and a lack of radiology specialists. (O'Brien, Tr. 3491; 3494; Chassin, Tr. 5359; RFF ¶¶ 2129-2130, 2136).

2343. The physical facilities at Highland Park Hospital, including surgical suites and dialysis program, were exceptional prior to the merger. (Newton, Tr. 383-84). There were no major deficiencies in Highland Park's medical equipment in the late 1990s. (Newton, Tr. 384). Before the merger, Highland Park Hospital always had the latest piece of medical equipment that it needed, and the hospital felt that it had the ability to make investments and purchase new technology. (Newton, Tr. 384).



**Response to Finding No. 2343:**

This proposed finding is false. As discussed earlier, before the Merger, HPH's physical facilities needed major repairs and upgrades, a need that required substantial investment to satisfy. (RFF-Reply ¶ 2319; RFF ¶¶ 1512-1513). As a result of its pre-Merger deficiencies, HPH almost lost its Medicare accreditation. (RX 545 at ENH JH 11578; RX 1379 at ENH JH 11544; RX 1380 at ENH JH 11480; RFF ¶ 1513). Similarly, HPH's radiology equipment was antiquated, HPH did not have cardiac monitoring equipment in patient rooms in the ED, it did not have anything similar to Pyxis for dispensing drugs, there was no Computerized Physician Order Entry ("CPOE"), and there was nothing remotely close to Epic. (RFF Reply ¶¶ 2337, 2341-2442). In addition to remedying physical plant deficiencies, ENH also invested in significant changes to the plant that constituted quality of care improvements. (Chassin, Tr. 5288; RX 1377 at ENH JH 11478; RFF ¶ 1516). Further, Newton did not oversee or have any responsibility for the quality of clinical services at HPH. (RFF-Reply ¶ 2216).

2344. Highland Park before the merger, started a cardiovascular program that provided "state of the art diagnostic screening that can detect symptoms of heart disease at an early age." (CX 699 at 6; *see* Spaeth, Tr. 2311).

**Response to Finding No. 2344:**

This proposed finding mischaracterizes the record evidence. Both the testimony and the document cited by Complaint Counsel reference a piece of machinery (a Cardio Screen), not a program that HPH used prior to the Merger. (CX 699 at 6; Spaeth, Tr. 2311).

**b. Highland Park Hospital Continually Added New Clinical Services and Made Improvements Before the Merger**

2345. Highland Park Hospital added new clinical services and made improvement before the merger. (Spaeth, Tr. 2101-05, 2110, 2113-14, 2122; Krasner, Tr. 3749-50; CX 2415 at 1-2; CX 1052 at 4; CX 98 at 2-3; CX 94).

**Response to Finding No. 2345:**

This proposed finding is overbroad. Whatever ostensible new services HPH added pre-Merger were substantially eclipsed by the panoply of new services ENH introduced at HPH as a result of the Merger including, for example, high-quality cardiac surgery and interventional cardiology programs; a comprehensive electronic medical record; and multidisciplinary cancer care with state-of-the-art diagnostic and treatment equipment not present in community hospitals. (RFF ¶¶ 1228-1229).

2346. Accomplishments for Highland Park Hospital in 1997 included the opening of a new GI Center and approval from the State of Illinois for additional dialysis stations (Spaeth, Tr. 2102; CX 2415 at 3); broadening and enhancement of a number of clinical care maps for patient care at the hospital (Spaeth, Tr. 2105; CX 2415 at 7); creation of an in-patient Pediatric Adolescent Unit with 24-hour physician coverage (Spaeth, Tr. 2110; CX 1052 at 4); and implementation of a Fast Track Triage System in the Emergency Department (Spaeth, Tr. 2110; CX 1052 at 4).

**Response to Finding No. 2346:**

Respondent has no specific response, other than to the issue of care maps, which is duplicative. (RFF- Reply ¶¶ 2241, 2351).

2347. The Highland Park Hospital in-patient pediatric unit created before the merger resulted from a relationship that Highland Park Hospital established with Children's Memorial Hospital. (Spaeth, Tr. 2121; CX 99 at 2). As of the end of 1998, Highland Park Hospital was also looking to develop an additional relationship with Children's Memorial Hospital to have pediatric sub-specialties at Highland Park Hospital. (Spaeth, Tr. 2122; CX 99 at 12).

**Response to Finding No. 2347:**

Respondent has no specific response.

2348. Accomplishments for Highland Park Hospital in 1998 included installation of a fast CT scanner in the hospital (Spaeth, Tr. 2113-14; CX 98 at 2) and the re-designation of its emergency room from a Level I training center to a Level II trauma center. (Spaeth, Tr. 2117; CX 98 at 5). A Level II Trauma Center designation by the State of Illinois requires 24-hour, seven-day a week physician coverage in the emergency room. (Spaeth, Tr. 2117).

**Response to Finding No. 2348:**

This proposed finding is incomplete. Notwithstanding the pre-Merger efforts at improvement, the ED continued to have significant problems prior to the Merger that were not corrected until after the Merger. (RFF ¶¶ 1872-1890).

2349. In 1998, Highland Park Hospital also expanded the family birthing center by adding nine beds to the unit. (Krasner, Tr. 3749; CX 98 at 2; CX 94 at 3). Prior to the merger, Highland Park Hospital also opened a fetal diagnostic center staffed by perinatologists from Evanston Hospital. (Krasner, Tr. 3750).

**Response to Finding No. 2349:**

This proposed finding is incomplete. Notwithstanding the pre-Merger efforts at improvement, Ob/Gyn had significant problems prior to the Merger that were not resolved until after the Merger. (RFF ¶¶ 1249-1275).

2350. The fast track program that Highland Park Hospital implemented in its emergency room in 1998, reduced turn-around time to 70 minutes or less that same year. (CX 566 at 1). Press-Ganey patient scores in 1998 for emergency care exceeded the target for that year. (CX 566 at 1).

**Response to Finding No. 2350:**

This proposed finding is misleading. The implementation of fast track at HPH resulted in an *average* turn-around time of 70 minutes or less for ED patients. (CX 566 at 1).

2351. Even before the merger, Highland Park Hospital continued to improve its Care Maps and create new ones. (CX 95 at 3; CX 100 at 4; CX 2415 at 7; Spaeth Tr. 2105).

**Response to Finding No. 2351:**

This proposed finding is duplicative. (RFF-Reply ¶ 2241).

2352. In the 1999-2003 Presentation of the Financial Plan, HPH management identified new strategies to invest in the development of expanded clinical services. (CX 545 at 4).

**Response to Finding No. 2352:**

This proposed finding is misleading to the extent it implies that HPH did invest in the expansion of clinical services. There is no evidence in the record that the strategies outlined in

CX 545 could have been, or were in fact, implemented. (RFF ¶¶ 2450-2352). Moreover, the evidence showed that HPH's future financial projections were unrealistic and that the cash and investments held by HPH were insufficient to compete in the marketplace. (RFF ¶¶ 2354-2670, 2393-2413). Therefore, these strategies are not evidence of pre-Merger improvements at HPH with respect to clinical services.

**2. Highland Park Hospital Already Had Plans to Implement Some of the Changes Before the Merger**

2353. Up until the time of the merger in the year 2000, there was a growing breadth of clinical services provided by Highland Park Hospital. (Newton, Tr. 376). In addition, Lakeland Health Services' (Highland Park's parent entity) 1999-2002 Strategic Plan called for continued development of additional and deeper clinical services. (Newton, Tr. 330; CX 1868 at 10). Highland Park Hospital wanted to enhance its clinical services in cardiology, oncology, orthopedics, surgical services, and behavioral services. (CX 1868 at 17; CX 1908 at 18). It wanted to also pursue cardiac surgery, a joint oncology program with its physicians, and advanced maternal/fetal health clinical capabilities. (CX 1868 at 17; CX 1908 at 18; CX 545 at 3).

**Response to Finding No. 2353:**

This proposed finding is misleading to the extent it implies that HPH did invest in the expansion of clinical services. In reality, HPH did not implement any of the plans outlined above before the Merger. Pre-Merger HPH did not begin a cardiac surgery program, did not implement an interventional cardiology program, nor did it engage in any joint oncology program. (RFF ¶¶ 1565-1566, 1649-1652, 1729-1733, 1755). Specifically, pre-Merger HPH studied the possibility of beginning a cardiac surgery program and decided it was not appropriate. (RFF ¶ 1578). Also, there is no evidence in the record of pre-Merger enhancements to behavioral health services.

That said, the fact that HPH developed strategic plans to implement such programs is evidence that additions such as these would be enhancements or improvements to the quality of care provided by the hospital prior to the Merger. It is logical to assume that the providers and

administrators of HPH would not name these areas as deficient or identify them as needed areas for enhancement if such services would not improve the care given to patients at HPH. The exhibits cited by Complaint Counsel are telling in this regard. For example, the need to expand HPH's services to include cardiac surgery, multidisciplinary oncology, and interventional cardiology are recorded several times in the two documents cited by Complaint Counsel in this proposed finding. (CX 1908 at 9, 18; CX 1868 at 10, 13). Moreover, the need to enhance physician coverage and increase HPH's clinical competencies, and utilize multidisciplinary approaches to care was needed at HPH according to these planning documents. (CX 1868 at 14, 19; CX 1908 at 7).

In actuality, the evidence in this case showed the named necessary enhancements in breadth of clinical services, physician coverage, and multidisciplinary care were only brought about at HPH by ENH through the Merger. ENH began clinical programs at HPH in cardiac surgery, interventional cardiology and multidisciplinary cancer care through opening the Kellogg Cancer Care Center – all as a result of the Merger. (RFF ¶¶ 1565-1566, 1577, 1649-1652, 1751-1762). Further, ENH enhanced physician coverage at HPH by implementing an intensivist program and installing nighttime obstetrician coverage. (RFF ¶¶ 1276-1280, 1690). ENH also enhanced radiology, radiation medicine and laboratory services and equipment – all as a result of the Merger. (RFF ¶¶ 2133-2145, 1790-1865). Finally, the clinical quality at HPH dramatically improved in nursing, pharmacy and emergency medicine – all as a result of the Merger. (RFF ¶¶ 1338-1413, 1950-1998, 1866-1949).

2354. In March 1999, Lakeland Health Services' Joint Finance and Planning Committee developed a plan to enhance and expand the services at Highland Park Hospital without a merger with another hospital. (CX 92 at 3; Spaeth, Tr. 2224-31). For example, they planned for Highland Park Hospital to develop a cardiovascular surgery program through an agreement with Evanston Hospital, not a merger, and to implement a comprehensive oncology program through a partner in the Northwestern Healthcare Network or an

affiliated medical group practice. (CX 92 at 12). They also planned for using technology to expand access to information to physician offices. (CX 92 at 20).

**Response to Finding No. 2354:**

This proposed finding is misleading to the extent it implies that HPH could have enhanced, or did enhance, its clinical services in this manner before the Merger. Again, the evidence established that, despite a professed “desire to enhance the services at HPH,” HPH never opened a cardiovascular surgery program before the Merger. (RFF ¶ 1576-1578). Historically, HPH considered aligning with other hospitals via joint ventures such as Condell, Lake Forest Hospital and the Mayo Clinic. However, despite those considerations, none of those joint ventures came to pass. (RFF ¶¶ 240-241). Therefore, this proposed finding places undue reliance on planning documents as evidence that clinical services could have viably been brought to the hospital through partnerships with other hospitals.

Further, the fact that Lakeland’s strategic plan to enhance and expand the services at HPH included opening a cardiac surgery program and beginning a comprehensive oncology program presupposes that changes in those areas would be an enhancement in quality at HPH. HPH began cardiac surgery and installed a comprehensive oncology program as a result of the Merger. (RFF ¶ 1565, 1724-1726, 1750).

At the end of the day, HPH never implemented any oncology program via agreement or joint venture before the Merger. (RFF ¶ 1722; Dragon Tr. 4346, 4330-31). Finally, HPH administrators and financial advisors testified that the addition of such services absent a merger were unlikely as HPH lacked the resources to undertake these projects. (RFF ¶¶ 2451-2452). Specifically, the financial projections made by HPH in its strategic plans were unrealistic. (RFF ¶¶ 2393-2404). Finally, Complaint Counsel’s assertion that HPH would have implemented oncology, cardiac surgery, and interventional cardiology programs via joint venture is belied by

the undisputed fact that HPH's existing joint ventures were losing more than \$2 million a year.

(RFF ¶¶ 2371, 2373-2375).

2355. Before the merger, Highland Park Hospital was seeking to develop a joint venture for a heart program with Evanston Hospital and a joint venture for an oncology program with Northwestern Memorial Hospital, both without merging. (CX 541 at 1; CX 1908 at 12; CX 1867 at 1-3).

**Response to Finding No. 2355:**

Again, this proposed finding is misleading and inaccurate in that it implies that HPH could have developed, or did develop, any heart program or comprehensive oncology program via a joint venture before the Merger. Dr. Dragon testified that "there was absolutely no connection or relationship with Northwestern [Memorial]" with respect to patient care. (Dragon, Tr. 4330-31). The only relationship with Northwestern Memorial's oncology program that HPH had pre-Merger was Northwestern Memorial's sponsorship of a small clinical trials program. (Dragon, Tr. 4330-31). Neither of these sorts of programs were ever opened before the Merger in any respect, least of all by joint venture or partnership. (RFF ¶¶ 1729-1749, 1577-1578).

2356. In the case of many of the improvements ENH claimed it made to HPH after the merger, such as the use of information technology, cardiac surgery and a comprehensive oncology program, HPH actively planned to make such changes before the merger regardless of whether it merged with another hospital. (CX 1908 at 3, 9, 12, 18, 20; CX 545 at 3).

**Response to Finding No. 2356:**

This proposed finding is inaccurate and misleading. (RFF-Reply ¶¶ 2353-2355).

**a. Highland Park Hospital Had Decided to Develop a Cardiac Surgery Program Before the Merger**

2357. Highland Park and ENH actually signed an agreement to develop a joint cardiac surgery program at Highland Park in April 1999, before they agreed to merge. (Rosengart, Tr. 4527-30, 4557; CX 2094).

**Response to Finding No. 2357:**

This proposed finding is misleading to the extent it implies that any cardiac surgery program was ever implemented at HPH outside of the Merger with ENH.

2358. Shortly after signing their April 1999 agreement, Highland Park and ENH commenced the application process for a Certificate of Need (“CON”) for open heart surgery at Highland Park Hospital. (Newton, Tr. 423). The CON application to the Illinois Health Facilities Planning Board, was signed by Mark Neaman, Mark Newton, and Ronald Spaeth. In the submission, the parties assert that Highland Park Hospital has brought “leading edge and innovative clinical services” to the community and has “consistently been the first provider in Lake County to develop and offer advanced clinical services.” (CX 413 at 7).

**Response to Finding No. 2358:**

Respondent has no specific response.

2359. In their 1999 CON application for open heart surgery, ENH and Highland Park Hospital estimated that the cost of the open heart program would be approximately \$2.9 million, all of which was to come from HPH. (CX 413 at 12). (Highland Park Hospital had previously estimated that an open heart surgery program would cost about \$1 million and would not require tapping into any Highland Park Foundation money. (Newton, Tr. 422)).

**Response to Finding No. 2359:**

This proposed finding is misleading in that it implies that the cited document supports Complaint Counsels position that the extension of a cardiac surgery program was agreed to prior to the Merger. In fact, the 1999 CON agreement expressly references the Merger and states that the actual extension of cardiac surgery to HPH was only brought about via the Merger with ENH. (CX 413 at 5; CX 501 at 41 (the Merger Agreement)). The State of Illinois only approved the CON for the cardiac surgery program with HPH and ENH as merged entities. As such, it is unknown whether due to concerns over volume or capabilities whether or not HPH could have received CON approval without the Merger.

2360. The parties’ actual agreement to implement this program without a merger followed a planning process which had determined that the program would be feasible without a merger. (CX 92 at 12; CX 1868 at 13). As far back as 1997, Highland Park Hospital



planned on developing a cardiovascular surgery program. (CX 1867 at 1; CX 91 at 2; CX 1869 at 4). Highland Park Hospital's 1999-2002 Strategic Plan called for implementing open heart surgery at Highland Park Hospital as part of a joint program with ENH. (Newton, Tr. 335).

**Response to Finding No. 2360:**

This proposed finding is inaccurate and misleading. The documents cited by Complaint Counsel do not establish that HPH's implementation of an open heart surgery program "would be feasible without a merger." At best, the addition of a cardiac surgery program is mentioned as a goal in several tactical documents. Its feasibility was never explored in the evidence cited by Complaint Counsel.

For example, Complaint Counsel cites to CX 1867 at 1 as support for this proposed finding regarding the feasibility of an independent HPH open heart surgery program. This document, however, merely states that cardiac surgery was a goal, and the feasibility of that goal by ENH and HPH was far from known: "We [ENH] remain enthusiastic on proceeding and hope for development and support of an Open Heart Surgery Program ... as [it] may be contemplated. *Obviously, there is a great deal of work ahead to achieve 'success' in any of these areas.*" (CX 1867 at 1 (emphasis added)). Further, none of the documents cited by this proposed finding outline any feasibility study done regarding cardiac surgery and, instead, only mention the development of a program as a goal or "potential avenue" to achieve growth. (CX 1869 at 4; CX 1868 at 13; CX 92 at 12; and CX 91 at 2).

2361. In the late 1990s, Highland Park Hospital and ENH had considered establishing open heart surgery at Highland Park as a joint program. (Neaman, Tr. 1243; Hillebrand, Tr. 2044; Spaeth, Tr. 2118; CX 99 at 1). The original pre-merger discussions between Highland Park Hospital and ENH to implement an open heart surgery program at Highland Park did not concern a merger between the two hospitals. (Hillebrand, Tr. 2045). Highland Park Hospital's proposals for a joint open heart surgery program with ENH or Northwestern Memorial Hospital prior to the merger were viable, despite the fact that they did not involve common ownership of the hospitals. (Newton, Tr. 422).

**Response to Finding No. 2361:**

This proposed finding is misleading to the extent it implies that a joint open heart program between HPH and Northwestern Memorial was viable before the Merger. The State of Illinois required in its Certificate Of Need (CON) process that at least one surgeon be within 30 minutes of HPH. (RFF ¶¶ 1596-1597). Dr. Rosengart testified specifically that, because of the emergent nature of cardiac surgery, physicians must be readily available within 30 minutes travel time from the hospital per national guidelines. (Rosengart, Tr. 4474-76).

**REDACTED**

(RX

1912 at 21 *in camera*). Therefore, it would be “essentially impossible” for surgeons from Northwestern Memorial to operate at HPH as part of a joint program. (Rosengart, Tr. 4475-76).

Further, a joint program still would not work if Northwestern Memorial chose to avoid the 30 minute travel dilemma by staffing such a program with a physician stationed at HPH full time. A single Northwestern Memorial surgeon staffed at HPH would constitute itinerant surgery as described by Dr. Rosengart. Cardiac surgery provided by an itinerant surgeon is not the proper manner to provide life-saving cardiac care. (Rosengart, Tr. 4554-55). As a result, that dislocated physician would never meet the surgeon volume requirements of 125 isolated CABG surgeries per year outlined by the State in the HPH cardiac surgery CON process. (RX 1371 at 4).

