
**UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION**

In the Matter of

EVANSTON NORTHWESTERN HEALTHCARE CORP.

Docket No. 9315

COMPLAINT COUNSEL'S PROPOSED FINDINGS OF FACT IN REPLY

(Public Version)

Volume V

(CCRFF 2145-2542)

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iv. ENH Made Significant Post-Merger Improvements To The Nuclear Medicine Department At HPH

2145. After the Merger, ENH purchased a CT pet for the nuclear medicine department. (O'Brien, Tr. 3496, 3501; Chassin, Tr. 5362-63; RX 1896 at ENHL MO 7109). A CT pet is a diagnostic tool in nuclear medicine used to detect things like tumors or Alzheimer's. (O'Brien, Tr. 3502). HPH did not have a CT pet, which is not commonly found in community hospitals, before the Merger. (O'Brien, Tr. 3502-03).

Response to Finding No. 2145:

RX 1896 does not support Respondent's finding. { [REDACTED]

[REDACTED]

[REDACTED] } (Newton, Tr. 401;

Spaeth, Tr. 2137-38, Romano, Tr. 3184-85, *in camera*. See generally CX 545 at 3).

j. The Medical Staff Integration And Academic Involvement Of Physicians That Resulted From The Merger Improved The Quality Of Care At HPH

i. Overview

2146. After the Merger, Evanston Hospital merged the clinical staffs at Evanston Hospital and HPH. (Chassin, Tr. 5373). HPH physicians now rotate regularly through all three ENH campuses. (Chassin, Tr. 5598).

Response to Finding No. 2146:

Complaint Counsel have no specific response.

2147. 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). Physicians' skills become impaired and begin to stagnate if they do not have access to a continuous influx of academic information. (Chassin, Tr. 5400-01).

Response to Finding No. 2147:

This finding is misleading. There is no evidence that HPH physicians could not

participate in educational conferences or that they did not have access to “academic information” before the merger. Further, there is no evidence that the skills of HPH physicians were “impaired” before the merger or that they improved after the merger.

{ [REDACTED]

[REDACTED] } (Romano, Tr. 3125, *in camera*).

2148. 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).

Response to Finding No. 2148:

The cited testimony does not support this finding. Moreover, as stated above in CCRFF 2147, there is no evidence that the skills of the HPH physicians changed or that physicians had increased access to “academic practice” as a result of the merger.

2149. 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).

Response to Finding No. 2149:

This finding is inaccurate and misleading. { [REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3118, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3124, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] }

(Romano, Tr. 3118, *in camera*). { [REDACTED]

[REDACTED]

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

ii. **HPH Physicians Rotate Through All Three ENH Campuses**

2150. Since the Merger, physicians in pathology, radiology, emergency medicine, cardiology, cardiac surgery and anesthesiology rotate through all three campuses. (Chassin, Tr. 5598). These physicians did not rotate before the Merger. (Chassin, Tr. 5598). With the exception of emergency medicine, all of the rotating physicians are specialists. (Chassin, Tr. 5598).

Response to Finding No. 2150:

Complaint Counsel have no specific response.

2151. In pathology, for example, the 19 faculty members rotate through the laboratories at Glenbrook Hospital, Evanston Hospital and HPH. (Victor, Tr. 3588-89). Additionally, the pathologists in the HPH and Evanston Hospital laboratories rotate back and forth. (Victor, Tr. 3629-30). The pathologists at Evanston Hospital see more complex specimens, and rotating allows the pathologists to stay abreast of all of the modern thinking and modern technologies relating to the practice of pathology. (Victor, Tr. 3589).

Response to Finding No. 2151:

This finding is misleading. There is no evidence that before the merger, HPH pathologists failed to stay “abreast of all the modern thinking and modern technologies relating to the practice of pathology.” These pathologists were highly trained, dedicated professionals who had access to professional literature and continuing education opportunities before the merger. (Harris, Tr. 4252-53).

2152. Physicians in the Department of Ob/Gyn also regularly work at all three ENH hospital campuses. (Silver, Tr. 3770).

Response to Finding No. 2152:

Complaint Counsel have no specific response.

iii. HPH Physicians Take Part In Teaching Activities For Residents And Medical Students At Evanston Hospital

2153. Teaching forces physicians to keep up with medical literature, answer questions they may not have considered, and generally keeps them sharp. (Chassin, Tr. 5376-77).

Response to Finding No. 2153:

This finding is vague and misleading. There is no evidence that because of the merger, more HPH physicians in fact “keep up with the medical literature” or that they are sharper because of the merger. There was no testimony from physicians who practiced at HPH before the merger that the merger had any effect on their ability to remain “sharp” or stay current with medical knowledge. Respondent is vague about how many HPH physicians actually teach residents. Nor do they state how many HPH physicians rotate through Evanston or Glenbrook Hospitals. There is no evidence that the merger had any effect on physician skills.

2154. After the Merger, a number of HPH physicians became involved in teaching at Evanston Hospital. (O’Brien, Tr. 3539). These academic instructors rotate between Evanston Hospital, Glenbrook Hospital and HPH. (O’Brien, Tr. 3541).

Response to Finding No. 2154:

This finding is vague and misleading. As stated above in CCRFF 2153, Respondent is purposefully vague about how many HPH physicians are actually involved in teaching at Evanston Hospital and what percentage of their time is actually spent teaching residents.

2155. Dr. Harris teaches emergency medicine at Evanston Hospital, which includes clinical bedside instruction of residents and medical students. (Harris, Tr. 4251-52). In addition, Dr. Harris delivers talks and lectures as part of the ongoing, biweekly clinical conferences for the

residents and attending physicians. (Harris, Tr. 4252). Most of the ED physicians are involved in the residency program at Evanston Hospital. (Harris, Tr. 4252.) This academic and teaching experience keeps physicians sharp by forcing them to research answers to questions, and by providing them with a venue for the exchange of new ideas. (Harris, Tr. 4252).

Response to Finding No. 2155:

This finding is misleading. As stated above in CCRFF 2153, there is no evidence that the skills of HPH physicians were deficient or that they improved because of the merger. Respondent omits Dr. Harris's testimony that before the merger HPH physicians did strive to keep themselves continually educated. (Harris, Tr. 4252-53).

2156. Dr. Silver has a faculty appointment as a professor in the Medical School of Northwestern University. (Silver, Tr. 3762). The ENH Department of Ob/Gyn holds teaching activities for residents and medical students at ENH. (Silver, Tr. 3762-63). Further, the department holds weekly teaching conferences regarding high-risk obstetrics and a combined conference with the departments of pathology and pediatrics. Departmental physicians participate in teaching rounds, which take place at all three hospital campuses. (Silver, Tr. 3767-68). The participation of HPH obstetricians and gynecologists in teaching activities at ENH improved the quality of Ob/Gyn at HPH. (Chassin, Tr. 5380).

Response to Finding No. 2156:

This finding is misleading and vague. Respondent is vague about how many HPH physicians participate in the weekly teaching conferences or in teaching rounds. Further, there is no evidence that the participation of some HPH obstetricians and gynecologists in the teaching activities at ENH actually improved their knowledge or skills or improved patient care for HPH patients.

2157. 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).

Response to Finding No. 2157:

This finding is misleading and vague. (See CCRFF 2156). There is no evidence

that by giving didactic lectures, the skills of HPH pathologists improved or that patients received better care.

2158. 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).

Response to Finding No. 2158:

This finding is misleading and vague. It is not clear how the "participation of these residents in formal academic programs in family medicine at HPH is a quality improvement." { [REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3124-25, *in camera*).

2159. 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. (Harris, Tr. 4253). For example, there are grand rounds for all physicians every Thursday in the Department of Ob/Gyn. (Silver, Tr. 3767).

Response to Finding No. 2159:

This finding is irrelevant. Presumably, ENH physicians were able to participate in grand rounds at Evanston Hospital before the merger. This finding does not state how many HPH physicians participate in grand rounds or whether participation in grand rounds changed after the merger.

iv. HPH Physicians Participate In Departmental Conferences That Broaden Their Skills

2160. ENH routinely holds conferences for ENH physicians only. These conferences are multidisciplinary and focus on treatment plans for individual patients and on quality assurance issues that involve specific ENH cases. (Chassin, Tr. 5599).

Response to Finding No. 2160:

This finding is irrelevant. There is no evidence that the practice of holding conferences for its physicians is unique to ENH. There is no evidence that HPH or many other hospitals did not engage in similar practices.

2161. More information is shared at educational and academic conferences among physicians within the same hospital compared to conferences that include physicians from different hospitals. (Chassin, Tr. 5599). In the latter type of conferences, the lectures and seminars are usually straightforward. (Chassin, Tr. 5599).

Response to Finding No. 2161:

This finding is irrelevant. As stated above in CCRFF 2160, there is no evidence that the conferences at ENH are at all unique or that it changed any practice at HPH.

Further, it is not clear what Respondent means when it states "In the latter type of conferences, the lectures and seminars are usually straightforward."

2162. Additionally, HPH physicians who are generalists are able to interact with the subspecialists at these conferences and during patient care consultation sessions, thereby improving their skills. (Chassin, Tr. 5378).

Response to Finding No. 2162:

This finding is inaccurate, misleading and speculative. First, it is unclear what Respondent means by "generalist" or "subspecialist." There is no evidence that all physicians at HPH are generalists. There is no evidence, except for the characterization of Dr. Chassin, that HPH physicians interact with specialists at these conferences or that as a result, their skills are improved.

**v. HPH Physicians Have Obtained Faculty Appointments
As A Result Of The Merger**

2163. Following the Merger, about 60 HPH physicians who did not have academic

appointments were able to obtain appointments at Northwestern Medical School. (Chassin, Tr. 5376; O'Brien, Tr. 3540). These faculty positions allow the HPH physicians to pursue research and drew many physicians into teaching roles in the residency program operated by ENH. (Chassin, Tr. 5376; Harris, Tr. 4252).

Response to Finding No. 2163:

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3125, *in camera*).

Thus, the teaching activity takes place at Evanston hospital, not at Highland Park.

{ [REDACTED]

[REDACTED] }

(Romano, Tr. 3125, *in camera*).

2164. Before the Merger, these appointments were not frequently granted to HPH physicians. (Chassin, Tr. 5376).

Response to Finding No. 2164:

See CCRFF 2163, above.

vi. ENH Provides HPH Physicians With A Continuing Medical Education Stipend

2165. ENH provides HPH physicians with a \$4,000 continuing medical education stipend. (Harris, Tr. 4253). No such stipend was available pre-Merger. (Harris, Tr. 4253).

Response to Finding No. 2165:

When referencing the stipend, Dr. Harris made clear that "I'm not saying that

[pre-merger] the physicians didn't strive to try to . . . keep themselves educated." (Harris, Tr. 4252). Further, there is no evidence that HPH physicians were not able to participate in continuing medical education because they lacked a stipend.

vii. HPH Has Gained An Academic Affiliation, Which Has Enabled It To Recruit Better Physicians

2166. An academic medical center is defined as a teaching hospital that is owned or operated or affiliated with a medical school. (O'Brien, Tr. 3542). Before the Merger, HPH did not have an academic affiliation. (Spaeth, Tr. 2239).

Response to Finding No. 2166:

Several studies have demonstrated academic hospitals to perform better than other hospitals. Those studies do not look at the "affiliation" cited by ENH. Instead, they typically look at the number of residency programs or the number of residents per bed. (Romano, Tr. 3118). Under these measures, it is true that HPH did not have an academic affiliation pre-merger, but the same remained true post-merger. (Romano, Tr. 3118).

2167. In contrast, ENH is an academic medical center through its affiliation with Northwestern University Medical School. (O'Brien, Tr. 3542).

Response to Finding No. 2167:

As to ENH as a whole, payors do not consider it to be an advanced teaching hospital (*See* Ballengee, Tr. 189; Neary, Tr. 621). As to HPH, that hospital does not qualify as a teaching hospital under the criteria used in the academic literature which has found some areas where teaching hospitals outperform other hospitals. (Romano, Tr. 3118).

2168. Additionally, the Medicare Payment Advisory Commission ("MedPac"), a federal body that defines academic medical center and major academic hospital categories, characterizes an academic hospital as a hospital that has at least a 0.25 resident-to-bed ratio. (O'Brien, Tr.

3541-42). ENH has a 0.29 ratio. (O'Brien, Tr. 3542).

Response to Finding No. 2168:

HPH does not qualify as a teaching hospital under the criteria used in the academic literature which has found some areas where teaching hospitals outperform other hospitals. (Romano, Tr. 3118).

2169. A hospital's status as an academic medical center has a substantial impact on its ability to recruit the highest quality physicians and administrators. (Chassin, Tr. 5600). Before the Merger, HPH had a major problem recruiting physicians. (Harris, Tr. 4251). After the Merger, HPH had an improved ability to hire quality residents due to its new affiliation with the Northwestern Medical School. (Harris, Tr. 4251; RX, 1148).

Response to Finding No. 2169:

This finding mischaracterizes the witness' testimony. Dr. Harris referred only to difficulty "staffing the emergency department," (Harris, Tr. 4251), not across the hospital.

Other doctors and administrators testified that HPH had plenty of good doctors pre-merger. (Dragon, Tr. 4315, Spaeth, Tr. 2239; Neaman Tr. 1228).

2170. During his time as HPH's CEO, Spaeth and HPH could not recruit subspecialty physicians to the hospital. (Spaeth, Tr. 2246-47). HPH had trouble 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).

Response to Finding No. 2170:

ENH accurately cites to Mr. Spaeth's testimony but that testimony was explicitly limited to the pre-merger period. ENH points to no evidence that, post-merger, physician recruitment has improved. There is no reason that it should have improved due to any "academic affiliation" since HPH is not an academic hospital under accepted measures and any teaching activity takes place at Evanston Hospital, not HPH. (Romano Tr. 3118).

2171. During his time as HPH's CEO, Spaeth and HPH were able to recruit and hire some primary care physicians and one or two radiologists and oncologists. (Spaeth, Tr. 2246-47). Pre-Merger HPH was able to recruit only a single physician from a university setting, Dr. Leon Dragon, who became HPH's director of radiology. (Spaeth, Tr. 2309).

Response to Finding No. 2171:

Respondent's finding is misleading. (See CCRFF 2170).

k. The Merger Improved The Quality Of Psychiatric Services At HPh

i. Overview

2172. Before the Merger and through the Spring of 2001, HPH and Evanston Hospital each had separate inpatient psychiatric units that treated both adult and adolescent patients. (O'Brien, Tr. 3516; RX 1754 at ENH RS 3086). In the Spring of 2001, however, ENH consolidated the adolescent inpatient services at HPH and the adult inpatient services at Evanston Hospital. (O'Brien, Tr. 3517; Chassin, Tr. 5339; Neaman, Tr. 1358-59; RX 1080 at ENHL PK 55405).

Response to Finding No. 2172:

Complaint Counsel does not deny that this separation of adult and adolescent psychiatric patients took place a year and a quarter after the merger. To the extent ENH claims that this change was part of a broad based "rationalization" of clinical services, that rationalization was not effective for reasons explained in CCRFF 2174 below. With regard to psychiatry alone, the effect of the separation on quality is discussed in CCRFF 2186 below.

2173. ENH also spent about \$1.2 million (excluding additional staffing costs) to make facility and program improvements to the HPH psychiatric unit. (O'Brien, Tr. 3519). In addition, the State conducted a full certificate of need review of the rationalization of psychiatric services at ENH before it was completed. (Chassin, Tr. 5340-41).

Response to Finding No. 2173:

Complaint Counsel does not deny the first sentence but notes once again that the

amount ENH claims to have invested was well within HPH's capital budget. (Newton, Tr. 430; CX 545 at 3; CX 1055 at 2).

2174. Rationalization of clinical services is the process of enhancing the quality and cost efficiency of clinical services by determining at what location in a hospital system clinical services should be rendered. (Hillebrand, Tr. 1986). Rationalization of clinical services takes into account the best ways to improve the quality and cost efficiencies of the clinical services. (Hillebrand, Tr. 1986).

Response to Finding No. 2174:

While this finding may accurately describe what rationalization should be, it does not describe what ENH did. In order to enhance the quality of clinical services by determining at which location in a hospital system clinical services should be located, a hospital should take account of the extensive literature on the relationship between volume and outcome. (Romano, Tr. 3173-75). The literature shows that for some services, higher volumes are correlated with better outcomes. (Romano, Tr. 3174). ENH, however, "derationalized" its services by spreading out heart surgery among two locations, thereby reducing the volume performed at each location, in spite of the strong volume outcome relationship. (Romano, Tr. 3175).

In other areas, ENH claimed to have rationalized services, but the evidence was "mixed as to whether these rationalizations actually occurred." (Romano, Tr. 3176). For example, ENH said it consolidated hysterectomies at HPH and dialysis at Evanston hospital, but the data indicated that such rationalization had not in fact occurred. (Romano, Tr. 3176).

- ii. **Before The Merger, The Adolescent Psychiatry Services Available At Both HPH And Evanston Hospital Were Limited**

2175. Before the Merger, the adolescent population at both HPH and Evanston Hospital was not large enough to provide the full complement of services for inpatient psychiatric care in terms of group therapy, intermittent therapy and other combinations of treatment plans. (Chassin, Tr. 5341; RX 1754 at ENH RS 3092).

Response to Finding No. 2175:

See CCRFF 2186, below.

2176. Additionally, before the Merger, psychiatric consultations in the ED were sought from either a private practice psychiatrist or the ED physicians. (Chassin, Tr. 5345). Patients presenting with psychiatric emergencies, however, often require specialized assessment that is beyond the scope of most ED physicians' capacity. (Chassin, Tr. 5342-43; RX 1111 at ENH GW 278).

Response to Finding No. 2176:

See CCRFF 2186, below.

iii. HPH's Adolescent Psychiatry Physical Facility Contained Hazards For Adolescent Patients

2177. Before the Merger, the physical facility that housed the HPH adolescent psychiatry unit contained many hazards for both the patients and the staff. (Chassin, Tr. 5341). For example, adolescents could hide from staff in the hallways, presenting unsafe situations. (Chassin, Tr. 5342; O'Brien, Tr. 3519).

Response to Finding No. 2177:

This finding is misleading, vague and speculative. There is no evidence that there were any negative results from adolescents "hiding in hallways." See also CCRFF 2186, below. (No indication that quality improved for psychiatric services after the merger).

iv. Consolidating Adolescent Psychiatric Services At HPH Allowed HPH To Offer New And Expanded Services

2178. After the Merger, HPH was able to offer a broader variety of treatment options for adolescent patients. (Chassin, Tr. 5339). One of the new services HPH opened after the Merger was a crisis intervention team that was dedicated to providing psychological counseling and evaluation to ED patients. (Chassin, Tr. 5339).

Response to Finding No. 2178:

See CCRFF 2186, below. (No indication that quality improved for psychiatric services after the merger).

2179. ENH also created a consultation service at HPH to address patients with chemical dependency problems. (Chassin, Tr. 5344-45; RX 1066; RX 1754 at ENH RS 3092).

Response to Finding No. 2179:

See CCRFF 2186, below. (No indication that quality improved for psychiatric services after the merger).

2180. Additionally, ENH added a Ph.D. in education to the HPH staff to work with adolescent issues. (O'Brien, Tr. 3517). Adolescents can be in the unit for five to ten days and away from their school work for that period of time. (O'Brien, Tr. 3517-18). The Ph.D. provides a curriculum for students while they are in the unit and helps to transition the adolescents back to school. (O'Brien, Tr. 3517).

Response to Finding No. 2180:

See CCRFF 2186, below. (No indication that quality improved for psychiatric services after the merger or that patient satisfaction improved). This finding also demonstrates the paucity of favorable evidence for Respondent. Because it has no relevant evidence to support its position, it presents findings regarding teenagers' schoolwork.

2181. ENH also added a full-time psychiatrist to provide consultation to HPH inpatients who were hospitalized for medical or surgical conditions but also had psychiatric problems. (Chassin, Tr. 5339). This specialty service allows psychiatrists who understand the relationship between the psychiatric illness and the medical or surgical illness to consult on patients and recommend an overall plan of care. (Chassin, Tr. 5344; RX 1781 at ENHL PK 55286). This service was not available pre-Merger. (Chassin, Tr. 5344).

Response to Finding No. 2181:

See CCRFF 2186, below. (No indication that quality improved for psychiatric services after the merger or that patient satisfaction improved).

2182. After the Merger, ENH extended the range of adolescents who could be treated in the unit from 12-18 years old to 24 years of age. (O'Brien, Tr. 3517; RX 1250).

Response to Finding No. 2182:

See CCRFF 2186, below. (No indication that quality improved for psychiatric services after the merger or that patient satisfaction improved).

2183. ENH also hired several adolescent psychiatrists to staff the HPH adolescent unit. (O'Brien, Tr. 3518).

Response to Finding No. 2183:

See CCRFF 2186, below. (No indication that quality improved for psychiatric services after the merger or that patient satisfaction improved).

v. ENH Expanded And Remodeled The Adolescent Psychiatry Unit To Make It Safer

2184. The HPH adolescent psychiatric unit was remodeled and opened in December of 2003. (O'Brien, Tr. 3518). Before the reconstruction, the rooms were semi-private. (O'Brien, Tr. 3518-19). Today, the unit today has ten private patient rooms. (O'Brien, Tr. 3518).

Response to Finding No. 2184:

ENH here touts more physical plant improvements, in this instance room renovations that took place four years after the merger. Complaint Counsel repeats that HPH constantly invested in physical plant improvements pre-merger and was financially capable of continuing such investment post-merger. See, e.g., CCF 2324-2354, 303-351.

2185. ENH added a keyless entry system with voice and sight recognition. (O'Brien, Tr. 3518). Furniture was also grounded and attached to the floor for patient safety reasons.

(O'Brien, Tr. 3519). There are no drawers or cabinets so that contraband can be easily monitored. (O'Brien, Tr. 3519).

Response to Finding No. 2185:

See CCRFF 2184, above.

**vi. The Improvements Made By ENH In Consolidating
And Expanding Psychiatric Services At HPH Improved
The Quality Of Care**

2186. All of the changes that ENH brought to HPH's psychiatric services after the Merger improved the quality of care. (Chassin, Tr. 5347).

Response to Finding No. 2186:

Dr. Chassin made clear at the cited portion of the transcript that his conclusion was based on "largely structural measures." (Chassin Tr. 5348). But structural measures are "insufficient by themselves" to measure quality. (Romano, Tr. 2988). Dr. Romano's testimony that there is no literature associating structural improvements of this type with improved outcomes stands undisputed. (Romano, Tr. 3115-16). ENH may have spent a lot of money on psychiatry improvements, but there is no evidence that they did anybody any good. Indeed, the only evidence in the record is to the contrary. [REDACTED]

[REDACTED]

[REDACTED] (Romano, Tr. 3115-17, *in camera*).

2187. To familiarize himself with psychiatric services, Dr. Chassin spoke to people in the facility, reviewed contemporaneous documents, interviewed the Chairman of psychiatry, and made a site visit to the facility at HPH. (Chassin, Tr. 5342).

Response to Finding No. 2187:

It is unclear whether Dr. Chassin spoke to psychiatrists who practiced at HPH

before the merger. No psychiatrist testified for Respondent regarding the changes that ENH made to the psychiatry department.

2188. In contrast, Dr. Romano used Press Ganey data to evaluate psychiatric services both pre- and post-Merger. This is not a valid way of evaluating patient satisfaction. (Chassin, Tr. 5348). Further, the Press Ganey data Dr. Romano used in his evaluation were inpatient data. (Chassin, Tr. 5348). In addition to all of the other problems with these data, they measure different services offered by completely different programs – the pre-Merger mixed adult/adolescent unit compared to completely separate post-Merger units. (Chassin, Tr. 5349).

Response to Finding No. 2188:

Dr. Chassin's testimony as a paid litigation expert is inconsistent with the day to day business practices of his client, ENH. ENH itself uses patient satisfaction surveys to analyze its performance. (RX 1130). { [REDACTED]

[REDACTED] } (Chassin, Tr. 5433-35; Neaman, Tr. 1136-37, *in camera*). { [REDACTED]

[REDACTED] } (Neaman, Tr. 1136, *in camera*; CX 1566 at 4). ENH's CEO admitted that Press Ganey is an important barometer for monitoring quality at ENH. (Neaman, Tr. 1127-28; CX 1566 at 4).

E. After The Merger, ENH Continued To Provide High Quality Hospital Services

1. ENH Has Been Independently Recognized For Having High Quality Of Care

a. ENH Received Solucient's 100 Top Hospital Award

2189. The Solucient Top 100 Hospital Award is a form of recognition given to hospitals once a year based on criteria chosen with a proprietary risk-adjustment program. (O'Brien, Tr. 3544). ENH does not subscribe, or pay money, to Solucient. (O'Brien, Tr. 3545). Solucient is a company that provides consulting and healthcare data analysis services to hospitals and other healthcare organizations and is a source of data that Dr. Romano has relied upon in his work in the healthcare quality field. (Romano, Tr. 2995-96). Solucient compares ENH's performance

against the median performance of benchmarked hospitals for quality related issues, such as risk-adjusted mortality, complications and patient safety. (RX 2032 at 5). In addition, Solucient also looks at financial performance. (RX 2032 at 5).

Response to Finding No. 2189:

This finding is incomplete and misleading. The Solucient survey had nine performance measures, five of which were financial performance indicators such as expense per adjusted discharge (case-mix and wage adjusted), profitability (operating profit margin), cash to total debt ratio, tangible assets (net PPE) per adjusted discharge and growth in percent community served. (RX 2032 at 5). For 2005, ENH exceeded the median performance of major teaching hospitals in the categories of profitability (92.8% above the median), net PPE (66.97% above the median) and patient safety (11.04% above the median). For mortality, ENH was .38% below the median and for complications, ENH was 1.79% below the median. (RX 2032 at 7).

2190. ENH has received the Top 100 Award from Solucient for ten years in the major teaching hospital category. (O'Brien, Tr. 3544-45). The most recent year was 2004. (O'Brien, Tr. 3544; RX 2032 at 6). There are 147 hospitals in the major teaching hospital category, 15 of which are selected for the Top 100 award in that category. (O'Brien, Tr. 3545).

Response to Finding No. 2190:

To the extent inclusion in the Solucient 100 says anything about quality of care (as opposed to finances), this finding demonstrates that quality of care at Highland Park Hospital was excellent before the merger. ENH continued to receive the Solucient Top 100 Award in 2000 immediately after it merged with Highland Park Hospital but before it made any changes to it. (O'Brien, Tr. 3544-45). If Highland Park Hospital had the problems to the extent claimed by Dr. Chassin, and if the changes later made by ENH

were of such great moment, then it seems unlikely that ENH would not have kept its top 100 rating for 2000.

2191. Solucient uses data from MedPar, the Agency for Healthcare Research and Quality ("AHRQ") and its own hospital database. (O'Brien, Tr. 3546). { [REDACTED] } (O'Brien, Tr. 3667, *in camera*). With respect to the risk-adjusted patient safety index, ENH has a favorable rating of 11.4 percent, which means that ENH out-performed more than just similar hospitals, but instead outperformed the elite Top 100 Hospitals in its peer group hospitals by 11.4 percent for this category. ENH's performance with respect to risk-adjusted mortality improved from -18.0 percent in the 2001 survey, to -0.38 percent in the 2004 Solucient Top 100 Hospital survey, a substantial decrease in risk-adjusted mortality during that period. (RX 2032 at 5-7; CX 1947; Romano, Tr. 3405).

Response to Finding No. 2191:

This finding is misleading. First, it is worth noting that, while Respondent criticizes Dr. Romano's use of administrative data, it touts results from Solucient that it portrays as favorable that use the same administrative data. Respondent is relying on the very same data that it criticizes as "flawed." (O'Brien, Tr. 3544-45).

Additionally, the Solucient survey cannot be linked to any of the alleged improvements made by ENH to Highland Park Hospital. ENH received the Solucient Top 100 Award from the time before it merged with Highland Park Hospital through 2005. (O'Brien, Tr. 3544-45). Before any alleged improvements were made to Highland Park Hospital by ENH, ENH continued to receive the Solucient award. For example, Epic was not deployed at Highland Park Hospital until 2004 (*See* CCFF 2453), the intensivist program was not implemented until spring 2001 (*See* CCFF 2454), implementation of the critical pathways for OB/Gyn occurred over a period from October 2001 through May 2004 (*See* CCFF 2461), and changes to staffing for the pharmacy department did not occur until 2003. (*See* CCFF 2468). Thus the Solucient award does

nothing to validate the specific claims of quality improvement at Highland Park Hospital that ENH attributes to the merger.

2192. Since 1999, ENH has received on multiple occasions both the Top 15 Teaching Hospital Award and the Top 100 Hospital Award. (Neaman, Tr. 1290-91).

Response to Finding No. 2192:

See CCRFF 2191; above.

2193. Dr. Romano agreed that ENH was ranked by Solucient in the top 100 hospitals based, in part, upon a quality assessment. (Romano, Tr. 3398-3400). While, ENH's profitability score decreased during the same period, significantly, its quality related scores for risk-adjusted mortality and patient safety index either improved or remained favorable. (RX 2032 at 7; CX 1947 at 15).

Response to Finding No. 2193:

Immediately before the testimony cited by ENH, Dr. Romano stated that "[ENH was] ranked [by Solucient] in the Top 100 hospitals based on their performance, not specifically quality." (Romano Tr. 3398). On redirect, Dr. Romano noted that on one of the Solucient rankings, ENH's profitability compared favorably to the benchmark hospitals by a measure of 101%, while its mortality compared unfavorably by 18%, and complications compared unfavorably by 6%. (Romano, Tr. 3404-05).

b. ENH Received Awards From HealthGrades For Clinical Excellence

2194. HealthGrades, which is a proprietary data analysis firm that sponsors a website that includes information about hospital and physician quality, has identified ENH as a Distinguished Hospital for Clinical Excellence for some of the last several years. (Romano, Tr. 2979, 3400).

Response to Finding No. 2194:

This finding is misleading. While it may be true that ENH may receive some

awards from time to time, this fact does not support the position that the quality at ENH improved as a result of the merger. Respondent omits the fact that before the merger, Highland Park Hospital received numerous awards and national recognition for its quality. In 1997, Highland Park Hospital received the Lincoln Award, which is given for quality improvement. Highland Park Hospital was one of five hospitals in Illinois to receive the Lincoln Award. (CX 2415 at 4). In 1996, Highland Park Hospital received a positive review from the Chicago Hospital Risk Pooling Program (CHRPP). { [REDACTED]

[REDACTED] } (RX 412 at ENHL PK 017794, *in camera*). Highland Park Hospital also performed well on Press Ganey surveys. { [REDACTED]

[REDACTED] } (RX 413 at ENHL PK 017847, *in camera*)

2195. HealthGrades also identified ENH as a recipient of the Award For Gastrointestinal Care Excellence for 2005. (Romano, Tr. 3400).

Response to Finding No. 2195:

This finding is misleading. (See CCRFF 2194 (Respondent omits the fact that before the merger, HPH received numerous awards and national recognition for its quality.)).

c. ENH Received Recognition From The Leapfrog Group

2196. In 2005, ENH received the Leapfrog Award for being the top hospital system in Illinois. (Neaman, Tr. 1291).

Response to Finding No. 2196:

This finding is misleading. (See CCRFF 2194 (Respondent omits the fact that

before the merger, HPH received numerous awards and national recognition for its quality.)).

d. ENH Hospitals Have Received National Recognition For Its Healthcare Quality

2197. A recent article in Consumers Digest named 50 exceptional hospitals in the United States. (O'Brien, Tr. 3549). The 50 hospitals were ranked based on the Leapfrog survey. (O'Brien, Tr. 3549-50).

Response to Finding No. 2197:

This finding is misleading. (See CCRFF 2194 (Respondent omits the fact that before the merger, HPH received numerous awards and national recognition for its quality.)).

2198. Hospitals completed the Leapfrog survey and were rated based on their compliance with four areas of care, called leaps. (O'Brien, Tr. 3549-50). These leaps included having an intensivist program, having a CPOE system, having certain volumes in procedures, and compliance with 27 performance indicators that are aggregated into the last leap. (O'Brien, Tr. 3550).