2362.

**REDACTED**

(Romano, Tr. 3060, *in camera*). See also (Newton, Tr. 423-24; Rosengart, Tr. 4527-28; CX 2078) (joint cardiac surgery program between Highland Park Hospital and ENH similar to other joint cardiac surgery programs not involving merger).

**Response to Finding No. 2362:**

This proposed finding is overly simplistic, vague and inaccurate to the extent Complaint Counsel is contending the evidence showed that a program opened via affiliation or joint venture would generate the same quality of cardiac surgery provided at HPH via the Merger. As a general matter, the evidence established that programs opened through joint venture are sub-optimal in terms of quality. (RFF ¶¶ 247-249). It is likely that if a cardiac surgery program were opened at a divested HPH through an affiliation agreement, the quality of that program would not be what it is today. (RFF ¶ 1646).

The level of care provided to cardiac surgery patients at post-Merger HPH is of a higher quality than that provided to patients in programs affiliated with ENH. (RFF ¶¶ 1636, 2463-2466). The evidence on this point is uncontroverted. Specifically, the evidence in this case established that the increased integration of nursing, staffing, equipment and resources engendered through the Merger created a program at HPH that is better clinically in four clear respects: (1) lower mortality rates; (2) the performance of more advanced surgeries; (3) the presence of advanced research; and, (4) shorter length of stay in the hospital for heart surgery patients. (RFF ¶¶ 1636-1646, 2459-2469).

First, HPH has had a 0% mortality rate for the past two-and-a-half years. (RFF ¶¶ 1610-1611). Mortality is the gold-standard by which to measure cardiac surgery programs and HPH's mortality rate is comparable to the best centers in the United States. (RFF ¶¶ 1608-1609). Swedish Covenant Hospital's program, which has been open since the beginning of HPH's program, has higher mortality rates than HPH. (RFF ¶ 1643). Moreover, the performance of cardiac surgery at Weiss Hospital has not been satisfactory according to the Chief of Cardiothoracic Surgery, Dr. Todd Rosengart. (RFF ¶ 1639). The fact that the program at Weiss

Hospital is operated as a joint venture has prevented Dr. Rosengart and the other surgeons from addressing critical issues of clinical care. Issues with Weiss Hospital's administration, resources (including things as basic as adequate lighting) and the ability to upgrade cannot seem to be rectified within the attenuated affiliation arrangement and the performance of Weiss Hospital has suffered. (RFF ¶¶ 1604-1605, 1638-1639). According to Dr. Rosengart, who opened all three sites for cardiac surgery in this case, HPH was more like Weiss Hospital in its ability to accept a new cardiac surgery program. (RFF ¶ 1604). Therefore, it is likely that HPH and its patients would have suffered the same fate as Weiss Hospital if it opened a cardiac surgery program through affiliation. (RFF ¶¶ 1604, 1646, 1629).

Second, the difference in clinical quality between the programs opened through affiliation and HPH is evidenced by the types of procedures performed and technology employed at Swedish Covenant Hospital, Weiss Hospital and HPH. (RFF ¶¶ 1637-1640, 1645). The ENH cardiac surgeons only perform advanced, cutting edge cardiac surgical procedures at HPH; not at Swedish Covenant Hospital or Weiss Hospital. (RFF ¶¶ 1637-1640). Procedures only performed at HPH include bloodless surgery, the use of advanced stenting technology, and new vein harvesting techniques. (RFF ¶¶ 1640, 1642). These procedures are not typically done at community hospitals and are only performed by a handful of hospitals in Chicago or the country. (RFF ¶¶ 1637, 1640). Advanced procedures are carried out at HPH because of the higher level of integration of anesthesia, nursing, equipment and resources between Evanston Hospital and HPH than what exists with Swedish Covenant Hospital and Weiss Hospital. (RFF ¶¶ 1638-1639). Because that level of integration does not exist at the affiliated program sites, it is unlikely that either Swedish Covenant Hospital or Weiss Hospital will provide these advanced techniques for their patients in the future due to safety concerns. (RFF ¶ 1638).

Third, as a result of the Merger, private and publicly funded research is undertaken at HPH and not at the affiliated sites. Swedish Covenant Hospital and Weiss Hospital under the affiliation agreements in place, maintain separate infrastructure, institutional review boards and contracting practices. This set-up does not allow for research to be undertaken at those hospitals. (RFF ¶ 1641).

Finally, the higher quality of care at HPH is demonstrated by the fact that patients recover more quickly and leave the hospital for home faster at HPH than patients at the affiliated hospitals. (RFF ¶ 1644). This is another indicator of the fact that, while programs may be opened through affiliation, it is clear that those programs do not possess the same level of clinical quality as merged and integrated programs of the sort implemented by ENH at HPH. 2363.

**REDACTED**  
(Romano, Tr. 3075, *in camera*).

**Response to Finding No. 2363:**

Respondent has no specific response.

2364. At the same time in 1999 that ENH and Highland Park Hospital were working on a joint open heart surgery program, ENH was pursuing a joint open heart surgery program with Swedish Covenant Hospital. At that time, Swedish Covenant Hospital's open heart surgery program with ENH was structured the same way as Highland Park Hospital's open heart surgery program with ENH. (Newton, Tr. 423-24).

**Response to Finding No. 2364:**

Respondent has no specific response.

2365. Swedish Covenant Hospital and ENH are separate hospitals. (Newton, Tr. 424). Their joint open heart surgery program did not require a merger of the hospitals, but was accomplished through a contractual arrangement. (Hillebrand, Tr. 2046; Rosengart, Tr. 4443, 4557; CX 2078).

**Response to Finding No. 2365:**

Respondent has no specific response.

2366. The original cardiac surgery affiliation agreement between ENH and Highland Park Hospital is almost identical to the agreement between ENH and Swedish Covenant. (Compare CX 2073 and CX 2094; Rosengart, Tr. 4527-28 (agreements are “relatively similar”). In addition, the CON process for Highland Park Hospital to perform cardiac surgery was essentially identical to the one for Swedish Covenant Hospital. (Rosengart, Tr. 4471-72).

**Response to Finding No. 2366:**

Respondent has no specific response.

2367. In addition to doing cardiac surgery at Swedish Covenant Hospital, ENH does cardiac surgery at Weiss Hospital through an affiliation agreement. (Rosengart, Tr. 4443). Both Swedish Covenant and Weiss are essentially community hospitals. (Rosengart, Tr. 4442). Each hospital runs its own cardiac surgery program, and Dr. Rosengart makes sure there are appropriate quality assurances in place. (Rosengart, Tr. 4444).

**Response to Finding No. 2367:**

Respondent has no specific response.

2368. Swedish Covenant Hospital and Weiss Hospital are located about seven to ten miles south of Evanston Hospital. (Rosengart, Tr. 4445).

**Response to Finding No. 2368:**

Respondent has no specific response.

2369. The medical director of cardiac surgery at Weiss Hospital is Dr. Rosengart. He also was the original medical director of cardiac surgery at Swedish Covenant Hospital, but he then eventually delegated that job to Dr. Curran, who is the ENH doctor performing cardiac surgery at Swedish Covenant. (Rosengart, Tr. 4442).

**Response to Finding No. 2369:**

Respondent has no specific response.

2370. In the case of Weiss Hospital, ENH insisted that Dr. Rosengart be the medical director of the cardiac surgery program in order to provide quality assurance as part of the agreement for ENH to perform cardiac surgery at that location. (Rosengart, Tr. 4443).

**Response to Finding No. 2370:**

This proposed finding is misleading as it implies that the quality assurance program at

ENH extends to Weiss Hospital and that cardiac surgery at Weiss Hospital is of the same quality

as HPH. Dr. Rosengart testified that, despite being the medical director at Weiss, the quality assurance program at ENH only extends to HPH and not to either affiliated programs at Weiss Hospital and Swedish Covenant Hospital. (RFF ¶ 1634). Moreover, Dr. Rosengart testified that the Weiss Hospital program performs in an unsatisfactory manner, and that the quality of the program is not comparable to that of HPH. (RFF ¶¶ 1638-1639).

2371. ENH's affiliation agreements with Swedish Covenant Hospital and Weiss Hospital require ENH to provide perfusionists, which play a critical role. (Rosengart, Tr. 4461). Swedish Covenant Hospital and Weiss Hospital each have their own separate quality assurance programs, but ENH monitors the results. (Rosengart, Tr. 4468).

**Response to Finding No. 2371:**

This proposed findings is misleading because the quality assurance program at ENH does not extend to Swedish Covenant Hospital or Weiss Hospital. (RFF ¶ 1634). This proposed finding is also incomplete as it names the only member of the cardiac surgery team, aside from the surgeons, that rotates between all four sites at issue in the case. Cardiac surgery is highly-team dependant, and there are a significant number of team members including: operating room nurses, ICU nurses, floor nurses, anesthesiologists, nurse practitioners, and physicians assistants. (RFF ¶¶ 1579, 2459). None of these providers rotate to Swedish Covenant Hospital or Weiss Hospital. Instead, they practice only as part of integrated teams at Evanston Hospital and HPH. (RFF ¶ 1630). Indeed, the overwhelming majority of providers within the cardiac surgery team at ENH do not rotate to Swedish Covenant Hospital or Weiss Hospital, thus highlighting the independent, stand-alone nature of those affiliated programs and explaining the difference in quality found at those hospitals with respect to cardiac surgery. (RFF ¶¶ 2459-2460).

2372. The mortality rates for Swedish Covenant Hospital's open heart surgery program are within acceptable limits. ENH is also comfortable with its results for open heart surgery at Weiss Hospital. (Rosengart, Tr. 4502-03). Both of the joint heart surgery programs get passing grades in terms of performance. (Rosengart, Tr. 4504). Mark Newton, the President of Swedish Covenant Hospital, also agrees that the arrangement between

Swedish Covenant Hospital and ENH is exceeding its quality parameters. (Newton, Tr. 424).

**Response to Finding No. 2372:**

This proposed finding is misleading to the extent that it equates the performance and quality of cardiac surgery at Swedish Covenant Hospital and Weiss Hospital with that of HPH. (RFF-Reply ¶ 2362).

2373. If an open heart program with ENH was not possible, Highland Park Hospital was thinking about developing a relationship with Northwestern Memorial Hospital or Lutheran General Hospital involving an open heart program. (Newton, Tr. 338).

**Response to Finding No. 2373:**

This proposed finding is incorrect regarding the ability of HPH to jointly develop a cardiac surgery program with Northwestern Memorial, as it does not meet the 30 minutes travel parameter set by the State of Illinois in the Certificate of Need for cardiac surgery at HPH. (RFF-Reply ¶ 2361). Moreover, any program opened through affiliation or joint venture with Advocate Lutheran General would likely suffer from the same quality problems that the affiliated and non-integrated programs at Swedish Covenant Hospital and Weiss Hospital face. (RFF-Reply ¶ 2362).

Finally, this proposed finding cannot support an assertion by Complaint Counsel that HPH could, in fact, have developed the referenced relationship with Northwestern Memorial or Advocate Lutheran General because this proposed finding merely states that HPH “was thinking about developing” such relationships. There is no evidence that such a relationship ever passed the “thinking” phase. Indeed, there is no evidence that either Northwestern Memorial or Advocate Lutheran General had similar thoughts. Accordingly, this proposed finding is purely speculative and, therefore, unhelpful.



**b. Highland Park Hospital Was Actively Pursuing a Joint Cancer Care Program with Other Hospitals, Including Evanston, Before the Merger**

2374. Before the merger, Highland Park Hospital was pursuing joint programs in oncology with other hospitals, such as ENH and Northwestern Memorial Hospital, that did not involve a merger. (Neaman, Tr. 1243; Hillebrand, Tr. 2044; Newton, Tr. 420; CX 1867 at 1-3; Spaeth, Tr. 2223-28; CX 1866 at 1, 5. *See also* CX 1862; CX 99 at 2 (referring to comprehensive oncology program)). As far back as 1998, Highland Park Hospital wanted to develop a “center of excellence” for cancer care services. (CX 91 at 2; CX 1869 at 4).

**REDACTED**  
(Romano, Tr. 3108, *in camera*).

**Response to Finding No. 2374:**

This proposed finding is inaccurate and misleading to the extent it implies that any of the initial discussions with other institutions at HPH regarding a joint program in oncology ever were realized before the Merger. (RFF ¶ 1722; CX 98 at 1-2; Dragon Tr. 4330-31, 4346). Moreover, the joint program being pursued by pre-Merger HPH was not comparable to the changes realized through the extension of the Kellogg Cancer Center to HPH after the Merger. Complaint Counsel’s own witness, pre-Merger HPH marketing executive Newton, testified that the joint programs being pursued by HPH before the Merger would bring little else but the nameplate or “image” of another hospital. (Newton, Tr. 417-20). The extension of the Kellogg Cancer Center to HPH, in contrast, has drastically changed the practice of oncology at HPH. (RFF ¶¶ 1750-1789). Advancements in technology, resources, access to specialists, centralized ancillary services, and the ability to provide multidisciplinary care to cancer victims has greatly changed the practice of oncology at HPH post-Merger. (RFF ¶¶ 1750-1789). These changes have been reflected in the change in designation of HPH from a community hospital to an academic hospital with respect to cancer care by the American College of Surgeons. (RFF ¶¶ 1722, 1726). Moreover, HPH is now designated one of 50 Community Clinical Oncology Programs in the country by the National Cancer Institute. This elite designation is further

evidence of a breadth and depth of change in quality much greater than simply the extension of a “name” or “image.” (RFF ¶¶ 1781-1782).

2375. In the late 1990s, Highland Park Hospital and ENH had considered implementing a cancer care program at Highland Park as a joint program. (Neaman, Tr. 1243; Hillebrand, Tr. 2044; Spaeth, Tr. 2223-28). As a matter of fact, Highland Park was considering implementing a joint comprehensive oncology program with its local physicians, particularly a local medical group practice, Physician Reliance Network. (CX 1868 at 13; CX 99 at 2). Highland Park Hospital had also considered an oncology program with Northwestern Memorial Hospital prior to the merger. (Newton, Tr. 420; CX 1866 at 1, 5).

**Response to Finding No. 2375:**

This proposed finding is inaccurate and misleading. (RFF-Reply ¶ 2374).

2376. The relationships that Highland Park Hospital pursued with Northwestern Memorial Hospital and ENH prior to the merger with regard to cancer care would have even been less formal than a structured joint venture with common ownership. (Newton, Tr. 420).

**Response to Finding No. 2376:**

Respondent has no specific response.

2377. \_\_\_\_\_ (Romano, Tr. 3107-08, *in camera*).

**REDACTED**  
(Romano, Tr. 3107-08, *in camera*).

**Response to Finding No. 2377:**

This proposed finding is speculative and inaccurate. First, only 50 cancer centers in the country are designated Community Clinical Oncology Programs (“CCOPs”) by the American College of Surgeons. The changes discussed in this proposed finding would have required significant effort on HPH’s part to accomplish, and there is no evidence that HPH was committed to such an effort. (RFF ¶ 1726). Further, Dr. Dragon, a practicing oncologist in Chicago for more than a two decades, testified that the multidisciplinary care given at HPH is not typically given by community hospitals in Chicago. (RFF ¶ 1727, 1759; Dragon, Tr. 4302-03).

Finally, the multidisciplinary care provided at HPH is inexorably linked with the construction of the Ambulatory Care Center (“ACC”). The facility houses medical oncology, cardiac stress center, breast imaging center, and the departments of nuclear medicine, rehabilitation medicine, and radiation therapy under one roof. (RFF ¶¶ 1760-1762). Construction of the ACC cost ENH more than \$25 million, and there is no evidence that regional academic centers make that kind of investment in community hospitals to allow them to practice multidisciplinary oncology of the sort provided at HPH today. (RFF ¶¶ 1559-1561).

2378.

**REDACTED**

(Romano, Tr. 3108, *in camera*).

**Response to Finding No. 2378:**

Respondent has no specific response.

2379.

**REDACTED**

(Romano, Tr. 3108, *in camera*).

**Response to Finding No. 2379:**

This proposed finding is inaccurate and misleading. (RFF-Reply ¶ 2374).

2380. Highland Park Hospital did not have a CT/PET machine before the merger because such a combined machine did not exist before the merger. (Newton, Tr. 470).

**Response to Finding No. 2380:**

This proposed finding is misleading. While it is true that a CT/PET machine is advanced technology, the evidence shows that HPH owned no significant equipment or facilities of its own dedicated to treating oncology patients. (RFF ¶¶ 1743, 1747). For example, the linear accelerator used by HPH patients was not owned by HPH, but an independent private practice. (RFF ¶ 1746). The accelerator HPH did have access to was antiquated and outdated and below what even a typical community hospital would possess. (RFF ¶ 1744). Moreover, the vault it

was contained in was small and constructed in such a way that prevented its expansion even had HPH wanted to upgrade. (RFF ¶ 1745). Therefore, to imply that HPH did not have modern diagnostic and therapeutic equipment for oncology treatment only because it was not yet developed is misleading.

**c. Highland Park Hospital Was Already Planning to Renovate and Expand Its Emergency Department Before the Merger**

2381. Highland Park Hospital was already planning to renovate and expand its Emergency Department before the merger. (Newton, Tr. 394; Harris, Tr. 4289-91; CX 98 at 2 (“overall plans for a major reconstruction”)). (These plans were in addition to the enhanced triage function and fast track plans that were actually executed pre merger. (CX 94 at 4)).

**Response to Finding No. 2381:**

This proposed finding is misleading to the extent that it implies pre-Merger HPH planned the same level of reconstruction that occurred after the Merger and to the extent that this proposed finding implies that the plans for reconstruction would have been implemented by pre-Merger HPH. First, the fact that any plans existed to enhance the ED facilities pre-Merger only serves as contemporaneous support for the evidence that HPH’s ED facilities were inadequate before the Merger. (RFF ¶¶ 1872-1877). Further, the plans to address the shortcomings in the ED facilities were never implemented despite the direct request of the HPH ED Medical Director, Dr. Harris, to pre-Merger HPH management. (RFF ¶¶ 1870, 1877). Finally, pre-Merger HPH lacked the financial capacity to implement the plans it had to enhance the hospital’s facilities. (RFF ¶¶ 2450-2452).

2382. In the late 1990s, Highland Park Hospital was making plans to expand the Emergency Department. (Newton, Tr. 394). Highland Park Hospital brought in an architect in the fall of 1998 to discuss expansion of the emergency room at the hospital. (Harris, Tr. 4290).

**Response to Finding No. 2382:**

This proposed finding is misleading. (RFF-Reply ¶ 2381).

2383.

**REDACTED**

(Romano, Tr. 3111, *in camera*).

*camera*).

**REDACTED**

(Romano, Tr. 3112, *in*

**Response to Finding No. 2383:**

This proposed finding is conclusory and not supported by the evidence in this case.

Despite what Dr. Romano speculates HPH could have done, the facts show that HPH did not enhance ED coverage or rectify issues with facilities even when asked to address these concerns by the Medical Director of its own ED. (RFF ¶ 1877). Dr. Harris specifically testified that he requested on numerous occasions prior the Merger that physician coverage be doubled in the ED and HPH never responded to this request for help. (RFF ¶ 1880). Outside regulatory agencies also were critical of HPH facilities. A notice of intent to terminate HPH's Medicare participation was received from Healthcare Finance Administration ("HCFA") as a result of HPH's deficiencies in facilities. (RFF ¶ 2377). Despite clearly being informed of the problems in hospital facilities and the ED, the evidence showed that HPH lacked the financial capacity to adequately respond. (RFF ¶ 2319-2413). Therefore, any implication that the mere presence of "plans" would serve to establish that HPH could have undertaken the reconstruction of facilities and improvement in coverage that ENH did after the Merger is untenable.

**3. Some of the Changes Were Part of a General Nationwide Trend of Improvement**

2384. There was a nationwide focus on quality during the time period of ENH's alleged improvements to Highland Park Hospital. (Romano, Tr. 2998). As noted above, ENH has offered no comparison of the quality at Highland Park Hospital to other "peer" hospitals, and it is likely that Highland Park Hospital would have been part of the quality improvement trend even without the merger. (Romano, Tr. 2998).

**Response to Finding No. 2384:**

This proposed finding is vague and misleading, as it implies that the changes at HPH would have occurred regardless of the Merger due to a purported national trend in improved quality.

**REDACTED**

(Chassin, Tr. 5269, 5271-72, 5278-83, 5294, 5297, 5329-30, 5595-96; RX 2043; RX 1571 at ENHL PK 52193; RX 1985, *in camera*; RFF ¶¶ 2205-2216). The evidence showed that post-Merger HPH outperforms peer hospitals with respect to a number of different aspects – including, cardiac surgery, interventional cardiology, treatment for heart attack, oncology, obstetrics, medical information technology, and the use of intensivists. (RFF-Reply ¶¶ 2033, 2384, 2394). Some of these clinical services were not even offered by HPH before the Merger. (RFF ¶¶ 1565 (cardiac surgery), 1650-1653 (interventional cardiology), 1755 (Kellogg Cancer Care Center), 2002 (Epic), and 1672, 1677 (intensivist program)).

For example, ENH is the only hospital in the Chicago area that has accomplished such a broad implementation of a complete, electronic medical record, across inpatient and ambulatory care areas. Indeed, systems like Epic continue to be rare in community hospitals such as pre-Merger HPH. (Wagner, Tr. 3985, 3999-4000, 4082, Ankin, Tr. 5071-72, Chassin, Tr. 5368, Romano, Tr. 3334; RFF ¶¶ 2105-2109, 2118-2120).

In addition, Dr. Chassin, as well as fact witnesses, compared quality of care at HPH and Evanston Hospital with contemporaneous changes in peer group hospitals in the State of Illinois as well as nationally during the pre- and post-Merger periods. For example, Dr. Silver presented evidence that ENH as a whole outperformed a national comparison peer group with respect to

both ENH's Cesarean section rate and operative vaginal delivery rate throughout the pre- and post-Merger periods.

**REDACTED**

**REDACTED**

(RX 1769 at ENHL PK 5873, *in camera*).

**REDACTED**

(RX 1769 at ENHL PK 5873, *in camera*).

**REDACTED**

(RFF ¶

1314, *in camera*).

Further, evidence of quality in comparison to peer hospitals also occurred in cardiac surgery. Dr. Rosengart, Dr. Chassin and Dr. Romano all testified that mortality rates for ENH cardiac surgeons and for ENH and HPH as institutions were better than national standards. (RFF ¶¶ 1608-1616).

**REDACTED**

(RX 1411 at ENHL PK 51288, *in camera*; RFF ¶¶ 1622-1623). In a related matter, HPH and ENH compare favorably post-Merger to Illinois hospitals in the administration of life-saving treatments for heart attack. (RFF ¶ 2205). HPH also performs better than national benchmarks in mortality for interventional cardiology procedures including elective PCI. (RFF ¶¶ 1661-64).

Finally, the evidence showed the improvements in the oncology program at HPH in comparison to national benchmarks and typical Chicago area community hospitals. The quality improvements in the HPH oncology program are substantiated by the change in rating by the American College of Surgeons ("ACS"). Pre-Merger, the ACS rated the HPH oncology program

as a typical community hospital commensurate with its peers in Chicago. After the Merger, HPH oncology was categorized by the ACS as an academic teaching center. Moreover, post-Merger HPH was designated one of 50 Community Clinical Oncology Programs (“CCOP”) in the country by the National Cancer Institute. Generally, a community hospital like HPH would not be categorized as a CCOP, which is further evidence of the improvements at HPH outpacing that of its peers. (RFF ¶¶ 1722, 1726, 1781-1782). Dr. Dragon, an oncologist practicing in Chicago for more than 20 years, testified that post-Merger HPH provides multidisciplinary care, undertakes significant research, participates in a large number of clinical trials, and possesses advanced equipment to treat cancer patients all at a level beyond that of typical community hospitals. (RFF ¶¶ 1750-1789).

2385. From 1997 to 2004, many studies were done relating to quality of care, including by the Center for Medicare and Medicaid Services and JCAHO. The National Quality Forum also was created for building consensus around quality measures and pushing forward the quality improvement agenda nationally. (Romano, Tr. 2999).

**Response to Finding No. 2385:**

Respondent has no specific response.

2386. In 1999, the Institute of Medicine published a well known report on patient safety. (Romano, Tr. 2998; Ankin, Tr. 5079-80). This report focused a huge amount of attention on the problem of healthcare quality, patient safety, and medical errors. In the years following the 1999 Institute of Medicine report, a tremendous amount of attention and resources have been put into measuring and improving healthcare quality. (Romano, Tr. 2999). This report was followed by recommendations from the Leapfrog Group in 2000. (Ankin, Tr. 5079-80).

**Response to Finding No. 2386:**

Respondent has no specific response.

2387. There have been studies showing that people were not only studying the quality problem, but also that hospitals were actually improving their quality during the time from 1997 through 2004. (Romano, Tr. 2999).



**Response to Finding No. 2387:**

This proposed finding is a general statement about information that Dr. Romano relied upon in order to opine in this case. However, the underlying studies referenced were never admitted for the truth of the matter asserted by Complaint Counsel and therefore the reliability of this testimony is limited.

2388. Dr. Jencks, who is with the Center for Medicare and Medicaid Services, found significant improvements across the country in quality. He found that performance of the average performing hospitals improved on 20 out of 22 indicators. The average per state improvement was 12% for inpatient indicators. (Romano, Tr. 3000-01). In Dr. Jencks' study on quality improvement, the trend in the State of Illinois was consistent with the 12% improvement on the national level. (Romano, Tr. 3001).

**Response to Finding No. 2388:**

This proposed finding is a recitation of statements made by Dr. Jenks and relied upon by Dr. Romano to support his testimony in this case. However, the findings by Dr. Jenks are clearly out of court statements and, as a result, hearsay. The conclusions of Dr. Jenks were never admitted for the truth of the matter asserted by Complaint Counsel and therefore the reliability of this testimony is questionable.

2389. Other studies have also found an actual improvement nationwide in quality of care from 1997 through 2004, including studies done by the National Committee for Quality Assurance using data from health plans as well as from the Department of Veterans Affairs. (Romano, Tr. 3001).

**Response to Finding No. 2389:**

This proposed finding is of limited weight as it is based on hearsay. (RFF-Reply ¶ 2387).

2390. In the absence of the merger, from 1997 to 2004, based upon what has happened nationwide, Highland Park Hospital would have been expected to move towards a more proactive stance in quality improvement, monitoring indicators prospectively and implementing some evidence-based systems to improve care. (Romano, Tr. 3003-04).

**Response to Finding No. 2390:**

This proposed finding is misleading.

**REDACTED**

(RFF ¶¶ 1420, 1424, 1428; RFF ¶¶ 1421-1427, *in camera*).

**REDACTED**

(RFF ¶¶ 2453-2457; RFF ¶ 2458, *in camera*).

**REDACTED**

(RFF ¶¶ 1420, 1424, 1428; RFF ¶¶ 1421-1427, *in camera*).

Moreover, HPH's limited financial condition prevented it from paying department chairs or reinvesting in the quality assurance and improvement processes in the hospital. (RFF ¶¶ 2450-2452).

2391. Respondent's economics expert, Dr. Monica Noether, agrees that there has been some improvement and an increased focus on quality nationwide. (Noether, Tr. 6011, 6014). There has been greater public awareness, on the part of the consumer public, for greater hospital quality. (Noether, Tr. 6012, 6016).

**Response to Finding No. 2391:**

Respondent has no specific response.

2392. Dr. Noether also notes that other hospitals in the Chicago area, such as Lake Forest and Condell, have also expanded and upgraded their facilities in the past five years. (Noether, Tr. 6024-6025).

**Response to Finding No. 2392:**

Respondent has no specific response.

2393. The Leapfrog Group recommended intensivist coverage and computerized physician order entry after the merger. Those programs were implemented at Highland Park Hospital in 2001 (intensivist coverage) and 2003 (computerized physician order entry). (RX 1097 at ENHL PK 016335).

**Response to Finding No. 2393:**

This proposed finding is misleading. There is no evidence that HPH intended, or could afford, to implement intensivist coverage or computerized physician order entry before the Merger.

**a. Subsequent to the Merger, There Has Been an Increase in the Use of Intensivists by Hospitals**

2394.

**REDACTED**

(Romano, Tr.

3113-14, *in camera*).

**Response to Finding No. 2394:**

This proposed finding is misleading. Contrary to the conclusory statement made by Dr. Romano, the evidence showed that intensivist programs, such as the one instituted by HPH after the Merger, are not common in community hospitals. The Leapfrog Group conducted a survey of hospitals in Illinois to determine the number of intensivist programs. Only six of the 37 reporting hospitals had such a program, and three of those six programs were at ENH hospitals. (RFF ¶ 1721).

2395.

**REDACTED**

(Romano, Tr.

3113, *in camera*). There has been increasing pressure from employers and purchasers for hospitals to provide intensivist coverage, and many hospitals have established such coverage. (Romano, Tr. 3003).

**Response to Finding No. 2395:**

This proposed finding is misleading as the evidence shows that hospitals in Illinois have been slow to adopt intensivist programs and that HPH is ahead of the curve in this respect. (RFF-Reply ¶ 2394).

2396. Mark Newton, President of Swedish Covenant Hospital, agrees that critical care medicine has advanced in the last four or five years where hospitals now must have critical care physicians on-site who either manage or co-manage critical care patients. (Newton, Tr. 393).

**Response to Finding No. 2396:**

This proposed finding should be given no weight. Newton is a marketing executive and not an expert about critical care in medicine in general. (RFF ¶ 310; RFF-Reply ¶¶ 1387, 1463, 1465). Accordingly, since this proposed finding relies entirely on Newton, it is unreliable and should be given no weight. This is another example of how Newton was not a credible witness given his propensity to speculate about matters beyond his expertise.

2397. The physicians who today are staffing Highland Park Hospital's Intensive Care Unit ("ICU") are the same physicians who staffed and treated patients in that ICU before the merger. (Newton, Tr. 466).

**Response to Finding No. 2397:**

This proposed finding is misleading to the extent that it implies that the care given by the pulmonologists before the Merger is the same as that given by physicians through the intensivist program after the Merger at HPH.

**REDACTED**

(RFF ¶¶ 1677-1678, *in camera*). HPH provided physician coverage of its ICU in the manner similar to most community hospitals. (RFF ¶ 1679). Since the Merger, seven physicians and a physician-in-training or fellow provide 12-hour-a-day coverage for patients in the ICU. The fellow provides overnight coverage for HPH ICU patients. (RFF ¶¶ 1691-1703).

2398.

**REDACTED**

(Ankin, Tr. 5103-04; CX 2176, *in camera*). Dr. Ankin is the President of Pulmonary Physicians of the North Shore. (Ankin, Tr. 5033).

**Response to Finding No. 2398:**

Respondent has no specific response.

2399. Dr. Ankin, the director of Highland Park Hospital's intensivist program, agrees that the Leapfrog Group's recommendations for intensivist coverage influenced ENH's decision to implement an intensivist program at Highland Park Hospital. (Ankin, Tr. 5050-51). The Leapfrog Group's recommendations came out in the year 2000. (Ankin, Tr. 5080).

**Response to Finding No. 2399:**

This proposed finding is misleading.

**REDACTED**

(RFF ¶ 1686, *in camera*).

2400.

**REDACTED**

(Ankin, Tr. 5063; CX 2176, *in camera*). Pulmonary Physicians of the North Shore would be free to enter into a contract with a new owner of Highland Park Hospital. (Ankin, Tr. 5104). If there was a new owner of Highland Park Hospital and it agreed to a contract similar to the current contract, Pulmonary Physicians of the North Shore would entertain servicing the intensivist contract for the new owner. (Ankin, Tr. 5105).

**Response to Finding No. 2400:**

Respondent has no specific response.

2401. Lake Forest Hospital is another hospital that did not have an intensivist program before the merger, but it later implemented an intensivist program through Pulmonary Physicians of the North Shore. (Ankin, Tr. 5072-74, 5089).

**Response to Finding No. 2401:**

This proposed finding is misleading to the extent it implies the program adopted by Lake Forest is the same as HPH. Lake Forest Hospital's intensivist program is more limited than HPH's. (RFF ¶ 1719).

2402. Dr. Ankin could not fault HPH for not having an intensivist program prior to the merger because few hospitals had such a program at that time and because he was unaware of any published materials advocating such a program prior to the merger. (Ankin, Tr. 5087).

**Response to Finding No. 2402:**

This proposed finding is irrelevant. Respondent did not criticize HPH for failing to institute an intensivist program before the Merger. To the contrary, Respondent's position is that such programs are rare at community hospitals, and HPH probably would not have implemented such a program but for the Merger consistent with the practice of most community hospitals. The issue here is whether ENH's implementation of the intensivist program at HPH enhanced quality of care at that hospital as a result of the Merger. This was clearly established.

**b. There Has Been An Increase in the Use of Information Technology by Hospitals to Improve the Quality of Care**

2403. The use of electronic medical records by hospitals has increased recently among community hospitals. (Wagner, Tr. 4067-69). Many other hospitals have purchased the EPIC electronic medical record system, and systems similar to it. (Wagner, Tr. 4066-68).

**REDACTED** (CX 94 at 2, Romano, Tr. 3165, *in camera*).

**Response to Finding No. 2403:**

This proposed finding is misleading and inaccurate. First, the testimony of Dr. Wagner cited by Complaint Counsel does not support the proposition that the use of electronic medical records has increased among community hospitals. Rather, Dr. Wagner only testified that other hospitals have purchased electronic medical records systems, not that there has been an increase among hospitals or community hospitals in particular. (Wagner, Tr. 4066-69). In fact, the

evidence was undisputed that, according to the Institute of Medicine, most of the nation's hospitals' orders for medication, laboratory tests and other services are still written on paper, and many hospitals lack even the capability to deliver laboratory and other results in an automated fashion. (RX 1423 at 7; RFF ¶ 2211). The situation is no different in community hospitals, where there has been little if any migration to electronic records. (RX 1423 at 7). Moreover, Complaint Counsel's own expert witness testified that the majority of community hospitals today do not have an electronic medical record that includes CPOE systems comparable to the one installed at all three ENH hospitals. (RFF ¶ 2475).

Further, the second sentence of this proposed finding is also not supported by the cited testimony. Dr. Wagner did not testify that "many" other hospitals have purchased EPIC and systems similar to it. Instead, Dr. Wagner testified that other hospitals have purchased electronic medical records systems and that other hospitals have purchased EPIC, but only Northwestern Memorial is identified as actually purchasing EPIC. (Wagner, Tr. 4066-68). To be clear, Dr. Wagner testified that no community hospital has deployed a system-wide electronic medical record such as EPIC. (RFF ¶ 2474).

2404.

**REDACTED**

(Romano, Tr. 3161,

*in camera*).

(Romano, Tr. 3162, *in camera*).

**REDACTED**

**Response to Finding No. 2404:**

This proposed finding is misleading to the extent that its reference to recent hospitals' adoption of Epic is evidence that HPH was likely to adopt Epic. Overall, few hospitals today have a fully-functional electronic medical record with computerized physician order entry and, further, in small practice settings, there has been little, if any, migration to such systems. (RX 1423 at 7; RFF-Reply ¶ 2044; RFF ¶ 2211).

**REDACTED**

(RFF ¶ 2118, *in camera*; RFF ¶¶ 2219-2220). Finally,

there is no evidence that HPH had any intent to adopt such a system before the Merger.

2405.

**REDACTED**

(Romano, Tr. 3163, *in camera*).

**REDACTED**

(Romano, Tr. 3162-63, *in camera*).

**Response to Finding No. 2405:**

This proposed finding is misleading and not supported by the evidence. According to the Institute of Medicine, hospitals face sizable technical, policy, organizational, as well as financial challenges that must be overcome to facilitate the adoption of EMR systems. (RX 1423 at 7). For the reasons more fully stated in RFF-Reply ¶ 2044, few hospitals today have a fully-functional electronic medical record with computerized physician order entry and, further, in small practice settings, there has been little, if any, migration to such systems. (RX 1423 at 7; RFF ¶ 2211).

2406.

**REDACTED**

*in camera*).

(Romano, Tr. 3163-65,

**REDACTED**

(Romano, Tr. 3164-65, *in camera*).

(Romano, Tr. 3165, *in camera*).

**REDACTED**

**Response to Finding No. 2406:**

This proposed finding is false. HPH could not maintain Epic if divested. (RFF ¶¶ 2523-2530).

2407. The decision at ENH to purchase the EPIC system was influenced by the public recommendations of the Institute of Medicine and Leapfrog Group. (Wagner Tr. 4066; RX 1117 at ENH GW 003511).



**Response to Finding No. 2407:**

Respondent has no specific response.

2408. Other hospitals have purchased the EPIC electronic medical record system. (Wagner, Tr. 4066-67) Other hospitals in the Chicago area have purchased an integrated medical record system similar to EPIC's. (Wagner, Tr. 4067), Northwestern Memorial Hospital purchased the same EPIC system as ENH. (Wagner, Tr. 4068).

**Response to Finding No. 2408:**

This proposed finding is misleading to the extent it implies that HPH could have implemented Epic. No other community hospital has deployed an enterprise grade electronic medical records system such as Epic. (RFF ¶¶ 2118-2220).

2409. Other community hospitals have purchased an electronic medical record system. (Wagner, Tr. 4067), Northwest Community Hospital, a stand-alone community hospital in the Chicago area, is considering purchasing an electronic medical record system from McKesson. (Wagner, Tr. 4068-4069).

**Response to Finding No. 2409:**

This proposed findings is incomplete and misleading. No community hospital has deployed an enterprise-grade electronic medical record system such as Epic. (RFF ¶¶ 2119, 2474). Moreover, the vast majority of community hospitals do not have an electronic medical record with CPOE systems. (Romano, Tr. 3334; RFF ¶¶ 2119-2220).

2410.