Response to Finding No. 2198:

This finding is misleading. (See CCRFF 2194 (Respondent omits the fact that before the merger, HPH received numerous awards and national recognition for its quality.)).

2199. Three hospitals in the state of Illinois were mentioned in the list of 50 exceptional hospitals. (O'Brien, Tr. 3550). Those three hospitals were Evanston Hospital, Glenbrook Hospital and HPH. (O'Brien, Tr. 3550).

Response to Finding No. 2199

This finding is misleading. (See CCRFF 2194 (Respondent omits the fact that before the merger, HPH received numerous awards and national recognition for its

quality.)).

2200. ENH also received the National Quality Award. (Neaman, Tr. 1291).

Response to Finding No. 2200

This finding is misleading. (See CCRFF 2194 (Respondent omits the fact that before the merger, HPH received numerous awards and national recognition for its quality.)).

e. US News & World Report Recognized ENH As A Top Hospital

2201. ENH received recognition from US News & World Report. (Neaman, Tr. 1291).

Response to Finding No. 2201:

This finding is misleading. (See CCRFF 2194 (Respondent omits the fact that before the merger, HPH received numerous awards and national recognition for its quality.)).

f. ENH Received The KLAS And Davies Award For Epic

2202. In 2004, ENH received both the KLAS and Davies Award for being the top-ranked medical information system hospital in the United States. (Neaman, Tr. 1291; RX 1899 at ENHE RS 30).

Response to Finding No. 2202:

This finding is misleading. (See CCRFF 2194 (Respondent omits the fact that before the merger, HPH received numerous awards and national recognition for its quality.)).

2. There Is No Evidence That Quality Deteriorated At Evanston Hospital After The Merger

2203. Dr. Chassin found no independent evidence of declines in quality of care at Evanston Hospital as a result of the Merger. (Chassin, Tr. 5275-76).

Response to Finding No. 2203:

This finding is misleading. Regardless of what Dr. Chassin found, there is clear evidence in the record of a { [REDACTED]

[REDACTED] } (Romano, Tr. 3081-82, *in camera*). The correlation of both data sources “increases our confidence in the truth of those findings.” (Romano, Tr. at 3007). { [REDACTED]

[REDACTED] } (Romano, Tr. 3046, 3050-01, 3054-55, *in camera*). The fact that Dr. Chassin did not find evidence of declines in quality at Evanston Hospital demonstrates that his methodology and analysis was not comprehensive.

2204. Further, there was no evidence to support Dr. Romano’s hypothesis that quality declined at Evanston Hospital as a result of a diversion of resources from Evanston Hospital to HPH after the Merger. (Chassin, Tr. 5275-76). *See* Section VIII.D.1. d.iv., *supra*.

Response to Finding No. 2204:

This finding is inaccurate and misleading. Evanston Hospital’s own cardiologists worried that the establishment of a cardiac surgery program at Highland Park Hospital by ENH would spread resources too “thin.” (CX 1998 at 21).

- F. The Programs Or Services ENH Improved And Added At HPH After The Merger Exceed National And State Quality Benchmarks**
 - 1. HPH’s Post-Merger Performance In Treating Patients With Acute Myocardial Infarction Exceeds The Average In Illinois Hospitals**

2205. HPH's use of highly valid process measures for the treatment of heart attack patients – the administration of aspirin and beta blockers upon arrival and discharge – has exceeded the Illinois hospital average during the post-Merger period. (Chassin, Tr. 5278-83; RX 2043). Before the Merger, HPH was consistently below the Illinois hospital average for almost all of these process measures and below Evanston Hospital for all four process measures. (RX 2043). Evanston Hospital's performance on these same measures was also superior to that of all other Illinois hospitals during both the pre- and post-Merger time periods. (Chassin, Tr. 5278; RX 2043). See Section VIII. D.1.d.iv.

Response to Finding No. 2205:

This finding is inaccurate and misleading. { [REDACTED]

[REDACTED] (Romano, Tr. 3081-82 (discussing

DX 441 at 83, *in camera*), *in camera*). { [REDACTED]

[REDACTED] (Romano,

Tr. 3083, *in camera*). { [REDACTED]

[REDACTED] (Romano,

Tr. 3083-84, *in camera*). { [REDACTED]

[REDACTED] (Romano, Tr. 3071-72,

in camera). { [REDACTED]

[REDACTED] } (Romano, Tr. 3083-84, *in*

camera). { [REDACTED]

[REDACTED] } (Romano, Tr. 3070-72, *in*

camera). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Romano,

Tr. 3072, *in camera*).

2. HPH's Post-Merger Cardiac Surgery Outcomes Exceed National Benchmarks

2206. HPH's post-Merger mortality rate for cardiac surgery is lower than the national benchmark taken from data submitted to the Society of Thoracic Surgeons ("STS"). (Chassin, Tr. 5294). Moreover, HPH is also lower than the benchmark for cardiac surgery programs in New York State. (Chassin, Tr. 5294).

Response to Finding No. 2206:

This finding is misleading. Even if HPH's post-Merger mortality rate for cardiac surgery is better than some benchmarks, it does not support the position that the merger improved care for heart patients at HPH. Respondent does not state whether HPH's pre-merger mortality rates exceeded benchmarks, so there is no way to judge whether this is an improvement.

2207. HPH's post-Merger major complication rate was also lower than national benchmarks established by STS. (Chassin, Tr. 5299). For example, HPH's post-Merger re-operation rate was about 1.8%, which is well under the accepted national benchmark published by STS of approximately 5.3%. (Chassin, Tr. 5299). HPH's post-Merger kidney failure rate of 1.2% was also much lower than the 3% national benchmark. (Chassin, Tr. 5299). *See Section*

VIII.D.2.a.vi., *supra*.

Response to Finding No. 2207:

This finding is misleading. ENH discusses here only major complications. When all complications are analyzed, the result is quite different. { [REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3046, 3050-01, 3054-55, *in camera*).

3. ENH Is A National Leader In The Implementation Of Electronic Medical Records

2208. Independent groups such as KLAS and Davies have recognized ENH as the national leader in electronic medical record implementation because of its uniquely successful implementation of the Epic system. (RX 1666; Neaman, Tr. 1356; Wagner, Tr. 3996-97; RX 1733). The Davies Award singled out ENH for being the only institution that has universally accepted inpatient physician order entry, physician documentation, and nurse documentation by employed and non-employed physicians; has extended this capability to the ambulatory world; and has an integrated medical record. (Wagner, Tr. 3996-97; RX 1733).

Response to Finding No. 2208:

This finding is misleading. While HPH may be recognized by organizations for various things, the evidence shows that there was nothing unique about ENH's implementation of Epic. { [REDACTED]

[REDACTED] }

(Romano, Tr. 3161, *in camera*). { [REDACTED]

[REDACTED] } (Romano, Tr. 3162, *in*

camera). The decision of 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). 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). 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. 4068-69).

2209. Additionally, Dr. Brailer, who was appointed by President Bush as the head of the Office of National Healthcare Information Technology, personally visited ENH to recognize its achievement of having a fully deployed and integrated electronic health record universally throughout the three ENH hospitals that was used by all physicians and patient accessible. (Wagner, Tr. 3959).

Response to Finding No. 2209:

Dr. Brailer's visit took place in November 2004, five years after the merger. In touting events so remote from the merger, ENH makes clear that its long list of claimed improvements cannot be attributed to the merger in the manner it claims. *See also* CCRFF 2208, above.

2210. Consequently, other academic hospitals in the Chicago area have sought to learn from ENH's successful deployment of EPIC. (Wagner, Tr. 3997-99).

Response to Finding No. 2210:

See CCRFF 2208, above.

2211. In contrast to ENH, in 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). The situation is no different in community hospitals, where there has been little if any migration to electronic records. (RX 1423 at 7). Indeed, the majority of community hospitals today do not have an electronic medical record that includes CPOE. (Romano, Tr. 3334).

Response to Finding No. 2211:

The finding is incomplete. The cited source notes that a well financed (allegedly) academic hospital is not necessary for the implementation of Epic, nor is it necessary for entities to merge in order to share appropriate health data electronically. To the contrary, “there are some noteworthy examples of healthcare settings in both the private and public sectors in which EHRs have been deployed. A handful of communities and systems have secure platforms for the exchange among providers; suppliers; patients and other authorized users.” (RX 1423 at 6 (citing several specific examples)).

4. ENH Exceeds National Benchmarks For Its Cesarean Section Rate

2212. ENH’s post-Merger cesarean section trend is favorable and has been consistently lower than the national average, as reflected in data reported through NPIC. (Silver, Tr. 3823-24 *discussing* DX 7037-001)). See Section VIII.D.1.a.v., *supra*.

Response to Finding No. 2212

This finding is misleading. { [REDACTED]

[REDACTED]

(Krasner, Tr. 3748-49; O’Brien, Tr. 3672, *in camera*). Even if at some point in time, ENH’s caesarean section trend is “favorable,” this does not support the position that the quality of care at ENH improved for obstetrics and gynecology.

Moreover, much more important than national trends is a comparison to control group hospitals at which prices increased less than at ENH. ENH did not measure its performance on any OB/Gyn measures against those hospitals. { [REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3188-89, 3226-28, 3231-32, *in camera*). { [REDACTED]

[REDACTED] } (Romano, Tr. 3127 (discussing DX 7033 at 19, *in camera*), *in camera*).

5. ENH Exceeds National Benchmarks For Its Operative Vaginal Delivery Rate

2213. Both before and after the Merger, ENH, has maintained a lower operative vaginal delivery rate than the national trend. (Silver, Tr. 3825 (*discussing* DX 7037-002)). See Section VIII.D.1.a.v., *supra*.

Response to Finding No. 2213:

This finding is misleading. (See CCRFF 2212 ({ [REDACTED]

[REDACTED]

[REDACTED] }), *in camera*).

6. ENH's Preoperative Gynecologic Surgical Review Program Is Unique

2214. { [REDACTED]
[REDACTED] } (Silver, Tr. 3924, *in camera*). See Section VIII.D.1.a.iv., *supra*.

Response to Finding No. 2214:

This finding is misleading. { [REDACTED]

[REDACTED] }

(Krasner, Tr. 3748-49; Silver, Tr. 3929-31, *in camera*; O'Brien, Tr. 3672, *in camera*).

Even if at some point in time, ENH had a preoperative gynecologic review program, this does not support the position that the quality of care at ENH improved for obstetrics and gynecology.

7. Post-Merger HPH Is A Leader In Terms Of Its Full-Time Intensivist Program

2215. Intensivist programs such as the one instituted at HPH after the Merger are not common in community hospitals. (Chassin, Tr. 5329).

Response to Finding No. 2215:

This finding is misleading. There is nothing unique about ENH's implementation of the intensivist program. { [REDACTED] } (Romano, Tr. 3113-14, *in camera*). This influenced ENH to implement an intensivist program at HPH. (Ankin, Tr. 5103-04). Lake Forest Hospital, a community hospital, implemented an intensivist program with Pulmonary Physicians of the North Shore. (Ankin, Tr. 5072-74, 5089).

2216. Moreover, a LeapFrog Group survey showed that only six out of thirty-seven hospitals in the State of Illinois had full-time intensivist programs. (Chassin, Tr. 5329-30; Romano, Tr. 3324). Three of those six hospitals were Evanston, Glenbrook and HPH. (Chassin, Tr. 5330). See Section VIII.D.2.c.v., *supra*.

Response to Finding No. 2216:

This finding is misleading because the Leapfrog survey is not credible. The majority of the hospitals in the state of Illinois did not even respond to the survey. (Romano, Tr. 3324). One hospital, Lake Forest, is not on the list although Lake Forest does have an intensivist program. (Romano, Tr. 3425; Ankin, Tr. 5073).

G. Dr. Romano's Analysis Did Not Properly Evaluate ENH's Significant Quality Improvements At HPH

2217. As a result of the Merger and the improvements outlined above, HPH provides care in a completely different way. (Chassin, Tr. 5402-03). The improvements made by ENH affect the care of every single patient at HPH and, as a result, HPH takes a very integrated and broad multidisciplinary approach to the care of its patients. Evanston Hospital, as an academic medical center, has brought a great deal of clinical expertise and training to physicians throughout HPH. (Chassin, Tr. 5400-04).

Response to Finding No. 2217:

This finding is misleading. { [REDACTED]

[REDACTED] } (Romano, Tr. 3124-25, *in camera*).

With regard to the purported “multidisciplinary approach” the most specific example of that change provided by ENH is its multidisciplinary oncology services. As discussed in more detail elsewhere, all ENH has done with regard to these services is make the same services available in a more coordinated fashion. Many other hospitals did the same thing at the same time, and at ENH the change did not register in the area where an improvement would most likely be measured, patient satisfaction. See CCRFF 1722-1789.

ENH’s citation to Dr. Chassin for the proposition that the claimed improvements “affect the care of every single patient at HPH” is curious, since he was candid in acknowledging that his study was quite limited. He never had a list of all of HPH’s patient services and focused his study on areas of either alleged pre-merger problems or alleged post-merger improvements. He therefore left out several areas. (Chassin, Tr. 5450).

2218. Further, the improvements that ENH has made are interconnected. (Chassin, Tr. 5404). For example, the establishment of cardiac surgery has required that the skills of physicians, nurses and technicians throughout the hospital be enhanced and maintained at a high-level. (Chassin, Tr. 5401; Rosengart, Tr. 4463-64, 4483-84; Ankin, Tr. 5064-65, 5068-69 ; RX 1445 at ENHL PK 51621).

Response to Finding No. 2218:

This finding is misleading. As discussed in more detail elsewhere, the cardiac

surgery facility was not merger specific. To the contrary, HPH had been planning for it for a long time and actually contracted with ENH for its implementation prior to agreeing to the merger.

[REDACTED] } (Romano, Tr. 3136, *in camera*; CX 405 at 8; RX 924 at ENHLMN 001411; RX 938 at ENHE F35 000317). Even if there was some unmeasured or unmeasurable improvement to nursing brought about by the existence of heart surgery at HPH, it was demonstrably not merger specific. When ENH and HPH contracted to jointly develop a cardiac surgery program at HPH without a merger, HPH agreed to pay ENH for necessary nurse training. (CX 2094 at 3-4).

2219. [REDACTED] } (Romano, Tr. 3308-09, 3317-18, 3327, 3332-33, 3390-93; Romano, Tr. 3067-68, 3109-11, 3160, 3178-79, 3194-98, 3228-29, *in camera*). Although he discounts the significance and relevance of those improvements, Dr. Romano admittedly was not comprehensive in his analysis. (Romano, Tr. 3244). In fact, he relied on incomplete and, in many cases, inappropriate data and methodologies to draw his conclusions. (Chassin, Tr. 5139).

Response to Finding No. 2219:

Respondent's citation to Dr. Romano's testimony is misleading for the same reason its citation to the same testimony in finding 1231 is misleading. In finding 1231, Respondent spelled out the specific areas in which it thinks Dr. Romano's testimony supports its position, and Complaint Counsel in response explained how Respondent had mischaracterized the relevant testimony. While there may have been some isolated evidence of improvement, that does not alter Dr. Romano's overall conclusions, based on an objective and systematic study, of "deterioration" in some areas, (Romano, Tr. 3054),

“no discernable improvement” in others, (Romano, Tr. 3005-06), and lack of “improved outcomes” from structural improvements in others, (Romano, Tr. 3008). *See also* CCRFF 1231.

The statement that Dr. Romano’s analysis was not “comprehensive” is also misleading. At the cited page of the transcript, Dr. Romano was asked about his initial report, and noted that he limited that report only to the areas where ENH had claimed an improvement. (Romano Tr. 3244). Against that background, he stated that the initial report had not been “comprehensive.” (Romano, Tr. 3244). When ENH significantly expanded the areas of claimed improvement in Dr. Chassin’s report, Dr. Romano looked at those areas as well. (Romano Tr. at 3010-11). As discussed in more detail below, the validity of Dr. Romano’s methodology is supported in the field of hospital quality.

(Romano, Tr. 6274-75, 6279-87).

2220. Specifically, as discussed in more depth below, Dr. Romano inappropriately relied on administrative data and patient satisfaction survey results. (Romano, Tr. 3255; Chassin, Tr. 5251).

Response to Finding No. 2220:

This finding is misleading. As discussed in more detail below, the validity of Dr. Romano’s methodology is supported in the field of hospital quality. (Romano, Tr. 6274-75, 6279-87).

1. Dr. Romano Relies Heavily Upon Flawed Administrative Data

2221. According to Dr. Romano a significant portion of his analysis in this case turns on his use of administrative data. (Romano, Tr. 3255).

Response to Finding No. 2221:

Dr. Romano agreed that administrative data is a big part of what he did in his

analysis. (Romano Tr. 3255).

2222. Administrative data include very limited sets of information, typically diagnosis and procedure codes, that are collected in the course of a hospital's administrative processes, as opposed to clinical processes. (Chassin, Tr. 5172-73). Administrative data are mostly intended for billing purposes and reporting to regulatory agencies. (Chassin, Tr. 5172-73). This definition is widely accepted in the field of hospital quality analysis. (Chassin, Tr. 5172-73).

Response to Finding No. 2222:

This finding is misleading. While Respondent has criticized the use of administrative data, it is possible to learn a lot more from using administrative data to evaluate risk-adjusted outcomes and quality of care than relying on structural data, a major source for Dr. Chassin's analysis. (Romano, Tr. 3409). In this case, relying on administrative data from the IDPH is more informative than relying on interview data, another major source for Dr. Chassin's analysis. (Romano, Tr. 3411).

2223. AHRQ, with which Dr. Romano is associated, publishes guidelines regarding administrative data. (Romano, Tr. 3255-56). AHRQ is the leading federal agency for quality of care. (Romano, Tr. 3270). In published guidelines, AHRQ avers that administrative data "should not be used as a definitive source of information on quality of health care." (Romano, Tr. 3255-56; RX 2004 at 29).

Response to Finding No. 2223:

Administrative data is used by many researchers to understand hospital quality of care. Analysts persist in using administrative data to evaluate quality, and Dr. Chassin, Respondent's own expert, relied on a study that used administrative data for his expert report. AHRQ issued a statement that reflected its opinion that administrative data should be used to evaluate hospital quality. For many clinical areas, clinical data is not available. As stated above, administrative data is more reliable than structural data or interview data. Administrative data is perfectly suitable for the purposes of Dr. Romano's

evaluation. AHRQ has recognized the value of appropriate use of administrative data, as compared to more reliable but much more difficult to develop clinical data, by noting (in a report authored in part by Dr. Kizer, one of Respondent's contemplated experts in this case) that we should not let the perfect be the enemy of the good. (Chassin, Tr. 5541-42).

2224. [REDACTED] (Romano, Tr. 3207-08, *in camera*; Romano, Tr. 3256-57; Chassin, Tr. 5175-82).

Response to Finding No. 2224:

See CCRFF 2222, above.

2225. First, administrative data contain few valid measures of process or structure. (Chassin, Tr. 5176). To account for improvements in those areas one would have to use other sources. (Chassin, Tr. 5176). The only useful information that can be taken from administrative data for this case is some information on outcomes. (Chassin, Tr. 5176).

Response to Finding No. 2225:

This finding is irrelevant. Dr. Romano used administrative data from the IDPH only to look at valid measures, which did in fact principally consist of outcomes. (Romano, Tr. 2978). (See CCRFF 2105-2110 for explanations of why the measures that Dr. Romano used are valid). Dr. Romano testified at length regarding the structure and process issues raised by Respondent, and analyzed the "other sources" relied upon by Respondent. (See CCRFF 2055). In this case, relying on administrative data from the IDPH is more informative than relying on interview data, another major source for Dr. Chassin's analysis. (Romano, Tr. 3411).

2226. Second, few, if any, outcome measures compiled from administrative data are valid. (Chassin, Tr. 5176).

Response to Finding No. 2226:

This finding is inaccurate and misleading. (See CCRFF 2225). Further, while Dr. Chassin claimed that only six of 46 AHRQ measures were valid, he did not identify the six nor explain why the others were invalid. (Romano, Tr. 6273-74). Dr. Romano's testimony concerning the validity of the AHRQ measures he used stands undisputed.

2227. Finally, to compare one hospital to another one must use a very exact method of risk-adjustment. (Chassin, Tr. 5176). Risk-adjustment must be done because patient populations of different hospitals are different. (Chassin, Tr. 5176). This fact must be taken into account when assessing changes in hospital quality. (Chassin, Tr. 5176).

Response to Finding No. 2227:

See CCRFF 2228, below. In addition, Dr. Romano's expertise in risk adjustment, and the validity of the techniques he used in this case, are discussed in detail at CCRFF 1182.

2228. There are three important deficiencies in using administrative data for risk adjustment. (Chassin, Tr. 5176-77).

Response to Finding No. 2228:

This finding is inaccurate and misleading. {

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (Romano, Tr. 3205-07, *in camera*). {

[REDACTED]

[REDACTED]

[REDACTED] (Romano, Tr. 3208-

09, *in camera*).

2229. First, administrative data lacks the depth of clinical detail for use in quality measurement. (Romano, Tr. 3257-58; Chassin, Tr. 5177). { [REDACTED] } (Romano, Tr. 3205-08, *in camera*).

Response to Finding No. 2229:

Respondent's finding is inaccurate and misleading. (See CCRFF 2228 (studies show high correlation between results of clinical data and administrative data)). As to risk adjustment, Dr. Romano's expertise in this area and the validity of the techniques he used in this case are discussed in more detail at CCRFF 1182.

2230. Specifically, administrative data do not contain the vast majority of clinical data that are known to affect risk. (Chassin, Tr. 5177). This is a significant problem because the most important factors that need to be accounted for in risk-adjustment do not appear in billing data. (Chassin, Tr. 5177).

Response to Finding No. 2230:

This finding is inaccurate and misleading. (See CCRFF 2228 (studies show high correlation between results of clinical data and administrative data)). (See also CCF 2113-2121). As to risk adjustment, Dr. Romano's expertise in this area and the validity of the techniques he used in this case are discussed in more detail at CCRFF 1182.

2231. This limitation is recognized by more than just Drs. Romano and Chassin. In fact, AHRQ has specifically published that AHRQ patient safety indicators based on administrative data must be cautiously used because the administrative data they are based on are not collected for research purposes and for measuring quality but, rather, for billing purposes only. (RX 2004 at 29; Romano, Tr. 3256-57).

Response to Finding No. 2231:

This finding is inaccurate and misleading. (See CCRFF 2228 (studies show high

correlation between results of clinical data and administrative data)). (See also CCRFF 2113-2121). [REDACTED]

[REDACTED] (Romano, Tr, 3209, *in camera*)

Administrative data are used by many researchers to understand hospital quality of care. Analysts persist in using administrative data to evaluate quality, and Dr. Chassin, Respondent's own expert, relied on a study that used administrative data for his expert report. (See Chassin, Tr. 5440-42). AHRQ issued a statement that reflected its opinion that administrative data should be used to evaluate hospital quality. As stated above, administrative data are more reliable than structural data or interview data. (See CCRFF 2228). Administrative data are perfectly suitable for the purposes of Dr. Romano's evaluation. As the AHRQ report authored in part by Dr. Kizer, one of Respondent's contemplated experts stated, we should not let the perfect be the enemy of the good. (Chassin, Tr. 5541-42).

2232. Second, the coding of administrative data are unreliable because they suffer from variation and inaccuracy in coding among different hospitals. (Chassin, Tr. 5177). Therefore, even when clinical information is present one cannot rely on it to be accurately coded. (Chassin, Tr. 5177; Romano, Tr. 3264-65, 3272-74).

Response to Finding No. 2232:

Respondent's finding is inaccurate and misleading. (See CCRFF 2228, 2231).

2233. The fact that administrative data are unreliably coded may lead to erroneous estimates associated with co-morbid disease (described below) and bias risk-adjusted models used to compare outcomes. (Romano, Tr. 3259).

Response to Finding No. 2233:

Respondent's finding is inaccurate and misleading. (See CCRFF 2228, 2231).

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr.

6311-12, *in camera*) { [REDACTED]

[REDACTED]

(Romano, Tr. 6312, *in camera*).

2234. { [REDACTED]

[REDACTED]

[REDACTED] Romano, Tr. 3207, *in camera*). [REDACTED]

[REDACTED] } (Romano, Tr. 3207, *in camera*).

Response to Finding No. 2234:

This finding is inaccurate and misleading. (See CCRFF 2228, above. (studies show high correlation between results of clinical data and administrative data). *See also*

CCRFF 2113-2121 ({ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr, 3209,

in camera)

2235. That said, administrative data generally under-reports most co-morbid conditions that could be important risk factors for adverse outcomes or complications. (Romano, Tr. 3259). In fact, according to Dr. Romano, roughly half of post-operative complications go unreported in

administrative data because of poor documentation, errors, or restrictive coding practices. (Romano, Tr. 3264).

Response to Finding No. 2235:

Respondent's finding is inaccurate and misleading. (See CCRFF 2228, 2231).

2236. Finally, administrative data fail to account for the difference between co-morbid conditions that a patient has before they come to a hospital and complications suffered after they begin to receive care. (Chassin, Tr. 5177). As a result, the data are often poorly risk-adjusted. (Romano, Tr. 3259-65, 3272-74; Chassin, Tr. 5177-79).

Response to Finding No. 2236:

Respondent's finding is inaccurate and misleading. (See CCRFF 2228, 2231).

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 6311-12, *in camera*); [REDACTED]

[REDACTED]

(Romano, Tr. 6312, *in camera*).

2237. Co-morbid conditions are complications that patients suffer from before they come to the hospital and are not indicative of the quality of care given to the patient after they are admitted to the hospital. (Chassin, Tr. 5177; Romano, Tr. 3273). On the other hand, complications that occur after the patient is admitted to the hospital can be the direct result of bad quality. (Chassin, Tr. 5177). The key failing of administrative data is that the data does not account for any difference in many complications that occur before and after admission. (Chassin, Tr. 5177). Proper risk-adjustment always avoids including complications that occur after admission. (Chassin, Tr. 5177). Therefore, administrative data cannot be accurately risk-adjusted to measure real changes in quality. (Chassin, Tr. 5177-78; Romano, Tr. 3273).

Response to Finding No. 2237:

Respondent's finding is inaccurate and misleading. (See CCRFF 2228, 2231,

2236).

2238. One should consider all of these failings in the reliability of administrative data when attempting to conduct proper quality of care analyses. (Chassin, Tr. 5178-79; Romano, Tr. 3263-65). In fact, according to survey work done by Dr. Romano, hospital leaders remain skeptical about the usefulness and validity of outcome comparisons based on administrative data. (Romano, Tr. 3264-65).

Response to Finding No. 2238:

Respondent's finding is inaccurate and misleading. (See CCRFF 2228, 2231).

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr.

6311-12, *in camera*) { [REDACTED]

[REDACTED] }

(Romano, Tr. 6312, *in camera*).

2239. In sum, the best use of administrative data, because it compiles so many records, is to look for large, global trends among large groups of hospitals. (Chassin, Tr. 5179). At that global level, differences between patient populations tend to cancel out. (Chassin, Tr. 5179). Nevertheless, one cannot reliably make judgments about an individual hospital's quality, as Dr. Romano has done in this case, by looking at the particular characteristics of patients admitted to individual hospitals based on administrative data. (Chassin, Tr. 5179). As stated above, administrative data at this particularized level are replete with significant errors. (Chassin, Tr. 5178-79).

Response to Finding No. 2239:

This finding is inaccurate and misleading. (See CCRFF 2228 (studies show high correlation between results of clinical data and administrative data). (See also CCRFF 2113-2121). { [REDACTED]

[REDACTED] } (Romano, Tr, 3209, *in camera*).

2240. Accordingly, in contrast to Dr. Romano, Dr. Chassin relied on a different type of data collected for healthcare quality in this case. (Chassin, Tr. 5171). Dr. Chassin relied heavily on clinical data in forming his opinions. (Chassin, Tr. 5171).

Response to Finding No. 2240:

This finding is inaccurate and misleading. For most of the clinical areas, Dr. Chassin did not look at clinical data. [REDACTED] } (See, Romano, Tr. 3046, 3050-51, 3054-55, *in camera*). It is possible to learn much more from administrative data to evaluate risk-adjusted outcomes and quality of care than relying on structural data, a major source for Dr. Chassin's analysis. (Romano, Tr.3409). Administrative data is much more informative than interview data, another major source of Dr. Chassin's analysis. (Romano, Tr. 3411).

Moreover, despite ENH's criticisms, Dr. Romano's analysis stands as the only comprehensive analysis of outcome measures in this case. When Dr. Chassin testified that he relied heavily on clinical data, he was referring to clinical data registries maintained by NRCMI and STS. (Chassin Tr. 5172). Counsel for Respondent then went on to note that "in fairness to Dr. Romano," he looked at the same data. (Chassin Tr. 5173). Dr. Chassin criticizes administrative data, but nowhere corrects Dr. Romano's analysis with the corresponding clinical data.

2241. Clinical data are the detailed measures of severity of illness and physiologic functioning, and are collected during the course of providing care to patients. (Chassin, Tr. 5171). Clinical data are found in the medical records of patients. (Chassin, Tr. 5171). As a

result, clinical data are the primary data used by hospitals and third-party organizations to monitor quality assessment and quality assurance. (Chassin, Tr. 5171-72).

Response to Finding No. 2241:

This finding is incomplete and inaccurate. Hospitals rely heavily on administrative data. (See CCFE 2122-2132). { [REDACTED]

[REDACTED] } (Romano, Tr. 3206, *in camera*).

2242. Most of the clinical data used in this case came from clinical data registries that are maintained by third-parties to which hospitals contribute clinical data as part of their quality assessment and quality assurance programs. (Chassin, Tr. 5172). For example, the kind of data collected and published by the Society For Thoracic Surgeons ("STS") in its registry is clinical data. (Chassin, Tr. 5172). STS data complies and tracks more clinical detail than administrative data. (Romano, Tr. 3259).

Response to Finding No. 2242:

This finding is inaccurate and misleading. Dr. Romano relied on clinical data when they were available. { [REDACTED]

[REDACTED] } (See Romano, Tr. 2979, 3051-54, *in camera*)

2243. Dr. Chassin also endeavored to collect clinical data from ENH and HPH that the hospitals had collected themselves to track their own clinical performance. (Chassin, Tr. 5171-72).

Response to Finding No. 2243:

This finding is misleading. Dr. Chassin's analysis of clinical data was not more thorough. Dr. Chassin relied on the same clinical data analyzed by Dr. Romano. (Chassin, Tr. 5171-72).

2244. Administrative data lacks clinical details that could be important in predicting the

risk of death in a patient with heart disease. (Romano, Tr. 3261-62). In fact, the State of California and State of New York require that clinical data, not administrative data, be submitted regarding cardiac bypass surgery or CABG. (Romano, Tr. 3263).

Response to Finding No. 2244:

This finding is inaccurate and misleading. { [REDACTED]

} (Romano, Tr.

3046, 3050-51, 3054-55; *in camera*).

2245. Not only did Dr. Romano utilize highly suspect administrative data, but the significant majority of outcome measures Dr. Romano relied on are themselves invalid irrespective of the data used to calculate them. Specifically, Dr. Romano utilized administrative data when he employed several different categories of outcome measures promulgated by the United States Agency on Healthcare Quality ("AHRQ"). (Romano, Tr. 3127-28). Dr. Romano used these measures to posit that quality of care did not improve at HPH. (Romano, Tr. 3127-28, 3217-31, 3255, 6273-74). There are more than 46 measures proffered by AHRQ and, according to the guidelines published by AHRQ for its own measures, only six are defined as valid regardless of the kind of data on which they are based. (Chassin, Tr. 5583; RX 2004 at 27-30; RX 2010 at 19-23).

Response to Finding No. 2245:

This finding is inaccurate and misleading. The AHRQ measures used by Dr. Romano are considered valid due to the consensus among experts in the field accepting their validity. (Romano, Tr. 6283-87). While Dr. Chassin claimed that only six of the 46 AHRQ measures were valid, he did not identify the six nor explain why the others are not valid. (Romano, Tr. 6273-74). Dr. Romano's testimony concerning the validity of the AHRQ measures he used stands undisputed.