**REDACTED**

3165, *in camera*).

(Romano, Tr. 3160,

**Response to Finding No. 2410:**

This proposed finding is incorrect. Evidence from those witnesses actually familiar with HPH's pre-Merger version of Meditech demonstrated that the capabilities of Meditech, as deployed at HPH pre-Merger, were essentially the same as those available at ENH in 1985. Meditech could not be accessed remotely, so it was used in conjunction with paper charts.

Meditech did not operate as the primary patient chart and did not allow for CPOE. Without CPOE, it is not possible to have the clinical decision support, such as alerts and reminders, that are part of EPIC today. (RFF ¶¶ 2121-2124).

2411.

**REDACTED** (CX 94 at 2; Romano, Tr. 3160, 3165, *in camera*). In 1997, Highland Park Hospital also revised its “Information Technology Strategic Plan” and began to implement key parts of that plan including looking for a new IT vendor. (CX 94 at 2).

**Response to Finding No. 2411:**

This proposed finding is misleading to the extent it equates these plans or programs to the installation of Epic. (RFF ¶¶ 2121-2127). There is no evidence that HPH planned to implement an electronic medical record system like Epic prior to the Merger.

2412. Prior to the merger, Highland Park Hospital was planning to utilize technology to support patient care by exploring the use of internet technology and expanding access to information to physician offices. (CX 1908 at 20).

**Response to Finding No. 2412:**

This proposed finding is misleading to the extent that it implies that these plans were ever executed pre-Merger at HPH.

2413. EPIC is an electronic clinical information system that includes an electronic medical record, a computer order entry system, and a clinical decision support system. (Amended Glossary of Terms at 6, April 22, 2005). There is no evidence that the merger has improved outcomes at Highland Park Hospital through the deployment of EPIC. (Wagner, Tr. 4065).

**Response to Finding No. 2413:**

The referenced glossary, by its terms, was submitted to the Court as a reference only and not as an admission by either party. Further, this proposed finding mischaracterizes Dr. Wagner’s testimony regarding the relationship between EPIC and outcomes at ENH. Dr. Wagner testified that no formal study had been conducted on EPIC’s effect on patient outcomes at ENH hospitals. (Wagner, Tr. 4065).

2414. EPIC was not deployed at Highland Park Hospital until January 2004. (Wagner, Tr. 4070).

**Response to Finding No. 2414:**

Respondent has no specific response.

2415. Only three independent physician practices have EPIC installed in their office. (Wagner, Tr. 3978).

**Response to Finding No. 2415:**

This proposed finding is misleading to the extent that it implies that Epic is not used by affiliated physicians. In fact, use of Epic, even if it is not installed in their offices, is mandatory for affiliated physicians in the ENH hospitals. (RFF ¶ 2049). ENH has trained 8,000 people to use Epic over the course of 119,352 training hours. This includes 1,500 physicians and staff at HPH. (RFF ¶ 2036).

**4. Highland Park Could Have Continued to Improve and Expand Other Clinical Services Without the Merger**

2416.

**REDACTED**

(Silver, Tr. 3791, 3834, 3841; Romano, Tr. 3159, 3177-80, *in camera*). As explained above, Complaint Counsel believes that many of the changes do not qualify as “improvements” because they reflect merely an ongoing process that took place both before and after the merger. But for a similar reason, even if they are seen as “improvements” it is clear that they could have been accomplished without the merger.

**Response to Finding No. 2416:**

This proposed finding is misleading and inaccurate. First, the conclusory statement that “HPH could have continued to improve and expand other clinical services without a merger” is not supported by the testimony of any witness with sufficient knowledge of the capabilities and financial wherewithal of HPH to improve or expand services. Dr. Silver was not at HPH pre-Merger, and Dr. Romano admitted that he has no opinion on the financial abilities of HPH. (RFF-Reply ¶ 2041). Those witnesses with knowledge of pre-Merger HPH’s ability to improve

and invest in clinical services testified that HPH did not have the financial capability to do so and was, in reality, in decline. (RFF ¶¶ 2298-2413). The remainder of this proposed finding has no basis in evidence and constitutes pure speculation by Complaint Counsel.

a. **Highland Park Hospital Could Have Implemented the Changes in Its Obstetrics and Gynecology Department Without the Merger**

2417. The changes instituted in Highland Park Hospital's obstetrics and gynecology department after the merger could have been implemented without investment in construction or equipment. (Silver, Tr. 3848-49, 3834).

**Response to Finding No. 2417:**

Respondent has no specific response.

2418. ENH instituted a pre-operative review program in the obstetrics and gynecology department that was separate from any specific concerns of physicians at the time Dr. Silver became chairman of the department. (Silver, Tr. 3780).

**REDACTED** (Silver, Tr. 3892, *in camera*).

**Response to Finding No. 2418:**

This proposed finding does not address the issue of the necessity of the Merger to implement the pre-operative review program at HPH.

**REDACTED**

(RFF ¶ 2482, *in camera*).

2419. Any deficiencies found through the pre-operative review program that might have related to Highland Park Hospital were not the reason for creating the program in the first place. (Silver, Tr. 3833-34). If the merger had not occurred, ENH still could have implemented the pre-operative review program at Evanston Hospital and Glenbrook Hospital. (Silver, Tr. 3834).

**Response to Finding No. 2419:**

This proposed finding is misleading in that it implies that HPH did not benefit from the pre-operative surgical review program resulting from the Merger. Regardless of whether the deficiencies found at HPH were the impetus for the program, the benefit was still extended to

HPH only as a result of the Merger.

**REDACTED**

(RFF ¶ 2482, *in camera*). The pre-operative review program was a quality enhancement in that, through the program, the misconduct of an HPH physician was discovered and dealt with. The importance of the program was that it shed light on a problem at HPH that was not known before the Merger and benefited patients and the Department of Obstetrics by enhancing the ability to preoperatively assess the need for elective gynecologic surgeries. (RFF ¶¶ 1311-1320). There is no reason to think that HPH would have implemented such a program absent the Merger.

2420. There has been a trend toward in-house physician coverage in hospital obstetrics departments in the region around ENH. (Silver, Tr. 3841). After Highland Park Hospital implemented in-house physician coverage in its obstetrics department, other Lake County hospitals such as Lake Forest Hospital, Condell Medical Center, and Victory Memorial Hospital also implemented in-house physician coverage in their obstetrics departments. (Silver, Tr. 3791).

**Response to Finding No. 2420:**

This proposed finding supports the fact that in-house obstetrical coverage was extended to HPH more quickly than it was to surrounding community hospitals.

2421. One of the reasons the Induction of Labor protocol was developed by the ENH OB Practice Committee was that it was an important subject area on a national level. (Silver, Tr. 3807).

**Response to Finding No. 2421:**

Respondent has no specific response.

2422. It was not necessary for ENH to construct buildings or invest in equipment in order to make changes in Highland Park Hospital's obstetrics and gynecology department such as implementation of in-house physician coverage, the pre-operative review program, changes in surgical procedures, and publishing of clinical protocols. (Silver, Tr. 3848).

**Response to Finding No. 2422:**

Respondent has no specific response.

2423. The changes made by ENH to Highland Park Hospital's obstetrics and gynecology department involved only changes in staffing levels, changes in procedures, and training of personnel, along with a budget of \$600,000 to pay stipends for ENH's obstetrics and gynecology department leaders. (Silver, Tr. 3848).

**Response to Finding No. 2423:**

This proposed finding does not correctly reflect the testimony given by Dr. Silver. Dr. Silver was asked by Complaint Counsel if the changes made by ENH to HPH's Ob/Gyn services only involved those asserted above and he said that this was not accurate. He went on to elaborate on the significant budget developed to pay physician leaders but was never asked if there were any other changes made by ENH. (Silver, Tr. 3848-49). This finding fails to account for changes in culture, leadership and nurse/physician relationships that Dr. Silver detailed extensively in his testimony. (RFF ¶¶ 1293-1300).

2424. The decision to stop doing D & Cs in the emergency room at Highland Park Hospital involved changing the location of the procedures. (Silver, Tr. 3857-58).

**Response to Finding No. 2424:**

Respondent has no specific response.

2425. If Highland Park Hospital were a stand-alone entity, it could simply pay \$150,000 per year to maintain the in-house OB physician coverage program. (Silver, Tr. 3864). If Highland Park Hospital were a stand-alone entity, it could also continue the policy of prohibiting D & Cs in the emergency room and second trimester abortions in labor and delivery. (Silver, Tr. 3864).

**Response to Finding No. 2425:**

This proposed finding is misleading to the extent that these facts establish that HPH could have made these changes without a Merger. There is no evidence in the record that pre-Merger HPH enacted either of these two changes and the evidence shows that HPH lacked the financial strength to enhance quality and the capacity to enact the necessary organizational changes to maintain the policy enhancements made by ENH. (RFF ¶¶ 2450-2458).

b. **Highland Park Hospital Could Have Implemented the Changes in Its Quality Assurance and Quality Improvement Activities Without the Merger**

2426.

**REDACTED**

(Romano, Tr.

3159, 3170-71, *in camera*).

**Response to Finding No. 2426:**

This proposed finding is speculative and not supported by the substantial evidence.

Specifically HPH could not have changed its QA and QI activities without the extensive clinical integration and collaborative culture exported by ENH to HPH via the Merger. For example, a complete transformation of leadership was required to bring about changes in quality assurance.

Before the Merger, there was no effective physician discipline, and the physician leaders were unable to address physician behavior. Issues with QI and QA activities could not be solved because HPH lacked a culture – throughout the hospital, throughout the administration, or through physician leadership – that promoted the necessary changes. (RFF ¶¶ 2453-2458).

Finally, and significantly, the undisputed evidence from the record showed that HPH did not correct its substantial problems with its quality assurance and quality improvement programs until the Merger. (RFF ¶¶ 1420-1459, 1464-1468). For example, there were statistically significant improvements in the use of aspirin therapy for heart attack patients at HPH immediately after the Merger, improvements that Dr. Chassin found was due to the Merger and attendant expert of Evanston Hospital's exportation of its superior quality improvement processes to HPH. (RFF ¶¶ 1495, 1509; Chassin, Tr. 5279-80).

2427.

**REDACTED**

(Romano, Tr. 3159, *in camera*).

**Response to Finding No. 2427:**

Respondent has no specific response.

2428.

**REDACTED**

(Romano, Tr. 3158-59, *in camera*).

**REDACTED**

(Romano, Tr. 3159, *in camera*).

**Response to Finding No. 2428:**

This proposed finding is speculative and not supported by the substantial evidence.

(RFF-Reply ¶ 2426).

2429.

**REDACTED**

(Romano, Tr. 3170-71, *in camera*). In developing the critical pathways ENH implemented at Highland Park Hospital, Highland Park Hospital's pre-merger care maps were taken into account. (CX 6286 at 4; O'Brien, Tr. 3560-61).

**Response to Finding No. 2429:**

Respondent has no specific response.

- c. **Highland Park Hospital Could Have Improved Its Physical Plant Without the Merger**

2430.

**REDACTED**

(Romano, Tr. 3177, *in camera*).

**Response to Finding No. 2430:**

This proposed finding is inaccurate and misleading. HPH lacked the financial resources to rectify deficiencies in the physical plant of the hospital, or to undertake the \$120 million of improvements completed by ENH after the Merger. (RFF ¶¶ 2446-2452).

2431.

**REDACTED**

(Romano, Tr. 3177, *in camera*).



**Response to Finding No. 2431:**

Respondent has no specific response.

2432. Highland Park Hospital's financial wherewithal to make the investments necessary to improve the physical plant is discussed below. (See CCF 2440-2443).

**Response to Finding No. 2432:**

This proposed finding is inaccurate and misleading. (RFF-Reply ¶ 2430).

**d. Highland Park Hospital Could Have Implemented the Changes in Its Laboratory Without the Merger**

2433.

**REDACTED**

(Romano, Tr. 3178, *in*

*camera*).

**Response to Finding No. 2433:**

This proposed finding is incorrect. ENH made at least \$1.6 million in investment in equipment and the creation of a histology lab at HPH. (RFF ¶¶ 1830, 1835). Further, as HPH did not maintain an on-site laboratory that it had control over the other changes in laboratory services such as remedying personnel issues, environmental concerns, water issues, laboratory manuals, quality control, and computer systems could not have been made. (RFF ¶ 1793, 1801-1855). Moreover, HPH did not have access to ENH specialists or pathologists who now oversee the HPH lab and have the ability to enhance their skills by rotating to other ENH campuses. (RFF ¶¶ 1852-1855).

2434.

**REDACTED**

(Romano, Tr. 3179, *in camera*).

**Response to Finding No. 2434:**

This proposed finding is vastly overbroad and incorrect. The evidence shows that HPH lacked the financial resources to make the quality enhancements made by ENH to the lab. (RFF

¶¶ 2450-2452). Moreover, HPH made many more changes than merely updating equipment to its lab. For example, ENH opened new histology and cytology labs. Moved all laboratory services to HPH reducing turn around times and provided specialists to oversee the HPH lab. (RFF ¶¶ 1827-65).

2435. Before the merger, Highland Park Hospital had a joint venture with Lake Forest Hospital in laboratory services through Consolidated Medical Laboratories, which was dissolved after the merger. (CX 10 at 2).

**Response to Finding No. 2435:**

Respondent has no specific response.

**e. Highland Park Hospital Could Have Implemented the Changes in Its Pharmacy Services Without the Merger**

2436.

**REDACTED**

(Romano, Tr.

3180, *in camera*).

**Response to Finding No. 2436:**

HPH was in no condition financially to rectify the issues it had with physical plant and undertake all of the vast improvements completed by ENH after the Merger. (RFF ¶¶ 2450-2452). To implement the Pyxis system hospital-wide, as accomplished by ENH, it would have cost HPH \$1 to 2 million. (RFF ¶ 1978). There is no evidence that HPH ever had any plan to implement a Pyxis system on this scale pre-Merger.

2437. In the late 1990s, the pharmacy at Highland Park Hospital was centralized, but had plans to move to a more decentralized operation. Equipment for a Pyxis system of drug distribution is not expensive for a hospital, around \$20,000 per machine. (Newton, Tr. 397, 399).

**Response to Finding No. 2437:**

This proposed finding is misleading. To implement the Pyxis system hospital-wide, as accomplished by ENH, it would have cost HPH \$1 to 2 million. (RFF ¶ 1978).

**f. Highland Park Hospital Could Have Implemented the Changes in Its Radiology Department Without the Merger**

2438.

REDACTED

(Romano,

Tr. 3184, *in camera*).

**Response to Finding No. 2438:**

Respondent has no specific response.

2439. The PACS technology ENH implemented at Highland Park Hospital was beginning to be available in the late 1990s. Highland Park Hospital had considered purchasing the technology, but had not made a decision by the time of the merger. Capital was available if the hospital wanted to move toward a PACS system. (Newton, Tr. 401; Spaeth, Tr. 2137-38. See generally CX 545 at 3).

**Response to Finding No. 2439:**

HPH did not have the resources to purchase in implement the Pictorial Archiving Communication System (“PACS”) system across the hospital as ENH did after the Merger. (RFF ¶¶ 2450-2452).

**5. Highland Park Hospital Possessed the Financial Assets to Implement Quality Changes on Its Own**

2440. Highland Park’s financial wherewithal is discussed in detail at (CCFF 302-372). Highland Park Hospital was financially able to implement the quality changes on its own. (CX 97 at 1; CX 545 at 3; CX 627 at 6; CX 1877 at 1; CX 1065 at 2-3; Newton, Tr. 383-84, 430-31; Spaeth, Tr. 2138, 2147).

**Response to Finding No. 2440:**

This proposed finding is inaccurate. The evidence established that HPH lacked the financial capacity to implement the quality improvements undertaken by ENH after the Merger. (RFF ¶¶ 2450-2452). Moreover, HPH’s financial condition was in rapid decline and the future financial projections relied upon by Complaint Counsel as evidence that HPH was able to implement changes on its own were unrealistic. (RFF ¶¶ 2319-2392, 2393-2404).

2441. In the absence of the merger, Highland Park Hospital would have gone forward with the Strategic Plan and the Financial Plan, both of which were adopted by Lakeland Health Service's and the hospital's finance committees as well as Highland Park's board. (Spaeth, Tr. 2146, 2155; CX 1055 at 3; CX 96 at 4). In March 1999, the finance committee concluded that the hospital would remain "financially strong over the foreseeable future." (Spaeth, Tr. 2147; CX 1055 at 3).

**Response to Finding No. 2441:**

This proposed finding is inconsistent with the evidence presented at trial. HPH's financial projections were inconsistent with HPH's historical fiscal trend line. HPH's future plans, as a result, were unrealistic. These conclusions were supported by fact witness and expert witness testimony as well as contemporaneous documents. (RFF ¶¶ 2393-2413).

2442. Prior to the merger, Highland Park Hospital routinely made capital investments to upgrade and improve the facilities. (Newton, Tr. 383-84).

**Response to Finding No. 2442:**

This proposed finding is incorrect. Pre-Merger HPH had outdated and outmoded equipment in several service areas. (RFF ¶ 2378). Before the Merger, HPH was reducing its spending on capital expenditures, and the level of investment was only equal to HPH's depreciation expenses. (RFF ¶ 2379). Moreover, the evidence established that capital investments that were made were insufficient to maintain critical systems, and that HPH had significant deficiencies in its physical plant before the Merger. In fact, HPH was sent a notice of intent to terminate its Medicare participation from HCFA as a result of its deficiencies in HPH's facilities. (RFF ¶ 2377). Further, according to an independent architectural review undertaken by ENH in its due diligence, HPH required \$15-19 million in "critical facilities improvements in order to maintain code compliance, provide for critical life safety measures, mechanical, and electrical requirements." (RFF ¶ 2376-2386).

2443. Highland Park continued to plan to make capital investments and improvements just prior to the merger. Highland Park Hospital's 1999 long-range capital budget had two major

components. One was for \$43 million for ambulatory, assisted-living, and facility expansion programs. The second component was another \$65 million for routine hospital construction. (Newton, Tr. 430-31; Spaeth, Tr. 2137-38; CX 545 at 3; CX 1055 at 2). The \$108 million specified in Highland Park Hospital's pre-merger long-range capital budget would have come out of operating earnings and cash and investments. (Newton, Tr. 431).

**Response to Finding No. 2443:**

This proposed finding is misleading. HPH's plans for capital investment and improvements were unrealistic in light of its financial condition. (RFF ¶¶ 2393-2413).

**D. Virtually All of the Alleged Quality Improvements Occurred After Health Care Contracts Were Re-Negotiated**

2444. Virtually all of the quality improvements claimed by ENH occurred after it had renegotiated its healthcare contracts at significantly higher rates. (See CCF 756, 759, 762, 765, 767, 831-832, 853, 855, 887, 970, 1094, 1221, 1289, 1306, 1308, 1311-1312).