2246. In fact, AHRQ itself cautions that its indicators were designed, in part, to identify hospital areas for further analysis and, "as a result, the [AHRQ] indicators were not intended as definitive measures of quality problems, but rather as screens for use in quality improvement. As screening tools, these indicators would serve as a first-round flag of potential quality problems, which should be investigated further by other methods, such as chart review." (RX 2007 at 26).

Response to Finding No. 2246:

This finding is inaccurate and misleading. Dr. Romano's use of AHRQ indicators was entirely appropriate to compare changes in performance at ENH to changes in performance in control group hospitals. { [REDACTED]

[REDACTED] } (Romano, Tr. 5205-07, *in camera*. See also CCRFF 2104-2121 (explaining why Dr. Romano's use of AHRQ indicators is valid).

2247. Moreover, Dr. Romano's analysis of almost all of these AHRQ and Joint Commission indicators are not statistically significant at the level that he states is the standard statistical threshold. (Romano, Tr. 3093, 3211-12, 3216-34). Dr. Romano admits that 17 of the 18 AHRQ and Joint Commission indicators that he employed in this case are not statistically significant. (Romano, Tr. 3093, 3211-12, 3216-34). The traditional threshold of statistical significance means that there is less than a 5% chance of finding an effect if, in fact, there were no deterioration, or improvement in performance. (Romano, Tr. 3213, 3221). Thus, Dr. Romano relied on indicators of quality, many of which were lacking in validity and, in addition, the analysis of almost all of those indicators did not reveal any statistically significant findings. (Chassin, Tr. 5582-83; Romano, Tr. 3093, 3211-12, 3216-34).

Response to Finding No. 2247:

This finding is inaccurate and misleading. (See CCRFF 2246 (explaining validity of AHRQ measures). { [REDACTED]

[REDACTED] } (Romano, Tr. 6311-12, *in camera*). { [REDACTED]

[REDACTED] } (Romano, Tr. 6312, *in camera*).

2. Dr. Romano Placed Undue Reliance On Patient Satisfaction Surveys

a. Overview

2248. Dr. Romano improperly relied on patient satisfaction surveys from Press Ganey, Associates, Inc. ("Press Ganey") and the Rhea & Kaiser marketing survey in an effort to show that patient satisfaction has not improved at ENH since the Merger. (Chassin, Tr. 5250-51).

Response to Finding No. 2248:

This finding is inaccurate and misleading. Both Evanston and Highland Park Hospital relied on Press Ganey before and after the merger. Many hospitals, including ENH, contract with Press Ganey to obtain systematic feedback about processes of care.

(See Amended Glossary of Terms, April 22, 2005, at 10). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (Romano, Tr. 3105, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED] (Romano, Tr.

3098, 3109-10, 3116-17, 3136-38, *in camera*).

2249. Press Ganey surveys patients on a number of items related to aspects of appearance, comfort and convenience – so-called amenities – that are not themselves measures of clinical quality. (Romano, Tr. 3337-39). Several of the questions from Press Ganey that Dr. Romano reviewed concerned such amenities having nothing to do with clinical quality. (Romano, Tr. 3339-40): For example, Press Ganey measures such things as courtesy of custodial staff; hospital food quality; and physicians' cordiality. (Spaeth, Tr. 2093-94; Romano, Tr. 3340). The deficiencies with the Press Ganey survey instrument include low response rates, a poorly-designed response scale, and the use of a mean score. (Chassin, Tr. 5244-46).

Response to Finding No. 2249:

This finding is inaccurate and misleading. In its own definition of quality set forth

in its Performance Improvement Plans, ENH stated that “satisfaction of all of our many customers,” including patients, is a key factor in quality at ENH. (CX 2052 at 5).

Additionally, patient satisfaction, specifically from Press Ganey, is an important indicator in ENH’s Performance Improvement Index. (CX 2052 at 45). Respondent contests the validity of Press Ganey now, after years of paying for it and analyzing it, only because the results of the Press Ganey surveys are not favorable to its position.

As to measures of amenities that do not relate to clinical quality, Respondent points to no specific instance where Dr. Romano inappropriately concluded that a Press Ganey amenity measure reflected upon clinical quality. Dr. Romano defined amenities for the court, and made clear that he considered them different from “things that are really likely to make a difference in terms of patient outcomes.” (Romano Tr. 2987-88). ENH discusses “hospital food quality,” in this finding, but Dr. Romano specifically disavowed “the temperature of the food” as a quality measure. (Romano, Tr. 2988).

The discussion CCFF 2133-48 of Complaint Counsel’s initial findings makes clear that Dr. Romano’s analysis of Press Ganey scores was not inappropriately skewed by consideration of amenities.

2250. ENH uses patient satisfaction surveys such as Press Ganey, in part, because the JCAHO requires them to do so. (Neaman, Tr. 1366). Although it is important for hospitals to have a general understanding of how patients perceive the hospital’s service, patient satisfaction surveys do not reflect real clinical care or clinical outcomes. (Neaman, Tr. 1366).

Response to Finding No. 2250:

This finding is inaccurate and misleading. ENH documents clearly state that patient satisfaction, as reported by Press Ganey, are an important performance area that

reflect quality of care. For example, patient satisfaction, specifically from Press Ganey, is an important indicator in ENH's Performance Improvement Index. (CX 2052 at 45). ENH's Performance Improvement Plan stated: "The Performance Improvement Index continues to provide the Board of Directors, Senior Management Staff and Physician Leadership with current information about key performance areas that reflect the quality of care. For 2001, the Performance Improvement Index will include the following performance measures... "Patient Satisfaction (from Press Ganey) - quarterly (each hospital reported separately)." Aspects of patient satisfaction highlighted were staff courtesy, pain management and staff attention to special needs. (CX 2052 at 44-45).

2251. The Rhea & Kaiser survey was a marketing survey done on a small number of patients who self-identified themselves as patients at HPH. (Chassin, Tr. 5249-50; RX 2031 at ENH DL 6549). The Rhea & Kaiser survey also is misleading and invalid as a measure of patient satisfaction. (Chassin, Tr. 5249; RX 2031).

Response to Finding No. 2251:

This finding is inaccurate and misleading. There is no evidence that the Rhea & Kaiser survey is "misleading" or "invalid" despite its small number of respondents. {

[REDACTED]

[REDACTED]

} (Romano, Tr. 3361; *see also* Romano, Tr. 3098, 3109-10, 3116-17, 3136-38, *in camera*). {

[REDACTED]

} (Romano, Tr. 3105, *in camera*).

2252. Consistent with recognized scientific methods for evaluating surveys, Dr. Chassin did not rely on Press Ganey data or the Rhea & Kaiser marketing survey in assessing whether quality of care changed at HPH after the Merger. (Chassin, Tr. 5243, 5249). Dr. Chassin did not make use of patient satisfaction data in his analysis because there were no reliable data available. (Chassin, Tr. 5468). This explains why Dr. Chassin also does not use Press Ganey scores at Mount Sinai, where the Patient Satisfaction Survey Center reports to him. (Chassin, Tr. 5244-45).

Response to Finding No. 2252:

This finding is inaccurate and misleading. { [REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3098, 3109-10, 3116-17, 3136-38, *in camera*). Dr.

Romano used data that ENH itself relies on to assess patient satisfaction. (CX 2052). In addition, Dr. Romano's analysis was not limited to patient satisfaction surveys. (See CCRFF 2104-2121). The fact that Dr. Chassin did not perform a comprehensive quantitative analysis of patient satisfaction points to the deficiencies and shortcomings of his methodology.

2253. Finally, there are other, methodologically stronger patient satisfaction surveys, such as H-CAHPS, which is a federally funded effort that will likely supercede the weaker Press Ganey survey that ENH uses. (Romano, Tr. 3346-47).

Response to Finding No. 2253:

This finding is irrelevant. In its day to day business practices ENH has chosen to pay for and extensively track Press Ganey data. (See CCRFF 2250). While Dr. Chassin criticizes Dr. Romano's analyses, Dr. Chassin himself did not use H-CAHPS to assess patient satisfaction or did not report the results of any analysis that he did perform.

b. Dr. Romano Improperly Relied On Unreliable Patient Satisfaction Surveys

2254. Press Ganey does not measure patient satisfaction or experience with care in a valid manner because of deficiencies in the survey assessment. (Chassin, Tr. 5243). The same conclusion applies to the Rhea & Kaiser survey. (Chassin, Tr. 5249).

Response to Finding No. 2254:

These alleged methodological deficiencies have not deterred ENH from paying for and making extensive use of Press Ganey data in its own business practices. (See also CCRFF 2250, 2251).

2255. The problems discussed below associated with the Press Ganey surveys and the Rhea & Kaiser survey apply to all of the services evaluated at HPH. (Chassin, Tr. 5250-51).

Response to Finding No. 2255:

Respondent's finding is misleading. (See CCRFF 2250 (describing ENH's use of Press-Ganey data)).

i. Press Ganey Survey Response Rates Are Too Low To Draw Valid Conclusions

2256. The first problem with the Press Ganey surveys is that the proportion of patients who respond to the surveys is incredibly low. (Chassin, Tr. 5244). Survey response rates are important in assessing how much weight to accord to a survey analysis. (Romano, Tr. 3344). Dr. Romano, however, did not even know the response rates for the Press Ganey surveys he analyzed. (Romano, Tr. 3344-45).

Response to Finding No. 2256:

This finding is inaccurate and misleading. { [REDACTED]

[REDACTED]

[REDACTED] (Romano, Tr. 3098, 3109-10, 3116-17, 3136-38, *in camera*). Dr.

Romano used data that ENH itself relies on to assess patient satisfaction. (CX 2052 at 44-45). While Dr. Chassin criticizes Dr. Romano's analyses, Dr. Chassin himself did not perform any assessment of patient satisfaction.

2257. Press Ganey has about a 20% response rate, a rate that is too low to draw valid conclusions. (Chassin, Tr. 5244). To determine the response rate, Dr. Chassin compared the number of patients who were discharged from HPH who received a survey with the number of surveys that were returned to HPH. (Chassin, Tr. 5247-48). HPH's practice was to survey every patient who had been hospitalized for a specific period of time. (Chassin, Tr. 5248). Once HPH received the surveys back from the patients, HPH sent them on to Press Ganey. (Chassin, Tr. 5248).

Response to Finding No. 2257:

Respondent's finding is inaccurate and misleading. (See CCRFF 2256).

2258. The 20% Press Ganey response rate means that only 20% of the patients who were sent the survey returned a completed (or at least partially completed) survey. (Chassin, Tr. 5247). This 20% response rate is suboptimal because the lower response rate increases the possibility of bias due to differences between the survey's respondents and the non-respondents. (Romano, Tr. 3346).

Response to Finding No. 2258:

This finding is inaccurate and misleading. ENH relies on Press Ganey and its results are reported to key decision makers at ENH. ENH's Performance Improvement Plan states: "The Performance Improvement Index continues to provide the Board of Directors, Senior Management Staff and Physician Leadership with current information about key performance areas that reflect the quality of care. For 2001, the Performance Improvement Index will include the following performance measures. Patient Satisfaction (from Press Ganey) - quarterly (each hospital reported separately)." Aspects of patient satisfaction highlighted were staff courtesy, pain management and staff attention to special needs. (CX 2052 at 44-45)

2259. Indeed, the 20% response rate does not deal with how completely all the survey questions were answered. (Chassin, Tr. 5247). Press Ganey did not report the results where fewer than 40% of the patients actually responded to a particular question. (Chassin, Tr. 5249). So it is possible that only 40% of the 20% who returned the surveys might have answered a particular question. (Chassin, Tr. 5249).

Response to Finding No. 2259:

Respondent's finding is misleading. (See CCRFF 2258).

2260. Hospitals that do well in assessing patient satisfaction typically have much higher response rates – in the 45-50% range. (Chassin, Tr. 5244).

Response to Finding No. 2260:

Respondent's finding is misleading. (See CCRFF 2258).

2261. In fact, Dr. Romano acknowledged that he has not published articles in peer-reviewed journals drawing conclusions on quality of care based upon unrepresentative samples from patient satisfaction surveys. (Romano, Tr. 3343-44).

Response to Finding No. 2261:

Complaint Counsel have no specific response.

ii. Press Ganey's Rating Scale Has A Ceiling Effect

2262. The second problem is the design of the Press Ganey survey responses, which vary from very good at the high end to good, fair, poor and very poor. (Chassin, Tr. 5245). There is no "excellent" category on the Press Ganey surveys that Dr. Romano reviewed and, as a result, patients who wanted to express a score of excellent could not do so. (Romano, Tr. 3351).

Response to Finding No. 2262:

This finding is irrelevant. Patients who wanted to rate a service highly could just give it the highest rating – very good.

2263. In the patient satisfaction field, patients tend to rate their experience with care highly, so scores are clustered at the high end of the scale. (Chassin, Tr. 5245; Romano, Tr. 3350). Thus, if an improvement were made that resulted in superb care, a patient would be unable to express that because the top end of the scale is only "very good," a phenomenon described as the "ceiling effect." (Chassin, Tr. 5245; Romano, Tr. 3350-51).

Response to Finding No. 2263:

This finding is inaccurate and misleading. { [REDACTED]

[REDACTED]

██████████ } (RX 1131 at ENH PL 001251, *in camera*). These results flatly contradict this finding.

iii. Press Ganey Uses Mean, Not Percentage, Scores

2264. The third problem with Press Ganey scores is the use of mean, as opposed to percentage, scores. (Chassin, Tr. 5245-46).

Response to Finding No. 2264:

This finding is irrelevant. ENH and many other hospitals use Press Ganey to track its patient satisfaction. Whether Press Ganey uses mean, as opposed to percentage scores, does not affect its ability to track patient satisfaction. Since Dr. Romano used the same measurement (the mean score) to compare Highland Park Hospital to the peer group both before and after the merger, it does not matter whether he used the mean score or the percentage score. (Romano, Tr. 3420-21).

2265. In patient satisfaction assessment, surveyors usually want to look at patient scores that are very high (so they can determine how to get more people in that category); and patient scores that are very low (so they can learn what drives dissatisfaction). (Chassin, Tr. 5246). Press Ganey has constructed a score that weights those ratings and puts them all together in a mean score. (Chassin, Tr. 5246).

Response to Finding No. 2265:

The finding is irrelevant. The fact that Press Ganey weights its ratings does not affect their usefulness.

2266. Press Ganey data could not be used to assess patient satisfaction to compare the changes in quality of care at HPH during the pre-Merger to the post-Merger period. (Chassin, Tr. 5246-47).

Response to Finding No. 2266:

This finding is inaccurate and misleading. ENH documents clearly state that

patient satisfaction, as reported by Press Ganey, are an important performance area that reflect quality of care. For example, patient satisfaction, specifically from Press Ganey, is an important indicator in ENH's Performance Improvement Index. (CX 2052 at 45).

ENH's Performance Improvement Plan states: "The Performance Improvement Index continues to provide the Board of Directors, Senior Management Staff and Physician Leadership with current information about key performance areas that reflect the quality of care. For 2001, the Performance Improvement Index will include the following performance measures... Patient Satisfaction (from Press Ganey) - quarterly (each hospital reported separately)." Aspects of patient satisfaction highlighted were staff courtesy, pain management and staff attention to special needs. (CX 2052 at 44-45). Dr. Chassin gives no valid reason for why Press Ganey cannot be used to track patient satisfaction.

2267. Dr. Romano's testimony on Press Ganey scores actually reported the mean scores for the Press Ganey surveys, rather than the percentage of patients giving good and very good ratings. (Romano, Tr. 3356-57). The mean score on the Press Ganey surveys often was lower than the percentage score, which combined the good and very good ratings. (Romano, Tr. 3356-57).

Response to Finding No. 2267:

This finding is inaccurate and misleading. Since Dr. Romano analyzed the differences in patient satisfaction before and after the merger, whether he looked at the mean or percentage score does not matter. (Romano, Tr. 3420-21).

2268. In Dr. Chassin's experience, particularly at Mount Sinai, he does not use mean scores in patient satisfaction surveys. (Chassin, Tr. 5246).

Response to Finding No. 2268:

This finding is irrelevant. It does not matter what Mount Sinai uses. ENH uses Press Ganey to inform its top management about its quality of care. ENH's Performance Improvement Plan states: "The Performance Improvement Index continues to provide the Board of Directors, Senior Management Staff and Physician Leadership with current information about key performance areas that reflect the quality of care. (CX 2052 at 44-45).

iv. The Rhea & Kaiser Survey Is Not A Valid Measure Of Patient Satisfaction At HPH

2269. Dr. Romano concedes that the Rhea & Kaiser should be used cautiously because it is based upon a small sample size. (Romano, Tr. 3361).

Response to Finding No. 2269:

The finding is misleading. Dr. Romano did not state that the small sample size made the Rhea & Kaiser survey invalid. (Romano, Tr. 3361).

2270. The actual survey methods were not described in the Rhea & Kaiser survey summary, including how patients were selected and their responses obtained. (Chassin, Tr. 5250; RX 2031 at ENH DL 6550). The proportion of patients who answered questions about their impressions of improvement in specific services was very small including, for example, only 26 patients using HPH's oncology services and 24 patients using HPH's maternity service. (Chassin, Tr. 5250; Romano, Tr. 3361; RX 2031 at ENH DL 6566).

Response to Finding No. 2270:

This finding is inaccurate and misleading. While Respondent criticizes the survey methods of the Rhea & Kaiser survey because the survey methods are not fully described, Dr. Chassin's methodology had much greater defects. Dr. Chassin did not clearly describe his sampling strategy for his interviews with ENH personnel. (Romano, Tr. 3013). Additionally, Dr. Chassin's sampling strategy was inadequate because there was

no effort to seek out alternative views of individuals who have contradictory opinions.

(Romano, Tr. 3015).

2271. Moreover, the Rhea & Kaiser survey asked patients about their perceptions of care that occurred up to two years prior. (Chassin, Tr. 5250; RX 2031 at ENH DL 6549-50). It is well established in patient satisfaction literature that patients' impressions of their care experience must be taken within a few weeks of that experience, otherwise their recollection deteriorates and changes dramatically. (Chassin, Tr. 5250).

Response to Finding No. 2271:

This finding is inaccurate and misleading. While Respondent criticizes Rhea & Kaiser for asking patients about their perceptions of care that occurred two years ago, Dr. Chassin interviewed physicians and administrators about their perceptions of quality at Highland Park Hospital five to six years earlier. (Romano, Tr. 3021).

c. Dr. Romano Improperly Relied On Insufficient Press Ganey Data

2272. Dr. Romano examined Press Ganey data for inpatient use of HPH's emergency services and the Kellogg Cancer Care Center only, thus omitting important information for HPH's outpatient services. (Romano, Tr. 3365-66; Chassin, Tr. 5372-73).

Response to Finding No. 2272:

This finding is inaccurate and misleading. {

[REDACTED]

[REDACTED] } (Romano, Tr. 3098, 3109-10, 3116-17, 3136-38, *in camera*). Dr.

Romano used data that ENH itself relies on to assess patient satisfaction. (CX 2052 at 44-45). While Dr. Chassin criticizes Dr. Romano's analyses, Dr. Chassin himself did not perform any assessment of patient satisfaction.

2273. Roughly 80% of patients who use HPH's emergency room are treated on an outpatient basis and, as a result, their experiences were not included in Dr. Romano's analysis of

patient satisfaction at HPH. (Romano, Tr. 3365; Harris, Tr. 4213).

Response to Finding No. 2273:

Respondent's finding is incomplete. (See CCRFF 2272).

2274. Moreover, the inpatient Press Ganey data relied on by Dr. Romano pertaining to emergency services was limited to only one quarter post-Merger. (Romano, Tr. 3365). More data would be required before reaching conclusions on patient satisfaction with emergency services. (Romano, Tr. 3364-65).

Response to Finding No. 2274:

{ [REDACTED] } (Romano, Tr. 3110, *in camera*). It is one tool that is of some use in objectively measuring ENH's subjective and anecdotal claims of improvements in the emergency room.

2275. Similarly, many patients use HPH's Kellogg Cancer Care Center on an outpatient basis, and their experiences also were not reflected in Dr. Romano's analysis of patient satisfaction at HPH. (Romano, Tr. 3366-67; Chassin, Tr. 5373).

Response to Finding No. 2275:

Respondent's finding is misleading. The reports from those who were treated as inpatients provide some objective measure of whether the increased convenience of consolidating existing services in one place has made a meaningful difference for patients. (Romano Tr. 3097-98).

2276. For the reasons discussed above, Dr. Romano improperly relied on Press Ganey data to reach conclusions concerning the effect of the Merger on the quality of nursing care. (Chassin, Tr. 5251).

Response to Finding No. 2276:

Respondent's finding is incomplete and misleading. (See CCRFF 2272).

Respondent's expert agreed that patient satisfaction with nursing care is a useful measure

of nursing quality. (Chassin, Tr. 5467).

2277. Finally, Dr. Chassin's opinion with respect to Dr. Romano's reliance on the Rhea & Kaiser survey or the Press Ganey surveys for HPH's oncology service is the same as his opinion with respect to those surveys in other areas of improvements. (Chassin, Tr. 373).

Response to Finding No. 2277:

This finding is inaccurate and misleading. In its own definition of quality set forth in its Performance Improvement Plans, ENH states that "satisfaction of all of our many customers," including patients, is a key factor in quality at ENH. (CX 2052 at 5).

Additionally, patient satisfaction, specifically from Press Ganey, is an important indicator in ENH's Performance Improvement Index. (CX 2052 at 44-45). Respondent contests the validity of Press Ganey now, after years of paying for it and analyzing it, only because the results of the Press Ganey surveys are not favorable to its position.

ENH documents clearly state that patient satisfaction, as reported by Press Ganey, are an important performance area that reflect quality of care. ENH's Performance Improvement Plan states: "The Performance Improvement Index continues to provide the Board of Directors, Senior Management Staff and Physician Leadership with current information about key performance areas that reflect the quality of care. For 2001, the Performance Improvement Index will include the following performance measures... Patient Satisfaction (from Press Ganey) - quarterly (each hospital reported separately)." Aspects of patient satisfaction highlighted were staff courtesy, pain management and staff attention to special needs. (CX 2052 at 44-45).

IX. OTHER COMPETITIVE EFFECTS CONSIDERATIONS

A. The Merger Was Not Anticompetitive Because Of Low Barriers To Market Entry And Repositioning By Competitors

2278. In evaluating the effects of the Merger, the proper economic analysis compares the actual situation post-Merger to the situation that would have existed during the post-Merger time period if the Merger had not occurred. (Noether, Tr. 6024). Consequently, the relevant question is whether HPH would have been a viable independent competitor since hospitals that compete with it have become more competitive through repositioning in the time since the Merger. (Noether, Tr. 6024).

Response to Finding No. 2278:

The finding's conclusions about "the relevant question" and "competitive repositioning" are misleading and incomplete. ENH's price increases have not been constrained by entry, as noted in Complaint Counsel's findings of fact ENH was not forced to roll back prices increases because of entry. (See CCFF 643-692, 952-954). Moreover, Illinois has a State Certificate of Need ("CON") law that governs future hospital entry or expansion. (D. Jones, Tr. 1653-54, 1655; Spaeth, Tr. 2167). Post-merger, ENH did not see a decrease in the number of managed care admissions as a result of ENH's price increases in 2000 (Neaman, Tr. 1211-12). At the same time, ENH management did not believe that other hospitals would act as a pricing constraint by changing their prices as a result of ENH's 2000 price increases (Neaman, Tr. 1212; Hillebrand, Tr. 1764-65; Newton, Tr. 367). In any event, HPH could have continued as a stand-alone competitor without the merger (CCFF 302-367), and was an attractive candidate for other mergers (CCFF 368-372).

2279. Repositioning or entry is "the enhancement of competition either through brand new entry – in a hospital case, it would be a new hospital being constructed and opened – or more modestly, repositioning can imply an existing hospital upgrading its capacity, expanding its

capacity, adding new services, updating its physical plant, doing things that essentially make it a more attractive facility to managed care organizations and their enrollees and thereby making it more competitive in the marketplace.” (Noether, Tr. 6023).

Response to Finding No. 2279:

The finding is misleading, incomplete, and irrelevant because there was no entry and no demand or supply side substitution following a large sustained price increase by ENH. ENH’s price increases have not been constrained by entry, as noted in Complaint Counsel’s findings ENH was not forced to roll back prices increases because of entry. (See CCFE 643-692, 952-954). Moreover, Illinois has a State CON law that governs future hospital entry or expansion. (D. Jones, Tr. 1653-55; Spaeth, Tr. 2167).

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2635-36, *in camera*). Post-merger, ENH did not see a decrease in the number of managed care admissions as a result of ENH’s price increases in 2000. (Neaman, Tr. 1211-12). At the same time, ENH management did not believe that other hospitals would act as a pricing constraint by changing their prices as a result of ENH’s 2000 price increases. (Neaman, Tr. 1212; Hillebrand, Tr. 1764-65; Newton, Tr. 367)

1. The Illinois CON Law Will Not Be A Barrier to Entry

2280. Certain transactions that are proposed by healthcare facilities in Illinois require approval from the Illinois Health Facilities Planning Board. (D. Jones, Tr. 1653). The applications for transactions requiring approval from the Illinois Health Facilities Planning Board

are commonly referred to as Certificate of Need, or CON applications. (D. Jones, Tr. 1653). The Illinois Health Facilities Planning Board reviews CON applications and Certificate of Exemption applications in Illinois. (D. Jones, Tr. 1652).

Response to Finding No. 2280:

Complaint Counsel have no specific response.

2281. The Illinois CON laws are scheduled to be repealed on July 1, 2006. (D. Jones, Tr. 1685). Unless the Illinois CON laws are extended or new laws are enacted, the CON process will cease to exist in July 2006. (D. Jones, Tr. 1685).

Response to Finding No. 2281:

The finding is misleading and incomplete. Illinois has had a certificate of need law since the early 1970s. (Spaeth, Tr. 2167). Although the CON law contains a sunset provision, that would apply if the law is not renewed, the CON law has been renewed in the past. (Spaeth, Tr. 2169). The CON law regulates hospital entry and expansion. (Spaeth, Tr. 2167). Even if there was no CON law, it would take about two and a half to three years to build a new hospital. (Spaeth, Tr. 2169).

2282. If the CON statute expires and there is no replacement and/or similar statute enacted, all of the regulatory barriers would be removed. (D. Jones, Tr. 1685-86). This legal change will likely make entry and expansion much easier. (Noether, Tr. 6025).

Response to Finding No. 2282:

The finding is misleading and incomplete, because although the CON law contains a sunset provision, which would apply if the law was not renewed, the CON law has been renewed in the past. (Spaeth, Tr. 2169). In addition to getting a Certificate of Need, a person would need to get approval from other state agencies and local governments to build a new hospital. The Illinois Department of Health reviews facility plans, and a city council may need to provide zoning approval for the new hospital.

(Spaeth, Tr. 2169). Even if there was no CON law, it would take about two and a half to three years to build a new hospital. (Spaeth, Tr. 2169).

a. Most CON Applications Are Approved

2283. From 1999 to mid-2004, 88% of the CON applications in Illinois were approved. (D. Jones, Tr. 1671-72).

Response to Finding No. 2283:

Respondent refers to a study done by Governors State College that is not in evidence. The finding's cited source, Mr. Jones, did not say that he knew how the percentages were calculated or if they were true, but only that the estimate "seems to be appropriate." (D. Jones, Tr. 1670-72). Furthermore, Mr. Jones lacked personal knowledge of the report, because he testified that he "did not review the analysis" done to determine the percentages. Thus, Respondent asked Mr. Jones to subscribe to the truth of a hearsay document not even in evidence and the specific contents of which he had no personal knowledge. This is contrary to the judge's ruling in JX 1, because even if the study had been admitted, neither the Governors State College study or Jones could be cited for the truth of the assertions in the study. (See JX 1).

The finding is also misleading in general and incomplete because the gross percentage of CON applications approved includes all projects, including numerous projects for various forms of equipment and replacement facilities that are not really new services or facilities and thus bear no relationship to competitive entry. (D. Jones, Tr. 1664). Indeed, there have been no certificate of need applications for the construction of new hospitals in the area around Highland Park, Evanston or Glenbrook over the past five

years. (D. Jones, Tr. 1664). The Health Facilities Planning Board (CON Board), responsible for granting CON applications, has denied hospitals beds where there is no bed need. (D. Jones, Tr. 1666). It has denied applications where the data suggested that there was "overbedding." (D. Jones, Tr. 1667). The CON Board has also denied applications in areas even when the data suggests the number of beds is already at the right number. Mr. Spaeth testified that, if an area is overbedded, the likelihood that the State of Illinois would approve additional beds is minimal. (Spaeth, Tr. 2168-69). Furthermore, in such cases, other hospitals might intervene to oppose the CON application. (Spaeth, Tr. 2168-69).

The Planning Board, when reviewing a CON application for additional beds, considers whether the proposed beds are actually needed at the facility. (D. Jones, Tr. 1656). Bed need is calculated with need formulas established by the board in its administrative rules. (D. Jones, Tr. 1656). The Division of Health Statistics compiles the data and variables necessary to compute those bed needs for the Division of Health Systems Development. (D. Jones, Tr. 1664). Based on the Planning Board's current addendum to its inventory, the area is overbedded, and there is no bed need in the Evanston, Glenview, and Highland Park areas (*i.e.*, the areas in which Evanston, Glenbrook, and Highland Park Hospitals are located) for services such as med/surg, pediatrics, or intensive care units. (D. Jones, Tr. 1665).

2284. From 1999 to mid-2004, 427 projects were approved in Illinois pursuant to CON applications. (D. Jones, Tr. 1672).

Response to Finding No. 2284:

Complaint Counsel's response is the same as CCRFF 2283.

b. Most CON Applications Are Approved In A Timely Manner

2285. In late 2002, early 2003, the Illinois Health Facilities Planning Board determined that it took an average of 75 calendar days from when a CON application was received by the agency until the permit was issued. (D. Jones, Tr. 1672).

Response to Finding No. 2285:

Complaint Counsel's response is the same as CCRFF 2283.

2286. From 1999 to mid-2004, the average time from when a CON application was deemed complete to the date the permit was issued was 68 business days. (D. Jones, Tr. 1672-73)

Response to Finding No. 2286

Complaint Counsel's response is the same as CCRFF 2283.

c. The CON Requirements In Illinois Have Been Revised And, As A Result, Fewer Projects Require CON Approval

2287. In 2000, Illinois increased the minimum capital expenditure threshold for a permit to be required from the Illinois Health Facilities Planning Board from \$2 million to \$6 million. (D. Jones, Tr. 1673). The threshold amount required for a permit prior to the acquisition of major medical equipment was also increased from \$1 million to \$6 million. (D. Jones, Tr. 1673-74).

Response to Finding No. 2287:

The finding is irrelevant and misleading and incomplete. Complaint Counsel's response is the same as CCRFF 2283. In addition, the finding is misleading because there is no evidence that anyone could construct a new hospital or add a substantial number of beds for as little as \$2 to \$6 million.

2288. As a result of the increases in the minimum capital expenditure and acquisition of major medical equipment thresholds, some projects that previously required a CON approval no longer require such approval. (D. Jones, Tr. 1674).

Response to Finding No. 2288:

The finding is misleading and incomplete. (See CCRFF 2283). There is no evidence that anyone could construct a new hospital or add a substantial number of beds for as little as \$2 to \$6 million. (See RFF 2287).

d. ENH's Competitors Have Been Able To Expand Their Facilities And Services Pursuant To The CON Process

2289. Repositioning is significant because, "in this case, there is substantial evidence that a number of hospitals in the Chicago area and most particularly hospitals around Highland Park [are] spending substantial resources to upgrade their facilities and thereby mak[ing] themselves competitive in the market place." (Noether, Tr. 6023).

Response to Finding No. 2289:

The finding is misleading and incomplete. (See CCRFF 2283). Even after five years have passed since ENH's price increases, there is no evidence that any hospital in the area is planning to enter or is likely to add a substantial number of beds. The competitive problem that the managed care organizations complained about testimony was the lack of alternate hospital facilities within the triangle formed by the three ENH hospitals, Evanston, Glenbrook, and Highland Park. (CCFF 1700-1707). The finding is misleading because none of the repositioning referred to here and discussed below involves the building of a new hospital facility within that geographic area to address the competitive problem the managed care organizations identified, but merely involve the addition of capacity outside of that area.

i. Northwestern Memorial Has Expanded Its Facilities And Services

2290. In 2003, the Illinois Health Facilities Planning Board granted Northwestern Memorial a permit to build a new women's hospital. (D. Jones, Tr. 1681).

Response to Finding No. 2290:

The finding is misleading and incomplete. The project was for a “replacement facility” of an existing hospital and did not expand bed capacity. (D. Jones, Tr. 1681-83).

2291. Northwestern Memorial, which already draws obstetrics patients from a very large area, is in the process of constructing a new women’s hospital “designed to make it an even bigger player in that field.” (Noether, Tr. 6025; RX 1296 at NMH 2508, 2510, 2512, 2520).

Response to Finding No. 2291:

The finding is misleading and incomplete. The project was for a “replacement facility” of an existing hospital and did not expand bed capacity. (D. Jones, Tr. 1681-83).

ii. Condell Has Expanded Its Facilities And Services

2292. In 2000, Condell filed a Certificate of Need application for a major modernization and expansion of its hospital facilities, including its inpatient, ancillary and support services. (RX 755 at CMC 5974). This expansion provided four new obstetrics beds, three new ICU beds, a new Women’s Center, an expanded and consolidated Surgery-Recovery-GI/Endo Department, an expanded Emergency Department, an expanded Radiology/Nuclear Medicine Department, and an expanded administrative and support space. (RX 755 at CMC 5974). The construction began in 2001 and continued until late 2003. (RX 997 at CMC 135; RX 1556 at CMC 6071).

Response to Finding No. 2292:

Condell is not a price-constraining substitute for ENH. (See CCRFF 387).

2293. In late 2002, the Illinois Health Facilities Planning Board granted Condell Medical Center a permit to increase its medical/surgical beds by 10 beds. (D. Jones, Tr. 1684).

Response to Finding No. 2293:

The finding is misleading and incomplete. It is only when a person wants to add either more than 10 beds or 10 percent of its current bed capacity to an existing hospital in Illinois that a prior certificate of need approval from the Planning Board is required. (D. Jones, Tr.1653-54.). In any event, Condell is not a price-constraining substitute for

ENH. (See CCRFF 387).

2294. In 2004, the Illinois Health Facilities Planning Board granted a permit to Condell to add eight ICU beds. (D. Jones, Tr. 1683). The Condell CON permit increased the total number of ICU beds at Condell by almost 33%. (D. Jones, Tr. 1683).

Response to Finding No. 2294:

This proposed finding is misleading and incomplete for the reasons stated in CCRFF 2293.

2295. In late 2003, the Illinois Health Facilities Planning Board allowed Condell to alter its permit for obstetric beds to increase the number of obstetric beds by 10 beds. (D. Jones, Tr. 1684). The 2003 permit increased Condell's total number of obstetric beds by almost 40%. (D. Jones, Tr. 1684).

Response to Finding No. 2295:

This proposed finding is misleading and incomplete for the reasons stated in CCRFF 2293.

2296. In 2004, the Illinois Health Facilities Planning Board granted Condell a permit to add another 10 medical/surgical beds. (D. Jones, Tr. 1684).

Response to Finding No. 2296:

The finding is misleading and incomplete for the reasons stated in CCRFF 2293.

iii. Lake Forest Hospital Has Expanded Its Facilities And Services

2297. In 2003, the Illinois Health Facilities Planning Board granted Lake Forest a permit to increase the number of medical/surgical beds by 10 beds. (D. Jones, Tr. 1684).

Response to Finding No. 2297:

This proposed finding is misleading and incomplete for the reasons stated in CCRFF 2293. It should also be noted that, despite Respondent's claim that quite a number of hospitals in the Chicago area compete with ENH, Respondent in this findings

section relating to entry has not been able to cite any new entry for the post-merger period (a new hospital rather than a replacement, since RFF 2290-2291 concern a replacement). Complaint Counsel also note that Respondent cites to only two hospitals (Condell and Lake Forest) that received a permit to add some beds. This is hardly price-constraining entry.

B. The Merger Was Not Anticompetitive Because HPH's Financial Condition Was Declining Before The Merger

1. HPH's Board Of Directors Determined That, Due To The Financial Condition Of HPH, HPH Could No Longer Maintain The Status Quo As An Independent Hospital

2298. The HPH Board of Directors was concerned about the long term-future of HPH. (Kaufman, Tr. 5781). 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). The Board believed that the quality of care at the hospital did not meet the demands of the community the hospital served. (Kaufman, Tr. 5819).

Response to Finding No. 2298:

Respondent's findings in Section IX(B) attempt to depict HPH as a declining competitor due to financial problems. Essentially, the findings set up a scene of a helpless, flailing Highland Park with Evanston having to come to the rescue.

Respondents' portrayal of HPH ignores key facts as discussed below in this section. It also overlooks the facts that 1) HPH could have continued as a stand-alone competitor without the merger (*see* CCF 356-367), and 2) HPH was considered an attractive candidate for other mergers. (*See* CCF 368-372).

Respondent's finding in RFF 2298 is vague. There is no explanation of what time frame constitutes HPH's "long-term future." Neele Stearns, HPH's former Chairman of

the Board, testified that HPH “had the financial wherewithal to sustain [itself].” (CX 6305 at 11 (Stearns, Dep.)). To the extent that Respondent is implying that the HPH Board believed that the merger with ENH in 2000 was financially necessary, Mr. Stearns’ testimony is to the contrary. He testified that “had the merger not gone through, financially, Highland Park, would have been able to sustain itself sufficiently to not be under pressure to have to merge with anybody.” (CX 6305 at 11 (Stearns, Dep.)). Mr. Stearns believed that, at the time, Highland Park’s continued existence was not in question for at least ten years. (CX 6305 at 4-5 (Stearns, Dep.)).

In addition, HPH management (and outside observers) believed that the quality of care of HPH was excellent at the time of the merger. (See CCF 2296-2324).

2299. The Board was concerned about HPH’s ability to compete effectively in the Chicago marketplace in light of its financial situation. (Kaufman, Tr. 5781-82). The HPH Board believed that it had a fiduciary obligation to HPH to take a close look at the hospital and chart out a course for the future. (Kaufman, Tr. 5781-82).

Response to Finding No. 2299:

Respondent’s finding is vague. In any event, in a March 23, 1999, joint meeting of the finance and planning committees of Lakeland Health Services and HPH, the attendees (including HPH chairman, Neele Stearns) discussed the “long term financial viability of the organization” should the merger not occur. (CX 1055 at 3). The attendees “concluded that the organization can remain financially strong over the foreseeable future.” (CX 1055 at 3).

2300. HPH’s declining operating income was discussed at HPH Board meetings. (CX 6305 at 3 (Stearns, Dep.)). The Board was concerned about the hospital’s declining operating income. (CX 6305 at 3 (Stearns, Dep.)). The Board also was concerned about being able to perpetuate the existence of the hospital as the 1990s progressed. (CX 6305 at 4 (Stearns, Dep.)).

Response to Finding No. 2300:

Respondent's finding is incomplete and misleading. Mr. Stearns also testified that the Board was not concerned about the actual future existence of Highland Park "at least for a reasonable period of time." (CX 6305 at 4-5 (Stearns, Dep.). He defined a "reasonable" period as ten years. (CX 6305 at 4-5 (Stearns, Dep.). HPH management believed that if the merger did not occur, "the organization can remain financially strong over the foreseeable future." (CX 1055 at 3). In addition, Mark Newton, HPH's then senior vice president of business development did not believe HPH was "wasting away" or was in a financial "downward spiral." (Newton, Tr. 448-49).

2301. The HPH Board hired Kaufman Hall & Associates ("Kaufman Hall") to evaluate the future of the hospital from a third party perspective. (Kaufman, Tr. 5782). Kaufman Hall began working for HPH in the late 1980s. (Kaufman, Tr. 5778; Spaeth, Tr. 2266-67). During the two decades that Kenneth Kaufman of Kaufman Hall worked with HPH, he became very familiar with the finances of the hospital as well as the available strategic options. (Kaufman, Tr. 5778-79; Spaeth, Tr. 2266; Newton, Tr. 437).

Response to Finding 2301:

Respondent's finding is not fully supported by the citations and the record. Mr. Spaeth testified that HPH first engaged Mr. Kaufman "in the early nineties." (Spaeth, Tr. 2266-67). By any account, Mr. Kaufman had not been working with HPH for "two decades." Mr. Kaufman's work with HPH ended in approximately July 1999. (Kaufman, Tr. 5789).

2302. Kaufman Hall is an independent consulting firm that provides financial and capital advisory services to not-for-profit hospitals. (Kaufman, Tr. 5773). Kaufman Hall has provided financial consulting services to over 100 hospital mergers and acquisitions. (Kaufman, Tr. 5776).

Response to Finding No. 2302:

The number of mergers and acquisitions for which Kaufman Hall has provided advice is irrelevant because Mr. Kaufman testified as a fact, not expert, witness. (See CCRFF 2304).

2303. In the Chicago healthcare market, Kaufman Hall has provided financial consulting services to many mergers and acquisitions – such as the sale of St. Francis Hospital in Evanston to Resurrection Healthcare, the sale of St. Joseph’s Hospital to Resurrection Healthcare and the sale of West Suburban Hospital to Oak Park. (Kaufman, Tr., 5777).

Response to Finding No. 2303:

Any other mergers for which Kaufman Hall has provided advice are irrelevant because Mr. Kaufman testified as a fact, not expert, witness. (See CCRFF 2304).

To the extent that Respondent in this finding implies that the “Chicago healthcare market,” is a relevant market, there is no evidence cited that the alleged market meets the SSNIP test for defining a relevant geographic market.

2304. Kaufman, who testified at trial, is a well-recognized and preeminent consultant on financial matters in the Chicago healthcare market. (Newton, Tr. 436-37). Kaufman has an exceptional reputation in the healthcare field. (Spaeth, Tr. 2141).

Response to Finding No. 2304:

Mr. Kaufman’s reputation as a consultant in the healthcare industry is irrelevant. These findings (RFF 2302-04) are attempts to bolster Mr. Kaufman’s expertise and constitute an inappropriate attempt to add expert opinion weight to a fact witness’ testimony. During Mr. Kaufman’s testimony, the Court recognized that Mr. Kaufman was appearing only as a fact witness and consequently struck a number of responses as inadmissible expert opinion testimony. (See, e.g., Kaufman, Tr. 5808-09).

To the extent that Respondent in this finding implies that the “Chicago healthcare

market," is a relevant market, there is no evidence cited that the alleged market meets the SSNIP test for defining a relevant geographic market.

2305. In November of 1996, Kaufman Hall was hired by HPH to "take a very detailed look at what the best future of HPH could be, and [] to evaluate the different options that were" available to the hospital. (Kaufman, Tr. 5780, 5818-19, RX 198). Kaufman Hall's strategic project for HPH began on November 18, 1996, and concluded with the signing of the letter of intent on June 30, 1999. (Kaufman, Tr. 5789; RX 198; RX 567). Kaufman Hall was the only third party consultant hired by HPH to assist the hospital in evaluating its future options. (Kaufman, Tr. 5783).

Response to Finding No. 2305:

During the merger negotiation period, from approximately the fall of 1998 to July 1999, Mr. Kaufman served only as transaction advisor to HPH. (Kaufman, Tr. 5839). He did not have discussions with Highland Park in 1999 about the viability of a status quo, unaffiliated option. (Kaufman, Tr. 5838-39).

2306. The HPH Board was focused on three primary criteria for the future of HPH: (1) an increase in capital capacity; (2) an increase in quality; and (3) the retention of local control. (Kaufman, Tr. 5786-87; 5817). The HPH Board's first criteria was focused on insuring that HPH obtain the capital capacity to make long-term investments in the hospital to provide first-class services to the Highland Park Community. (Kaufman, Tr. 5786-87). The HPH Board also sought to address concerns about the overall quality of the hospital and to find a way to improve quality at the hospital. (Kaufman, Tr. 5786-87). The HPH Board's third criteria was to maintain local control of the hospital for the benefit of the Highland Park community. (Kaufman, Tr. 5786-87).

Response to Finding No. 2306:

Respondent's finding is incomplete, misleading and irrelevant. There is no requirement of proving an anticompetitive intent in a merger case. Furthermore, Respondent's finding regarding HPH's purportedly philanthropic or innocent intentions is misleading in implying that the merging parties' motive in merging was philanthropic or innocent. Even if, *arguendo*, the merging parties had one or more philanthropic or

innocent motives, they were by no means the only motives. Pre-merger documents of HPH show the motivations of HPH management and board members with regard to the merger:

- To reap “the economic benefit” of “not do[ing] battle” with Evanston (CX 4 at 1)
- To “stop competing with each other” (CX 1879 at 3-4)
- To “push back on the managed care phenomenon” (CX 4 at 2)
- To be “a big enough concerted enough entity (CX 4 at 2)
- To “get geographic leverage” (CX 4 at 9)
- To achieve “critical mass” in the North Shore (CX 4 at 9)
- To “exploit an area of the market in a meaningful way” (CX 3 at 2)
- To build “power to deal with managed care” (CX 3 at 2).

Highland Park knew that “it would be real tough for any of the Fortune 40 companies in this area whose CEOs use either this place or that place to walk from Evanston, Highland Park, Glenbrook, and 1700 of their doctors.” (CX 4 at 1-2; Spaeth, Tr. 2210-11).

2307. 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). The financial needs of HPH outweighed the capital capacity of the hospital. (Kaufman, Tr. 5828). As a result of the financial needs of HPH and the competitive pressures of the Chicago marketplace, Kaufman Hall concluded that HPH would be unable to maintain the status quo of the hospital. (Kaufman, Tr. 5819-20, 5828).

Response to Finding No. 2307:

Mr. Kaufman’s own contemporaneous analysis runs counter to his testimony in 2005. At the start of the merger negotiations in late 1998, Mr. Kaufman advised the Highland Park Board and management that “the financial condition of both parties [was]

such that neither require a financial reason” to go forward with the merger and that “at no time should anyone in the community or the media be given that impression.” (Kaufman, Tr. 5840; CX 1923 at 2).

HPH’s internal evaluations and strategic plans in 1998 and 1999 also contradict Mr. Kaufman’s trial testimony. In March 1999, Highland Park’s management and board asserted that Highland Park “can remain financially strong over the foreseeable future.” (CX 1055 at 3). { [REDACTED] } (Spaeth, Tr. 2147, *in camera*). Mr. Kaufman, by contrast, did not have discussions with Highland Park about the status quo, unaffiliated option in 1999. (Kaufman, Tr. 5838-39).

In the 1999-2003 financial plan for HPH presented in March 1999, management noted that HPH “has historically achieved strong financial results compared to the median of not-for-profit hospitals.” (CX 545 at 3). The plan also concluded that “[e]xisting cash and investments are available to fund strategic initiatives and generate new programs.” (CX 545 at 3). The 1999-2003 financial plan set forth a “long range capital budget” that included \$43 million for “strategic initiatives and master plan items,” including “ambulatory, assisted living and facility expansion.” (CX 545 at 3). The plan also budgeted for \$65 million primarily for “[h]ospital construction, routine capital and information technology” investments. The combined budget for the two categories was in excess of \$100 million. (Newton, Tr. 430-31; CX 545 at 3; CX 1055 at 2). In addition, HPH concluded that “[c]ash and investments are forecasted to grow from \$238 million in 1998 to \$323 million in 2003.” (CX 1055 at 3).

2. The HPH Board Decided That Merging With Evanston Hospital Was

The Best Option For The Future Of HPH

2308. The HPH Board considered numerous options, but believed that a full asset merger was the best option to improve the future of HPH. (Kaufman, Tr. 5820-21). The Board wanted to merge the hospital into a “stronger healthcare company that could bring much stronger services over the long term to the Highland Park community.” (Kaufman, Tr. 5821-22).

Response to Finding No. 2308:

Highland Park’s strategic motivations are irrelevant to the merger analysis:

philanthropic goals will not rescue an anticompetitive merger from a Section 7 violation.

In addition, Highland Park aimed to increase market power through the merger, whatever

philanthropic goals it might have had. (See CCRFF 2306). In any event, HPH was an

attractive candidate for other mergers. (See CCF 368-372).

2309. The Board did not feel that HPH could continue to serve its community in the long-run absent a partnership with another institution. (CX 6305 at 11 (Stearns, Dep.)). The Board concluded that HPH needed to find a partner that would enhance HPH’s ability to serve the community by bringing new programs to HPH – programs that HPH could not itself justify creating as an independent institution. (CX 6305 at 10 (Stearns, Dep.)).

Response to Finding No. 2309:

In his testimony, Mr. Stearns emphasized that there was no pressing need to merge with ENH (or anyone else) in the 1999-2000 time frame. Mr. Stearns stated that HPH “had the financial wherewithal to sustain [itself] . . . to not be under pressure to have to merge with anybody.” (CX 6305 at 11 (Stearns, Dep.)). As Mr. Stearns noted, “There was no urgency to have to an alternative immediately available.” (CX 6305 at 11 (Stearns, Dep.)). In any event, HPH was an attractive candidate for other mergers. (See CCF 368-372).

2310. To guarantee HPH’s future, the HPH Board decided to find a partner that would bring in capital, talent and clinical programs that would enhance HPH and its ability to serve the

community. (CX 6305 at 7 (Stearns, Dep.)).

Response to Finding No. 2310:

Highland Park's strategic motivations are irrelevant to the merger analysis: philanthropic goals will not rescue an otherwise anticompetitive merger from a Section 7 violation. In addition, Highland Park aimed to increase market power through the merger, whatever philanthropic goals it might have had. (See CCRFF 2306). In any event, HPH was an attractive candidate for other mergers. (See CCF 368-372).

2311. The HPH Board considered divesting the hospital to a for-profit provider, but ultimately rejected that option because it would require changing the culture of a not-for-profit hospital to a for-profit corporation. (Kaufman, Tr. 5822). The for-profit option conflicted with the Board's criteria to retain local control over the hospital because a sale to a for-profit would mean that "local control is completely lost." (Kaufman, Tr. 5822).

Response to Finding No. 2311:

The finding that the HPH Board itself rejected divesting to a for-profit provider is not fully supported by the record citation. Mr. Kaufman testified that *Kaufman Hall* examined the possibility of divesting to a for-profit company and made a recommendation not to do so. (Kaufman, Tr. 5822 (emphasis added)). The cited testimony makes no mention of the *Board's* decision in analyzing Mr. Kaufman's recommendation. (Kaufman, Tr. 5822).

2312. Kaufman Hall, in cooperation with the HPH Board, evaluated a number of other options for the future of the hospital – including developing relationships or possible mergers with Northwestern Memorial Hospital, Advocate Healthcare and the Mayo Clinic. (Kaufman, Tr. 5823). Each of the parties HPH contacted were not interested in pursuing possible merger options. (Kaufman, Tr. 5823-24; CX 6305 at 12 (Stearns, Dep.)).

Response to Finding No. 2312:

Mr. Stearns also noted that, had the merger with Evanston not gone through, HPH

would have explored alternatives with other institutions and “would have pursued those more aggressively.” (CX 6305 at 11-12 (Stearns, Dep.)). The HPH Board did not view the Evanston merger as a “make or break partnership.” (CX 6305 at 11 (Stearns, Dep.)). Indeed, HPH had a strategic plan in place as a stand-alone institution that addressed its capital needs. (See CCRFF 2307).

2313. The HPH Board also considered joint ventures, but that option was not recommended by Kaufman Hall. (Kaufman, Tr. 5823). Kaufman Hall did not recommend joint ventures because they would not solve HPH’s main problem of capital capacity. (Kaufman, Tr. 5823). A joint venture may be successful in bringing additional services, but it does not add capital capacity to an organization. (Kaufman, Tr. 5823).

Response to Finding No. 2313:

Complaint Counsel agree that a joint venture “may be successful in bringing additional services.” In any event, Lakeland Health Services had adequate capital capacity. At the end of 1999, long-term debt declined to \$117 million, and cash and unrestricted investments increased to \$260 million. (CX 693 at 16-17).

2314. After reviewing all of HPH’s strategic options, Kaufman Hall recommended to the HPH Board that the hospital pursue a merger with Evanston Hospital. (Kaufman, Tr. 5824). A merger between HPH and Evanston Hospital was the best option because it met the three criteria established by the HPH Board for the future of HPH – capital capacity, increased quality and local control. (Kaufman, Tr. 5824).

Response to Finding No. 2314:

Highland Park’s listed motivations are irrelevant to the merger analysis: philanthropic or innocent goals will not rescue an anticompetitive merger from a Section 7 violation. In addition, Highland Park aimed to increase market power through the merger, whatever philanthropic or innocent goals it might have had. (See CCRFF 2306).

2315. Kaufman Hall recommended that HPH merge with Evanston Hospital because

Kaufman Hall's strategic analysis of the hospital revealed that HPH could not maintain its capital capacity, improve its quality and improve its level of services on its own. (Kaufman, Tr. 5828-29).

Response to Finding No. 2315:

HPH's own internal evaluations and strategic plans in 1998 and 1999 contradict Mr. Kaufman's 2005 testimony. (See CCRFF 2307).

2316. As the 1990s progressed, the HPH Board's principal concern became whether a community hospital like HPH could long exist. (CX 6305 at 7 (Stearns, Dep.)). Some Board members did not believe that HPH had a future. (CX 6305 at 7 (Stearns, Dep.)). In the mid to late 1990s, HPH's existing volume of business was not sufficient to sustain the hospital. (CX 6305 at 5 (Stearns, Dep.)).

Response to Finding No. 2316:

Respondent's finding is incomplete and misleading. Mr. Stearns believed that Highland Park could sustain itself for at least ten years, and the HPH management and board as a whole in 1999 had confidence in HPH's financial results and future as a stand-alone entity. (See CCRFF 2298).

In addition, HPH was searching for other ways of increasing volumes besides external growth through a merger. Mr. Stearns noted that Highland Park in the 1990s acquired other physician practices in order "to reach into areas which [HPH] had not serviced significantly in the past." (CX 6305 at 5 (Stearns, Dep.)). An internal August 1998 strategic plan outlined a series of "internal growth" steps that HPH could follow in order to position itself as a "market leader," including creating "Centers of Excellence" and engaging in joint ventures to offer a wider range of services. (CX 1869 at 3-5).

2317. The HPH Board had a fiduciary duty to the hospital and the community to insure that the best possible and highest quality care was made available to the Highland Park community. (Kaufman, Tr. 5829). The Board consisted of very sophisticated business people

from companies throughout Chicago who had a deep experience with asset mergers from their professional businesses. (Kaufman, Tr. 5821).

Response to Finding No. 2317:

Highland Park's listed motivations are irrelevant to the merger analysis: philanthropic or innocent goals will not rescue an anticompetitive merger from a Section 7 violation. In addition, Highland Park aimed to increase market power through the merger, whatever philanthropic or innocent goals it might have had. (*See* CCRFF 2306).

2318. As it turned out, the Merger between HPH and Evanston Hospital best met the fiduciary duty of the Board, as well as the HPH Board's three criteria discussed above. (Kaufman, Tr. 5824, 5829). First, Evanston Hospital was able to bring very significant capital capacity to HPH. (Kaufman, Tr. 5824). Second, Evanston Hospital also had a very good reputation for quality in the Chicago area and, through its connection with Northwestern Medical School, was able to bring quality and an academic link to HPH. (Kaufman, Tr. 5824). Finally, a merger between HPH and Evanston Hospital met the third criteria of the Board because HPH could maintain a good level of local control due to the fact that there is some overlap in the Evanston and Highland Park communities. (Kaufman, Tr. 5824).

Response to Finding No. 2318:

Highland Park's listed motivations are irrelevant to the merger analysis: philanthropic or innocent goals will not rescue an anticompetitive merger from a Section 7 violation. In addition, Highland Park aimed to increase market power through the merger, whatever philanthropic or innocent goals it might have had. (*See* CCRFF 2306).

3. HPH's Financial Condition Was Rapidly Declining

2319. As the 1990s progressed, HPH's operating income declined. (CX 6305 at 2-3 (Stearns, Dep.)). HPH began to lose money in the mid to late 1990s. (CX 6305 at 5, 10 (Stearns, Dep.)).

Response to Finding No. 2319:

Respondent's finding is misleading and incomplete. By a number of different

measures in the evidentiary record, Highland Park only lost money from operations in 1999, and that included losses due to merger-related expenses. (See CCRFF 2320).

2320. From 1996 to 1999, HPH was not making money from operations on a year-to-year basis. (Kaufman, Tr. 5811). In 1996, HPH's operating margin was \$3.889 million, but by 1999, its operating margin hovered near losses of over \$3 million. (RX 609 at EY 236). In 1999, HPH's audited financials reported an \$11 million loss. (Spaeth, Tr. 2307; CX 1732 at 4).

Response to Finding No. 2320:

Mr. Kaufman's testimony that HPH was not making money from 1996 to 1999 is contradicted by the second sentence of Respondent's finding as well as by other evidence. As a clarifying matter, the operating margins that Respondent refers to are for Lakeland Health Services, Inc., not HPH standing alone. (RX 609 at EY 236). Furthermore, these figures exclude the impact of Highland Park Hospital Foundation. (RX 609 at EY 236).

In any event, on its own terms, the results listed in the cited document (which is the due diligence report prepared by ENH, also found at CX 1720) demonstrate that operating and net margins for LHS were positive in 1996, 1997, and 1998. The first year they were negative was 1999. (RX 609 at EY 236).

According to that same document, Highland Park Hospital standing alone had positive operating income in 1996, 1997, and 1998. The first year that HPH had a negative operating income was in 1999. (RX 609 at EY 257). These figures exclude investment income as well as financing and interest payments. (RX 609 at EY 257).

Respondent's finding that HPH experienced an \$11 million loss in 1999 is misleading. First, LHS's 1999 audited financials show that \$8.7 million of that loss was attributable to "merger-related costs." (CX 1732 at 4).

Second, HPH also explained to ENH that its 1999 results were below budget partly due to unbudgeted, one-time costs. (CX 517 at 1). In particular, HPH noted that “one-time” items included “costs related to the Meditech conversion, [and] a change in pension discount rate and employee benefit costs.” (CX 517 at 1). If the ten month operating income were adjusted for these nonrecurring costs, HPH calculated that it would have had a positive operating profit of approximately \$1 million for that ten month period ending July 1999. (CX 517 at 4).

2321. From 1997 to 1998, HPHs operating revenue was steadily decreasing. (Kaufman, Tr. 5793-94; RX 1979 at FTC KHA 2167). Despite experiencing a slight increase in total revenue in 1998, HPH was having more and more trouble turning a dollar of revenue into any type of profit. (Kaufman, Tr. 5794).

Response to Finding No. 2321:

Respondent’s finding is not supported by the cited record. There is no concept in the cited record of “operating revenue.” There are references to “operating income” and “total revenue.” (RX 1979 at FTC KHA 2167; Kaufman, Tr. 5793-94). Total revenue increased from 1997 to 1998 while operating income declined during that same period. (RX 1979 at FTC KHA 2167; Kaufman, Tr. 5793-94).

To the extent Respondent is referring to “operating income,” Respondent’s selective, and brief, time period reporting is misleading. A review of a longer time period demonstrates that HPH experienced ups as well as downs in its year-over-year operations during the mid to late 1990s. According to HPH’s audited financials, for the hospital standing alone, operating income increased from 1996 to 1997 and then declined from 1997 to 1998. (*Compare* CX 413 at 158 to CX 413 at 139). This volatility is also seen in

the ENH due diligence report for LHS overall as well as HPH standing alone. (CX 1720 at 256-57).

Evanston itself exhibited similar volatility in its operating results. In 1999, ENH also experienced a net income decline from 1997 to 1998 and anticipated a decline in 1999 with recovery in following years. (H. Jones, Tr.4104-06; RX 514 at FTC-KHA 1665). Focusing on a short time period, as Respondent does, can give a distorted view of a hospital's financial situation.

2322. From 1997 to 1998, HPH's operating margin "deteriorated significantly." (Kaufman, Tr. 5798; RX 1979 at FTC KHA 2172). From 1997 to 1998, HPH's operating margin dropped by half of its value the prior year. (Kaufman, Tr. 5798; RX 1979 at FTC KHA 2172). The declining operating margin was significant because HPH's financial momentum was trending downward. (Kaufman, Tr. 5798-99).

Response to Finding No. 2322:

Respondent's finding is misleading and incomplete. As described in CCRFF 2321, both LHS's and HPH's operating income increased from 1996 to 1997 and then subsequently decreased in 1998 and 1999. (See CCRFF 2321). Respondent and Mr. Kaufman are inappropriately drawing broad conclusions from a carefully selected, and brief, time frame.

2323. In the late 1990s, the Balanced Budget Act of 1997 ("Balanced Budget Act") had an impact on HPH. (Spaeth, Tr. 2260). In the 1990s, HPH's operating revenues were being reduced by the Balanced Budget Act. (Spaeth, Tr. 2263). According to the April 1998 Lakeland Finance Committee meeting minutes, HPH projected a \$1.3 million loss in 1998 because of the Balanced Budget Act. (RX 327 at ENH DR 3695). HPH further projected a \$4-6 million loss due to the Balanced Budget Act in the years after 1998. (RX 327 at ENH DR 3695).

Response to Finding No. 2323:

Respondent's finding is incomplete and misleading. The Balanced Budget Act

affected all hospitals with Medicare/Medicaid programs, including ENH. In 1999, ENH also experienced a net income decline from 1997 to 1998 and anticipated a decline in 1999 with recovery in following years. (H. Jones, Tr.4104-06; RX 514 at FTC-KHA 1665). According to Harry Jones, Evanston's chief financial officer at the time, this decline was primarily attributable to the effect of the Balance Budget Act. (H. Jones, Tr.4106).

In addition, Respondent's finding on the projected \$4-6 million loss "in the years after 1998" is misleading to the extent that it implies certainty in the projections or timeline. The minutes state that the estimate is "uncertain, due to lack of specific rules which have yet to be developed." (RX 327 at ENH DR 3695). In any event, HPH subsequently projected an improvement in its net operating income for later years. (See CCRFF 2307).

Finally, Respondent mischaracterizes the document, RX 327. There is no mention of the term "loss" as Respondent suggests in RFF 2323. The minutes merely state that the changes "will reduce payments" in 1998 and possibly the future.

In addition, Respondent's finding on the projected \$4-6 million loss "in the years after 1998" is misleading to the extent that it implies certainty in the projections or timeline. The minutes state that the estimate is "uncertain, due to lack of specific rules which have yet to be developed." (RX 327 at ENH DR 3695). In any event, HPH subsequently projected an improvement in its net operating income for later years. (See CCRFF 2307).

Finally, Respondent mischaracterizes the document. There is no mention of the

term "loss" as Respondent suggests in RFF 2323. The minutes merely state that the changes "will reduce payments" in 1998 and possibly the future.

2324. HPH's operating income came under pressure in the late 1990s because of the Balanced Budget Act and because of a decline in HPH's inpatient admissions. (CX 6305 at 3 (Stearns, Dep.)). HPH financial health was also negatively affected by reduced reimbursements from MCOs. (CX 6305 at 10 (Stearns, Dep.)).

Response to Finding No. 2324:

Both Highland Park and Evanston experienced operating income pressure due to the effects of the Balanced Budget Act. (See CCRFF 2323). In 1998 and 1999, Highland Park formulated various strategic responses to increase market share and revenue. (See, e.g., CX 1869 (1998 Strategic Planning Retreat Draft Presentation); CX 545 (1999-2003 Financial Plan)). HPH projected an improvement in its net operating income for later years. (See CCRFF 2307).

2325. {

} (RX 349 at ENH RS 3440, *in camera*).

Response to Finding No. 2325:

As noted above, Highland Park, as with other hospitals, experienced a negative impact from the Balanced Budget Act and was formulating strategic plans in response. (See CCRFF 2324). In any event, HPH subsequently projected an improvement in its net operating income for later years. (See CCRFF 2307).

2326. The 1999-2002 Lakeland Strategic Plan, written in August 1998, also concluded that the Balanced Budget Act would have a "significant impact on [Lakeland] and Highland Park Hospital." Specifically, the 1999-2002 Lakeland Strategic Plan also predicted that the Balanced Budget Act would decrease HPH's Medicare payments by \$3.6 million in fiscal year 1999. (RX

363 at FTC-KHA 2350).