**Response to Finding No. 2444**

This proposed finding is incomplete and misleading. Although the improvements at HPH occurred after renegotiation, the record evidence demonstrated that MCOs were aware of the planned quality improvements at the time of the contract re-negotiations in 1999 and 2000. When Evanston Hospital and HPH signed the letter of intent in June of 1999, ENH widely distributed press releases to news agencies and MCOs detailing ENH's plans for capital expansion and quality enhancement at HPH. (RX 563, RX 564). In addition, MCOs such as

**REDACTED**

(RX

1208 at UHCENH 3394-98, *in camera*). Further, the topic of capital improvements was also discussed during the contract renegotiations.

**REDACTED**

(Mendonsa, Tr. 537, *in camera*).

Finally, the following 24 proposed findings are admissions by Complaint Counsel of the many quality enhancements that were a direct result of the Merger. Since ENH did not have authority to run and manage HPH until the Merger was legally consummated, it is obvious why the improvements did not occur prior to the closing. Although planning and work regarding most of the improvements began after the letter of intent in 1999, the actual physical improvements could not have been realized unless and until the Merger was finalized.

2445. Highland Park Hospital's new ambulatory care center did not open until February 2005. (O'Brien, Tr. 3498).

**Response to Finding No. 2445**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2446. ENH opened a new open heart surgery suite at Highland Park Hospital in April 2000. The open heart surgery program started at Highland Park Hospital in June 2000. (O'Brien, Tr. 3504-05; Rosengart, Tr. 4482).

**Response to Finding No. 2446**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2447. ENH started a construction project at Highland Park Hospital in December 2003 to remodel patient units. (O'Brien, Tr. 3510).

**Response to Finding No. 2447**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2448. The equipment in the cardiac cath lab began to be upgraded in April 2000 in order to be able to start doing interventional cardiac cath. (O'Brien, Tr. 3488-89). Changes in HPH's cardiac cath lab were not completed until March 2002. (O'Brien, Tr. 3490).

**Response to Finding No. 2448**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2449. ENH did not extend RADNET, its radiology information system, to Highland Park Hospital until February 2001. (O'Brien, Tr. 3494). In February or March 2001, ENH also extended PACS, its filmless radiology system, to Highland Park Hospital. (O'Brien, Tr. 3494-95).

**Response to Finding No. 2449**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2450. ENH added equipment to the HPH radiology department after the merger, but ENH did not add the majority of the equipment until 2002 and later (equipment costing \$2.3 million was added in 2000 and 2001 and equipment costing \$4.1 million was added in 2002, 2003, and 2004). (O'Brien, Tr. 3496-97).

**Response to Finding No. 2450**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2451. In the spring of 2001, ENH made changes to the psychiatry services to provide adolescent services at Highland Park Hospital and adult services at Evanston Hospital. (O'Brien, Tr. 3516-17). Before then, both hospitals had provided psychiatric services to adolescents and adults. An upgraded adolescent psychiatric unit did not open at Highland Park Hospital until December 2003. (O'Brien, Tr. 3518).

**Response to Finding No. 2451**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2452. EPIC began to be operational at ENH in 2003 and became fully implemented at all sites by April 2004. (Neaman, Tr. 1251).

**Response to Finding No. 2452**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2453. ENH did not implement the EPIC computer system at Highland Park Hospital until December 2003. (O'Brien, Tr. 3495-96). The physician order entry system component of EPIC was not implemented at HPH until five months later (April 2004). (O'Brien, Tr. 3521-22).

**Response to Finding No. 2453**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2454. ENH did not implement an intensivist program at Highland Park Hospital until May 2001. (O'Brien, Tr. 3529; Ankin, Tr. 5041).

**Response to Finding No. 2454**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2455. Veronica Zaman joined Highland Park Hospital as its vice president of nursing in August 2002. (O'Brien, Tr. 3538, 3575). Significant changes in the nursing culture at Highland Park Hospital did not occur until the period 2002 to 2004. (O'Brien, Tr. 3536-37).

**Response to Finding No. 2455**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2456. ENH took over the management of the Highland Park Hospital lab on June 1, 2000. (Victor, Tr. 3600). Dr. Rosencrans, a clinical laboratory scientist, was placed in the HPH lab in the fall of 2000. (Victor, Tr. 3618). ENH constructed new histology and cytology labs at Highland Park Hospital over the summer and fall and winter of 2000. (Victor, Tr. 3619).

**Response to Finding No. 2456**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2457. A replacement computer system was installed in the lab at Highland Park Hospital on June 1, 2000. (Victor, Tr. 3627-28). The earliest that lab results from Highland Park Hospital would have been available through the EPIC computer system at ENH was December 2003. (Victor, Tr. 3649).

**Response to Finding No. 2457**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2458. Dr. Silver became chairman of ENH's OB/GYN department in spring 2001. (Silver, Tr. 3841).

**Response to Finding No. 2458**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2459. ENH's OB/GYN department did not initiate the preoperative surgical review program until the fall of 2001. (Silver, Tr. 3889-90).

**REDACTED**

(Silver, Tr. 3892-93, *in camera*).

**Response to Finding No. 2459**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2460. ENH did not implement the in-house physician coverage program in the obstetrics department at Highland Park Hospital until the summer of 2001. (Silver, Tr. 3842).



**Response to Finding No. 2460**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2461. The dates that the various OB Practice Committee Protocols were implemented range from October 17, 2001, to May 31, 2004. (RX 1416 at ENHL PK 054590).

**Response to Finding No. 2461**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2462. The D&C surgical procedures performed in HPH's ER and the second trimester abortions performed in labor/delivery at HPH were not stopped at those particular locations until after the spring of 2001 (after Dr. Silver became chairman of the OB/GYN department at ENH). (Silver, Tr. 3857-58).

**Response to Finding No. 2462**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2463. Phase I of the HPH emergency department renovation involved the major clinical areas of the emergency room. (Harris, Tr. 4219). The Phase I renovation was not completed until September 2001. (Harris, Tr. 4219; RX 1148 at ENH GW 000271).

**Response to Finding No. 2463**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2464. Phase II of the HPH emergency department renovation involved mostly the non-clinical areas of the emergency room, such as the registration area, the triage room, and the waiting room. (Harris, Tr. 4226; RX 1148 at ENH GW 000271). The Phase II renovation was not complete until approximately December 2001. (Harris, Tr. 4226).

**Response to Finding No. 2464**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2465. Double physician coverage in the emergency room at HPH did not begin until July 2001. (Harris, Tr. 4230-31; RX 1148 at ENH GW 000271).

**Response to Finding No. 2465**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2466. The new equipment used to provide oncology services did not become available until the new Kellogg Cancer Care Center opened in February 2005. (Dragon, Tr. 4390).

**Response to Finding No. 2466**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2467. The PET scan technology has been commercially available for the last two to three years. Neither Evanston Hospital nor Glenbrook Hospital has a PET scanner. (Dragon, Tr. 4393-94).

**Response to Finding No. 2467**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2468. ENH did not add a third shift pharmacist at Highland Park Hospital until the summer of 2003. (Kent, Tr. 4849). ENH did not install Pyxis machines at Highland Park Hospital until near the end of 2000. (Kent, Tr. 4854-55).

**Response to Finding No. 2468**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

2469. The pharmacists at Highland Park Hospital did not become decentralized until near the end of the 2000. (Kent, Tr. 4865). The ICU pharmacist did not begin practicing at Highland Park Hospital until the end of the year 2000 as the first decentralized pharmacist. (Kent, Tr. 4866-67). HPH pharmacists began participating in clinical rounds at the end of 2000 at HPH. (Kent, Tr. 4866).

**Response to Finding No. 2469**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2444).

**E. ENH Did Not Negotiate Managed Care Contract Price Increases with Health Plans on the Basis of Quality Improvements**

2470. During the internal contract negotiation strategy discussions at ENH during the winter of 2000, there was no discussion about the cost of making quality changes. (Newton, Tr. 366, 368).

**Response to Finding No. 2470:**

This proposed finding is irrelevant because it is based solely on Newton's testimony, which was not credible. (RFF-Reply ¶ 1465). Specifically, Newton did not have responsibility for financial matters. He did not have primary responsibility for Merger strategy. He was

excluded from most Merger discussions. And he was not primarily responsible for managed care contracting at HPH and certainly not at Evanston Hospital. (Spaeth, Tr. 2283-84, Newton, Tr. 436, 452-54, 512-13).

2471. In the late 1990s, health plans would generally require Highland Park Hospital to have JCAHO accreditation as a term in their contracts. (Newton, Tr. 384-85).

**Response to Finding No. 2471:**

This proposed finding is misleading because JCAHO accreditation is only a minimum standard. (Holt-Darcy, Tr. 1421; Styer, Tr. 5024-25, 5030; RFF ¶ 1519-1520; RFF-Reply ¶¶ 1165-1166). In fact, the vast majority of hospitals in the United States receive JCAHO accreditation. (Newton, Tr. 460-61). And many hospitals receive JCAHO scores around 95. (Spaeth, Tr. 2122). Before the Merger, Chicago hospitals in general received JCAHO scores in the mid-90s. (Spaeth, Tr. 2149; RFF ¶ 1521; RFF-Reply ¶ 1167).

2472. PHCS assesses the quality of care of hospitals in its network by looking at JCAHO accreditation or accreditation by the Osteopathic Society. PHCS also looks at Medicare certification. (Ballengee, Tr. 186).

**Response to Finding No. 2472:**

This proposed finding is misleading because JCAHO accreditation is only a basic measure of hospital quality. (RFF-Reply ¶ 2471). Medicare certification is also a minimum standard because it is often based on nothing more than the results of a JCAHO accreditation survey. (RX 545 at ENH JH 11578; RFF ¶ 1530).

2473. For PHCS, the negotiations with ENH after the merger in 2000 did not involve any quality issues. In addition, ENH never claimed that costs were going to rise because of quality changes at Highland Park Hospital. PHCS did not feel that, in agreeing to price increases with ENH, PHCS was paying for more quality at Highland Park Hospital. (Ballengee, Tr. 187-88).

**Response to Finding No. 2473:**

This proposed finding is misleading for several reasons. First, ENH's negotiations with PHCS did not involve quality issues because, as Hillebrand testified, "quality is not a factor in [MCOs] contract negotiating." (Hillebrand, Tr. 1783).

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

**REDACTED**  
(Ballengee, Tr. 158-59; Holt-Darcy, Tr. 1590, *in camera*; RFF ¶ 102, *in camera*).

**REDACTED**

(Mendonsa, Tr. 565, *in camera*; Ballengee, Tr. 158-59, 189; Holt-Darcy, Tr. 1590, 1592-93, *in camera*; RFF ¶ 103, *in camera*). Given that PHCS labeled Evanston Hospital a teaching hospital affiliated with Northwestern Medical School, whether or not quality was discussed during the 2000 negotiations is immaterial. (Ballengee, Tr. 159, 212; RX 107 at GWL 859; RFF-Reply ¶ 1632). PHCS and Ballengee understood that they were paying for ENH's academic services, which were now being extended to HPH.

Further, MCOs – including PHCS – received press releases in July 1999 that announced Evanston Hospital's commitments to add tertiary services and expand its academic base to HPH. (RX 563 at ENH TH 1570-71; Hillebrand, Tr. 1857-58; RFF ¶ 268). Neaman and Spaeth held a press conference that was also later reported in all the major Chicago media. (Hillebrand, Tr. 1858). And just before the Merger, Spaeth and HPH communicated to the HPH community the types of services the Merger would bring to HPH. (Spaeth, Tr. 2304; RFF ¶ 284). Hillebrand also recalled that ENH's planned service line additions at HPH, including the initiation of

cardiac surgery, was a point of conversation in several meetings with MCOs. (Hillebrand, Tr. 1859).

2474. As of April 1, 2000, the date that the new contract between PHCS and ENH became effective, PHCS had no knowledge of any improvements in quality at Highland Park Hospital. (Ballengee, Tr. 188).

**Response to Finding No. 2474:**

This proposed finding is misleading because PHCS and Ballengee already understood that they had negotiated for ENH's academic services, which were now being extended to HPH. Further, PHCS received the July 1999 press release announcing Evanston Hospital's commitments to add tertiary services and expand its academic base to HPH. (RFF-Reply ¶ 2473).

2475. PHCS considers the quality of care at Highland Park Hospital to be the same today as it was before the merger. (Ballengee, Tr. 187).

**Response to Finding No. 2475:**

This proposed finding is based solely on Ballengee's clearly under-informed opinion of post-Merger HPH. At trial, Ballengee claimed that she was not even aware of HPH's new cardiac surgery unit or its Kellogg Cancer Care Center, all things she could have easily read about in the July 1999 press release or since the Merger personally verified. (Ballengee, Tr. 201; RFF-Reply ¶ 2473).

2476. ENH has not told PHCS about any quality changes in Highland Park Hospital. (Ballengee, Tr. 188). PHCS was unaware of any changes at Highland Park Hospital involving heart surgery, invasive cardiology, cancer care, emergency services, intensive care, radiology, and information systems. (Ballengee, Tr. 201-03).

**Response to Finding No. 2476:**

This proposed finding is based solely on Ballengee's clearly under-informed opinion of post-Merger HPH. (RFF-Reply ¶ 2475).

2477. As of September 2003, Jillian Foucre of United did not know whether the merger of ENH and Highland Park Hospital had created an improved healthcare system that enhanced the quality of care at each hospital. (Foucre, Tr. 926-27). ENH has never provided United with information necessary to evaluate the quality of care at ENH. (Foucre, Tr. 927).

**Response to Finding No. 2477:**

This proposed finding is misleading because it is the perception of quality that matters more to MCOs. (RFF-Reply ¶ 2473).

**REDACTED**

(RFF-Reply ¶ 2473, *in camera*; Foucre, Tr. 1112, *in camera*).

2478.

**REDACTED**

(Mendonsa, Tr. 538, *in camera*).

**Response to Finding No. 2478:**

This proposed finding is misleading because JCAHO accreditation is only a minimum standard. (RFF-Reply ¶ 2471).

2479.

**REDACTED**

*in camera*).

(Mendonsa, Tr. 538,

**Response to Finding No. 2479:**

This proposed finding is incomplete and misleading.

**REDACTED**

(Mendonsa, Tr. 565, *in camera*; RFF ¶ 103, *in camera*).

**REDACTED**

(Mendonsa, Tr. 565, *in camera*;

Ballengue, Tr. 158-59, 189; Holt-Darcy, Tr. 1589, 1592-93, *in camera*; RFF ¶ 103; RFF-Reply ¶ 2473).

2480.

**REDACTED**

(Mendonsa, Tr. 537-38, *in camera*).

**Response to Finding No. 2480:**

This proposed finding is misleading. (RFF-Reply ¶¶ 2473, 2479).

**REDACTED**

(Mendonsa, Tr. 538, *in camera*; Hillebrand, Tr.

1783).

**REDACTED**

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

**REDACTED**

(Mendonsa, Tr. 565, *in camera*; Noether, Tr. 5922; RX 1912 at 60; RFF ¶ 559 (showing that ENH had enough medical residents per bed to easily qualify as a “major teaching hospital” under MedPAC standards)). Therefore, because ENH was an “academic teaching hospital” with a very high public perception, Mendonsa understood that Aetna was paying for ENH’s academic services, which were now being extended to HPH. Further, Aetna received the July 1999 press release announcing the plans to add tertiary services and expand Evanston Hospital’s academic base to HPH. (RX 563 at ENH TH 1570-71; Hillebrand, Tr. 1857-58; RFF ¶ 268; Mendonsa, Tr. 537-38, *in camera*).

2481. With regard to quality, One Health looked to make sure that hospitals were accredited and licensed by Medicare and the state. (Neary, Tr. 625). During negotiations between ENH and One Health after the merger in connection with managed care pricing, no one from ENH talked about quality of care. (Dorsey, Tr. 1447).

**Response to Finding No. 2481:**

This proposed finding is misleading because Medicare accreditation standards are not strict. (RFF-Reply ¶¶ 2471-2472). This proposed finding is further misleading because MCOs primarily care about the perception of quality. And because One Health viewed Northwestern Memorial and Advocate Lutheran General as alternatives to ENH, One Health understood that it was paying for ENH's academic/tertiary services, which were extended to HPH after the Merger. (RFF-Reply ¶¶ 1633, 2473, 2479-2480, 2482).

2482. During negotiations between ENH and One Health after the merger in connection with managed care pricing, no one from ENH talked about quality increases or plans to improve quality in the future. (Neary, Tr. 624; Dorsey, Tr. 1447-48). In a telephone conversation with One Health personnel during contract negotiations after the merger, ENH's Chief Operating Officer, Jeffrey Hillebrand, did not say anything about higher quality services. (Dorsey, Tr. 1450).

**Response to Finding No. 2482:**

This proposed finding is misleading. (RFF-Reply ¶¶ 2473, 2481).

2483. In negotiating with One Health after the merger, ENH did not promise to improve quality in return for higher prices. (Neary, Tr. 627). The language in the managed care contracts between One Health and ENH relating to quality remained the same before and after the merger. (Neary, Tr. 625).

**Response to Finding No. 2483:**

This proposed finding is misleading. (RFF-Reply ¶ 1633, 2473, 2479-2480, 2482).

2484. As of September 2004, Patrick Neary of One Health did not know that Highland Park Hospital had made any changes relating to cardiac surgery, invasive cardiology, emergency department, intensive care, radiology, or cancer care. (Neary, Tr. 639-40).

**Response to Finding No. 2484:**

This proposed finding is based solely on Neary's clearly under-informed opinion of post-Merger HPH. Evanston Hospital made very public commitments to add such services to HPH



and a simple visual inspection would have confirmed that these commitments were kept. (RFF-Reply ¶ 2473).

2485.

**REDACTED**  
, (Holt-Darcy, Tr. 1546, *in camera*).

**Response to Finding No. 2485:**

This proposed finding is extremely misleading.

**REDACTED**

(Holt-Darcy, Tr.

1546, *in camera*). In fact, Hillebrand testified that certain of ENH's planned service line additions to HPH, including the initiation of cardiac surgery, were a point of conversation in several meetings with MCOs. (Hillebrand, Tr. 1859). But even assuming Unicare and ENH did not discuss new services, Unicare, like every other MCO in the Chicago area, received a press release in July 1999 announcing Evanston Hospital's commitments to add tertiary services and expand its academic base to HPH. (RX 563 at ENH TH 1570-71; Hillebrand, Tr. 1857-58; RFF ¶¶ 284, 268; Spaeth, Tr. 2304; RFF).

**REDACTED**

(RFF-Reply ¶ 1779, 2473, 2479-2480, 2482-2483).

2486. ENH's Chief Executive Officer, Mark Neaman, did not recall seeing any documents linking the new contract prices negotiated with health plans in 2000 with the costs of quality improvements that ENH intended to implement at Highland Park Hospital. (Neaman, Tr. 1241-42).

**Response to Finding No. 2486:**

Respondent has no specific response.

2487. ENH's Chief Operating Officer, Jeffrey Hillebrand, whose responsibilities at ENH include managed care contracting, did not believe that quality of care is a factor for health plans when they negotiate managed care contracts. (Hillebrand, Tr. 1783).