Response to Finding No. 2326:

As noted above, Highland Park, as with other hospitals, experienced a negative impact from the Balanced Budget Act and was formulating strategic plans in response.

(See CCRFF 2324). HPH subsequently projected an improvement in its net operating income for later years. (See CCRFF 2307).

2327. HPH's operating margin in 1998 was considerably lower than the comparative universe of hospitals in the United States at that time. (Kaufman, Tr. 5804-05; RX 465 at FTC-KHA 280). HPH's operating margin in 1998 was 2.6 whereas the margin for an A-rated hospital in 1997 was 4.4. (Kaufman, Tr. 5804-05; RX 465 at FTC-KHA 2179-80). HPH's low operating margin was very significant because the hospital was going to need a significant amount of investment into its facilities, services and plant to compete in the marketplace. (Kaufman, Tr. 5804-05; RX 465 at FTC-KHA 2180).

Response to Finding No. 2327:

Respondent's comparisons between HPH and other hospitals in RX 465 (identical to CX 1912) are misleading and incomplete. Mr. Kaufman drafted this document to help justify why Lakeland Health Ventures (HPH's parent) could spin off \$100 million in LHS assets to a new foundation to serve the Highland Park community rather than having ENH take over the assets in the merger. (CX 1912 at 2; Kaufman, Tr. 5843). All the financial comparisons made by Mr. Kaufman in that memorandum excluded the \$100 million in assets. (Kaufman, Tr. 5858). Most of these assets were contained in the pre-merger Highland Park Foundation. (CX 710 at 17).

Part of HPH's operating margin expenses was its interest and financing costs for its long-term debt. (CX 710 at 18). This debt was backed by the assets of not only HPH but also by the pre-merger Highland Park Foundation. (Kaufman, Tr. 5844-45).

However, all the financing payments on the debt were expensed under HPH. (CX 710 at 18).

Thus, the operating margin comparison found in CX 1912/RX 465 is fundamentally misleading. The purpose of the document was to justify spinning off \$100 million in assets outside of the merger. (Kaufman, Tr. 5843). However, these assets backed the debt for which HPH alone was paying financing payments, thereby reducing the hospital's operating margin. If instead the \$100 million were used to reduce the long-term debt, HPH's financing payments would decrease, and its operating margin would increase. Mr. Kaufman's use of the operating margin comparison in his testimony to make HPH appear financially weak is completely at odds with the purpose of the memorandum, which was to assure the HPH board that the merged entity would be "receiving an appropriately capitalized partner" in Highland Park even without the \$100 million in spun-off assets. (CX 1912 at 2).

Highland Park's bond documents demonstrate how it accounted for the fact that Highland Park Hospital and the pre-merger foundation both were liable for the interest and financing payments on the long-term debt. When presenting financial statements in the bond documents, Highland Park combined the hospital and foundation operations, cash flows and assets into a single "combined statement of operations." (CX 6321 at 87-91). Counting interest and financing payments on the long-term debt only against the hospital (as Mr. Kaufman did), presents a distorted picture of the hospital's true finances.

This can be seen clearly by comparing the 1996 "combined statements of operations" against the 1996 statement of operations for just Highland Park Hospital.

(Compare CX 6321 at 89 and CX 413 at 158). In both statements, the interest and financing costs for 1996 totaled \$4.1 million. (CX 6321 at 89; CX 413 at 158).

However, operating income for 1996 was \$6.8 million for just the hospital (CX 413 at 158), as compared to \$9.5 million for the combined hospital and foundation operations. (CX 6321 at 98).

If the merger had not occurred, the pre-merger Foundation's assets would have remained in the corporate structure of Highland Park. (Kaufman, Tr. 5856). Prior to the merger, the foundation raised funds which were available for use by HPH. As the former chairman of the pre-merger foundation testified, "The funds from the pre-merger Foundation went to support the hospital, fulfill needs." (Styer, Tr. 4954). These "needs" included specific hospital projects, such as improvements to the hospital's dialysis center. (Styer, Tr. 4959-60).

2328. HPH's excess margin was considerably lower at 3% in 1998, while an A-rated hospital in 1997 had 7% excess margin. (Kaufman, Tr. 5804-05; RX 465 at FTC-KHA 2179-80). Despite taking into account HPH's strong investment income in 1998, HPH's excess margin was still less than half of the excess margin that was being shown by A-rated hospitals. (Kaufman, Tr. 5804-05; RX 465 at FTC-KHA 2179-80).

Response to Finding No. 2328:

Operating margin is a component of excess margin. (Kaufman, Tr. 5804-05). Thus, as discussed in CCRFF 2327, Respondent's comparison between HPH and other hospitals' excess margins is misleading and incomplete because it did not take into account the \$100 million in assets that HPH proposed to contribute to a post-merger Foundation. (See CCRFF 2327).

2329. HPH's negative operating revenue trend-line continued into 1999 (Kaufman, Tr.

5795-96). In June of 1999, HPH's declining financial performance accelerated even faster. (H. Jones, Tr. 4093). HPH reported a negative net margin of approximately \$2 million for the first 6 months of 1999, approximately \$4.7 million lower than what HPH had budgeted to achieve during the same time period. (RX 609 at EY 19; H. Jones, Tr. 4121).

Response to Finding No. 2329:

Respondent's finding is inaccurate. The cited source (RX 609) is not for Highland Park Hospital alone but rather Lakeland Health Services as a whole, which includes Lakeland Health Ventures. As Respondent notes in RFF 2355, LHV sustained an operating loss of \$2 million for the October 1999 year-to-date period. (See RFF 2355). Thus, Respondent's claim that the *hospital* had a \$4.7 million unfavorable variance is incorrect. Respondent's finding that the variance is to a 1999 budget is also inaccurate. The variance was to the same six month period in 1998, not to the 1999 budget. (RX 609 at EY 19).

There are a number of factors that made HPH's 1999 performance unusual. HPH explained to ENH that its part-year 1999 results were below budget partly due to unbudgeted, one-time costs. (CX 517 at 1). In particular, HPH noted that "one-time" items included "costs related to the Meditech conversion, [and] a change in pension discount rate and employee benefit costs." (CX 517 at 1). If the ten-month operating income were adjusted for these nonrecurring costs, HPH calculated that the hospital standing alone would have had a positive operating margin of approximately \$1 million. (CX 517 at 4).

2330. In September 1999, HPH's Chief Financial Officer reported to the HPH Board "significant operating shortfalls relative to budget reflected in June and preliminary July 1999 income statements." (RX 592A at ENH RS 880; Spaeth, Tr. 2305; Newton, Tr. 443-44). The June 1999 financial statements reflected a consolidated year-to date operating loss of \$2,235,000

compared to a budgeted loss of \$196,000. (RX 592A at ENH RS 882; Newton, Tr. 444).

Response to Finding No. 2330:

The Highland Park results in 1999 were in great part attributable to unbudgeted, one-time costs. (See CCRFF at 2329).

2331. Other area hospitals such as Condell recognized that HPH was experiencing financial difficulties. (RX 1764 at CMC 19916-17, 19927). Internal Condell documents further show the explosive growth Condell enjoyed while HPH struggled to get by in 1999. For example, in 1999, Condell's \$155,832,106 in gross revenue more than doubled HPH's \$70,949,405. (RX 1764 at CMC 19920).

Response to Finding No. 2331:

Respondent's finding is misleading and incomplete. The Condell document cited sets forth financial results only for 1999. (RX 1764 at CMC 19915). Without a comparison with previous years, there can be no assessment of the rate of Condell's growth. An absolute comparison between Condell's and HPH's gross revenues is meaningless without an adjustment for relative size of the hospitals. In addition, HPH's operating expenses in 1999 included millions of dollars in "merger-related costs." (CX 693 at 18).

2332. As early as January 31, 1999, HPH faced a year-to-date net margin loss of over \$3.5 million. (RX 449 at ENH HJ 1945). When taking into account adjustments for bad debt, necessary merger accruals and other year-end adjustments related to the Merger, as of January 1999, HPH stood to lose over \$11.7 million. (RX 449 at ENH HJ 1945). HPH's audited financial for 1999 showed an \$11 million operating loss. (Spaeth, Tr. 2307).

Response to Finding No. 2332:

Respondent's finding that HPH faced a year-to-date net margin loss of over \$3.5 million by January 1999 is based on a typographical error in the source document. Although the document is dated January 31, 1999, the document refers to "Lakeland

Health Services' 1999 Financial Close." (RX 449 at ENH HJ 1945). The document clearly was created after December 1999 (*i.e.*, in 2000 or later) because it repeatedly refers to December 1999 financials and balance sheets "as of 12/31/99." (RX 449 at ENH HJ 1945-59). In addition, the document refers to the "new Healthcare Foundation of Highland Park," which was not created until December 1999. (RX 2037 at HFHP 1351).

Even if Respondent in RFF 2332 were discussing HPH's loss in calendar year 1999, Respondent's finding is misleading and incomplete. As previously described, much of the 1999 operating loss was attributable to merger-related costs. (*See* CCRFF 2320). In addition, HPH experienced a number of nonrecurring, one-time costs in 1999. (*See* CCRFF 2320).

2333. In response to the significant financial losses in the late 1990s, HPH attempted to enact cost containment programs. (Spaeth, Tr. 2263, 2305; RX 592A at ENH RS 880; Newton, Tr. 444). Initially, HPH was able to reduce overhead costs. But, as time progressed, HPH started to look into cutting patient services such as nursing and radiology. (Spaeth, Tr. 2263-64). HPH successfully reduced costs only to a certain extent. (CX 6305 at 4 (Stearns, Dep.)).

Response to Finding No. 2333:

Respondent's finding is vague as to the success of the cost containment program as well as the actual scope and timing. First, Respondent's citation of Mr. Stearns' testimony is misleading. Mr. Stearns noted that HPH implemented cost reduction measures and were successful in reducing costs "[t]o a certain extent." (CX 6305 at 4 (Stearns, Dep)). Mr. Stearns did not negatively characterize the cost cutting program as Respondent's finding implies.

In addition, in contrast to Mr. Spaeth's imprecise testimony, Lakeland Health

Service's 1999-2002 strategic plan noted that "[s]ince 1993 the hospital has experienced a steady decline in cost per adjusted admission from \$6,149 to \$5,701 in 1997," with a further reduction to \$5,522 in 1998. (RX 363 at FTC-KHA 2357).

2334. In December 1999, the CEO of HPH told the Board that HPH did not have a rosy financial future. (Spaeth, Tr. 2307-8). HPH's "Financial Statement Highlights for the 10 Months Ended October 31, 1999" stated that the "Hospital's operating margin for the 10 months ended October 31, 1999 was (\$5,050,000) which is 455.6% unfavorable to budget." (RX 2013 at ENH RS 6102; Newton, Tr. 447).

Response to Finding No. 2334:

Respondent's finding is incomplete and misleading. HPH had a strategic plan in place for financial success. (See CCRFF 2307). HPH was profitable (setting aside nonrecurring costs such as the information systems conversion) at July 1999. (See CCRFF 2329). At his deposition in December 1999, Neele Stearns, HPH's chairman of the board, testified that he believed that HPH was not in danger of exiting the market for at least ten years. (CX 6305 at 5 (Stearns, Dep.)).

2335. In December of 1999 a member of HPH's financial team "reported on the October 1999 financial statements (excluding the Merger-related accruals noted above) which show a consolidated year-to-date operating loss of \$4,686,000 compared to a break-even budget. Operating loss of the Hospital was \$2,740,000, which was \$4,160,000 under budget. Operating income of the Foundation was \$392,000 or \$209,000 under budget. Operating loss of Lakeland Health Ventures was \$2,062,000 compared to a budgeted loss of \$1,738,000." (RX 2013 at ENH RS 6097; Spaeth, Tr. 2306-07; Newton, Tr. 446).

Response to Finding No. 2335:

Respondent's finding is incomplete and misleading to the extent that it implies that a one year operating loss means that a company is not financially viable. HPH had a strategic plan for financial success, and as of July 1999, setting aside nonrecurring costs, was profitable. (See CCRFF 2334).

4. Evanston Hospital's Due Diligence Revealed That HPH's Financials Were On A "Downward Spiral"

2336. The Merger due diligence process revealed that HPH was on a financial "downward spiral." (H. Jones, Tr. 4157). In 1999, the financial condition of HPH was deteriorating and continuing to get worse. (Kaufman, Tr. 5816-17; H. Jones, Tr. 4157-58). HPH's finances were described as a "deteriorating financial trend." (H. Jones, Tr. 4093).

Response to Finding No. 2336:

All Respondent's findings on ENH's 1999 due diligence on HPH must be considered in the context of the negotiations of the terms of the proposed merger. ENH and HPH were engaged in arms-length negotiations over a number of topics, most notably the size of the post-merger Highland Park Foundation and the contribution to that Foundation from HPH's assets. (Kaufman, Tr. 5862-66).

ENH had an incentive during these negotiations to portray HPH as financially weak to minimize the level of contribution from HPH into the post-merger Foundation. (See Kaufman, Tr. 5863-66) (ENH attempted to negotiate downward the size of the post-merger Foundation). For example, ENH claimed that HPH would have to contribute \$47 million from its cash position immediately following the merger for "important capital expenditures" and merger-related expenses. (CX 1905 at 4; Kaufman, Tr. 5862-63).

HPH, through Mr. Kaufman, disagreed. In Mr. Kaufman's memorandum to HPH on that contention, he wrote, "the HPH forecasted financial statements clearly demonstrate that HPH can support such expenditures from ongoing operations and that a contribution from cash would not be required." (CX 1905 at 4).

In addition, ENH's conclusion that HPH was financially weak was at odds with Mr. Kaufman's and HPH's own contemporaneous analyses of HPH's financial condition

and prospects, including analyses not prepared expressly for the merger negotiations.

(See CCRFF 2307).

2337. Evanston Hospital's pre-Merger due diligence revealed problems with HPH's financial condition. (CX 6304 at 4 (Livingston, Dep.)). ENH's pre-Merger due diligence further revealed that the perception that HPH was a "strong community hospital" was not accurate. (CX 6304 at 4 (Livingston, Dep.)). To the contrary, HPH was not "strong." (CX 6034 at 5 (Livingston, Dep.)).

Response to Finding No. 2337:

Respondent's finding is inconsistent with HPH's internal analyses and projections. (See CCRFF 2307). As noted previously, ENH had an incentive to portray HPH as financially weak during the pre-merger negotiations stage. (See CCRFF 2336).

In any event, HPH was a good and strong community hospital pre-merger. (See CCFF 2295-2323). Financially, HPH pre-merger had a strong balance sheet and could have continued as a stand-alone competitor without the merger. (See CCFF 303-324, 356-367).

2338. Preliminary due diligence meetings between Evanston Hospital and HPH occurred in March and April of 1999. (H. Jones, Tr. 4091-92). After the Merger was approved by the Board of Directors for each hospital in June 1999, the due diligence process began in earnest. (H. Jones, Tr. 4092). The heavy lifting of the due diligence process occurred primarily during July through September of 1999. (H. Jones, Tr. 4091-92). The due diligence process ended on or about September 15, 1999, with a report to Evanston Hospital's Board of Directors. (H. Jones, Tr. 4092).

Response to Finding No. 2338:

Complaint Counsel have no specific response.

2339. The primary players in the financial due diligence were Harry Jones and Larry Damron from Evanston Hospital, Jack Gilbert and Steve Berger from HPH, as well as Ken Kaufman and Jason Sussman from Kaufman Hall & Associates. (H. Jones, Tr. 4103-04; RX 514 at FTC-KHA 1658). Mark Newton, who testified at trial for Complaint Counsel, was not involved in the financial due diligence and was not a finance person at HPH. (H. Jones, Tr.

4104; Spaeth, Tr. 2282-83). (Soon after the Merger, Newton left ENH to assume a position at Swedish Covenant Hospital, one of ENH's competitors. (Hillebrand, Tr. 2028-29; Newton, Tr. 279).

Response to Finding No. 2339:

Respondent's finding with respect to Mark Newton is misleading and incomplete. Mr. Newton was a senior member of management: his last position at HPH was senior vice-president of business development. (Newton, Tr. 279). He regularly attended HPH's board meetings and finance committee meetings. (Newton, Tr. 285, 289). As a member of the Highland Park executive team, he had knowledge of and was involved in financial issues and discussions. (Newton, Tr. 289).

As for Swedish Covenant Hospital being "one of ENH's competitors," Swedish Covenant is not a price-constraining competitor of ENH. (See CCRFF 389 (f)).

2340. At the conclusion of the due diligence process, Evanston Hospital created a full due diligence report in coordination with various consultants that Evanston Hospital hired to assist with the process. (RX 609; H. Jones, Tr. 4117-18; Hillebrand, Tr. 1903; RX 635 at ENH JH 3979). The due diligence discovered three major issues with respect to HPH: (1) Results from operations in 1999; (2) Facility Code Compliance and Life Safety Issues; (3) Executive Compensation. (RX 609 at EY 8; H. Jones, Tr. 4119; RX 635 at ENH JH 3978).

Response to Finding No. 2340:

Complaint Counsel have no specific response.

2341. The due diligence team determined that the overall financial situation of HPH was "High Risk." (H. Jones, Tr. 4120-21; RX 609 at EY 19; RX 635 at ENH JH 3989; Hillebrand, Tr. 1905). At the time of the due diligence in the Summer of 1999, HPH's earnings were negative and were continuing to trend to greater negative earnings. (H. Jones, Tr. 4093; Kaufman, Tr. 5798-99). HPH's downward financial trend was a problem that needed to be addressed in the Merger transaction discussion process. (Kaufman, Tr. 5798-99).

Response to Finding No. 2341:

Respondent's finding is inconsistent with HPH's internal analyses and projections

at the time. (See CCRFF 2307). As noted previously, ENH had an incentive to portray HPH as financially weak during the pre-merger negotiations stage. (See CCRFF 2336). Mr. Kaufman's 2005 testimony also is directly contradicted by his contemporaneous advice during the beginning of the merger negotiations to HPH that "the financial condition of both parties [was] such that neither require a financial reason" to go forward with the merger and that "at no time should anyone in the community or the media be given that impression." (Kaufman, Tr. 5840; CX 1923 at 2).

2342. During the due diligence, ENH discovered several "materially adverse results" with respect to the condition of HPH. (RX 569 at ENH JH 1215). HPH's 1999 operating results showed that HPH lost \$1,584,000 during the first six months of 1999. (RX 569 at ENH JH 1215). In addition, Lakeland posted non-operating losses of \$405,000 in the first six months of 1999. (RX 569 at ENH JH 1215). Further, expenses were \$3,753,000 unfavorable to budget. (RX 569 at ENH JH 1215).

Response to Finding No. 2342:

Respondent's finding is incomplete. First, the cited source is a letter sent by ENH in the context of merger negotiations and must be viewed in that light. (See CCRFF 2336, 2387). Second, HPH experienced a number of unbudgeted, nonrecurring expenses in 1999 that contributed to a budget variance. (See CCRFF 2320).

2343. Evanston Hospital was concerned that HPH did not have sufficient financial reserves to sustain itself in light of the declining financial situation it was experiencing. (H. Jones, Tr. 4101). In June 1999, Neaman informed the Evanston Hospital Board that "Highland Park must be viewed as a significant turnaround effort with some risks." (RX 557 at ENH GW 4253). Adding HPH's financial condition to the already declining financial condition of Evanston Hospital would be a "tremendous strain" on Evanston Hospital's ability to turn the organization around. (H. Jones, Tr. 4101).

Response to Finding No. 2343:

Respondent's finding is inconsistent with HPH's internal analyses and projections

at the time. (See CCRFF 2307). As noted previously, ENH had an incentive to portray HPH as financially weak during the pre-merger negotiations stage. (See CCRFF 2336). In addition, during the June 1999 board presentation, Evanston management noted that Lakeland Health Services (HPH's parent) was requesting a \$100 million spin-off of LHS assets to establish a post-merger Highland Park Foundation, indicating that Mr. Neaman was not factoring \$100 million of assets available to LHS in his comment about the "turnaround effort." (RX 557 at ENH GW 4253). Respondent's finding at RFF 2345 confirms this exclusion. (See RFF, 2345). Furthermore, at the end of 1999, LHS's long-term debt declined to \$117 million, and cash and unrestricted investments increased to \$260 million. (CX 693 at 16-17).

2344. The HPH financial statements prepared during the due diligence process identified a number of "nonrecurring costs." (H. Jones, Tr. 4181; CX 517 at 4). While a portion of these costs related to Merger-specific items, the majority of the nonrecurring costs identified in the due diligence process were year-end adjustments that needed to be accounted for regardless whether the Merger proceeded. (H. Jones, Tr. 4181). For example, due diligence revealed that the HPH Board passed a new compensation plan in 1999 for its executives that had not been accrued within HPH's financial statements. (H. Jones, Tr. 4119-20).

Response to Finding No. 2344:

Respondent's finding is misleading and incomplete. The new 1999 compensation package for HPH executives is a good example. That package was directly tied to the merger. The accruals for executive compensation were severance agreements related to the merger. (Spaeth, Tr. 2228). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

2347. HPH's financial statements appeared to show that the hospital was making money from operations because the hospital was including investment income into operations. (Kaufman, Tr. 5811). But when HPH's investment income was subtracted from its operating revenue, it shows that the hospital was showing a "significant operating loss." (Kaufman, Tr. 5811).

Response to Finding No. 2347:

Respondent's finding is misleading and incomplete. Other evidence shows that even if, *arguendo*, Respondent is correct that HPH should not count investment income as part of operational income, HPH was making money in the mid to late 1990s.

According to the ENH due diligence report itself, operating income for both LHS and HPH was positive in 1996, 1997, and 1998. (RX 609 at EY 256-57). These figures do not include the pre-merger Highland Park foundation, investment income, or financing and interest payments. (RX 609 at EY 256-57).

2348. The due diligence process revealed that HPH was losing money and was utilizing investment earnings in an attempt to bolster its operating performance. (H. Jones, Tr. 4093, RX 408 at ENHL TH 1509). HPH's financial statements reported investment income "above the operating line," or as part of operating income. (Kaufman, Tr. 5796).

Response to Finding No. 2348:

Respondent's finding that HPH was reporting investment income in "an attempt to bolster its operating performance" is not supported by the cited record. Mr. Jones was an employee of ENH and not part of the pre-merger HPH management team. (H. Jones, Tr. 4088). As Mr. Jones noted about HPH's practice of reporting investment income as part of operating income, HPH's external auditors "signed off on [the practice], so [the auditors] must have been comfortable with that presentation." (H. Jones, Tr. 4094).

Indeed, ENH itself reported investment income as operating income in its audited

financials. (See CCRFF 2349).

2349. Hospital accounting methods and the Hospital Audit Guide suggest that investment income should not have been reported as operating revenue, but rather as nonoperating revenue because investment income is not part of the delivery of patient care services. (H. Jones, Tr. 4093-94). Investment earnings should not have appeared as operating revenue because investment funds are intended to be set aside and reinvested into the hospital. (H. Jones, Tr. 4095-96).

Response to Finding No. 2349:

Respondent's finding inappropriately assigns expert witness weight to the testimony of Mr. Jones, a lay and fact witness. Respondent did not introduce the "Hospital Audit Guide" into evidence, and Mr. Jones' citation to that purported "guide" is inadmissible hearsay evidence. As Mr. Jones acknowledged, HPH's external, independent auditors signed off on HPH's practice of counting investment income in operational income. (H. Jones, Tr. 4094).

Furthermore, ENH also reported investment income, in both the pre-merger and post-merger periods, as part of its operational income. For example, in 1999, ENH counted \$3.3 million in investment earnings as part of its "total unrestricted revenue and other support." (RX 1194 at ENHL TH 001407). In 2000, ENH counted approximately \$12 million of its investment earnings in its operating income; in 2001, \$12 million; in 2002, \$10 million, and in 2003, \$20 million. (RX 1194 at ENH TH 001407; CX 2068 at 6).

2350. The capital lending markets in the healthcare industry do not accept the inclusion of investment income in operating income as a legitimate practice. (Kaufman, Tr. 5811). The practice of reporting investment income as part of operating income was not done in other parts of the healthcare industry. (Kaufman, Tr. 5796).

Response to Finding No. 2350:

Respondent's finding inappropriately assigns expert witness weight to the testimony of Mr. Kaufman, a lay and fact witness. As previously noted, HPH's external auditors approved the practice, and ENH's own audited financial statements also utilized investment income as part of operational income in both the pre- and post-merger periods. (See CCRFF 2349).

2351. To really determine the profit and loss from HPH, the investment income had to be removed from the operating income. (Kaufman, Tr. 5796). Once investment income is removed from the operating income for 1998, it shows that HPH actually lost money from operations. (Kaufman, Tr. 5796; RX 1979 at FTC KHA 2167). The audited financials for HPH show an operating income loss in excess of \$1 million for 1997, and a loss of over \$7 million in 1998 – once investment income is removed from HPH's operating revenue. (RX 408 at ENHL TH 1509, H. Jones, Tr. 4095-96).

Response to Finding No. 2351:

Respondent's finding appropriately assigns expert witness weight to the testimony of Mr. Kaufman, a lay and fact witness. In addition, Respondent's finding of a \$1 million loss in 1997 and a \$7 million loss in 1998 is not supported by the cited evidence.

Respondent's figures are derived for Lakeland Health Services overall, not just for the hospital. In particular, the LHS figures include the operational results for Lakeland Health Ventures, which recorded a loss of \$2.5 million in 1998. (CX 710 at 18). Using the audited results for the hospital standing alone (which also does not include the benefits of the pre-merger Highland Park foundation) and deducting investment income shows that Highland Park had positive operating income of about \$2 million in 1997 (\$8.3 million operating income in 1997 less \$6.5 million in investment income) and a loss of about \$4 million in 1998 (\$3.3 million operating income in 1998 less \$7.4 million in investment income). (CX 413 at 139).

In addition, the financials (RX 514) cited in Respondent's finding RFF 2353 indicate that Lakeland Health Services (HPH's parent) had positive operating income in 1997 and 1998, further contradicting Respondent's contention in RFF 2351 that HPH had negative operating income starting in 1997 when not counting investment income. (RX 514 at FTC KHA 1669).

2352. Pre-Merger Evanston Hospital and post-Merger ENH did not report investment income as part of operating revenue. (H. Jones, Tr. 4096). Instead, ENH reports investment income "below the line" – as part of nonoperating income. (H. Jones, Tr. 4096).

Response to Finding No. 2352:

Respondent's finding is contradicted by the evidence. ENH did report some portions of its investment income as part of its "above the line" operating income in both the pre- and post-merger periods. (See CCRFF 2349). From 2000 to 2003, the investment income totals reported within operating income ranged from \$10 million to \$20 million per year. (RX 1194 at ENH TH 001407; CX 2068 at 6).

2353. Accordingly, the due diligence team requested that Kaufman Hall present HPH's financial information with the investment income reported "below the line," *i.e.* not as part of operating revenue, in an effort to be consistent with Evanston Hospital's financial statements and allow for a more consistent comparison of the two entities' financial statements. (H. Jones, Tr. 4111-12; RX 514 at FTC-KHA 1669).

Response to Finding No. 2353:

As noted previously, both pre-merger Evanston and post-merger ENH counted portions of its investment income as part of its operational income. (See CCRFF 2349). In addition, the financials (RX 514) cited in Respondent's finding RFF 2353 indicate that Lakeland Health Services (HPH's parent) had positive operating income in 1997 and 1998, further contradicting Respondent's contention in RFF 2351 that HPH had negative

operating income starting in 1997 when not counting investment income. (RX 514 at FTC KHA 1669).

b. HPH's Debt Capacity Was Severely Constrained

2354. Kaufman Hall determined that HPH's capital capacity was "insufficient to compete in the changing Chicago marketplace." (Kaufman, Tr. 5789-90). HPH had not been making money from operations for a long period of time. (Kaufman, Tr. 5789-90). Since capital capacity in the non-profit area is developed almost entirely from success in operations, HPH never made enough money to develop any excess capital capacity. (Kaufman, Tr. 5789-90).

Response to Finding No. 2354:

Mr. Kaufman's testimony is vague, incomplete and contradicted by the evidence. According to the ENH due diligence report, both LHS and HPH had positive operating and net margins for 1996, 1997, and 1998. (RX 609 at EY 236, 257). These figures excluded investment income, as well as financing and interest income. The only year of negative operating income and negative net margin for either entity as set forth in the due diligence document is 1999. (RX 609 at EY 236, 257).

2355. In 1998, HPH had a total of \$120 million in long-term debt, which was considered to be a large amount of debt for the hospital. (Kaufman, Tr. 5816; H. Jones, Tr. 4137; Newton, Tr. 441-42; Spaeth, Tr. 2260-61; RX 465 at FTC-KHA 2179). HPH's debt in 1998 exceeded its cash and unrestricted investments by \$3 million. (Kaufman, Tr. 5816; RX 465 at FTC-KHA 2179). During the same time period in 1998, Evanston Hospital, by comparison, had no debt. (RX 518 at ENH GW 2054).

Response to Finding No. 2355:

Respondent's finding is misleading and incomplete. Mr. Kaufman drafted RX 465 (identical to CX 1912) to help justify why Lakeland Health Venture's (HPH's parent) could spin off \$100 million in LHS assets to a new foundation to serve the Highland Park community rather than having ENH take over the assets in the merger. (CX 1912 at 2;

Kaufman, Tr. 5843). All of the financial comparisons made by Mr. Kaufman in that memorandum excluded the \$100 million in assets. (Kaufman, Tr. 5858). Most of these assets were contained in the pre-merger Highland Park Foundation. (CX 710 at 17).

However, both the pre-merger Highland Park Foundation and HPH were part of the "obligated group" that backed the \$120 million in long-term debt. (CX 413 at 120). In other words, these assets together backed the entirety of long-term debt that Respondent now incorrectly attributes entirely to Highland Park Hospital. (Kaufman, Tr. 5844-45).

Respondent misleadingly attempts to place the entire burden of the long-term debt on the hospital without counting any portion of the \$100 million in pre-merger foundation assets that also backed the debt. Respondent claims that HPH's debt in 1998 exceeded its cash and investments position by \$3 million, citing Mr. Kaufman's memorandum. What Respondent neglects to mention is that Mr. Kaufman calculated that LHS (HPH's parent) would have \$102 million left over in "existing cash and investments" to contribute to a post-merger Highland Park Foundation. (CX 1912 at 3; Kaufman, Tr. 5843).

At the end of 1998, Highland Park and its affiliated corporations had a total of \$235.6 million in cash and unrestricted investments. The components of this total were the \$102 million earmarked for the independent, post-merger foundation and \$133.6 million in cash and unrestricted investments that Highland Park planned to contribute to the ENH-Highland Park merger entity. (Kaufman, Tr. 5842, 5844). Thus, at the end of 1998, Lakeland Health Services had an excess of \$115 million in cash and unrestricted investments over long-term debt. This surplus increased in 1999: long-term debt declined

to \$117 million, and cash and unrestricted investments increased to \$260 million. (CX 693 at 16-17).

2356. HPH's large amount of long-term debt "was a big problem." (Kaufman, Tr. 5816). HPH's long-term debt and its debt-to-capitalization ratio meant that HPH's "ability to borrow significant dollars into the future was limited." (Kaufman, Tr. 5816).

Response to Finding No. 2356:

Respondent's finding is misleading and incomplete. Respondent ignores the \$100 million in assets available to the hospital and its affiliated corporations pre-merger, which also backed the overall long-term debt amount of \$120 million at the end of 1998. (See CCRFF 2355).

2357. For not-for-profit hospitals such as HPH, there are really only two sources of investable funds: (1) the money that the hospital makes; and (2) the money that the hospital borrows. (Kaufman, Tr. 5801-02). HPH's revenues were declining significantly as well as the hospital's ability to borrow funds. (H. Jones, Tr. 4093; Kaufman, Tr. 5798-99, 5801-02; RX 1979).

Response to Finding No. 2357:

Respondent's finding is misleading and incomplete. As an initial matter, HPH had an additional source revenue: the funds it received from the pre-merger Highland Park Foundation and the community. Fund raising and donor support were strong, and the donor based was wealthy. (Newton, Tr. 320-21). For example, one fund raising campaign in the 1990s raised more than \$10 million for the development of new surgical suites. (Newton, Tr. 321). Another campaign raised funds for HPH's dialysis center, which was established in 1998. (Styer, Tr. 4959-60).