**Response to Finding No. 2487:**

This proposed finding is misleading. Hillebrand did not believe that quality of care is a factor for MCOs when they negotiate contracts. (Hillebrand, Tr. 1783). MCOs, instead, rely on a hospital's perceived quality. For this reason, Bain advocated that ENH emphasize its brand name during negotiations. Given the very public commitments ENH made to HPH, the MCOs ultimately understood that they were paying for ENH's academic/tertiary services, which were extended to HPH after the Merger. (RFF-Reply ¶¶ 1779, 2473, 2479-2480, 2482-2483).

2488. ENH does not advertise to managed care companies. (Hillebrand, Tr. 1999).

**Response to Finding No. 2488:**

This proposed finding is extremely misleading. Hillebrand testified that Evanston Hospital has been running advertisements since the 1970s, first using newspapers and direct mail, and now ENH uses TV, radio, focus groups, and community activities among other means to get out its message and brand name to the public. (Hillebrand, Tr. 1999-2000). And while the ultimate target of these ads is the patient, it would be impossible for MCOs and their personnel not to take notice of these very public pieces of information about ENH and its capabilities. (Hillebrand, Tr. 2000). Moreover, MCOs were one of the specific targets of the July 1, 1999, press release detailing the aims of the Merger. (RFF-Reply ¶ 2473).

2489. During contract negotiations with health plans after the 2000 merger, Mr. Hillebrand never told anyone from health plans that the higher prices that ENH was seeking were justified by quality improvements that would be implemented in the future. (Hillebrand, Tr. 1784).

**Response to Finding No. 2489:**

This proposed finding is misleading because MCOs primarily care about the perception of quality, a characteristic the MCOs understood was one of ENH's strong points. (RFF-Reply ¶ 2487).

2490. Lois Huminiak, ENH's Director of Performance Improvement, has not been involved in negotiating contracts with payers, nor has anyone within her area of responsibility been involved in negotiating such payer contracts. (CX 6285 at 2 (Huminiak, Dep.)).

**Response to Finding No. 2490:**

This proposed finding is misleading. Because ENH realized that MCOs are not interested in discussing quality, ENH had no incentive to involve people like Huminiak with contract negotiations. (RFF-Reply ¶ 2487).

2491.

**REDACTED**

(CX 6285 at 3 (Huminiak, Dep.), *in camera*).

**Response to Finding No. 2491:**

This proposed finding is misleading. (RFF-Reply ¶ 2487).

2492. Peggy King, ENH's Senior Vice President, is responsible for quality initiatives. She has been the quality coordinator at ENH since 1994. (CX 6286 at 3 (King, Dep.)). Ms. King is not involved at all in negotiating contracts with third-party payers. No one who is involved in contract negotiations with third-party payers has ever asked her for quality related information. (CX 6286 at 5 (King, Dep.)).

**Response to Finding No. 2492:**

This proposed finding is misleading. Because ENH realized MCOs are not interested in discussing quality, ENH had no incentive to include people like King. (RFF-Reply ¶ 2487).

2493. Mary O'Brien has been president of Highland Park Hospital since October 2002. From October 2000 to October 2002, she served as executive vice president at Highland Park Hospital, and prior to that she served as senior vice president at Evanston Hospital since 1998. In these positions (except executive vice president of Highland Park), Ms. O'Brien

has had responsibilities for quality and quality initiatives. (CX 6287 at 2 (O'Brien, Dep.)).

**Response to Finding No. 2493:**

Respondent has no specific response.

2494. Ms. O'Brien has never been involved in negotiating contracts with third-party payers. She has never worked with employees who work on contract negotiations with third-party payers, and no one within any of the groups she has been part of at ENH has ever been involved in third-party payer negotiations. (CX 6287 (O'Brien, Dep. at 19)). She knows of no one in the quality improvement group at ENH who has been involved in negotiations with third-party payers. (O'Brien, Tr. 3575).

**Response to Finding No. 2494:**

This proposed finding is misleading. Because ENH realized MCOs are not interested in discussing quality, ENH had no incentive to include people like O'Brien. (RFF-Reply ¶ 2487).

2495. Around September 2003, ENH asked United to send a letter to the FTC stating that the merger of ENH and HPH created an "improved and expanded integrated healthcare delivery system that has enhanced the quality of care delivered at each of their hospitals." (Foucre, Tr. 921, 926; CX 6284 at 2). United refused to send the letter to the FTC. (Foucre, Tr. 924, 927).

**Response to Finding No. 2495:**

This proposed finding is misleading. (RFF-Reply ¶¶ 1019, 1023). It bears emphasis that both sides agree that Moeller, the president and CEO of United, requested the draft letter and pursuant to that request, Hillebrand provided it. (Foucre, Tr. 923; Hillebrand, Tr. 1887). Accordingly, the evidence upon which this finding is based should be accorded no weight. (Foucre, Tr. 928 (ruling that the Court will be mindful of CX 6284's due weight)).

And to be clear, Foucre testified that she did not know whether the above cited statement was true. (Foucre, Tr. 926-27).

**REDACTED**

**REDACTED**

(RFF-Reply ¶ 2473, *in camera*;

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

2496. To determine whether ENH had improved quality after the merger, United would have needed information that included re-admission rates, complication rates, average length of stay, and other measures of that nature. (Foucre, Tr. 927).

**Response to Finding No. 2496:**

This proposed finding is irrelevant, incomplete and misleading because Moeller, United's President and CEO, requested the draft letter and, pursuant to that request, Hillebrand provided it to him. (RFF-Reply ¶¶ 1019, 2495). Moreover, there is no indication that United followed up its request for the letter with a request for the information Foucre deemed necessary to determine whether the Merger improved quality.

**XVII. ENH'S NON-PROFIT STATUS DID NOT RESTRAIN ITS EXERCISE OF MARKET POWER**

**A. ENH's Not-For-Profit Status Did Not Affect Its Approach to Post-Merger Price Increases**

2000 Contract Changes

2497. As part of the merger with Highland Park, ENH decided to renegotiate contracts with the health plans in 2000. (Neaman, Tr. 1031).

Response to Finding No. 2497

Respondent has no specific response.

2498. When ENH set prices for the 2000 contract re-negotiations with health plans, the fact that it was a non-profit entity did not weigh in as a reason not to take actions toward higher prices. (Neaman, Tr. 1032-33).

Response to Finding No. 2498

This proposed finding is misleading. The trial record illustrated that, during the 2000 contract re-negotiations, ENH needed additional revenue to fulfill its mission as a non-profit hospital – *i.e.*, “to maintain the organization’s viability to meet its long-term commitment to the communities it serves.” (RX 1004 at ENH GW 3501; RFF ¶¶ 1-2). The record evidence showed that all area hospitals, including ENH, were suffering from Medicare cuts that forced cost reductions and efforts to obtain increased revenue from other areas. (RFF ¶¶ 105-115). As an academic hospital, ENH lost approximately \$80 million in revenue over five years. (RX 551 at ENH DR 3196; Hillebrand, Tr. 1844). Since ENH needed more revenue – not less – its status as a non-profit hospital with a commitment to remain viable drove the hospital to find new areas of revenue to continue the public service mission of the hospital. (RFF ¶¶ 624-645). Through an examination of HPH’s managed care contracts, ENH became aware that it had been severely underpaid by MCOs for years and sought to obtain needed revenue from under-market managed care contracts. (RFF ¶¶ 656-669). Acting in accordance with its status as a not-for-profit

hospital, ENH used its new knowledge of under-market contracts to obtain more revenue from MCOs, thus enabling the hospital to continue its mission.

2499. “ENH’s board did not try to ensure that price was set at basically the competitive level.” (Simpson, Tr. 1622).

**Response to Finding No. 2499**

This proposed finding is false, irrelevant and misleading. The record evidence demonstrated that the ENH Board is actively involved in the management of the hospital and ultimately approves the overall strategy and priorities for ENH. (CX 6304 at 17 (Livingston, Dep.)). Consistent with the testimony of ENH executives at trial, the ENH Board was familiar with the negative impact the Balanced Budget Act had on the finances of the hospital and the need for additional revenue. (CX 6304 at 12 (Livingston, Dep.); RFF-Reply ¶ 2498). The ENH Board was also familiar with the due diligence findings and Bain analysis, both of which revealed that ENH’s managed care contracts were under-market. (CX 6304 at 17 (Livingston, Dep.)). As a result, the ENH Board approved of the efforts to obtain additional revenue from the MCOs by renegotiating managed care contracts to competitive market levels. (CX 6304 at 17 (Livingston, Dep.)). Finally, the members of the ENH Board were business leaders who live and work within the community. (Simpson, Tr. 1639-40).

2500. ENH identified which among Highland Park and Evanston contracts had the better terms and rates for the particular health plan. ENH gave no consideration to going with the lower priced health plan contract. (Neaman, Tr. 1031-32).

**Response to Finding No. 2500**

This proposed finding is misleading. Since ENH was in need of additional revenue, it naturally did not pursue options that would have resulted in a decrease in revenue. (RFF-Reply ¶ 2498). Further, there is no evidence ENH's post-Merger prices are above the competitive marketplace. (RFF ¶¶ 1110-1155).

2501. ENH decided to take whichever was the more profitable of the two hospital contracts for the particular health plan and to apply those rates across the board for the post-merger entity. (See CCF 884-895).

**Response to Finding No. 2501**

This proposed finding is irrelevant and misleading. (RFF-Reply ¶¶ 884-895, 2498).

2502. ENH did not stop at electing the more favorable of the two hospital contract rates. In addition to choosing the higher of the two rates, ENH senior management decided to add a premium. (See CCF 848-852).

**Response to Finding No. 2502**

This proposed finding is false and not supported by the record evidence. (RFF-Reply ¶¶ 848-852, 1465). Although not specifically cited here, Complaint Counsel's proposed finding is an indirect quote from Newton, who was not part of the contract re-negotiations at ENH and, therefore, has no basis to provide testimony on the topic. (Newton, Tr. 364; Spaeth, Tr. 2283-84; RFF-Reply ¶¶ 1387, 1500). Regardless of this finding and Mr. Newton's claims, the evidence showed the ENH's post-Merger prices remained at competitive levels. (RFF ¶¶ 1110-1155).

2503. ENH does not see any limit on what is a reasonable enhancement of revenues for a hospital "in the context of what the community needs." (Spaeth, Tr. 2217-18).

**Response to Finding No. 2503**

This proposed finding incorrectly cites the record evidence by alleging that ENH does not see any limit on revenues when the trial record clearly shows that Complaint Counsel's question asked Spaeth to answer the question from his perspective "before the Merger." (Spaeth, Tr. 2217). Since Spaeth was not an employee of ENH until after the Merger, this proposed finding is improperly attributed to ENH. Further, there is no evidence ENH believes it can price above the competitive marketplace since ENH's post-Merger prices remained at competitive levels. (RFF ¶¶ 1110-1155).



### 2000 and Later Chargemaster Increases

2504. As part of the merger integration process, ENH consolidated the Highland Park and Evanston chargemasters in 2000. ENH examined the chargemasters at the two hospitals and adopted the higher of the Highland Park or Evanston chargemaster rates across the board for each line item. (See CCFE 884-895). ENH repeatedly increased the chargemaster rates after the merger. (See CCFE 918-924).

#### **Response to Finding No. 2504**

This proposed finding is misleading. (RFF-Reply ¶¶ 884-895, 918-924). As shown by the record evidence, ENH's chargemaster was analyzed by Deloitte and found to be severely under-market. (RFF ¶¶ 924-964). The chargemaster increases brought ENH's rates up to competitive levels.

#### **B. The Hospital Boards Did Not Get Involved in Pricing Issues**

2505. The Highland Park Hospital board was not involved in pricing issues. (Spaeth, Tr. 2218).

#### **Response to Finding No. 2505**

Respondent has no specific response.

2506. "ENH's board did not try to ensure that price was set at basically the competitive level." (Simpson, Tr. 1622).

#### **Response to Finding No. 2506**

This proposed finding is an exact duplicate of CCFE 2499 and is false, irrelevant and misleading. (RFF-Reply ¶¶ 2499).

2507. The ENH board did not actively monitor the pricing decisions of hospital management. (Simpson, Tr. 1629).

#### **Response to Finding No. 2507**

This proposed finding is false, irrelevant and misleading. (RFF-Reply ¶¶ 2499).

2508. Mr. Spaeth attended the board meetings of the Highland Park board before the merger and of the ENH board after the merger. (Spaeth, Tr. 2215). Over the years, including after the merger, Mr. Spaeth has never heard a board member make any comment

regarding the rate at which the hospital was contracting with a particular payor. (Spaeth, Tr. 2218-19).

**Response to Finding No. 2508**

This proposed finding is irrelevant. Complaint Counsel has offered no evidence to support the concept that a hospital must seek to lower managed care rates in order to establish that it is acting in accordance with its not-for-profit mission. To the contrary, it would be illogical for HPH to seek a reduction in managed care rates in light of the growing needs at the hospital. (RFF ¶¶ 105-115). In short, a hospital does not have to give a MCO under-market rates to fulfill a not-for-profit mission.

2509. Since the merger, Mr. Spaeth has not heard any board member or Mr. Neaman say that ENH should lower its rates to health plans. (Spaeth, Tr. 2219).

**Response to Finding No. 2509**

This proposed finding is irrelevant for the same reasons discussed in RFF-Reply ¶ 2508.

2510. Mr. Spaeth has never heard a hospital board member say that hospital prices should not go up. (Spaeth, Tr. 2215).

**Response to Finding No. 2510**

This proposed finding is irrelevant. (RFF-Reply ¶ 2508).

2511. Spaeth has never heard a hospital board member look behind a price increase to see whether it was warranted for that health plan or not. (Spaeth, Tr. 2215-16).

**Response to Finding No. 2511**

This proposed finding is irrelevant. (RFF-Reply ¶ 2508).

2512. ENH's board is not involved in negotiations with health plans. (CX 6304 at 17 (Livingston, Dep.)).

**Response to Finding No. 2512**

This proposed finding is false, irrelevant and misleading. (RFF-Reply ¶¶ 2499).

2513. The ENH board does not review contracts, nor is the board informed in advance of negotiating strategies. (CX 6304 at 18 (Livingston, Dep.)).

**Response to Finding No. 2513**

This proposed finding is false, irrelevant and misleading. The record evidence demonstrated that the ENH Board is actively involved in the management of the hospital and ultimately approves the overall strategy and priorities for ENH. (CX 6304 at 17 (Livingston, Dep.); RFF-Reply ¶ 2499).

2514. Mr. Livingston, the chairman of the board, does not have knowledge of contract structures, nor does he recall discussions about forms of contracts (*e.g.*, per diems or discount off charges) at board meetings. (CX 6304 at 19 (Livingston, Dep.)).

**Response to Finding No. 2514**

Respondent has no specific response.

**C. The Interests of Evanston, Highland Park, and ENH Management Did Not Align with the Interests of Consumers in Terms of Pricing and in Terms of Passing on Increased Revenues Resulting from the Merger**

2515. ENH's compensation contracts did not align management's interests with consumers on the issue of price. (Simpson, Tr. 1629).

**Response to Finding No. 2515**

This proposed finding is false, incomplete and misleading. Based on Dr. Simpson's testimony, this proposed finding suggests that in order to be aligned with consumers interests ENH should provide its employees with incentives to reduce prices. (Simpson, Tr. 1629-30). The evidence showed that all Chicago area hospitals, including ENH, are under pressure to increase revenue to pay for quality improvements in patient care. At the same time, they are attempting to offset reductions in Medicare funding and investment income. (RFF ¶¶ 111-115, 624-645). ENH, similar to other hospitals, seeks to increase revenue through cutting costs and obtaining additional revenue from its services. (RFF ¶¶ 624-645). Since a reduction in prices

would result in a reduction of available revenue, providing an incentive to reduce price would result in a reduction of funds available for patient care. Contrary to Dr. Simpson's theory, such an incentive program would in fact be contrary to the interest of the consumer.

Dr. Simpson's theory also fails to consider that ENH has compensation contracts that provide financial incentives for meeting quality targets, which he agreed is aligned with the interests of consumers. (Simpson, Tr. 1641). The employees at ENH, including management, strive to improve patient care at the hospital – which is directly aligned with the interests of the consumer. (RFF ¶ 2-3).

2516. ENH's managers were given bonuses for meeting revenue targets from operations. This gives managers the incentive to set supra-competitive prices. (Simpson, Tr. 1629).

**Response to Finding No. 2516**

This proposed finding is false and misleading. **REDACTED**

(RFF ¶¶ 1148-1155, *in camera*). Further,

Dr. Simpson admitted that managers at ENH can also meet revenue targets by attempting to control costs rather than increase prices. (Simpson, Tr. 1640). Since a revenue target can be achieved without price increases, Dr. Simpson's opinion regarding the incentives of ENH managers is incorrect. (RFF-Reply ¶ 2515).

2517. Dr. Simpson noted that there were two instances in which ENH's board offered managers bonuses for growing ENH's overall market share. This would have had little effect in prompting ENH's managers to lower price in order to gain market share. (Simpson, Tr. 1630).

**Response to Finding No. 2517**

This proposed finding is not supported by record evidence. Dr. Simpson never "noted that there were two instances" as referenced in this proposed finding. Complaint Counsel's

question at trial referenced “two instances” within Dr. Simpson’s expert report (which is not in evidence), but Dr. Simpson’s response did not identify or provide any explanation of the “two instances.” (Simpson, Tr. 1630). As a result, this proposed finding is not supported by the record. Further, Dr. Simpson admitted at trial that growth in market share could be achieved by lowering prices to increase volume. (Simpson, Tr. 1640-41).

2518. Evanston’s managers thought they could meet the overall market share target simply through acquisition of Highland Park. (Simpson, Tr. 1630).

**Response to Finding No. 2518**

This proposed finding is not supported by the record. Dr. Simpson’s opinion was based upon “a note” he recalled seeing, but he did not identify any document or other piece of evidence as support for his opinion. (Simpson, Tr. 1630). Respondent is unable to either confirm or dispute an alleged piece of evidence that Dr. Simpson cannot identify. (RFF-Reply ¶ 2517).

2519. On June 29, 1999, shortly before the Letter of Intent to Merge was signed, Highland Park senior executives entered into enhanced compensation agreements that replaced their previous agreements. The new agreements “offered additional retention bonuses as well as enhanced severance agreements” at a cost of \$8 million. (CX 534 at 3).

**Response to Finding No. 2519**

This proposed finding is incomplete and misleading.

**REDACTED**

(Spaeth,

Tr. 2329-32, *in camera*).

**REDACTED**

(Spaeth, Tr. 2331, *in camera*).

2520. ENH management had a plan for using some of the money derived from raising hospital prices post-merger. The president of ENH proposed adding an additional \$3 million into the 2000 bonus pool attributable to the merger integration activities. The board reduced

this amount to \$1 million, which ultimately was the amount distributed to the top 50 people. (Neaman, Tr. 1263-64; CX 31 at 1).

**Response to Finding No. 2520**

This proposed finding is incomplete and misleading. The bonus pool was intended to reward the top 50 people at ENH who worked long hours and took on additional responsibility to assist with the Merger integration. (Neaman, Tr. 1263). The ENH Board has an independent compensation committee, which approved the compensation. (Neaman, Tr. 1372-73). The compensation committee has two independent consultants, one who provides data and one who is legal counsel employed specifically for compensation matters. (Neaman, Tr. 1372-73).

2521. In his bonus proposal, Mr. Neaman proposed distributing bonuses to a number of personnel, including Mr. Hillebrand, Mr. Sirabian, Mr. Spaeth, and himself. (Neaman, Tr. 1264-65; CX 31 at 1).

**Response to Finding No. 2521**

This proposed finding is incomplete and misleading. The bonus pool distributed \$3 million across 50 people. (Neaman, Tr. 1263; RFF-Reply ¶ 2520).

2522. Several of ENH's senior executives received merit increases in their salaries in the range of 5-6% in 1998 to 1999 and a 10% increase from fall of 2000 to fall of 2001. This spike in compensation increases coincided with the completion of the merger integration efforts. The executives included Messrs. Hillebrand, Neaman, and Grady. (Neaman, Tr. 1265-67; CX 2099 at 2-3).

**Response to Finding No. 2522**

This proposed finding is misleading to the extent that it refers to a "spike" in compensation. The cited document contains all relevant compensation information and demonstrates that salaries rose at reasonable levels. (CX 2099 at 2-3).

2523. A similar trend is apparent with annual incentive compensation awards. Various ENH executives received substantially higher awards at the end of 2000 compared to the awards in 1998 and 1999. (Neaman, Tr. 1267-69; CX 2099 at 8-9).

**Response to Finding No. 2523**

This proposed finding is misleading. All compensation awards were deemed to be reasonable and approved by an independent compensation committee. (Neaman, Tr. 1372-73).

**D. Economic Studies Support the View That Non-Profit Hospitals Exercise Market Power**

2524. John Simpson has been a staff economist in the FTC's Bureau of Economics for the past 15 years. He has a doctorate in economics from UCLA. He has also published four articles relating to healthcare antitrust issues, one of which examined whether non-profit hospitals exploit market power. (Simpson, Tr. 1616-1617).

**Response to Finding No. 2524**

Respondent has no specific response.

2525. "[E]conomic studies suggest that non-profit hospitals exercise market power." (Simpson, Tr. 1621). Market power is defined as the ability for the possessor of such power to set price above a competitive level. (Simpson, Tr. 1621).

**Response to Finding No. 2525**

This proposed finding is incomplete and misleading. While the economic study authored by Dr. Simpson suggests that not-for-profit hospitals exercise market power, there are contrary economic studies that suggest the opposite. (Simpson, Tr. 1622). For example, two studies by Dr. William Link conclude that a not-for-profit hospital will not exercise market power. (Simpson, Tr. 1622). Moreover, Dr. Simpson's economic study was written while he was an employee of the FTC and immediately after the FTC lost two hospital merger cases based in part on the finding that not-for-profit hospitals would not exercise market power. (Simpson, Tr. 1623-24).

2526. A non-profit hospital will exploit market power due to the influence of various interest groups within a hospital: the medical staff, hospital managers, and the employees of the hospital. (Simpson, Tr. 1623).

### **Response to Finding No. 2526**

This proposed finding is false and irrelevant. Dr. Simpson testified that his study predicts that “various interest groups” at a not-for-profit hospital would tend to exploit market power. However, Dr. Simpson expressly stated that this concept was “beyond the scope of [his] testimony” and “not part of [his] testimony” in this case. (Simpson, Tr. 1635-36). Dr. Simpson did not undertake any analysis to determine if his theory was true with respect to ENH post-Merger and there is no evidence in the record that this actually occurred. Dr. Simpson even testified that “[e]conomic theory does *not necessarily* predict that a not-for-profit hospital would try to maximize profits.” (Simpson, Tr. 1646 (emphasis added)). Dr. Simpson’s pure academic theory, which is not based on any evidence in this case, is irrelevant as a proposed finding.

2527. The managers of a non-profit hospital may want the prestige that comes from operating a hospital that is very large and very sophisticated. (Simpson, Tr. 1623).

### **Response to Finding No. 2527**

This proposed finding is irrelevant. Dr. Simpson testified that this concept was “beyond the scope of [his] testimony” and he did not know if this actually occurred at ENH post-Merger. (Simpson, Tr. 1635-36; RFF-Reply ¶ 2526).

2528. An interest group within a non-profit hospital can cause the hospital to set high prices so the group can build up a surplus to fund a hospital that is larger and more sophisticated than the community needs. (Simpson, Tr. 1623).

### **Response to Finding No. 2528**

This proposed finding is irrelevant. Dr. Simpson testified that this concept was “beyond the scope of [his] testimony” and he did not know if this actually occurred at ENH post-Merger. (Simpson, Tr. 1635-36; RFF-Reply ¶ 2526).

2529. The customers in that situation have to pay for a hospital that is larger and more sophisticated than the community needs. (Simpson, Tr. 1623-1624).



**Response to Finding No. 2529**

This proposed finding is irrelevant. Dr. Simpson testified that this concept was “beyond the scope of [his] testimony” and he did not know if this actually occurred at ENH post-Merger. (Simpson, Tr. 1635-36; RFF-Reply ¶ 2526).

2530. A non-profit hospital could set supra-competitive prices and use some of the surplus revenue for charity care, but some of the surplus could also be used on wasteful expenditures. (Simpson, Tr. 1648).

**Response to Finding No. 2530**

This proposed finding is irrelevant. Dr. Simpson testified that this concept was “beyond the scope of [his] testimony” and he did not know if this actually occurred at ENH post-Merger. (Simpson, Tr. 1635-36; RFF-Reply ¶ 2526).

2531. The surplus resulting from supra-competitive prices can also be used for higher executive salaries. In other words, it can be used to benefit the hospital executives rather than consumers. (Simpson, Tr. 1649).

**Response to Finding No. 2531**

This proposed finding is irrelevant. Dr. Simpson testified that this concept was “beyond the scope of [his] testimony” and he did not know if this actually occurred at ENH post-Merger. (Simpson, Tr. 1635-36; RFF-Reply ¶ 2526).

2532. There are six peer-reviewed studies, which look at whether hospitals in more concentrated markets tend to set higher prices than hospitals in less concentrated markets. Four of these studies found that hospitals tend to exploit market power and that non-profit hospitals in concentrated markets set higher prices than in less concentrated markets. (Simpson, Tr. 1624-25).

**Response to Finding No. 2532**

This proposed finding is misleading. At least two of the studies which found that not-for-profit hospitals tend to exploit market power were authored by economists employed by the FTC. (Simpson, Tr. 1643, 1645).

2533. The two remaining studies, which found that non-profit hospitals did not exercise market power, were both performed by Dr. William Lynk. These two studies used different data sets from the four studies finding that hospitals tend to exploit market power. (Simpson, Tr. 1625-27).

**Response to Finding No. 2533**

Respondent has no specific response.

2534. The four studies refuting Dr. Lynk's studies by concluding that non-profit hospitals tend to exploit market power were done by four different sets of researchers. An additional case study involving a single merger of non-profit hospitals that was done by a different set of researchers, using a different methodology, also found that non-profit hospitals exercised market power. (Simpson, Tr. 1627-1628).

**Response to Finding No. 2534**

This proposed finding is misleading. At least two of the studies which found that non-profit hospitals tend to exploit market power were authored by economists employed by the FTC. (Simpson, Tr. 1643, 1645).

**XVIII. ENH'S MEMBERSHIP IN THE NORTHWESTERN HEALTHCARE NETWORK DOES NOT ELIMINATE ENH'S LIABILITY UNDER SECTION 7 OF THE CLAYTON ACT**

**A. The Northwestern Healthcare Network Did Not Exercise Central Control**

2535. The Northwestern Healthcare Network lacked central control over the individual member hospitals. (CX 6304 at 3 (Livingston, Dep.); CX 6306 at 17-18 (Mecklenburg, Dep.)).

**Response to Finding No. 2535:**

This proposed finding is inaccurate and misleading. As an initial matter, Complaint Counsel is mistaken to rely on the testimony of Homer Livingston. Livingston testified that he did not have any direct involvement with NHN and by the time he became Evanston/ENH's deputy chairman and then chairman, NHN was "winding" down. (CX 6304 at 3 (Livingston, Dep.)).

In addition, this proposed finding is misleading because NHN possessed all the powers to be a strong, cohesive organization with central control over its member institutions. (RFF ¶¶ 207-218). Since 1989, the Network was the *sole* corporate member of both Evanston Hospital and HPH, pursuant to the Network Affiliation Agreement. (RFF ¶¶ 198, 207). This is confirmed by the fact that Evanston Hospital and HPH were not required to file a form pursuant to the Hart-Scott-Rodino Act. Before the Merger, Evanston Hospital and HPH asked the staff of the FTC's Premerger Notification Office whether they would be required to file such a form, given that a common parent, NHN, was the sole corporate member of both merging entities. The parties were advised by staff that "because the parent already holds all of the assets held by the entities it controls," they were not required to file the form. (RFF ¶¶ 298-300).

During Phase II of the Network's development, which started in 1993 and was the premise for Hart-Scott-Rodino review and approval, NHN had the power to: review and approve member institutions' strategic plans; create a "macro" strategic plan for the entire network;

review and approve member institutions' operating and capital budgets; appoint and remove member institutions' Boards of Directors and CEOs; direct asset transfers by member institutions to accomplish Network goals and objectives; and, negotiate with MCOs on behalf of member institutions. (RFF ¶¶ 208-212, 222-223). And even when the Network did not directly exercise these powers, there was significant discussion about individual hospital actions and decisions at the Network level. (RFF ¶ 217).

2536. The Northwestern Healthcare Network was not effective because the individual member hospitals were unwilling to give up any of their autonomy. (CX 1777 at 49, 52; CX 6305 at 6 (Stearns, Dep.)).

**Response to Finding No. 2536:**

This proposed finding is misleading because the Network possessed the power to enforce unified action among its members. (Hillebrand, Tr. 1788-89; RFF ¶ 225; RFF-Reply ¶ 2535).

2537. Even after the formation of the Northwestern Healthcare Network, the individual hospital members "operated as independent entities." (Newton, Tr. 307).

**Response to Finding No. 2537:**

This proposed finding is misleading. (RFF-Reply ¶ 2535). Network members did not, as a matter of course, operate independently. Specifically, the Network negotiated contracts for the provision of hospital services by its member hospitals with the International Brotherhood of Teamsters, Health Network, Great West and MultiPlan. (CX 6307 at 18 (Schelling, Dep.); RFF ¶ 219). The Network also negotiated a capitated Home Health services agreement with Humana. (CX 6307 at 5 (Schelling, Dep.); RFF ¶ 222). And it negotiated and entered into an agreement with North American Medical Management ("NAMM"). (CX 6307 at 6 (Schelling, Dep.); RFF ¶ 220).

2538. The hospitals that were members of the Northwestern Healthcare Network continued to compete with each other, unilaterally negotiating contracts with managed care

companies, “‘slicing’ each other up in the market,” and “undercutting each other.” (CX 1768 at 3).

**Response to Finding No. 2538:**

This proposed finding is inaccurate and misleading. (RFF-Reply ¶ 2535).

**B. Evanston and Highland Park Were Two Separate Entities Prior to the Merger**

**1. Separate Administrations**

2539. Under the Network Affiliation Agreement of the Northwestern Hospital Network, the governing boards of each of the hospitals retained “local autonomy and control.” (CX 1777 at 50, 52, 68).

**Response to Finding No. 2539:**

This proposed finding is misleading because the Network (which was called the “Northwestern Healthcare Network”, not the Northwestern *Hospital* Network as indicated in this proposed finding) was the sole corporate member of both Evanston Hospital and HPH, and other member hospitals. (RFF-Reply ¶ 2535). This proposed finding is further misleading because it fails to provide necessary context for the cited section of the Network Affiliation Agreement. Specifically, the Agreement states that, “[g]iven the community of interests of the various governing boards, one of the key objectives of the Network will be to preserve, to the greatest extent possible consistent with the unity of interest resulting from the formation of the Network, local autonomy and control over the ‘micro’ issues related to the delivery of healthcare services, while delegating the ‘macro’ issues to the Network.” (CX 1777 at 49). Consequently, “local autonomy and control” did not come at the expense of the Network’s ability to act as a cohesive and unified organization.

2540. The Northwestern Healthcare Network could not exercise its discretion to terminate the employment of the administrators of the individual member hospitals. (CX 1831 at 13).

**Response to Finding No. 2540:**

This proposed finding is inaccurate and misleading. (RFF-Reply ¶ 2535). The Network had the authority to remove the directors and CEOs of the individual member hospitals for cause. (CX 1831 at 4, 13).

2541. Under the Network Affiliation Agreement, a member of the Northwestern Healthcare Network could withdraw from the network if the network attempted to implement network-wide managed care agreements that substantially favored one member hospital to the detriment of the withdrawing hospital. (CX 1831 at 9-11).

**Response to Finding No. 2541:**

This proposed finding is incomplete and misleading because member hospitals could not withdraw without the approval of the Network Board of Directors and the Council of Governors. (CX 1831 at 9). This proposed finding is further incomplete and misleading because it fails to provide the necessary context for the quoted grounds for withdrawal. Stated more completely, a member institution had to “claim and set forth grounds that...NHN has engaged in a pattern of implementing Network-wide managed care arrangements and/or products that, without the consent of the petitioning member Institution, provide for payment and reimbursement rates which: (i) do not reflect the risks associated with the population served by the contracting Institution; and (ii) substantially favor particular member Institutions to the material detriment of the petitioning member Institution, unless NHN has determined, based upon the goals and objectives set forth in the Affiliation Agreement, that the action is in the best interests of the Network, as a whole. As so set forth, the Network’s best interests include financial considerations, as well as furtherance of charitable purposes and community benefits.” (CX 1831 at 9).

Member hospitals making such claims had to first petition the Network’s President and CEO to investigate the claim. If the claim were substantiated, the member Institution and the

Network President and CEO would meet to develop a plan of action to correct the condition given rise to the claim. If, after all of this, the member hospital still believed the condition given rise to the claim existed, the hospital could then petition NHN's board for withdrawal. The board would then evaluate the claim and attempt to correct the underlying conditions if necessary. If the hospital did not agree with the board's findings, the hospital and NHN were required to enter into arbitration. And only after the arbitration panel determined that the underlying condition could not be corrected or that the NHN board failed to adopt an appropriate plan of correction could the member Institution actually withdraw. (CX 1831 at 9-12).

2542. Under the Network Affiliation Agreement, a member of the Northwestern Healthcare Network could withdraw from the network if the network failed to exercise reasonable efforts to support the academic affiliation of that hospital. (CX 1831 at 10).

**Response to Finding No. 2542:**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2541).

**2. Separate Staffs**

2543. Each hospital in the Northwestern Hospital Network maintained its own medical staff. (Hillebrand, Tr. 1786).

**Response to Finding No. 2543:**

This proposed finding is inaccurate and misleading. (RFF-Reply ¶ 2535). The Affiliation Agreement left medical staff affairs at the local level because NHN recognized "the preservation of current medical staff relations and patient referral patterns is an important element in the delivery of healthcare services at each Hospital." (CX 1777 at 72).

2544. Under the Network Affiliation Agreement of the Northwestern Hospital Network, each member of the Northwestern Hospital Network retained the exclusive authority over granting medical staff privileges at its hospital. (CX 1777 at 72).

**Response to Finding No. 2544:**

The proposed finding is misleading. (RFF-Reply ¶ 2543).

2545. Under the Network Affiliation Agreement, a member of the Northwestern Healthcare Network could withdraw from the network if the network attempted to require members of that hospital's medical staff to become members or employees of a network-wide organization. (CX 1831 at 10).

**Response to Finding No. 2545:**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2541).

2546. Under the Network Affiliation Agreement of the Northwestern Hospital Network, the medical staff of each hospital remained autonomous. (CX 1777 at 49-50, 52).

**Response to Finding No. 2546:**

This proposed finding is inaccurate and misleading. (RFF-Reply ¶ 2543).

**3. Separate Services**

2547. Under the Network Affiliation Agreement of the Northwestern Hospital Network, each institution retained autonomy and control over the local-based decisions related to the delivery of health care services. (CX 1777 at 52).

**Response to Finding No. 2547:**

This proposed finding is inaccurate and misleading. (RFF-Reply ¶ 2535). Indeed, the Affiliation Agreement stated that while the "Network structure will provide a significant degree of local autonomy to each Institution," the structure would still provide the "Network with sufficient authority over the Institutions to accomplish effectively the goals of the Network." (CX 1777 at 52).

2548. The president and chief executive officer of Northwestern Memorial Healthcare does not recall the Northwestern Healthcare Network ever consolidating any services among the hospitals. (CX 6306 at 7 (Mecklenburg, Dep.)).

**Response to Finding No. 2548:**

This proposed finding is inaccurate and misleading. (RFF-Reply ¶ 2535). Moreover, on at least two occasions, NHN generated "synergies" for its members: (1) bringing Children's



Memorial Hospitals services to Glenbrook Hospital; and (2) bringing Evanston Hospital's professional oncology services to Swedish Covenant Hospital. (CX 381 at 3).

2549. Under the Network Affiliation Agreement, a member of Northwestern Healthcare Network could withdraw from the network if the network attempted to implement program expansions or consolidations that substantially favored one member hospital to the detriment of the withdrawing hospital. (CX 1831 at 9-10).

**Response to Finding No. 2549:**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2541). Specifically, a member could not withdraw for the above-stated reasons if NHN determined that "based upon the goals and objectives set forth in the Affiliation Agreement, that the action is in the best interests of the Network, as a whole." (CX 1831 at 10).

**4. Financial Independence**

2550. Under the Network Affiliation Agreement of the Northwestern Hospital Network, the network hospitals were autonomous in their financial operations. (CX 1777 at 50; *see* CX 6307 at 12-13 (Schelling, Dep.)).

**Response to Finding No. 2550:**

This proposed finding is inaccurate and misleading. During Phases I and II, the Network had the powers to approve the member hospitals' respective operating and capital budgets. (Neaman, Tr. 967; CX 1780 at 16-17; Newton, Tr. 457-59; CX 6306 at 3 (Mecklenburg, Dep.); RFF ¶ 208; CX 6307 at 12-13 (Schelling, Dep.)). Once Phase II was initiated, there were a number of financial and operating mechanisms that needed the approval of the Network and the Network's Board. (Neaman, Tr. 969-70). For example, Evanston Hospital submitted budget summaries to the Network. (RX 182 at ENHL HJ 3672-76; RFF ¶ 214). And member hospital budgets were modified as a result of discussions with the Network. (CX 6306 at 6-7 (Mecklenburg, Dep.); RFF ¶ 212). The Network Board also reviewed and commented on member hospital expansion plans. (CX 6307 at 16-17 (Schelling, Dep.); RFF ¶ 213).

During Phase II, the Network had the reserved power and authority to direct asset transfers by the member institutions to the extent necessary to accomplish Network goals and objectives. (CX 1780 at 18; RFF ¶ 211). Specifically, the Network Affiliation Agreement stated that, “in order to accomplish Network goals and objectives, NHN shall have the right to assess or require asset transfers from Network Institutions” for “(a) Ongoing capital formation necessary for operating of NHN; (b) Funding a NHN research and development program in accordance with the Network strategic plan; and (c) Financial assistance to individual Network Institutions or Institution Group members for operating or capital purposes, subject to the express written approval of the Institutions providing the funds.” (CX 1780 at 18-19).