Highland Park's July 1999 Certificate of Need Application for an open heart surgery program provides a more complete and balanced portrayal of its debt position.

(CX 413 at 1-2, 119). In the application, Highland Park indicated that because assets of both the pre-merger foundation and the hospital backed up its long-term debt, the ratios should be calculated using all the assets. (CX 413 at 120). For the end of 1998, Highland Park calculated a debt service coverage ratio of 2.3 and a debt to capitalization ratio of 46%. (CX 413 at 119). Including the entirety of the obligated group's assets improves the debt service coverage ratio from 1.8 (Mr. Kaufman's figure without the entirety of the assets) to 2.3 (HPH's figure including all the obligated group), a 28% improvement.

(Compare CX 1912 at 1 to CX 413 at 119). In addition, Highland Park projected that by the year 2003, the debt service coverage ratio would improve from 2.3 to 3.1 and the debt to capitalization ratio would improve from 46% to 39%. (CX 413 at 119).

2358. HPH had borrowed money heavily through the 1980s and 1990s in an effort to compete in its service area and as a result had a very high debt/capitalization ratio. (Kaufman, Tr. 5802; RX 1979 at FTC KHA 2172). In 1991, HPH issued \$61.7 million in bonds. (CX 6320 at 1). In 1992, HPH issued bonds for an additional \$30 million that were insured by a financial guaranty insurance company. (CX 6319 at 1, 6). In 1997, HPH issued another \$40 million in bonds, which were again insured by a financial guaranty insurance company. (CX 6321 at 1, 9-10, 36).

Response to Finding No. 2358:

Respondent's finding is misleading and incomplete. As an initial matter, there is no evidence that HPH borrowed "heavily through the 1980s." The debt to capitalization ratio of 61% listed in RX 1979 did not include the entirety of the debt's obligated group. (Kaufman, Tr. 5858). Highland Park in its July 1999 certificate of need application presented far superior debt to capitalization ratios when it did include the entirety of the obligated group's assets, as it said it should do "as indicated in the debt instruments." (CX 413 at 120; *see also* CCRFF 2357).

2359. HPH's debt-to-capitalization in 1998 was 61%, as compared to 33% for A-rated hospitals in 1997. (Kaufman, Tr. 5806; RX 465 at FTC KHA 2179-80). HPH's high debt-to-capitalization percentage was "very high" and is evidence that, by any measure, HPH was "significantly over-leveraged." (Kaufman, Tr. 5802, 5806; RX 465 at FTC-KHA 2179; RX 1979 at FTC KHA 2172).

Response to Finding No. 2359:

Respondent's finding is misleading and incomplete. The 61% debt to capitalization ratio did not include the entirety of the obligated group's assets backing up the debt. (See CCRFF 2357-2358). Including the assets brought the 1998 debt to capitalization ratio down to 46%. (CX 413 at 119).

2360. HPH's decreasing debt service coverage ratio was an indication of the decreasing capital capacity of the hospital. (Kaufman, Tr. 5801-02). The decreasing capital capacity of the hospital was a very important issue for the HPH Board in evaluating the future of the hospital. (Kaufman, Tr. 5801-02).

Response to Finding No. 2360:

Highland Park in July 1999 projected that its debt service coverage ratio would improve from 1998 to 2003, from 2.3 to 3.1. (CX 413 at 119).

2361. HPH's debt service coverage in 1998 was 1.8 as compared to 3.8 for A-rated hospitals in 1997. (Kaufman, Tr. 5805-06; RX 465 at FTC-KHA 2179-80). HPH's debt service coverage ratio in 1997 was "very weak." (Kaufman, Tr. 5805-06; RX 465 at FTC-KHA 2179). The capital markets in the healthcare industry believe that a debt service coverage below 2 is a "significant warning signal" (Kaufman, Tr. 5805-06; RX 465 at FTC-KHA 2179). Debt service coverage is a primary indicator of capital capacity in the healthcare business, and HPH's ratio was trending in the "wrong direction." (Kaufman, Tr. 5801-02; RX 1979 at FTC KHA 2172).

Response to Finding No. 2361:

As explained in greater detail in previous reply findings, Highland Park's debt service coverage indicator, when calculated correctly by Highland Park itself, never fell below 2. (CX 413 at 119; *see also* CCRFF 2357). In addition, Highland Park projected

its debt service coverage ratio would improve from 1998 to 2003, from 2.3 to 3.1. (CX 413 at 119).

2362. The due diligence process revealed that HPH did not issue its own debt based on its credit rating, but rather purchased bond insurance to obtain better rates and guarantee payment to the bond holders. (H. Jones, Tr. 4099). The due diligence discovered that HPH was paying its outstanding debt at interest rates that were 120-230 basis points (1.2% - 2.3%) higher than Evanston Hospital was able to receive. (RX 609 at EY 23; H. Jones, Tr. 4125-26). The higher interest rates translated to approximately \$1-2 million per year in interest payments. (H. Jones, Tr. 4125-26).

Response to Finding No. 2362:

Respondent's finding is irrelevant and misleading. Nothing in the documentary or testimonial citations indicates whether the practice of purchasing bond insurance is an unacceptable practice in the industry or whether such a practice is an indication of financial weakness. Likewise, whether or not Evanston could obtain better financing rates than Highland Park says nothing about Highland Park's absolute financial condition or about what prevailing interests were at the time the particular debt was incurred.

2363. Due to its precarious financial situation, HPH was unable to receive interest rates on its debt similar to what Evanston Hospital was able to achieve. (H. Jones, Tr. 4125-26; RX 609 at EY 23). Lakeland's \$120 million in outstanding debt was "credit enhanced by bond issuers" to AAA rating. (RX 518 at ENH GW 2077). If the debt were held by Lakeland standing alone, the rating would have been lower. (RX 518 at ENH GW 2077).

Response to Finding No. 2363:

Respondent's finding pre-supposes, without evidence, that Evanston and HPH incurred their debt at the same time and should therefore have received identical interest rates. Nothing in the record cited indicates that Highland Park was unable to receive interest rates similar to Evanston due to Highland Park's "precarious financial situation." The fact that Highland Park had obtained higher financing rates for a time is not in itself

an indication of financial weakness. In addition, a relative financial comparison between Evanston and HPH says nothing about HPH's absolute level of financial health.

2364. To account for the "medium risk" associated with HPH's accounts receivables, the due diligence team recommended refinancing HPH's debt to take advantage of the lower interest rates that Evanston Hospital was able to receive as compared to HPH. (RX 609 at EY 23; H. Jones, Tr. 4126). After the Merger, Evanston Hospital was able to refinance all of HPH's debt and obtain a lower interest rate. (H. Jones, Tr. 4126).

Response to Finding No. 2364:

There is no connection in the cited record between the purported status of HPH's accounts receivable and the refinancing of the debt. (See RX 609 at EY 23; H. Jones, Tr. 4126). The due diligence team recommended that ENH "centralize patient billing functions at ENH" to deal with any accounts receivable issue. (RX 609 at EY 23; H. Jones, Tr. 4126).

c. HPH's Cash And Investments Were Insufficient To Compete In The Marketplace

2365. HPH had "very weak capital capacity on the operating side," however they shored up their credit by maintaining significant cash balances. (Kaufman, Tr. 5806; RX 465 at FTC-KHA 2180). In 1998, HPH had 444 days cash on hand, as compared to the median of 186 days cash on hand for A-rated hospitals. (Kaufman, Tr. 5806; RX 465 at FTC-KHA 2180). HPH's 444 days of cash on hand would translate to \$177 million in actual dollars. (Kaufman, Tr. 5807; RX 465 at FTC-KHA 2180).

Response to Finding No. 2365:

Respondent's finding on the "weak capital capacity on the operating side" is misleading, incomplete and incomprehensible as written. Mr. Kaufman never defined what he meant by "capital capacity on the operating side" and, standing alone, the term appears to be meaningless. (See Kaufman, Tr. 5806).

To the extent that the term refers to HPH's operating margins as compared to

other institutions, Respondent's finding is misleading and incomplete. RX 465 is a memorandum prepared by Mr. Kaufman to help justify why HPH's parent could spin off \$100 million in assets to a new post-merger Highland Park foundation rather than having ENH take over the assets in the merger. (RX 465 at FTC KHA 2180; Kaufman, Tr. 5843). All the financial comparisons made by Mr. Kaufman excluded \$100 million in assets. Mr. Kaufman's memorandum attested to HPH's financial health, stating that the HPH board "can be well assured that [ENH-HPH] is receiving an appropriately capitalized partner [in HPH]," despite the exclusion of \$100 million in assets. (RX 465 at FTC KHA 2180).

By contrast, when Highland Park itself calculated debt service ratios and margin percentages in a 1999 certificate of need, it included all the assets that backed the long-term debt of Lakeland Health Services, including the pre-merger foundation assets. (CX 413 at 120). When Highland Park calculated its net margin percentages, it found that net margin percentages were 5.8 in 1996, 8.4 in 1997, and 3.2 in 1998. (CX 413 at 119). Mr. Kaufman only calculated margin percentages for one year, 1998. (RX 465 at FTC KHA 0002179). Because he excluded the \$100 million in assets, he calculated an operating margin of 2.6% in 1998. (RX 465 at FTC KHA 0002179). In addition, HPH pre-merger relied upon its foundation and the community for additional funds. (See CCRFF 2357).

2366. Despite HPH's cash on hand and additional investment money, HPH's funds were still insufficient to meet the competitive challenges of the Chicago marketplace. (Kaufman, Tr. 5806-07; RX 465 at FTC-KHA 2179-80). Although HPH had a considerable amount of money, on a relative basis it in fact was not a lot of money. (Kaufman, Tr. 5806-07; RX 465 at FTC-KHA 2179-80).

Response to Finding No. 2366:

Respondent's finding is misleading. First, Mr. Kaufman is not an expert witness and cannot opine on the capital requirements to meet the "competitive challenges of the Chicago marketplace." In any event, the cited documentary evidence, RX 465, does not support the finding and makes no mention of whether "HPH's funds were still insufficient to meet the competitive challenges of the Chicago marketplace." (RX 465 at FTC-KHA 2179-80). (To the extent that Respondent's finding implies that the Chicago "marketplace" is a relevant market, there is no evidence cited that the alleged market meets the SSNIP test for defining a relevant geographic market.). Indeed, as previously explained, Mr. Kaufman's document explained why the merged entity was receiving "an appropriately capitalized partner," even with Lakeland Health Services spinning off \$100 million in assets for a post-merger Highland Park foundation. (RX 465 at FTC KHA 2180). In addition, HPH pre-merger relied upon its foundation and the community for additional funds. (*See* CCRFF 2357).

2367. HPH's bondholders required that the hospital have cash on hand to secure the bonds. (Spaeth, Tr. 2261). During the 1990s, other than its cash on hand, HPH did not have access to other sources of cash. (Spaeth, Tr. 2261).

Response to Finding No. 2367:

Respondent's finding is not supported by the cited evidence. Mr. Spaeth testified that HPH "did not have access to other types of cash other than having then to go back to a debt market." (Spaeth, Tr. 2261). In other words, if Highland Park required more capital resources, it could look to debt market sources, such as issuing more bonds. Highland Park's bond documents expressly permitted Highland Park to incur "additional indebtedness" subject to certain conditions. (CX 6321 at 10, 133-37). For example, it

could permit additional "funded indebtedness" if the debt service coverage ratio was not less than 1.25. (CX 6321 at 113). At the end of 1998, HPH's debt service coverage ratio stood at 2.3, almost double the 1.25 required. (CX 413 at 119).

Respondent's finding also is misleading. For example, for the 1997 series bond, only 70 days cash on hand was required. (CX 6321 at 19). HPH easily met this requirement. (CX 413 at 119; CX 1912 at 1). In addition, HPH pre-merger relied upon its foundation and the community for additional funds. (See CCRFF 2357).

2368. Kaufman Hall did not recommend that HPH spend its cash on hand or investment dollars because the existence of those funds on the balance sheet was "the only thing that was providing a financial cushion for the hospital to operate in what was becoming an increasingly competitive market." (Kaufman, Tr. 5809). If HPH would have spent either its cash on hand or investment dollars, the hospital "would have nothing at all, because they had no [revenue from] operations." (Kaufman, Tr. 5809). The cash on the HPH balance sheet was the only thing keeping the hospital from mere survival because spending the funds would have removed all financial flexibility from the hospital. (Kaufman, Tr. 5809).

Response to Finding No. 2368:

Respondent's finding is contradicted by the record. Contrary to Mr. Kaufman's testimony that HPH "had no [revenue from] operations," Highland Park had positive operating income for all years in the mid to late 1990s except for 1999. (See CCRFF 2320, 2354). As for the so-called "increasingly competitive market," the alleged increase in competition did not prevent ENH from instituting significant post-merger price increases. (See CCF 392-93).

2369. If HPH had spent down their cash and investments, the hospital's operating results would have declined at an even faster rate because the investment income that was being used by HPH to prop-up the operations at the hospital would no longer be available. (Kaufman, Tr. 5813). HPH was reporting investment income as part of operating revenue in an attempt to bolster its operating performance. (H. Jones, Tr. 4093-94; Kaufman, Tr. 5796; RX 408 at ENHL TH 1509). Using the cash and investments to pay off debt or invest into the hospital would

actually have resulted in a deterioration of the balance sheet because there would be significantly less cash available. (Kaufman, Tr. 5876-77).

Response to Finding No. 2369:

Respondent's finding that HPH deliberately utilized investment income to "prop up" the operations at the hospital is contradicted by other evidence. Mr. Kaufman testified that the accounting practice was one used by HPH's external auditor. (Kaufman, Tr. 5796). Mr. Jones was an employee of Evanston, not HPH. In any event, ENH also reported investment income, in both the pre-merger and post-merger periods, as part of its operational income. (See CCRFF 2349).

Respondent's finding also is incomplete because it implies HPH was contemplating using its cash and investments to pay off debt or make capital investments. HPH's 1999-2004 strategic plan contemplated \$79 million in capital expenditures and \$28 million in strategic/master plan initiatives. (CX 1903 at 1). HPH management believed that the hospital would "generate sufficient cash for the capital plan" without utilizing existing cash and investments. (CX 1903 at 1). Indeed, HPH expected its cash and investments to increase by nearly \$50 million from 1999 to 2004. (CX 1903 at 1).

2370. HPH could have lived off the cash on its balance sheet for a while. But merely surviving was inconsistent with the goals of the HPH Board and management. (Kaufman, Tr. 5875-76). The HPH Board and management believed that they were no longer able to produce the type of hospital they wanted for the Highland Park community. (Kaufman, Tr. 5875).

Response to Finding No. 2370:

Respondent's finding is contradicted by the evidence. Highland Park board and management believed that Highland Park was financially strong in 1999 and would be for the foreseeable future. (See CCRFF 2307). In any event, HPH was a good and strong

community hospital pre-merger. (See CCFF 2295-2323). Financially, HPH pre-merger had a strong balance sheet and could have continued as a stand-alone competitor without the merger. (See CCFF 303-324, 356-367).

d. HPH's Joint Ventures Were Losing Money

2371. The due diligence process also revealed that HPH's joint ventures were a "medium risk" assessment. (RX 609 at EY 25; H. Jones, Tr. 4127). HPH's joint ventures had a projected loss of \$2.5 million for 1999. (RX 609 at EY 25; H. Jones, Tr. 4127).

Response to Finding No. 2371:

Respondent's finding is incomplete and misleading. Lakeland Health Ventures ("LHV"), a for-profit subsidiary of LHS, had a projected net loss of \$2.5 million for 1999. Most of the loss for LHV was attributable to the Lakeland Primary Care Associates and the Highland Park Management Services Organization. (RX 609 at EY 25).

However, the cited record does not indicate that all of LHS's or HPH's joint ventures were contained within LHV (*i.e.*, RFF 2371 assumes, without evidence, that all HPH's joint ventures were in LHV and were, in total, unprofitable.).

There is evidence that not all of HPH's partnerships with other institutions were covered by LHV. Indeed, in 1999, Highland Park Hospital (not LHV or LHS) filed a certificate of need application to develop an open heart surgery program in conjunction with ENH. (CX 413 at 5). The application described the close cooperation, prior to the merger, between ENH and HPH in developing a multi-facility open heart program that would extend ENH's open heart services to the HPH facility. (CX 413 at 5). This cooperative partnership was not described in the "joint ventures and service contracts" section of the due diligence report. (See RX 609 at EY 61-78).

2372. Evanston Hospital did not get involved in many joint ventures because it was outside of Evanston Hospital's core competencies. (H. Jones, Tr. 4127-28).

Response to Finding No. 2372:

Complaint Counsel have no specific response.

2373. HPH, in contrast, became involved in numerous joint ventures and failed to demonstrate that they could successfully and profitably operate the ventures. (H. Jones, Tr. 4127-28; RX 609 at EY 25).

Response to Finding No. 2373:

As previously noted, it appears that LHV did not cover all of HPH's working relationships and partnerships to bring additional services to HPH. (See CCRFF 2371).

Thus, drawing the general conclusion from LHV's losses that all of HPH's joint ventures were unsuccessful and unprofitable is not warranted. In addition, the finding is vague.

There is no indication of how many joint ventures constitute a "numerous" amount.

2374. In 1999, Newton was the chief operating officer of HPH's joint ventures, or Lakeland Health Ventures, Inc. (Newton, Tr. 444-45). At the Lakeland Health Services Board of Directors meeting on August 23, 1999, Jack Gilbert (HPH's former CFO) reported that "[o]perating loss of Lakeland Health Ventures, Inc. was \$1,235,000 compared to a budgeted loss of \$1,114,000." (RX 592A at ENH RS 882; Newton, Tr. 445).

Response to Finding No. 2374:

Respondent's finding is incomplete and misleading. Drawing the general conclusion from LHV's losses that all of HPH's joint ventures were unsuccessful and unprofitable is not warranted. (See CCRFF 2373).

2375. Lakeland Health Ventures had a projected net loss of \$2.5 million in 1999. (RX 569 at ENH JH 1218; RX 609 at EY 25). Lakeland Health Ventures, lost an additional \$2 million in 1999. (Neaman, Tr. 1335).

Response to Finding No. 2375:

Complaint Counsel have no specific response.

e. HPH Made Insufficient Capital Expenditures

2376. Evanston Hospital's due diligence process included an architectural review of HPH. (H. Jones, Tr. 4097-98). The due diligence discovered that HPH immediately required \$15-19 million in "critical facility improvements in order to maintain code compliance, provide for critical life safety measures, mechanical, and electrical requirements." (RX 569 at ENH JH 1215, 1225-26; H. Jones, Tr. 4097-98, 4119). In addition to the numerous critical facility upgrades, there were dozens of "priority facility upgrades" as well. (RX 569 at ENH JH 1225-29).

Response to Finding No. 2376:

Respondent's finding is misleading and incomplete. HPH was a good hospital prior to the merger. (See CCRFF 2295-2323). In addition, HPH had a plan in place to make needed capital investments into its facility and infrastructure. (See CCRFF 2369).

2377. A notice of intent to terminate HPH's Medicare participation was received from HCFA as a result of its deficiencies in facilities. (RX 609 at EY 12).

Response to Finding No. 2377:

Respondent's finding is misleading to the extent that it implies that HPH's Medicare participation was in any real danger. After it received the deficiencies notification, HPH began correcting them prior to the merger and had corrected the vast majority by the end of 1999. ENH corrected the remainder, and the total cost of the repairs was \$922,000. (See CCRFF 1512).

2378. Before the Merger, HPH was tired and old. (Styer, Tr. 4970). HPH had significant deficiencies in its physical plant that limited HPH's capacity to render adequate care and ensure the health and safety of its patients. (Chassin, Tr. 5285-86; RX 545 at ENH JH 11578). Additionally, the equipment in several service areas such as radiology and pathology was old and outdated and in need of replacement. (O'Brien, Tr. 3491, 3508; Chassin, Tr. 5359; Victor, Tr. 3614).

Response to Finding No. 2378:

Respondent's finding is misleading and incomplete. HPH was a good hospital prior to the merger. (See CCFF 2295-2323). In addition, HPH had a plan in place to make needed capital investments into its facility and infrastructure. (See CCRFF 2369).

2379. Before the Merger, HPH was investing in its capital expenditures at an amount equal to its depreciation expense. (H. Jones, Tr. 4098; Kaufman, Tr. 5814). HPH's low level of capital expenditure investment was an indication of insufficient cash flow and reserve assets. (H. Jones, Tr. 4098-99). Reinvesting an amount equal to historical depreciation was insufficient to improve patient care and grow services at HPH and was insufficient to sustain HPH's competitive position over the next five to fifteen years. (H. Jones, Tr. 4099; Kaufman, Tr. 5814-15).

Response to Finding No. 2379:

Respondent's finding is incomplete and misleading. Highland Park management and board (the same "sophisticated business people" referenced in Respondent's Finding 2317) approved of various strategic plans in 1998 and 1999 to maintain Highland Park's run of "strong financial results compared to the median of not-for-profit hospitals." (CX 545 at 3). The 1999-2003 financial plan concluded that "[e]xisting cash and investments are available to fund strategic initiatives and generate new programs." (CX 545 at 3). The financial plan set forth a capital budget that included \$43 million for "strategic initiatives and master plan items," and \$65 million primarily for "[h]ospital construction, routine capital and information technology" investments. HPH also concluded that "[c]ash and investments are forecasted to grow from \$238 million in 1998 to \$323 million in 2003." (CX 1055 at 3). In March of 1999, the Highland Park finance committee "concluded that the organization can remain financially strong for the foreseeable future. (CX 1065 at 3).

2380. A HPH Investment Committee report from 1998 revealed that the hospital was

forced to reduce its spending on capital expenditures because of financial pressures from various sources, including the Balanced Budget Act. (RX 400 at ENH RS 6702).

Response to Finding No. 2380:

Respondent's finding is incomplete and misleading. Strategic plans after this report planned for levels of capital expenditures sufficient to increase cash and investments by approximately \$50 million and reduce long-term debt by almost \$25 million. (CX 1903 at 1).

2381. HPH's five year capital expenditure plan anticipated spending an amount equal to the hospital's depreciation expense on an annual basis for the coming years. (H. Jones, Tr. 4134, 4138; RX 609 at EY 251). HPH's 1997-2001 strategic financial plan anticipated capital expenditures in excess of \$75 million. (Kaufman, Tr. 5825-26; CX 1868 at FTC-KHA 2357). HPH's capital expenditure plan of \$75 million "wasn't going to begin to get at the problems" that were occurring at HPH. (Kaufman, Tr. 5826).

Response to Finding No. 2381:

Respondent's finding is incomplete and inconsistent with a contemporaneous HPH document. In April 1999, HPH management outlined the 1999-2004 strategic plan. (CX 1903 at 1). The plan included \$79 million (as opposed to \$75 million in the 1999-2003 plan) in "routine capital for equipment and facility improvement, construction for renovation of patient care areas, information system enhancements and physician development." (CX 1903 at 1). The plan also included "strategic/master plan initiatives" for the hospital and Lakeland Health Ventures totaling approximately \$28 million. (CX 1903 at 1). From 1999 to 2004, HPH management anticipated debt to decline by \$25 million and cash and investments to increase by approximately \$50 million. (CX 1903 at 1). None of this analysis included the \$100 million in assets that Highland Park planned to spin off for a new post-merger Highland Park community foundation. (CX 1903 at 1).

2382. The 1999-2003 HPH strategic plan included \$65 million in capital expenditures. (CX 96 at 4; Styer, Tr. 5019). The passage of the 1999-2003 strategic plan did not change HPH's need to merge with Evanston Hospital because HPH's capital expenditure needs were far beyond what the 1999-2003 strategic plan could provide and because those needs were immediate in 1999. (Styer, Tr. 5029). Further, the \$65 million included in the 1999-2003 strategic plan was not sufficient to ensure the healthcare needs of the Highland Park community. (Styer, Tr. 5029).

Response to Finding No. 2382:

Respondent's finding is misleading and inconsistent with the evidence. In the 1999-2004 strategic plan, Highland Park planned to invest \$79 million for routine capital expenditures and an additional \$28 million for strategic initiatives. (CX 1903 at 1). At that time, Highland Park management believed that such levels of spending would be sufficient to increase cash and investments and decrease long-term debt levels. (CX 1903 at 1).

Furthermore, HPH's management and board believed that HPH was financially strong pre-merger (*see* CCFF 335-351), and that it could have continued as a stand-alone competitor without the merger. (*See* CCFF 356-367).

2383. During the same time period, ENH was in the midst of a \$350 million capital expenditure plan, which equaled two to three times its depreciation expense. (H. Jones, Tr. 4098, 4138). And HPH's primary competitors, Lake Forest Hospital and Condell, had major expansion plans of their own. (RX 1206 at FTC-LFH 2171).

Response to Finding No. 2383:

As previously noted, Highland Park's management believed that its planned levels of capital spending would be sufficient to maintain its needs. (*See* CCRFF 2382). The characterization of Lake Forest Hospital and Condell as HPH's "primary competitors" is inconsistent with Highland Park's management's belief. They believed that within

HPH's "core" region, "competition is mainly from Lake Forest and Evanston." (RX 363 at FTC-KHA 2349). Evanston and HPH were direct competitors before the merger. (See CCFF 284-301).

2384. The due diligence team thus projected that the investment funds at HPH were insufficient to cover the cost of the work that was needed on the hospital facilities and plant. (H. Jones, Tr. 4137-38). The HPH capital expenditure plan, if carried out, would have nearly depleted HPH's investments by the end of 2003. (H. Jones, Tr. 4133; RX 609 at EY 251).

Response to Finding No. 2384:

Respondent's finding is misleading and inconsistent with the evidence. In the 1999-2004 strategic plan, Highland Park planned to \$79 million for routine capital expenditures and an additional \$28 million for strategic initiatives. (CX 1903 at 1). At that time, Highland Park management believed that such levels of spending would be sufficient to increase cash and investments and decrease long-term debt levels. (CX 1903 at 1). In addition, ENH was in negotiations with HPH on various merger terms, such as the size of the post-merger foundation and amount of assets that Lakeland Health Services would contribute, and ENH had an incentive to highlight purported financial weakness at HPH. (See CCRFF 2336).

2385. The due diligence team prepared projections that illustrated the effect of the HPH capital expenditure plan on HPH's investments. (H. Jones, Tr. 4136-38; RX 603 at KHA 32). The financial projections showed that the HPH capital plan, or "Board Designated Investments," decreased the HPH investments to a balance of \$15 million in 2004 and would have been entirely depleted if projected out one additional year. (H. Jones, Tr. 4136-37; RX 603 at KHA 32). The due diligence team concluded that if there were not significant changes made to HPH's operations, the HPH capital expenditure plan would have driven the hospital out of business. (H. Jones, Tr. 4137).

Response to Finding No. 2385:

Respondent's finding is incomplete, misleading and contradicted by other

evidence. As previously noted, Highland Park management anticipated that it could make sufficient capital investments while increasing cash and investment levels and reducing long-term debt. (See CCRFF 2384). The capital costs would be "funded in the financial plan through existing cash and investments and cash flow." (CX 1903 at 1).

The projections prepared by the due diligence team do not include over \$100 million in assets that HPH planned to spin off to the post-merger foundation. Thus, in the Lakeland Health Services 1999 audited financials, total LHS assets at the end of 1999 were \$358 million (of which \$254 million was "unrestricted investments" and \$5.5 million was "cash and cash equivalents"), which included \$117 million in unrestricted investments in the pre-merger foundation. (CX 693 at 16). By comparison, the due diligence materials estimate "total assets" for 1999 for just the hospital, which, according to the due diligence materials, were \$228.9 million. (RX 603 at KHA 32). Of course, if the merger had not occurred, the assets would have remained in the HPH corporate structure and would have been available for use by HPH. (Kaufman, Tr. 5856).

2386. If HPH had depleted their investments, as was anticipated through their five year capital expenditure plan, the hospital's investment earnings would have decreased significantly, and the hospital would no longer be able to subsidize its operations with investment earnings. (H. Jones, Tr. 4139). HPH was utilizing its investment earnings to subsidize its operations. (H. Jones, Tr. 4139).

Response to Finding No. 2386:

Respondent's finding is incomplete, misleading and contradicted by other evidence. The finding also is supported only by the self-serving testimony of an ENH employee. As previously noted, Highland Park management anticipated that it could make sufficient capital investments while increasing cash and investment levels and

reducing long-term debt. (See CCRFF 2384). The capital costs would be “funded in the financial plan through existing cash and investments and cash flow.” (CX 1903 at 1).

The due diligence projections also did not include the impact of the approximately \$100 million in foundation assets, which were excluded from the analysis. (See CCRFF 2385).

f. HPH’s Collection Rates/Accounts Receivable Were Declining

2387. The due diligence team also reviewed the accounts receivable performance at HPH and determined it to be a “medium risk” area. (RX 609 at EY 23; H. Jones, Tr. 4123-24). The due diligence process discovered that HPH’s cash position was “substantially overstated.” (RX 429 at FTC-KHA 995). HPH had credit balances of \$2.6 million over 270 days and may have had “legal issues” associated with the long-standing credit balances. (RX 429 at FTC-KHA 995). Evanston Hospital interpreted those numbers to mean that there was not enough attention or resources available to collect on HPH’s accounts. (RX 429 at FTC-KHA 996).

Response to Finding No. 2387:

As an initial matter, findings based on ENH’s due diligence on HPH must be viewed with caution. ENH and HPH were engaged in negotiations in 1999 over a number of issues, and ENH had an incentive to portray HPH as financially weak. (See CCRFF 2336).

Respondent’s finding also is misleading and incomplete in that it does not discuss the reasons behind the credit balances issue nor the steps taken by HPH to address the issue. HPH management addressed the issue of credit balances in a memorandum to ENH. (CX 517 at 1). HPH explained that it went through a “major systems conversion [of the Meditech computer system] effective May, 1999.” As a result, its accounts receivables increased due to HPH’s “efforts to insure the accuracy of billings and the diverting of staff resources to the conversion effort.” By September 1999, HPH had reduced unbilled accounts receivable significantly. It did not believe that there was any

legal exposure related to the credit balances. (CX 517 at 1).

During the systems conversion, HPH experienced current accounts receivable increases. To address this issue, HPH provided for additional reserves, turned over the pre-conversion accounts to a collection agency, and began focusing on post-conversion account collections. HPH noted that cash flow had increased, and it believed reserves were adequate. HPH offered to share the results of the analysis with ENH's external auditors, Ernst & Young. (CX 517 at 1).

2388. The due diligence report highlighted that HPH's gross collection rates decreased from 64.6% in 1996 to 55.1% through June of 1999. (RX 609 at EY 19). The Evanston Hospital due diligence team observed a downward trend in the amount of money HPH was collecting from MCOs. (H. Jones, Tr. 4123).

Response to Finding No. 2388:

Respondent's finding is incomplete. The increase in unbilled charges was due to the internal Meditech conversion. (See CCRFF 2387). By September 1999, the relevant indicators had improved, and HPH anticipated no further problems. (CX 517 at 1).

2389. The due diligence found that gross unbilled charges at HPH had increased from \$5.3 million in 1997 to \$8.6 million in June of 1999. (RX 609 at EY 23; H. Jones, Tr. 4124). In conjunction with HPH's change to the Meditech billing system, the hospitals unbilled charges had increased from \$5.3 million in 1997 to \$8.6 million in 1999. (H. Jones, Tr. 4124; RX 609 at EY 23; RX 569 at ENH JH 1218). HPH's unbilled charges was determined to be a risk because the longer it took for a bill to be processed, the likelihood that the bill will be paid decreases. (H. Jones, Tr. 4124-25).

Response to Finding No. 2389:

As described above, and as noted in Respondent's finding, HPH attributed the increase in unbilled charges to the internal Meditech conversion. (See CCRFF 2387). By September 1999, the relevant indicators had improved, and HPH anticipated no further

problems. (CX 517 at 1).

2390. HPH's financial condition was affected by administrative matters that required "immediate attention." (RX 569 at ENH JH 1218). Provision for bad debt at HPH increased by \$1.6 million in the first six months of 1999. (RX 569 at ENH JH 1218).

Response to Finding No. 2390:

Respondent's finding is misleading and incomplete. First, the cited source is a letter sent by ENH in the context of merger negotiations and must be viewed with caution. (See CCRFF 2336, 2387). Second, HPH raised bad debt provisions due to a one-time, major information system conversion. (See CCRFF 2387).

2391. HPH's accounts receivable was a cause for concern as Evanston Hospital weighed the Merger. (RX 429 at FTC-KHA 996). HPH's inpatient unbilled charges of \$3.2 million was "unusually high." (RX 429 at FTC-KHA 996). At the time, Evanston and Glenbrook Hospitals' accounts receivables totaled only \$1.3 million. (RX 429 at FTC-KHA 996). HPH's accounts receivable days were "high and rising" from 88 days at HPH, as compared to 50 days at ENH. (RX 569 at ENH JH 1219).

Response to Finding No. 2391:

Respondent's finding is misleading and incomplete. First, the cited source is a letter sent by ENH in the context of merger negotiations and must be viewed with caution. (See CCRFF 2336, 2387). Second, HPH's issues with accounts receivables were due to a one-time, major information, system conversion. (See CCRFF 2387).

2392. The due diligence also discovered that HPH's credit balances increased from \$1 million in 1997 to \$3.1 million in June of 1999, meaning that HPH owed Medicare and patients \$3.1 million in refunds for duplicate payments. (RX 609 at EY 23; H. Jones, Tr. 4125). The amount that HPH owed for duplicate payments tripled from 1997 to 1999. (H. Jones, Tr. 4125).

Response to Finding No. 2392:

Respondent's finding is misleading and incomplete. First, the cited source is a letter sent by ENH in the context of merger negotiations and must be viewed with

caution. (See CCRFF 2336, 2387): Second, HPH's issues with accounts receivables were due to a one-time, major information, system conversion. (See CCRFF 2387).

g. Due Diligence Revealed That HPH's Future Financial Projections Were Unrealistic

2393. HPH's future financial projections were inconsistent with HPH's historical trend line. (H. Jones, Tr. 4112; RX 514 at FTC-KHA 1669). Despite HPH's declining trend line, HPH "thought that somehow they were going to reverse that trend." (H. Jones, Tr. 4112; RX 514 at FTC-KHA 1669). But the HPH future financial projections were unrealistic. (H. Jones, Tr. 4097).

Response to Finding No. 2393:

Respondent's finding is misleading. ENH's contentions about HPH's future financial projections were made in the context of merger negotiations and must be viewed with caution. (See CCRFF 2336, 2387).

Furthermore, in October 1999, HPH management based year 2000 projections on the fact that 1999 operating income would be negative and below budget. (CX 397 at 1). HPH set forth a number of remedial steps to address the issues it faced in 1999 and bring operating income positive once again. (CX 397 at 3-4).

2394. The HPH due diligence financial projections prepared in coordination with Kaufman Hall showed that HPH's "Excess of Revenue over Expenses from Operations," or operating revenue, decreased from \$4 million in 1997, to approximately \$317 thousand in 1998. (RX 514 at FTC-KHA 1669; Kaufman, Tr. 5834-35). HPH's financials projected a loss of \$793,000 in 1999, a loss of \$868,000 in 2000, and a slow but gradual return to profitability in 2001-2004. (RX 514 at FTC-KHA 1669; Kaufman, Tr. 5834-35). The actual financial results of HPH, however, were not supporting the hospital's projections that the financial situation was going to turn around in the future. (H. Jones, Tr. 4121).

Response to Finding No. 2394:

Respondent's finding that HPH's actual results did not support the projections is misleading and incomplete. In the cited testimony, Mr. Jones identified the "actual"

results as covering the first half of 1999. In other words, Mr. Jones raised a concern because HPH's first half 1999 results did not meet its budgeted expectations. (H. Jones, Tr. 4121). As HPH explained to ENH, much of this shortfall was due to "one-time, nonrecurring (and unbudgeted) items." (CX 517 at 1). Thus, focusing on first half 1999 results presents a distorted picture of HPH's "actual" performance.

2395. HPH, in coordination with Kaufman Hall, projected a "downward trend" and "on a going forward basis, [HPH] just didn't expect to be doing very well." (RX 514; Kaufman, Tr. 5834-35).

Response to Finding No. 2395:

The cited document (RX 514) does not set out a "downward trend" in income. In the document, net operating income increases from a \$793,000 loss in 1999 to a \$2.552 million profit by 2004. (RX 514 at FTC KHA 1669). Although the projected 2004 net income level is still below the net income figure for 1997, this same trend can be seen in the ENH projections. (RX 514 at FTC KHA 1665). In the ENH projections, net income for 1997 also was significantly higher than projected net income for 2000 through 2004. (RX 514 at FTC KHA 1665).

2396. As the due diligence process continued into the Summer of 1999, HPH's actual financial results were significantly below what the HPH projections illustrated. (H. Jones, Tr. 4113). In addition, the due diligence process identified capital costs required for critical improvements to the HPH facility as well as unrecorded executive compensation packages that were not taken into account within HPH's financial projections. (H. Jones, Tr. 4113).

Response to Finding No. 2396:

Respondent's finding is misleading and incomplete. ENH's contentions about HPH's future financial projections were made in the context of merger negotiations and must be viewed with caution. (See CCRFF 2336, 2387). In addition, much of the

shortfall in 1999 was attributable to one-time, nonrecurring expenses. (See CCRFF 2320). Finally, the accruals for executive compensation were severance agreements related to the merger and would not have occurred but for the merger. (Spaeth, Tr. 2228); (See also CCRFF 2344).

2397. As the due diligence process continued, the due diligence team worked to revise the initial financial projections and create a set of more "realistic" projections for the combined organizations. (H. Jones, Tr. 4113-14, 4116; RX 514; RX 603). The revised financial projections for HPH show the hospital's operating revenue declining from approximately \$1.8 million in 1997, to negative \$3.4 million in 1998, negative \$19 million in 1999 and remaining in the negative for the foreseeable future with a negative \$37 million in 2004. (RX 603 at KHA 31).

Response to Finding No. 2397:

Respondent's finding is misleading. ENH's contentions about HPH's future financial projections were made in the context of merger negotiations and must be viewed with caution. (See CCRFF 2336, 2387). There also is nothing in evidence that reveals the assumptions made by ENH in revising the projections to make them more "realistic." Knowledge of these assumptions is particularly critical given that ENH would benefit in merger negotiations from more pessimistic financial projections for HPH.

2398. HPH's financial projections were based on a set of assumptions that were more aggressive than its actual historical performance. (RX 539 at DC 7657). For instance, HPH's actual 1996 to 1998 volume as measured by discharges decreased by 1%, yet HPH's 1999 to 2004 projections assumed 1.2% growth. (RX 539 at DC 7657). While HPH's actual 1996 to 1998 average length of stay was 1.2%, its projections assumed only .7%. (RX 539 at DC 7657). Similarly, while net revenue per patient day decreased by .2% from 1996 to 1998, HPH projected that it would increase 1.7% from 1999 to 2004. (RX 539 at DC 7657).

Response to Finding No. 2398:

The fact that HPH's projected that its strategic initiatives and growth plans would improve its performance beyond its most recent years is not surprising. Indeed, ENH's

own financial projections showed that ENH's operating net income had declined from \$25 million in 1997 to \$9 million in 1999. (RX 514 at FTC KHA 1665). Based upon that negative historical performance alone, ENH should be expected to make less net income in subsequent years. However, ENH projected a slight recovery in 2000 to 2004. (RX 514 at FTC KHA 1665).

2399. Astoundingly, while HPH's operating income was actually decreasing by 45% from 1996 to 1998, HPH projected that it would increase 34% from 1999 to 2004. (RX 539 at DC 7657).

Response to Finding No. 2399:

ENH likewise projected increasing operating income from 2000 onward for itself despite declining income in previous years. (See CCRFF 2398).

2400. As a result, ENH re-calibrated HPH's projections using "more reasonable" assumptions as to HPH's financial position in light of its historical experience. (RX 539 at DC 7658; RX 609 at EY 37). Using the more reasonable assumptions, ENH projected that HPH was on a downward trend in operating income that would continue to worsen as time passed. (RX 539 at DC 7659). While losses would be \$.6 million in 2000, by 2004 the losses would be \$9.1 million in operations. (RX 539 at DC 7659). The due diligence document projected that operating losses could exceed \$20.9 million by 2002. (RX 609 at EY 38).

Response to Finding No. 2400:

Respondent's finding is misleading and incomplete. ENH's contentions about HPH's future financial projections were made in the context of merger negotiations and must be viewed with caution. (See CCRFF 2336, 2387). ENH itself experienced declining operating income from 1997 to 1999 but projected increases in its operating income despite that decline. (See CCRFF 2398). Furthermore, HPH in October 1999 set a plan in place recognizing the operating loss in 1999 and setting forth remedial steps to bring HPH back to a positive operating income by 2000. (See CCRFF 2393).

Finally, Respondent's finding is inaccurate. The plan does not state that HPH had to take the steps outline in order "to survive" as RFF 2401 indicates. It simply states that "HPH must continue to expand its revenue base and develop current product lines while maintaining cost controls." (RX 363 at FTC-KHA 2357). Respondent's finding is also misleading and incomplete. ENH's contentions about HPH's future financial projections were made in the context of merger negotiations and must be viewed with caution. (See CCRFF 2336, 2387). ENH itself experienced declining operating income from 1997 to 1999 but projected increases in its operating income despite that decline. (See CCRFF 2398). Furthermore, HPH in October 1999 set a plan in place recognizing the operating loss in 1999 and setting forth remedial steps to bring HPH back to a positive operating income by 2000. (See CCRFF 2393).

2401. The 1999-2002 Lakeland Strategic Plan stated that HPH's "long range financial plan anticipates operating margins to decrease over the next several years." (RX 363 at FTC-KHA 2357). The Plan also stated that HPH's cash flows would be positive between 1997 and 2001, but primarily because of returns from investments. (RX 363 at FTC-KHA 2357). Moreover, the Plan stated that "[g]reater returns must be achieved through operations." (RX 363 at FTC-KHA 2357). Finally, the Plan concluded that, for HPH to survive, it had "to continue to expand its revenue base and develop current product lines while maintaining cost control." (RX 363 at FTC-KHA 2357). Lakeland's 1999-2002 Strategic Plan itself stated that it was "linked to the organization's long term financial plan and annual operating and capital budgets." (RX 363 at FTC-KHA 2349).

Response to Finding No. 2401:

Respondent's finding is incomplete. The 1999-2002 strategic plan also outlined a number of strategies to "increase market share" from the 1997 level of 9.0% to 15% by 2002. (RX 363 at FTC KHA 2358. See also CX 92 at 2 (increase market share from 9.2% to a targeted 12%); Spaeth, Tr. 2124-25). In addition, HPH could have continued as

a stand-alone competitor without the merger and was also an attractive candidate for mergers with other institutions. (See CCF 356-372).

2402. In 1999, HPH was budgeted to make an operating gain but, in reality, was headed for an operating loss. (Neaman, Tr. 1257). HPH's operating finances deteriorated substantially in 1999, despite HPH having predicted a profit. (Neaman, Tr. 1332-33). HPH had a very high accounts receivable along with rising debt and strained credit. (Neaman, Tr. 1333).

Response to Finding No. 2402:

Respondent's finding is incomplete and misleading. As previously discussed, HPH experienced a number of one-time, nonrecurring costs in 1999. (See CCRFF 2321). Without these costs, HPH would have had a positive net income result in the ten months ending July 1999. (See CCRFF 2321). In addition, the 1999 information system conversion led to high accounts receivable balances, and HPH had successfully begun dealing with the issue by September 1999. (See CCRFF 2387).

2403. During the due diligence period, ENH concluded that "[i]f LHS [*i.e.*, Lakeland] continues to operate as it historically has, ENH management expects LHS to experience operating losses over the next several years." (RX 435 at DC 7498). In fact, the due diligence showed that ENH management expected that LHS would experience operating losses of \$.6 million in 2000, \$2.5 million in 2001, \$4.5 million in 2002, \$6.6 million in 2003 and \$9.1 million in 2004. (RX 435 at DC 7498).

Response to Finding No. 2403:

Respondent's finding is misleading. ENH's contentions about HPH's future financial projections were made in the context of merger negotiations and must be viewed with caution. (See CCRFF 2336, 2387). ENH itself experienced declining operating income from 1997 to 1999 but projected increases in its operating income despite that decline. (See CCRFF 2398).

2404. ENH management also concluded that "[u]nder [ENH's] Baseline Scenario, LHS

would be expected to have negative cash from operations, thus requiring significant investment income to maintain liquidity.” (RX 435 at DC 7499).

Response to Finding No. 2404:

Respondent’s finding is misleading. ENH’s contentions about HPH’s future financial projections were made in the context of merger negotiations and must be viewed with caution. (See CCRFF 2336, 2387). ENH itself experienced declining operating income from 1997 to 1999 but projected increases in its operating income despite that decline. (See CCRFF 2398).

In any event, LHS always had positive cash from operations. In 1997, LHS had \$20.2 million in positive cash from operations (CX 710 at 6); in 1998, almost \$17.0 million (CX 1732 at 6), and in 1999, almost \$13.5 million (CX 1732 at 6).

5. Expert Testimony Confirms The Significance Of HPH’s Declining Financial Condition

2405. Based on an independent review of HPH’s financial statements and a review of the record evidence, Dr. Noether concluded that HPH was in substantially weakened financial condition after the Merger and that had it remained independent, such a scenario would have limited its competitive significance in the market. (Noether, Tr. 5902, 6027).

Response to Finding No. 2405:

Respondent’s finding is contradicted by other evidence. HPH management believed that HPH was financially strong. (See CCRFF 2307. See CX 1055 at 3). In addition, Dr. Noether relied upon Ken Kaufman’s testimony as a basis for her conclusions about HPH’s purported financial weakness. (Noether, Tr. 6027). Mr. Kaufman, in contemporaneous writings at the time of the merger, noted that “the financial condition of both parties [was] such that neither require a financial reason for such an affiliation.”

(CX 1923 at 2; *See* CCRFF 2307). HPH could have continued as a stand-alone competitor without the merger. (*See* CCF 356-367).

2406. HPH's cash flow before the Merger fluctuated somewhat from year-to-year, but "in general, it was not generating substantial cash flow." (Noether, Tr. 6034). Given the \$100 to \$200 million of capital investments that HPH needed to make, it was not generating sufficient cash to be able to make the necessary investments. (Noether, Tr. 6033-34).

Response to Finding No. 2406:

Respondent's finding is misleading and contradicted by other evidence. The first year HPH generated a loss was 1999. All other years prior to that had a positive operating margin. (*See* CCRFF 2320). Even in 1999, cash flow from operations for LHS was a positive of almost \$13.5 million. (CX 1732 at 6).

At the time of the merger negotiations, Mr. Kaufman wrote that "the HPH forecasted financial statements clearly demonstrate that HPH can support [certain capital expenditures totaling \$47 million] from ongoing operations and that a contribution of cash would not be required." (CX 1905 at 4). HPH's strategic plan anticipated that it would not need to dip into its cash and investments pool of assets to fund over \$100 million in capital investments. (*See* CCRFF 2369).

2407. Particularly given the expansion effort and capital expenditures that were being made by neighboring hospitals, HPH's financial condition would not have allowed it to "keep up" with what the competition was doing. (Noether, Tr. 6026-27).

Response to Finding No. 2407:

Respondent's finding, which only has Dr. Noether's testimony as support, is speculative and not supported by the record evidence. Dr. Noether's conclusions about HPH "keeping up" with other hospitals were based on testimony from Harry Jones and

Ken Kaufman as well as the due diligence information. (Noether, Tr. 6027). However, neither Mr. Jones nor Mr. Kaufman addressed this issue in admissible testimony. (Jones, Tr. 4084-4192; Kaufman, Tr. 5772-5881). The Court specifically struck Mr. Kaufman's testimony when he attempted to describe the impact of capital investments by other hospitals. (Kaufman, Tr. 5826-27). With respect to the due diligence report, there is also no mention in the report of activities by other hospitals in the Chicago area and their capital investments or competitive significance. (*See, generally, CX 1720*).

2408. HPH had negative \$11.3 million in operating income in 1999. (Noether, Tr. 6179-80). Any suggestion that certain costs characterized as Merger-related costs were the cause of the downturn in HPH's operating income is misguided because evidence suggests that many of these costs would have been incurred even absent the Merger. (Noether, Tr. 6031, 6180-81, 6207). Even if these costs were excluded from the analysis, HPH still would have reported an operating loss of around \$3 million. (Noether, Tr. 6207).

Response to Finding No. 2408:

Respondent's finding is not supported by the record evidence. Dr. Noether relied upon testimony of Mr. Hillebrand and Mr. Jones who purportedly concluded that the merger-related costs would have occurred without the merger. (Noether, Tr. 6206-07). However, Complaint Counsel was unable to locate any testimony from either of these witnesses making that contention. { [REDACTED]

[REDACTED]

[REDACTED] } (Spaeth, Tr. 2327, *in camera*).

2409. Although HPH had made some projections that suggested it would be able to reverse the downward operating income trend, the Merger due diligence team concluded that these projections were unrealistic in light of the passage and impact of the Balanced Budget Act and the stock market decline in 2000. (Noether, Tr. 6031).

Response to Finding No. 2409:

Respondent's finding is inaccurate and not supported by the record evidence. The merger closed on January 1, 2000, and the due diligence team had completed its work by September 1999. (CX 1720 at 1). There was no way the due diligence team could have considered the impact of the purported stock market decline in 2000. In addition, ENH's contentions about HPH's future financial projections were made in the context of merger negotiations and must be viewed with caution. (See CCRFF 2336, 2387).

2410. Dr. Noether weighed HPH's future cash needs against its sources of cash. (Noether, Tr. 6028). HPH needed cash for three primary reasons: (1) to fund operations; (2) to make necessary capital expenditures in the range of \$100 to \$200 million; and, (3) to pay off its debt of \$115 million. (Noether, Tr. 6035). Although HPH had a significant amount of cash on its balance sheet, it had only enough cash to meet two of its three pressing needs for cash. (Noether, Tr. 6035).

Response to Finding No. 2410:

Respondent's finding is misleading and contradicted by the record evidence.

HPH management had a plan in place to make necessary capital investments (totaling \$100 million over 2000-2004) as well as service its debt. (See CCRFF 2406). The debt was amortized on a payment schedule that stretched to 2026; there was of course no need to pay it off in one lump sum. (See, e.g., CX 6321 at 34 (setting forth payment schedule for certain of HPH's bond issues)). Neither HPH management nor Mr. Kaufman believed that HPH had to dip into its cash and investments assets to fund operations. (See CCRFF 2406).

2411. HPH also had a "substantial" amount of debt, approximately \$115 million in 1999. (Noether, Tr. 6034). HPH needed cash to service that debt. (Noether, Tr. 6034). HPH's precarious financial condition is further evidenced by the fact that HPH took out debt insurance to lower the interest rate that it had to pay on its debt. (Noether, Tr. 6036).

Response to Finding No. 2411:

Respondent's finding on the amount of debt is incomplete. At the end of 1999, Lakeland Health Services had long-term debt of \$117 million (CX 693 at 17) and cash and unrestricted investments of \$260 million (CX 693 at 16 (\$254 million in "unrestricted investments" and \$5.5 million in "cash and cash equivalents")), for an excess of \$140 million in cash and investments over long-term debt. (See also CCRFF 2355).

Respondent's finding on debt insurance is irrelevant. Nothing in the documentary or testimonial citations indicates whether the practice of purchasing bond insurance is an unacceptable or imprudent practice in the industry or whether such a practice is an indication of financial weakness.

2412. Dr. Noether's analysis concluded that HPH was likely to get even weaker without the Merger and that, in the long run, HPH would have a hard time meeting its cash needs. (Noether, Tr. 6028-29).

Response to Finding No. 2412:

Respondent's finding is based on vague and incomplete record evidence. To reach her conclusions that HPH "was likely to get even weaker without the merger," Dr. Noether "looked at various financial metrics for [HPH] in 1999 and in the years leading up to it, namely operating income, operating cash flow, also looked at the balance sheet of [HPH]." (Noether, Tr. 6028). Dr. Noether also looked at the due diligence analysis and "other statements about [HPH]." (Noether, Tr. 6028).

With respect to the due diligence information, ENH's contentions about HPH's future financial projections were made in the context of merger negotiations and must be viewed with caution. (See CCRFF 2336, 2387). With respect to operation trends and HPH's balance sheet, HPH had a strong balance sheet with an excess of \$140 million in

cash and investments over long-term debt. (CX 693 at 16-17). HPH experienced operating income losses for the first time in 1999, and formulated a strategic plan to increase operating income from 2000-2004. (See CCRFF 2406). HPH management and board believed that HPH could “remaining financially strong over the foreseeable future.” (CX 1055 at 3. See CCRFF 2307). They did not believe that the merger with Evanston was financially necessary. (See CCRFF 2309).

2413. Dr. Haas-Wilson did not undertake an analysis of the financial condition of HPH before the Merger. (Haas-Wilson, Tr. 2441; Noether, Tr. 6027). As a result, Dr. Haas-Wilson did not offer an opinion on the pre-Merger financial condition of HPH. (Haas-Wilson, Tr. 2441).

Response to Finding No. 2413:

Respondent’s finding is incomplete. Dr. Haas-Wilson did not offer an opinion on the pre-merger financial condition of HPH, but HPH’s former chairman of the board, Neele Stearns, did. Mr. Stearns testified that he believed that HPH was not in danger of exiting the market for at least ten years. (CX 6305 at 5 (Stearns, Dep.)). The HPH board and management believed that HPH “can remain financially strong over the foreseeable future.” (CX 1055 at 3; Newton, Tr. 432-34; Spaeth, Tr. 2147. See also CCFF 335-51).

C. ENH’s Not-For-Profit Status Is Relevant To The Competitive Effects Analysis

1. Not-For-Profit Status Plays A Role In Hospital Pricing

2414. Not-for-profit hospitals, like ENH, reinvest their revenue into the hospitals. (CX 6304 at 11 (Livingston, Dep.)). Revenue earned by a not-for-profit hospital, like ENH, does not leak out of the hospital system in any way at all. (CX 6304 at 12 (Livingston, Dep.)).

Response to finding No. 2414:

The finding is misleading, because it implies, incorrectly, that the excess revenue

gained through the market power resulting from the merger went for medical purposes. Surplus resulting from supra-competitive prices can be used to benefit hospital executives rather than consumers. (Simpson, Tr. 1649). Following the Evanston and Highland Park merger, ENH's compensation contracts did not align management's interests with consumers on the issue of price. (Simpson, Tr. 1629).

In fact, 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. (Neaman, Tr. 1263-64; CX 31 at 1). Furthermore, ENH's managers were given bonuses for meeting revenue targets from operations. (Simpson, Tr. 1629, 1630). Additionally, shortly before the Letter of Intent to Merge was signed, Highland Park senior executives entered into enhanced compensation agreements that "offered additional retention bonuses as well as enhanced severance agreements" at a cost of \$8 million. (CX 534 at 3). Several of ENH's senior executives received merit increases in their salaries in the range of 5-6% in 1998 to 1999 and another salary increase of 10% from the fall of 2000 to the fall of 2001. (Neaman, Tr. 1265-67; CX 2099 at 2-3).

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).

2415. For example, HPH's management and its Board took the hospital's not-for-profit status into account when determining its pricing and profit approaches. (Newton, Tr. 473). HPH's management philosophy was to be careful about not overcharging the community for healthcare because HPH was responsible for healthcare in the community. (Newton, Tr. 473). As a not-for-profit hospital, and as an asset of the community, HPH kept its price increases

appropriate to give the community a level of care that the community appeared to need. (Spaeth, Tr. 2180-81).

Response to finding No. 2415:

The testimony cited in this finding refers to HPH's pre-merger behavior. Post-merger, ENH's not-for-profit status did not affect its approach to price increases. ENH did in fact raise prices, and this was entirely consistent with the incentives that the board had given the management. (Haas-Wilson, Tr. 2500-01; Simpson, Tr. 1629-30. *See, e.g.* CCRFF 335). Furthermore, when ENH set prices for the 2000 contract renegotiations 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). 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). ENH decided to take whichever was the more profitable of the two hospital contracts and chargemaster rates for the particular health plan and to apply those rates across the board for the post-merger entity. (*See, e.g.* CCF 884-895). In addition to choosing the higher of the Highland Park and Evanston contract rates, ENH senior management decided to add a premium, and ENH repeatedly increased the chargemaster rates after the merger. (*See, e.g.*, CCF 848-852, 918-924).

2. The Opinions Of Complaint Counsel's Not-For-Profit Expert Support The Fact That ENH, As A Not-For-Profit Entity, Acts Differently Than A For-Profit Entity

2416. Economic theory does not necessarily predict that a not-for-profit hospital would try to maximize profits. (Simpson, Tr. 1646).

Response to finding No. 2416:

The finding is incomplete. *See* CCRFF 336 discussing the fact that the theory by

Drs. Lynk and Neumann requires that the board set up a mechanism to ensure that the not-for-profit hospital sets the price at basically the competitive level, which was not the case here. (Simpson, Tr. 1622, 1629) (The ENH board did not actively monitor the pricing decisions of hospital management and “did not try to ensure that price was set at basically the competitive level.”).

Furthermore, Respondent neglects to mention that Dr. Simpson also testified that economic studies do support the view that not-for-profit hospitals exercise market power. (Simpson, Tr. 1621). Four peer-reviewed studies performed by four different sets of researchers and using four different research methods found that hospitals tend to exploit market power and that not-for-profit hospitals in concentrated markets set higher prices than in less concentrated markets. (Simpson, Tr. 1624-25). An additional case study, involving a merger of not-for-profit hospitals, that was done by a different set of researchers, using a different methodology, also found that not-for-profit hospitals exercised market power. (Simpson, Tr. 1627-28). The two studies finding that not-for-profit hospitals tend not to exploit market power were both performed by Dr. Lynk and used different data sets and a different analysis structure from the four studies finding that hospitals do tend to exploit market power. (Simpson, Tr. 1625-27).

2417. The decision to open a new service not in the hospital where it would be most profitable, but in the hospital that would best benefit the community, is evidence that the hospital system is not acting like a profit-maximizing firm. (Simpson, Tr. 1633).

Response to finding No. 2417:

The finding is incomplete. Respondent neglects to mention that Dr. Simpson also said that a not-for-profit hospital could both exploit market power and do some good

things for a community. (Simpson, Tr. 1648-49). For example, a not-for-profit hospital might set prices above a competitive level, and that would generate a surplus, which could be used in part for charity care, and in part for things that people might view as wasteful. (Simpson, Tr. 1648-49).

2418. After the Merger, ENH elected to open a comprehensive adolescent psychiatry center at HPH, not because it was profitable, but because it would benefit the community. (RX 1754 at ENH RS 3091; Neaman, Tr. 1358). Before the Merger, adolescent patients at HPH in need of psychiatric services were treated in a "mixed adult and adolescent facility." (RX 1754 at ENH RS 3086; Neaman, Tr. 1358). Treating adolescents in such an environment with adult psychiatric patients did not meet minimal Medicare standards. (RX 1754 at ENH RS 3085; Neaman, Tr. 1358-59). Rather than consolidate all psychiatric services at Evanston Hospital, a consolidation that would have been more profitable, ENH elected to create dedicated adolescent and adult psychiatric centers that benefit both patients and the community. (RX 1754 at ENH RS 3091; Neaman, Tr. 1358-59).

Response to finding No. 2418:

The creation of the adolescent psychiatry center is irrelevant to whether the hospital abuses market power. (See CCRFF 2417) Respondent has provided no evidence that this change in psychiatric services was less profitable. Furthermore, in creating the adolescent psychiatry center, Respondent took the adolescent services away from Evanston and moved them to Highland Park. (O'Brien, Tr. 3516-17; Neaman 1358-59). Pre-merger, Evanston and HPH both had inpatient units for adults and adolescents. (O'Brien, Tr. 3516). Post-merger, adults living near HPH who previously went to HPH lost that choice. Likewise, adolescents living near Evanston who previously went to Evanston lost that choice. In other words, Respondent cut back psychiatric services and reduced consumer choice after the merger. There is no evidence that Evanston could not have separated adult and adolescent patients simply by having them go to different wings

of Evanston Hospital and to different wings of HPH. { [REDACTED]

[REDACTED] } (See Romano, Tr. 3115-16, *in camera*).

2419. Moreover, the provision of more charity care would benefit the community and is an example of how a not-for-profit hospital provides benefits to the community that a for-profit hospital might not. (Simpson, Tr. 1633).

Response to finding No. 2419:

The good deeds of a not-for-profit hospital are irrelevant to whether the hospital abuses market power. See CCRFF 337 discussing the fact that a not-for-profit hospital can both exploit market power and do some good things for a community.

2420. ENH uses funds it receives from the Highland Park Healthcare Foundation to offset the cost of charity care that is provided at HPH. (RX 2037 at HFHP 1362; Styer, Tr. 4981; Neaman, Tr. 1312). The cost of charity care at HPH exceeds the annual payment that ENH receives from the Foundation. (H. Jones, Tr. 4179-80).

Response to finding No. 2420:

Even if, *arguendo*, ENH uses funds to offset the cost of charity care provided at HPH, it is irrelevant to whether the hospital abuses market power. See CCRFF 337 discussing the fact that a not-for-profit hospital can both exploit market power and do some good things for a community.

2421. Complaint Counsel's expert further explained the existence of a theory by Dr. William Lynk "that non-profit hospitals tended not to exploit market power; specifically, he found that non-profit hospitals – that the prices of non-profit hospitals in more concentrated markets were not higher than the prices of non-profit hospitals in less concentrated markets." (Simpson, Tr. 1625). A subsequent study by Dr. Lynk and Lynette Neumann "also found that non-profit hospitals tended not to exploit market power." (Simpson, Tr. 1626).

Response to finding No. 2421:

The finding is misleading and incomplete. Respondent neglects to mention that

Dr. Simpson also testified that economic studies do support the view that not-for-profit hospitals exercise market power. (Simpson, Tr. 1621). Four peer-reviewed studies performed by four different sets of researchers and using four different research methods found that hospitals tend to exploit market power and that not-for-profit hospitals in concentrated markets set higher prices than in less concentrated markets. (Simpson, Tr. 1624-25). An additional case study, involving a merger of not-for-profit hospitals, that was done by a different set of researchers, using a different methodology, also found that not-for-profit hospitals exercised market power. (Simpson, Tr. 1627-28). The two studies finding that not-for-profit hospitals tend not to exploit market power were both performed by Dr. Lynk and used different data sets and a different analysis structure from the four studies finding that hospitals do tend to exploit market power. (Simpson, Tr. 1625-27).

2422. Complaint Counsel's expert also explained that Dr. William Lynk's theory goes on to state "that if you have a non-profit hospital with community representatives on the board of directors, these community representatives will use their influence on the board and the non-profit hospital to ensure that the non-profit hospital basically sets the competitive price." (Simpson, Tr. 1622).

Response to finding No. 2422:

The finding is incomplete. *See* CCRFF 2421 regarding Dr. Simpson's testimony that economic studies do support the view that not-for-profit hospitals exercise market power. *See also* CCRFF 336 discussing the fact that the ENH board failed to set up any mechanisms to ensure that the not-for-profit hospital sets the price at basically the competitive level.

2423. ENH's Board contains community representatives who provide oversight to the

organization. (Simpson, Tr. 1639). Approximately three-quarters of ENH's Board are outside directors chosen from the community. (Simpson, Tr. 1639). In addition to the ENH Board, the Healthcare Foundation of Highland Park also monitors ENH's activities, specifically its commitments to HPH and the Highland Park Community. (RX 2037 at HFHP, 1364; Styer, Tr. 4971, 4985).

Response to finding No. 2423:

The finding is misleading and overlooks key facts. The Highland Park Hospital board was not involved in pricing issues. (Spaeth, Tr. 2218). The ENH board did not actively monitor the pricing decisions of hospital management and did not try to ensure that price was set at basically the competitive level. (Simpson, Tr. 1622, 1629).