2551. The president and chief executive officer of Northwestern Memorial Healthcare does not recall Northwestern Memorial Healthcare ever being placed at financial risk for a debt of another hospital in the Northwestern Hospital Network. (CX 6306 at 5 (Mecklenburg, Dep.)).

**Response to Finding No. 2551:**

This proposed finding is misleading because, under the Network Affiliation Agreement, the Network had the right to assess or require asset transfers from Northwestern Memorial or any other member for the purpose of providing financial assistance to other members, subject to the express written approval of the member providing the funds. (CX 1780 at 18-19; RFF-Reply ¶ 2550). The Network Affiliation Agreement also stated that it was intended that, “in the event a particular Institution experiences financial difficulties, NHN shall have the power to direct and implement remedial steps, including, but not limited to, participation in the management of such Institution and, subject to each Institution’s express written approval, assessment of other Network Institutions to provide needed capital as appropriate.” (CX 1780 at 19).

2552. ENH was not responsible for any debts incurred by other members of the Northwestern Hospital Network. (CX 6304 at 4 (Livingston, Dep.)).

**Response to Finding No. 2552:**

This proposed finding is misleading. (RFF-Reply ¶ 2551; Neaman, Tr. 971-72).

2553. Members of the Northwestern Hospital Network only shared the cost of running the network. There was no combined profit and loss or profit-sharing. Members' balance sheets were separate. (Newton, Tr. 311).

**Response to Finding No. 2553:**

This proposed finding is misleading because the Network Affiliation Agreement explained that the "Network structure will be developed eventually to satisfy accounting criteria for consolidated reporting purposes in accordance with generally accepted accounting principles. Consolidation of financial statements will permit external recognition of the Network as a whole and serves as a critical underpinning to cooperation among otherwise distinct financial operations of the Institutions." (CX 1777 at 50; CX 1780 at 8).

2554. The Network Affiliation Agreement restricted the authority of the network to transfer assets of any individual member hospital. (CX 1777 at 62).

**Response to Finding No. 2554:**

This proposed finding is misleading. Even with these restrictions in place, NHN still had the authority to transfer assets from member to member, and NHN still had the authority to exercise central, unified control over its members. (RFF-Reply ¶¶ 2535, 2550).

2555. Under the Network Affiliation Agreement, a member of the Northwestern Healthcare Network could withdraw from the network if the network attempted to impose certain obligations to transfer assets to another member of the network. (CX 1831 at 9).

**Response to Finding No. 2555:**

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 2541).

**C. The Northwestern Healthcare Network Disbanded Before the Evanston-Highland Park Merger Occurred**

2556. In an August 3, 1999, board meeting, the ENH board voted to authorize the termination of the Northwestern Healthcare Network effective October 31, 1999. (CX 872 at 7).

**Response to Finding No. 2556:**

This proposed finding is misleading because NHN's dissolution agreement did not go into effect until January 2, 2000. (Neaman, Tr. 1016; CX 5 at 4; RFF ¶ 230). Moreover, the Articles of Dissolution were not "filed" until January 3, 2000. (CX 1833 at 1-2; RFF-Reply ¶ 1563). Therefore, the Network still existed when the Merger was consummated on January 1, 2000.

2557. The Lakeland Health Services board of directors voted on August 23, 1999, to approve the dissolution of the Northwestern Healthcare Network. (RX 592A at ENH RS 000880).

**Response to Finding No. 2557:**

This proposed finding is misleading. (RFF-Reply ¶¶ 1563, 2556).

2558. The Northwestern Healthcare Network members authorized the dissolution of the network on October 26, 1999. (CX 1833 at 2).

**Response to Finding No. 2558:**

This proposed finding is misleading as the cited document shows that the Articles of Dissolution were not "filed" until January 3, 2000. (RFF-Reply ¶¶ 1563, 2556).

2559. The articles of dissolution were adopted by the Northwestern Healthcare Network on December 22, 1999. (CX 1833 at 2).

**Response to Finding No. 2559:**

This proposed finding is misleading as the cited document shows that the Articles of Dissolution were not "filed" until January 3, 2000. (RFF-Reply ¶¶ 1563, 2556).

## **XIX. REMEDY**

### **A. The Proposed Remedy Is Practicable and Will Restore Competition**

2560. Complaint Counsel's proposed order calls for divestiture of HPH. (See Complaint Counsel's proposed order). Under that order, improvements, if any, to HPH would remain with HPH.

#### **Response to Finding No. 2560**

This proposed finding is not based on any record evidence. Respondent introduced a wealth of evidence to show that a vast number of the improvements at HPH post-Merger will no longer be available in the event of a divestiture. (RFF ¶¶ 2483-2532).

2561. There was some post-merger consolidation of Evanston and Highland Park, which is dealt with in the proposed order. After the merger, ENH consolidated HPH staff, consolidated clinical procedures, and moved some clinical and corporate services to locations other than Highland Park Hospital:

1. The physicians at Highland Park Hospital were merged into ENH's professional staff. (Neaman, Tr. 1354. *See also* CX 501 at 36). The responsibilities of the clinical chairmen at ENH were also extended to oversee Highland Park Hospital. (Neaman, Tr. 1354; Hillebrand, Tr. 1841; O'Brien, Tr. 3525);

#### **Response to Finding No. 2561 - 1**

Respondent has no specific response.

2. ENH eliminated all of the corporate functions at Highland Park Hospital including human resources, purchasing, managed care contracting, the business office, and the information systems department. (Hillebrand, Tr. 1839. *See also* Neaman, Tr. 1345). ENH also eliminated Highland Park Hospital's separate registration process and consolidated the chargemaster to have a single billing system. (Hillebrand, Tr. 1990); and

#### **Response to Finding No. 2561 - 2**

Respondent has no specific response.

3. In other clinical areas, ENH aligned the care maps at Highland Park Hospital with the clinical pathways at Evanston Hospital. The two sets of clinical procedures were brought together. (O'Brien, Tr. 3528, 3560). ENH also eliminated adult inpatient psychiatric services at Highland Park Hospital. (O'Brien, Tr. 3516-17).

**Response to Finding No. 2561 - 3**

This proposed finding is incomplete. ENH elected to consolidate adult inpatient psychiatric services at Evanston Hospital and move all adolescent psychiatric services to HPH because treating adults and adolescents together, as HPH had done pre-Merger, did not meet Medicare standards. (RFF ¶ 2418). Separating the two types of patients, while not cost-effective, increased the quality of care psychiatric patients would receive. (RFF ¶ 2418).

2562. Because ENH consolidated HPH staff and combined some services at locations other than Highland Park Hospital, the proposed order requires reasonable ancillary provisions to assist an acquirer to re-establish clinical and corporate functions at HPH in connection with divestiture.

**Response to Finding No. 2562**

This proposed finding is improper because it is not based on any record evidence.

Respondent introduced a wealth of evidence to show that a vast number of the improvements at HPH post-Merger will no longer be available in the event of a divestiture. (RFF ¶¶ 2483-2532).

2563. Highland Park, which has been in existence since 1918, was a good hospital before the merger. (See CCF 2295-2352).

**Response to Finding No. 2563**

This proposed finding is incomplete. The record evidence demonstrated that pre-Merger HPH was a good hospital that experienced financial trouble and quality issues. (RFF ¶¶ 44-49; RFF-Reply 2295-2352).

2564. HPH could have continued as a stand-alone competitor without the merger. (See CCF 302-367).

**Response to Finding No. 2564**

This proposed finding is incomplete, speculative and misleading. While HPH was not in immediate danger of going bankrupt, the status quo of the hospital could not be maintained. (RFF ¶¶ 2298-2413; RFF-Reply ¶¶ 302-367). The Board was concerned about the financial

capability of the organization and the quality of services that were being offered at HPH.

(Kaufman, Tr. 5781-82). Kaufman Hall's analysis determined that HPH could not maintain the status quo as an independently operated hospital because of the hospital's financial situation.

(Kaufman, Tr. 5811, 5818).

2565. Highland Park was and remains an attractive candidate for other mergers and acquisitions, due to its location and various other factors. (See CCF 368-372).

**Response to Finding No. 2565**

This proposed finding is incomplete, speculative and misleading. HPH evaluated a number of other options for the future of the hospital – including developing relationships or possible mergers with Northwestern Memorial, Advocate Healthcare, Mayo Clinic and other hospitals. (Kaufman, Tr. 5823). Each of the parties HPH contacted was not interested in pursuing possible merger options. (Kaufman, Tr. 5823-24; CX 6305 at 12 (Stearns, Dep.); RFF ¶¶ 2308-2318; RFF-Reply ¶¶ 368-372).

2566. The proposed remedy will restore the competition lost due to the Evanston-HPH merger. (See CCF 284-301, 2560-2565).

**Response to Finding No. 2566**

This proposed finding is false. The Merger did not lessen competition, and Complaint Counsel's proposed remedy will harm patients. (RFF-Reply ¶¶ 284-301, 2560-2565).

**B. Divestiture Would Not Have a Significant Impact on Quality at Highland Park Hospital**

2567. **REDACTED**

3193, *in camera*).

(Romano, Tr.

**Response to Finding No. 2567:**

This proposed finding could not be further from the truth. Divestiture clearly would have adverse consequences for quality of patient care at HPH. For example, divestiture would result in the loss of cardiac surgery, interventional cardiology and improvements in nursing. Further, the quality of care for heart attack patients would be compromised if there were a divestiture, and delays due to the need to transfer patients would cause them harm. Finally, divestiture would return HPH to a community governance model and deprive the medical staff of clinical, academic and research activities that enhance their skills and improve patient care. (RFF ¶¶ 2490-2530).

2568. Prior to the merger, Highland Park Hospital had been pursuing plans to establish a cardiac surgery program. (See CCF 2357-2361). ENH operates a joint cardiac surgery program with Swedish Covenant Hospital and Weiss Memorial Hospital, each pursuant to an affiliation agreement. (See CCF 2363-2367).

**Response to Finding No. 2568:**

This proposed finding is misleading to the extent it implies that a cardiac surgery program was brought about at HPH in any manner other than via the Merger with ENH. (CX 501 at 41).

2569. If Highland Park Hospital is divested, the new operating room suite, the equipment used in cardiac surgery, and the clinical protocols would all remain in place at that hospital. (Rosengart, Tr. 4558-60).

**Response to Finding No. 2569:**

This proposed finding is misleading to the extent it asserts that clinical protocols would remain as effective after a divestiture of HPH. Clinical protocols are not designed to be static, and to the extent that they should be changed and adapted to be consistent with cutting edge practices, this process would be impeded by divestiture. Dr. Rosengart testified extensively as to



why the knowledge and skill of the providers within the program would not be maintained if there were a divestiture. (RFF ¶¶ 2483-2486; Rosengart, Tr. 4562-64).

2570. **REDACTED**

(Romano, Tr. 3194, *in camera*).

**Response to Finding No. 2570:**

This proposed finding is incorrect. As Complaint Counsel states above, divestiture would mean the end of cardiac surgery at HPH. (RFF ¶¶ 2490-2497). If there were no cardiac surgery program at HPH, interventional cardiology and, specifically, percutaneous coronary interventions (“PCIs”), could not be sustained because elective PCIs could not be done at HPH without cardiac surgical back-up. (RFF ¶¶ 2498-2499).

2571. **REDACTED**

(Romano, Tr. 3073, *in camera*).

**REDACTED**

3073-74, *in camera*).

(Romano, Tr.

**Response to Finding No. 2571:**

This proposed finding is absolutely incorrect. First, Complaint Counsel’s expert, Dr. Romano, conceded that HPH could not establish an interventional cardiology program before the Merger because it did not have cardiac surgery on site to respond immediately to emergencies arising during interventional procedures. (RFF ¶ 1671). Most importantly, the state of Illinois, the American College of Cardiology, and the American Heart Association require that an elective interventional cardiology program have cardiac surgery as backup within the hospital. (RFF ¶ 1668). Finally, HPH, which performs only 50 or 60 emergent PCI cases annually, does not have the requisite volume to support a stand-alone emergent PCI program (without cardiac

surgery). (RFF ¶¶ 1665-1671). For all of these important reasons, interventional cardiology would not be maintained if there were a divestiture of HPH from ENH.

2572. **REDACTED**

(Romano, Tr. 3073-74, *in camera*).

**Response to Finding No. 2572:**

This proposed finding is misleading. Dr. Romano failed to name any hospital in Illinois that has established or maintained an interventional cardiology program without on-site cardiac surgical backup, and this omission was for good reason. Such a program would violate Illinois law. (RFF ¶ 1668).

2573. **REDACTED**

(Romano, Tr. 3075, *in camera*).

**Response to Finding No. 2573:**

This proposed finding is incorrect and misleading. (RFF-Reply ¶¶ 2571-2572).

2574. **REDACTED**

(Romano, Tr. 3075, *in camera*).

**Response to Finding No. 2574:**

This proposed finding is incorrect and misleading. (RFF-Reply ¶¶ 2571-2572).

2575. **REDACTED**

(Romano, Tr.

3194-95, *in camera*).

**Response to Finding No. 2572:**

Respondent has no specific response.

2576. **REDACTED**

(Romano, Tr. 3195, *in camera*).

**Response to Finding No. 2576:**

This proposed finding is incorrect. Several benefits to HPH's ED would be lost in the case of divestiture. First, the ability of ED physicians to rotate among all three hospitals would vanish if HPH were divested. HPH ED nurses and physicians currently rotate through, and collaborate with peers, at Evanston and Glenbrook Hospitals. This system is a considerable quality improvement in that it permits a variety of experiences that sharpens providers' clinical skills and broadens their clinical acumen. (RFF ¶¶ 1920-1921). Second, the HPH ED has greater access to specialists uncommon to community hospitals. For example, HPH now has a toxicologist on staff, access to its own crisis intervention service, and the support of family medicine residents. (RFF ¶¶ 1922-1926). Finally, the addition of critical pieces of advanced technology that are networked throughout the hospital system would certainly be compromised if there were a divestiture. The post-Merger HPH ED utilizes PACS as well as Epic. (RFF ¶¶ 1939-1948). The value of these networked systems would be lost as a result of an order requiring divestiture of HPH from ENH. (RFF ¶¶ 2523-2530).

2577. **REDACTED**

(Romano, Tr. 3195-96, *in camera*).

**Response to Finding No. 2577:**

This proposed finding is conclusory, vague and incorrect. First, the benefits to HPH brought about by the creation of an interventional cardiology program would be lost if there were a divestiture for the reasons cited herein. (RFF-Reply ¶¶ 2571-2572). Second, as a related matter, HPH would lose its capacity to treat heart attack patients if divestiture were ordered. Unquestionably, without cardiac surgery and an interventional cardiology program, HPH would

lack the tools needed to care for heart attack patients and patients dying from heart attacks would be forced to be re-routed or transferred to other hospitals as they were pre-Merger. (RFF ¶¶ 2506-2507). Finally, divestiture would terminate the existence of the Kellogg Cancer Care Center at HPH. Through the Kellogg Cancer Care Center, cancer patients at HPH have access to multidisciplinary care provided by specialists throughout the ENH system. A stand-alone HPH would necessarily revert back to the community hospital model it employed before for oncology services and the exposure to research, academic medicine, ancillary services and super-specialty practices provided via the Kellogg Cancer Care Center would be lost for HPH patients. (RFF ¶¶ 2476-2479, 2484-2486).

2578. **REDACTED**

(Romano, Tr. 3195-96, *in camera*). Indeed, the psychiatric services HPH lost due to the merger (CCFF 2283-2285) could be restored.

**REDACTED**

(Romano, Tr. 3196, *in camera*).

**Response to Finding No. 2578:**

This proposed finding is incorrect. First, as Complaint Counsel concedes, the rationalization of clinical services, including psychiatric services, would be undone with a divestiture of HPH. This would result in a deterioration of care. The rationalization of psychiatric services benefited patients in that it allowed children and adults to be treated separately and more effectively. Moreover, pre-Merger, the adolescent psychiatric population at both Evanston Hospital and HPH were not large enough to provide the full complement of services for inpatient care in terms of group therapy, intermittent therapy and other combinations of treatment plans. These services are only provided as a result of rationalization and would be lost through divestiture. (RFF ¶¶ 2172-2175).

The separation of medical staffs through divestiture would reduce the quality of care provided to HPH patients. Specifically, the loss of integrated medical staffs would deprive HPH of clinical, academic and research activities. (RFF ¶¶ 2514-2518).

2579.

**REDACTED**

(Romano, Tr. 3196-97 (discussing the clinical areas in DX 7033 at 7, *in camera*), *in camera*).

**Response to Finding No. 2579:**

This overly broad proposed finding is incorrect and not supported by the evidence. As an initial matter, divestiture would lead to the return of HPH to a community hospital governance model. Hospital governance plays a key role in providing structure for effective peer review, quality improvement and quality assurance processes. And divestiture would undo the academic model in place at HPH today and revert the hospital back to the weaker private practice model employed pre-Merger. (RFF ¶¶ 2511-2513). Further, quality assurance and quality improvement processes at the hospital would be impaired due to the loss of close integration among providers in programs such as cardiac surgery and pre-operative gynecologic surgical review. (RFF ¶¶ 2519-2522).

Also, divestiture would certainly result in HPH's loss of the benefits of Epic. The value of Epic is enhanced by the greater participation in the system. The more institutions, care givers, and physicians who analyze the same data and have access to patients' electronic medical records with the systems safety features, the better the care given to patients. The Merger increased the value of ENH's implementation of Epic by increasing the number of participants, sites of care, and providers of care. Divestiture would reverse these benefits. In fact, a stand-alone HPH would not have the infrastructure to run Epic on its own and, if divestiture were

ordered, it would take three to five years to get Epic up and running at a divested HPH. (RFF ¶¶ 2523-2530).

Finally, all service areas in the hospital would be harmed by the loss of integration among the medical staffs, which enables providers to better care for patients through participation in multidisciplinary care, academic activities, research partnerships and more. (RFF ¶¶ 2514-2518).

2580.

**REDACTED**

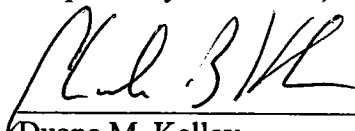
(Romano, Tr. 3197, *in camera*).

**Response to Finding No. 2580:**

This proposed finding is incorrect. (RFF-Reply ¶ 2579).

Dated: July 1, 2005

Respectfully Submitted,



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**CERTIFICATE OF SERVICE**

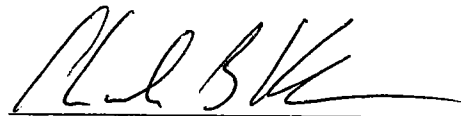
I hereby certify that on July 1, 2005, a copy of the foregoing *Respondent's Replies to Complaint Counsel's Proposed Findings of Fact (Public Version)* was served (unless otherwise indicated) by email and first class mail, postage prepaid, on:

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