2424. Complaint Counsel's expert did not testify that ENH used surplus funds in a wasteful manner. (Simpson, Tr. 1648, 1650). He also did not testify that ENH's managers tried to build a prestigious facility that the community might not otherwise need. (Simpson, Tr. 1635).

Response to finding No. 2424:

The finding is misleading and incomplete. Dr. Simpson did not express an opinion on what ENH did or did not do with regard to surplus funds or building. *See also* CCRFF 338 discussing the fact that while Dr. Simpson never claimed that ENH built unnecessary facilities, this was merely an illustrative example. Dr. Simpson did testify that the surplus resulting from supra-competitive prices can be used for higher executive salaries. In other words, it can be used to benefit the hospital executives rather than consumers. (Simpson, Tr. 1649). This is precisely what happened following the Highland Park and Evanston merger. (*See, e.g.*, CCRFF 335). Dr. Simpson also testified that ENH's compensation contracts did not align management's interests with consumers on the issue of price. (Simpson, Tr. 1629).

3. The Pre-Merger HPH Foundation Is Evidence Of How A Not-For-

Profit Hospital Benefits The Community

2425. HPH had a Foundation that was part of the hospital pre-Merger. (Styer, Tr. 5001-2). The HPH Foundation Board consisted of many members of the Highland Park community, including the Mayor of Highland Park and the CEO of the hospital. (Styer, Tr. 4957-58, 5008).

Response to Finding No. 2425:

Complaint Counsel have no specific response.

2426. The HPH Foundation's bylaws required that the Foundation raise funds exclusively for Lakeland Health Services and HPH. (Styer, Tr. 5001-2). The funds the HPH Foundation raised went to HPH in an attempt to fulfill the hospital's needs. (Styer, Tr. 4954). The funds from the HPH Foundation were never used to support causes outside of HPH. (Styer, Tr. 4954).

Response to Finding No. 2426:

Respondent's finding is incomplete and misleading to the extent that it implies the foundation was a new, merger-related benefit to the Highland Park community. Pre-merger, HPH had an affiliated foundation "responsible for fund raising for and on behalf of Lakeland Health Services, Inc. ("Lakeland"), the Hospital [HPH] and their affiliates" that benefitted the community and the hospital. (CX 6321 at 61).

2427. Pre-Merger HPH was able to raise \$1-1.2 million per year through fundraising efforts. (Spaeth, Tr. 2294-95; Styer, Tr. 5005). However, HPH could not have survived alone on its fundraising income. (Spaeth, Tr. 2295-96). Specifically, the \$1 million annually raised was not close to being sufficient to cover pre-Merger HPH's requests to the Foundation. (Styer, Tr. 4959-60, 5028).

Response to Finding No. 2427:

Respondent's finding is incomplete and misleading. HPH relied upon fund raising and donor contributions as a significant source of revenue. Fund raising and donor support were strong, and the donor based was wealthy. (Newton, Tr. 320-21). For example, one fund raising campaign in the 1990s raised more than \$10 million for the

development of new surgical suites. (Newton, Tr. 321). Another campaign raised funds for HPH's dialysis center, which was established in 1998. (Styer, Tr. 4959-60).

2428. As HPH started to suffer operating income losses in the late 1990s, the HPH Foundation's funds were used to help offset HPH's operating losses. (Styer, Tr. 4961; RX 400 at ENH RS 6692). The HPH Foundation's funds were used to offset HPH's operating losses because HPH management was concerned about maintaining the hospital's bond ratings and the hospital's future viability. (Styer, Tr. 4961-62).

Response to Finding No. 2428:

Respondent's finding is misleading to the extent that it implies that HPH experienced operating losses for more than one year. According to ENH's own due diligence report, HPH in the late 1990s experienced an operating loss only in 1999. (RX 609 at EY 257). In addition, HPH management believed that HPH was viable over the long-term. (See CCRFF 2299; CX 1055 at 3).

4. The Creation Of The Independent Highland Park Healthcare Foundation As A Result Of The Merger Demonstrates How ENH Acts To Benefit The Community As A Not-For-Profit

2429. In December 1999, Evanston Hospital and the HPH Foundation signed the agreement creating the Healthcare Foundation of Highland Park. (RX 2037; Styer, Tr. 4977-78). The Healthcare Foundation of Highland Park came into being on January 1, 2000, as a result of the Merger. (Styer, Tr. 4951, 4971; Belsky, Tr. 4894; Spaeth, Tr. 2281).

Response to Finding No. 2429:

Respondent's finding is incomplete and misleading to the extent that it implies the foundation was a new, merger-related benefit to the Highland Park community. Pre-merger, HPH had an affiliated foundation "responsible for fund raising for and on behalf of Lakeland Health Services, Inc. ("Lakeland"), the Hospital [HPH] and their affiliates" that benefitted the community and the hospital. (CX 6321 at 61).

2430. The Healthcare Foundation of Highland Park started with a corpus of roughly \$100 million. (Neaman, Tr. 1260). As of March 2005, the Healthcare Foundation had a \$85 million corpus, down from its original \$100 million due to poor performance of investments in 2000 and 2001 and because the Foundation has given away more than \$28 million. (Styer, Tr. 4979-80).

Response to Finding No. 2430:

Respondent's finding is incomplete and misleading. As Respondent describes in RFF 2439, the post-merger Healthcare Foundation had an obligation to send annual payments to ENH. (See RFF 2439). These payments totaled at least \$8 million in 2000, \$6 million in 2001 and 2002, and \$4 million from that point onwards. (See RFF 2439). These payments represented the floor: the post-merger foundation would need to pay more if its return on investments exceeded the thresholds. (See RFF 2439). ENH recorded these payments as "above the line" payments in its audited financials, listing them as "unrestricted revenue and other support." (CX 2068 at 6).

Moreover, these mandatory payments came as a result of the 1999 merger negotiations between Evanston and Highland Park. (CX 6304 at 7 (Livingston, Dep.)). Evanston pointed out a number of purported financial issues at HPH. (CX 6304 at 7 (Livingston, Dep.); CX 534 at 6-7). According to Homer Livingston, ENH's chairman of the board, the parties made revisions to the Foundation agreement, "the net result of it was that [HPH] had to provide ENH out of the Foundation a certain percentage of [the foundation's] income over a number of years." (CX 6304 at 8 (Livingston, Dep.); CX 534 at 8).

2431. The Healthcare Foundation of Highland Park has a significantly different mission than the pre-Merger HPH Foundation in that the post-Merger Foundation dispenses money instead of raising money. (Styer, Tr. 4972). The Healthcare Foundation of Highland Park also

supports causes beyond HPH: (Styer, Tr. 4972-73).

Response to Finding No. 2431:

Respondent's finding is misleading and incomplete. The pre-merger Highland Park foundation's mission also was to benefit the greater Highland Park community. (See CCRFF 2429).

2432. The creation of the Healthcare Foundation of Highland Park was another means of fulfilling HPH's primary Merger goal of benefiting the Highland Park community. (CX 6305 at 16 (Stearns, Dep.); Neaman, Tr. 1373). The Foundation Agreement establishing the Healthcare Foundation of Highland Park describes the Foundation's mission to support HPH and healthcare in the general Highland Park community. (RX 2037 at HFHP 1356; Styer, Tr. 4951, 4979; Neaman, Tr. 1373).

Response to Finding No. 2432:

Respondent's finding is irrelevant. There is no requirement of proving an anticompetitive intent in a merger case. Furthermore, Respondent's finding regarding HPH's purportedly philanthropic intention is misleading and incomplete in implying that the merging parties' motive in merging was philanthropic. Even if, *arguendo*, the merging parties had one or more philanthropic motives, they were by no means the only motives. Pre-merger documents of HPH show the motivations of HPH management and board members with regard to the merger:

- To reap "the economic benefit" of "not do[ing] battle" with Evanston (CX 4 at 1)
- To "stop competing with each other" (CX 1879 at 3-4)
- To "push back on the managed care phenomenon" (CX 4 at 2)
- To be "a big enough concerted enough entity (CX 4 at 2)
- To "get geographic leverage" (CX 4 at 9)

- To achieve “critical mass” in the North Shore (CX 4 at 9)
- To “exploit an area of the market in a meaningful way” (CX 3 at 1-2)
- To build “power to deal with managed care” (CX 3 at 2).

Highland Park knew that “it would be real tough for any of the Fortune 40 companies in this area whose CEOs use either this place or that place to walk from Evanston, Highland Park, Glenbrook, and 1700 of their doctors.” (CX 4 at 1-2; Spaeth, Tr. 2210-11).

2433. The Bylaws of the Healthcare Foundation detail the Foundation’s main purposes as: (1) to foster, promote, develop, and support HPH and other community benefit charities which provide or support healthcare or other similar services in Highland Park and the surrounding communities; and (2) to monitor and enforce the obligations of ENH set forth in the Agreement and Plan of Merger to the extent provided in the Foundation Agreement between the Healthcare Foundation and ENH. (RX 1409 at HFHP 1071; Styer, Tr. 4971).

Response to Finding No. 2433:

Respondent’s finding is irrelevant. Proof of anticompetitive intent is not a requirement, and in any event, HPH had specific intentions of building market power through the merger. (See CCRFF 2432).

2434. The Healthcare Foundation of Highland Park is not legally connected to HPH and is separate and independent of ENH. (Styer, Tr. 4972; Belsky, Tr. 4916; Neaman, Tr. 1373; CX 6304 at 7 (Livingston, Dep.); Hillebrand, Tr. 1784).

Response to Finding No. 2434:

Complaint Counsel have no specific response.

a. The Healthcare Foundation of Highland Park is Required to Monitor the Commitments ENH Made to the Community

2435. The Foundation Agreement gives the Healthcare Foundation the power to notify the Illinois Attorney General of “a material breach by ENH of any of its obligations under the Merger Agreement which substantially undermines or adversely affects the Highland Park community” if ENH and the Healthcare Foundation cannot themselves resolve ENH’s alleged breaches within 90 days. (RX 2037 at HFHP 1364; Styer, Tr. 4971, 4985).

Response to Finding No. 2435:

Complaint Counsel have no specific response.

2436. The Healthcare Foundation is able to monitor whether ENH is fulfilling its commitments under the Merger Agreement through the regular reports it receives from Spaeth at board meetings and through a visual inspection of the physical improvements at HPH. (Styer, Tr. 4986; RX 926 at HFHP 2044; RX 990 at HFHP 2041; RX 1055 at HFHP 2037-39; RX 1102 at HFHP 2034-35; RX 1151 at HFHP 2021; RX 1408 at HFHP 2005; RX 1442 at HFHP 10762-63; RX 1546 at HFHP 1997-98; RX 1573 at HFHP 1994; RX 1691 at HFHP 2454).

Response to Finding No. 2436:

Complaint Counsel have no specific response.

2437. As of March 2005, the Healthcare Foundation has not found ENH to be in breach of the Merger Agreement. (Styer, Tr. 4985). In fact, Styer believes that ENH far exceeded the commitments it made to HPH and the Highland Park community in the Merger Agreement. (Styer, Tr. 4986).

Response to Finding No. 2437:

Respondent's finding is irrelevant. Proof of anticompetitive intent is not a requirement in a merger case, and in any event, whatever philanthropic motivations HPH might have had, HPH had specific intentions of building market power through the merger. (See CCRFF 2432). In addition, Evanston's pre-merger strategic documents and testimony from ENH senior managers show that Evanston's goals were the like the HPH goals discussed in CCRFF 2432. Evanston's goals were:

- “[T]o join forces and grow together rather than compete with each other”
(CX 2 at 7)
- To “not compete with self” (CX 1 at 3)
- To “strengthen negotiation capability with managed care companies through merge entities” (CX 1 at 3)

- { [REDACTED] } (CX 1566 at 9; Neaman, Tr. 1138, *in camera*; RX 2015 at ENHL MO 3485)
- { [REDACTED] } (CX 1566 at 9; Neaman, Tr. 1138, *in camera*; RX 2105 at ENHL MO 3485)
- To make the merged entity “indispensable to marketplace” (CX 19 at 1)
- To get better prices and better terms on contracts with health plans (Neaman, Tr. 1036)
- “To achieve negotiating strength as a combined system of 3 hospitals.” (RX 704 at ENH HJ 001643).

2438. As chairman of the Healthcare Foundation of Highland Park, Styer believes that the Merger has unequivocally improved HPH and the patient’s experience from the time the patient enters to when the patient exists the hospital. (Styer, Tr. 4986-87; RX 1359). The Healthcare Foundation of Highland Park, again another product of the Merger, has been “absolutely” beneficial to the Highland Park community. (Spaeth, Tr. 2282).

Response to Finding No. 2438:

Respondent’s finding is contradicted by the record evidence. With respect to the purported improvement in patient experience, Complaint Counsel’s expert, Dr. Romano, found no discernible improvement in quality of care at Highland Park after the merger.

(See CCFF 2058-2132). { [REDACTED] }
 { [REDACTED] } (See CCFF 2135, *in camera*).

Furthermore, Respondent’s finding is incomplete and misleading to the extent that it implies the foundation was a new, merger-related benefit to the Highland Park community. (See CCRFF 2426). The establishment of a separate, post-merger foundation to serve Highland Park was designed to compensate the Highland Park community for the loss of control when HPH merged with Evanston. (Kaufman, Tr.

5855-56). Without the merger, there would be no loss of control and hence no need to compensate the community. (Kaufman, Tr. 5856). Respondent's reference to the creation of the foundation is especially ironic given that, during the merger negotiations, Evanston attempted to minimize the amount of funds that Highland Park would contribute to the post-merger foundation. (Kaufman, Tr. 5863).

b. The Highland Park Healthcare Foundation Contributes Funds to HPH for the Benefit of the Community

2439. The Foundation Agreement creating the Healthcare Foundation of Highland Park obliged the Foundation to send to ENH the greater of 100% of its investment earnings or \$8 million in 2000, the greater of 75% of its investment earnings or \$6 million in 2001 and 2002, and the greater of 50% of its investment earnings or \$4 million for every year thereafter. (RX 2037 at HFHP 1362; Styer, 4980-81; Spaeth, Tr. 2281; Neaman, Tr. 1261; Belsky, Tr. 4898). The Foundation Agreement, in turn, obliges ENH to use the money it gets from the Healthcare Foundation to offset the costs of uncompensated care and other clinical programs at HPH selected at ENH's discretion. (RX 2037 at HFHP 1362; Styer, Tr. 4981).

Response to Finding No. 2439:

Respondent's finding is irrelevant. Proof of anticompetitive intent is not a requirement in a merger case, and even assuming, *arguendo*, the existence of philanthropic motivations or conduct, both ENH and HPH had other motivations related to building market power through the merger. (See CCRFF 2432, 2437).

2440. The majority of the Healthcare Foundation's funds sent to ENH are used to support indigent or uncompensated care at HPH. (Styer, Tr. 4981; H. Jones, Tr. 4179-80). Even though Highland Park is a wealthy community, it has a large number of seniors and minority groups who cannot pay for healthcare. (Styer, Tr. 4981). Consequently, the cost of charity care at HPH exceeds the annual payment that ENH receives from the Foundation. (H. Jones, Tr. 4179-80).

Response to Finding No. 2440:

Respondent's finding is irrelevant. Proof of anticompetitive intent is not a

requirement in a merger case, and even assuming, *arguendo*, the existence of philanthropic motivations or conduct, both ENH and HPH had other motivations related to building market power through the merger. (See CCRFF 2432, 2437).

2441. The HPH team that negotiated the Foundation Agreement agreed to the annual contribution to ENH because: (1) they wanted the Highland Park community to know that the money raised by the community for the old HPH Foundation would still support HPH; and (2) to assure that the money would be spent at HPH. (Styer, Tr. 4982).

Response to Finding No. 2441:

Respondent's finding is irrelevant. Proof of anticompetitive intent is not a requirement in a merger case, and even assuming, *arguendo*, the existence of philanthropic motivations or conduct, both ENH and HPH had other motivations related to building market power through the merger. (See CCRFF 2432, 2437).

2442. Styer believes that the annual payment from the Healthcare Foundation to ENH is a very fair arrangement because it is a "drop in the bucket" compared to the over \$100 million ENH has spent on improving the HPH campus since 2000. (Styer, Tr. 4982; Kaufman, Tr. 5833-34). In addition, Styer believes that the annual payment from the Healthcare Foundation to ENH is a very fair arrangement because the annual contributions demonstrate to the Highland Park community and ENH the desire to continue to support the HPH campus. (Styer, Tr. 4983; Kaufman, Tr. 5833-34).

Response to Finding No. 2442:

Respondent's finding is irrelevant. Proof of anticompetitive intent is not a requirement in a merger case, and even assuming, *arguendo*, the existence of philanthropic motivations or conduct, both ENH and HPH had other motivations related to building market power through the merger. (See CCRFF 2432, 2437).

c. The Highland Park Healthcare Foundation Provides Grants To Community Organizations

2443. The Healthcare Foundation of Highland Park also dispenses grants to charities in

the Highland Park area.' (Styer, Tr. 4987-88). Since its creation, the Healthcare Foundation of Highland Park has given roughly \$26 million back to HPH and another \$3-4 million to organizations within the greater Highland Park community. (Styer, Tr. 4974).

Response to Finding No. 2443:

Respondent's finding is irrelevant. Proof of anticompetitive intent is not a requirement in a merger case, and even assuming, *arguendo*, the existence of philanthropic motivations or conduct, both ENH and HPH had other motivations related to building market power through the merger. (See CCRFF 2432, 2437). In addition, the pre-merger Highland Park foundation's mission also was to benefit the greater Highland Park community. (See CCRFF 2429).

2444. In 2002, the Healthcare Foundation awarded \$500,000 to the Lake County Health Department to establish a community healthcare clinic in the Highland Park/Highwood area to improve access to healthcare for underserved populations in southeast Lake County. (RX 1238 at HFHP 2565).

Response to Finding No. 2444:

Respondent's finding is irrelevant. Proof of anticompetitive intent is not a requirement in a merger case, and even assuming, *arguendo*, the existence of philanthropic motivations or conduct, both ENH and HPH had other motivations related to building market power through the merger. (See CCRFF 2432, 2437). In addition, the pre-merger Highland Park foundation's mission also was to benefit the greater Highland Park community. (See CCRFF 2429).

2445. Groups interested in receiving funding from the Healthcare Foundation must then submit an application to the Foundation which the allocation subcommittee will first review. (Belsky, Tr. 4896). The allocation subcommittee will vote on applications for funding and will decide how much money should be allocated to which groups before passing their recommendations on to the full board. (Belsky, Tr. 4896).

Response to Finding No. 2445:

Respondent's finding is irrelevant. The process by which funds are granted have nothing to do with the merger analysis.

X. REMEDY

A. Divestiture Is Not A Proper Remedy Because The Merger Was Necessary To Achieve Quality Improvements At HPH

2446. Overall, ENH spent \$120 million on capital improvements at HPH after the Merger. (Hillebrand, Tr. 1977; Neaman, Tr. 1250). HPH could not have made comparable investments in HPH on its own. (Spaeth, Tr. 2280-81).

Response to Finding No. 2446:

This and all of Respondent's findings in Section X(A) are irrelevant to the issue of divestiture. Section X(A) of Respondent's remedy findings has the title "The Merger Was Necessary To Achieve Quality Improvements At HPH." Thus, by invoking facts that Respondent views as proving that post-merger changes at HPH were merger specific, Respondent is simply arguing the question of liability. Complaint Counsel objects to this practice because a discussion of remedy assumes, *arguendo*, that Respondent has not prevailed on the question of liability. This means, among other things, that consideration of remedy begins with the assumption that the Court has already rejected Respondent's claims that *merger-specific* improvements in quality of care outweighed the merger's anticompetitive harm (various evidence also supports the view that most of ENH's post-merger changes at HPH were not merger-specific, *see* CCF 2294-2443). Moreover, even if the merger was necessary to a particular change, it does not follow that the change could not be maintained by an acquirer after divestiture of HPH (various evidence supports the view that most post-merger changes could be maintained after divestiture, *see* CCF 2560, 2567-2580). Without waiving this objection, Complaint Counsel nevertheless responds below as to Respondent's remedy findings.

Finding 2446 is irrelevant to the issue of remedy. To the extent it has relevance to the issue of liability, various evidence supports the view that the changes were not merger specific because HPH possessed the financial assets to implement changes on its own (*see* CCFF 302-372, 2440-2443; CCRFF 2298-2413) and was an attractive candidate for other mergers (*see* CCFF 368-372). In any event, divestiture is needed in this case, in part to prevent future anticompetitive harm.

Future Anticompetitive Harm

Respondent has claimed that Complaint Counsel must show that, with the merger, there is a likelihood of future anticompetitive harm. As discussed in the brief, there is no requirement of showing in 2005 future anticompetitive harm, although Complaint Counsel has proved it in at least two ways.

First, Complaint Counsel's and Respondent's experts, as well as Respondent, all made estimates of the post-merger market shares and market concentration, which show that the post-merger market is highly concentrated and that the increase in concentration was sufficient to create a presumption that the merger created or enhanced market power or facilitated its exercise. (Haas-Wilson, Tr. 2452, 2667; Noether, Tr. 5963; CX 84 at 21. *See* Merger Guidelines, §§ 1.5 n.17, 1.51).

Second, Complaint Counsel has presented direct evidence that, through the merger, Respondent gained market power, and direct evidence of market power in the past has significant probative value in demonstrating that a defendant will continue to dominate the market. This direct evidence that Respondent had market power includes the following.

Post-merger, ENH exercised market power, attained through the merger, to raise prices in various ways. For example, ENH: (1) moved health plans to one contract for all three ENH facilities, *i.e.*, the Evanston or Highland Park pre-merger contract, whichever had the higher rates (*see* CCFF 822-847); (2) added a *premium* to the higher of the Evanston or Highland Park contract rates (*see* CCFF 848-880); (3) moved health plans from a fixed price contract to a discount off charges contract or to a contract that contained more discount off charges provisions than the pre-merger contract (*see* CCFF 813-821); (4) “equalized” the Evanston and Highland Park chargemasters by adopting in 2000 the higher of the Evanston or Highland Park chargemaster list prices for the particular product or service (*see* CCFF 881-903); and (5) repeatedly increased ENH’s chargemaster list prices in the years following the merger (*see* CCFF 918-927, 942-958).

None of these price increases was a one-time price increase that was rescinded a year after the increase. (*See, e.g.*, CX 5910, regarding the dates of the contract revisions of fifteen health plans, as well as the post-merger contracts listed in CX 5910, which are in evidence). Instead, as Respondent itself recognized, these price increases would be in effect indefinitely:

- At least \$10 million “ongoing” (*i.e.*, annually into the future) in revenue enhancement just from converting all of Respondent’s hospitals to the existing contract of either Evanston Hospital or Highland Park, whichever contract had the more favorable rate. (CX 23 at 2).
- At least \$18 million in additional annualized net revenue from the re-negotiation with *only six named health plans and some small PPO contracts* (out of a total of

approximately 35-40 contracts) (CX 5 at 5; Hillebrand, Tr. 1820; Sirabian, Tr. 5717. See CX 17 at 5-8).

- A projected \$100 million in increased gross revenue annually from adopting in 2000 the higher of the Evanston or Highland Park chargemaster list prices (CX 2237 at 1; CX 42 at 2; CX 2462 at 1; CX 2238 at 1; CX 2239 at 1; CX 2384 at 2).

- { [REDACTED]

[REDACTED]

[REDACTED] } (CX 45 at 8; RX 1687 at ENHL BW 027653, *in camera*).

Furthermore, none of these dollar estimates (which came from ENH's files) reflect the total antitrust injury caused (and still being caused) by ENH's post-merger exercise of its market power. Generally, each method that ENH used to raise prices would further increase the revenues that ENH received from the other methods it used to raise prices. For example, ENH increased its revenues when it re-negotiated its contracts to add one or more discount off charges formulas, and then it further increased the effect of those contract re-negotiations when it increased the list prices in its chargemaster. (Newton, Tr. 366; CCF 799-800, 955-957).

{ [REDACTED]

[REDACTED]

[REDACTED] } (Hillebrand, Tr. 1706. See Hillebrand, Tr. 1711; Ballengee, Tr. 227, *in camera*; Chan, Tr. 667). With a discount off charges provision in the contract, ENH can get a price increase, by implementing a chargemaster increase, as often as it wishes without having to re-negotiate the contract. { [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED] (Newton, Tr. 365-66; RX 1687 at ENHL BW 027653, *in camera*).

Furthermore, Complaint Counsel presented evidence that health plans remained unwilling to terminate their contracts with ENH and to discipline ENH by contracting with other hospitals, in response to the price increases. (*See, e.g., Neaman, Tr. 1211-12; CCFF 273, 278, 283*). Indeed, ENH management did not even consider the risk of health plans switching to other hospitals due to ENH's price increases. (*Neaman, Tr. 1212; Hillebrand, Tr. 1753-55, 1757-58, 1764-65; Newton, Tr. 367*). Health plans need ENH in their network, meaning that ENH will continue to enjoy market power in the future. (*See, e.g., CCFF 273, 278, 283*). [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED] (Foucre, Tr. 898, 889. *See Neary, Tr. 609; Newton, Tr. 366; Holt-Darcy, Tr. 1522, in camera; Mendonsa, Tr. 524-28* ({ [REDACTED] }), *in camera*). The only recourse a health plan such as United has in the face of large chargemaster increases is to request the re-negotiation of its contract in an attempt to achieve more fixed rates and more predictable pricing - just as United first did in 2002. (Foucre, Tr. 892-93).

Finally, ENH's change in pricing strategy after 2003 with respect to United (after the FTC instituted its investigation of the merger), does not have any probative value to

show that prices were then reasonable and, thus, that the merger was not anticompetitive.

{ [REDACTED] }
[REDACTED] } (Foucre, Tr. 897; CX 57 at 1, *in camera*. See Foucre, Tr. 897 ([REDACTED])
[REDACTED] }
[REDACTED] }
[REDACTED] } (CX 20 at 1. See CCRFF 911; Foucre, Tr. 892-93, 921-23; Foucre, Tr. 1101, *in camera*; CX 6284 at 1; CX 426 at 1, *in camera*; CX 5176 at 1).

In summary, the merger violates Section 7 of the Clayton Act, whether or not ENH has fully exercised its market power in the past year. If ENH is not ordered to divest itself of Highland Park, ENH will retain the market power it gained through the merger, and it will be unfettered to implement more and larger price increases.

2447. The quality improvements ENH made after the Merger enabled HPH to offer services not typically offered by community hospitals. (Wagner, Tr. 3999-4000; Romano, Tr. 3334; Neaman, Tr. 1352; Dragon, Tr. 4325, 4344-48, 4370-71; Chassin, Tr. 5329; RX 1341 at ENHE TH 975).

Response to Finding No. 2447:

This finding is irrelevant to the issue of remedy. To the extent it has relevance to the issue of liability, various evidence supports the view that the changes made by ENH after the merger were not merger-specific because HPH, on its own or with others, could have achieved the same changes. (See CCFF 2374-2380, 2394-2415; CCRFF 1677,

1714-1721, 1724-1725, 2001, 2004, 2006).

2448. There was no evidence that, before the Merger, HPH had the plans or the capacity to implement the quality changes that occurred after the Merger, or that HPH could have accomplished similar improvements through a joint venture. (Chassin, Tr. 5390-93).

Response to Finding No. 2448:

This finding is irrelevant to the issue of remedy. To the extent it has relevance to the issue of liability, various evidence supports the view that the changes made by ENH after the merger were not merger specific because HPH, on its own or with others, could have achieved the same changes. (See CCFF 2294-2443).

2449. Accordingly, the Merger was necessary to bring about the vast majority of the quality improvements made at HPH, thus improving patient care. (Chassin, Tr. 5381).

Response to Finding No. 2449:

This finding is irrelevant to the issue of remedy. To the extent it has relevance to the issue of liability, various evidence supports the view that the changes made by ENH after the merger were not merger specific because HPH, on its own or with others, could have achieved the same changes. (See CCFF 2294-2443).

1. HPH Was Not Capable Of Remediating Its Quality Problems, Implementing New Services, Or Improving Old Ones Without The Merger

a. HPH Lacked The Financial Capacity To Implement Necessary Quality Improvements

2450. Before the Merger, HPH had significant deficiencies in its physical plant that limited HPH's capacity to render adequate care and ensure the health and safety of its patients. (Chassin, Tr. 5285-86; RX 545 at ENH JH 11578). Additionally, the equipment in several service areas such as radiology and pathology was old and outdated and in need of replacement. (O'Brien, Tr. 3491, 3508; Chassin, Tr. 5359; Victor, Tr. 3614).

Response to Finding No. 2450:

This finding is irrelevant to the issue of remedy. To the extent it has relevance to the issue of liability, various evidence supports the view that: (1) prior to the merger, HPH had some, *but not significant*, deficiencies that concerned the Department of Health and Human Services most of which HPH corrected before the merger (*see* CCRFF 1512); (2) the changes made to HPH's facilities do not necessarily constitute improvements in quality of care to the extent that the changes made to the HPH plant after the merger constitute structural changes (*see* CCRFF 1516); and (3) the changes were not merger specific because the physical facilities at HPH would have been upgraded had the merger not occurred (*see* CCRFF 1514).

2451. HPH also lacked the money to improve patient care and grow services before the Merger. (H. Jones, Tr. 4098-99; Kaufman, Tr. 5814-15). The capital expenditures proposed in its 1997-2001 strategic plan were not "going to begin to get at the problems" occurring at HPH. (Kaufman, Tr. 5826).

Response to Finding No. 2451:

This finding is irrelevant to the issue of remedy. To the extent it has relevance to the issue of liability, various evidence supports the view that HPH was financially strong prior to the merger and possessed the financial assets to implement changes on its own.

(*See* CCF 302-372, 2440-2443; CCRFF 2298-2413).

2452. Due to HPH's declining financial condition, it lacked the capacity or resources to make the \$120 million in capital investments that was made by ENH. (Neaman, Tr. 1353). Capital expenditures similar to ENH's investment would have "tanked" the organization. (Neaman, Tr. 1353). Thus, HPH's declining financial condition prevented it from making the necessary capital expenditures to remedy its quality problems, improve the services it already provided, or add new services. *See* Section IX.B If HPH had merged with a hospital other than Evanston Hospital, it could have achieved the same quality improvements that resulted from the Merger only if that other hospital had the capacity to make the same level of investment in HPH that Evanston Hospital did. (Chassin, Tr. 5395).

Response to Finding No. 2452:

This finding is irrelevant to the issue of remedy. To the extent it has relevance to the issue of liability, various evidence supports the view that HPH was financially strong prior to the merger and possessed the financial assets to implement changes on its own. (See CCFF 302-372, 2440-2443; CCRFF 2298-2413).

HPH Lacked The Capacity To Effect Organizational Change

2453. Before the Merger, HPH also lacked the capacity to implement the quality changes that occurred post-Merger. (Chassin, Tr. 5390-91).

Response to Finding No. 2453:

This finding is irrelevant to the issue of remedy. To the extent it has relevance to the issue of liability, various evidence supports the view that the changes made by ENH after the merger were not merger specific because HPH, on its own or with others, could have achieved the same changes. (See CCFF 2294-2443).

2454. As discussed in Section VIII.D, ENH improved the quality at HPH after the Merger in 16 different areas. (Chassin, Tr. 5381-82; RX 2045). It accomplished this improvement in three ways: (1) by integrating the clinical and administrative systems of management and oversight between Evanston Hospital and HPH, an integration that required merging all of the clinical departments, service departments and management structures; (2) by immediately and broadly exporting Evanston Hospital's collaborative and multidisciplinary culture to HPH; and (3) by investing in either expanding clinical services, upgrading equipment, or changing the physical plant. (Chassin, Tr. 5382).

Response to Finding No. 2454:

This finding is irrelevant to the issue of remedy. To the extent it has relevance to the issue of liability, various evidence supports the view that: (1) quality did not significantly improve at HPH after the merger. (See, e.g., CCRFF 1229; CCFF 2032-2293); and (2) the changes made by ENH after the merger were not merger specific

because HPH, on its own or with others, could have achieved the same changes. (See CCFF 2294-2443).

2455. Clinical integration and ENH's collaborative culture were necessary to achieving the vast majority of the improvements. (Chassin, Tr. 5388; RX, 2045). For example, a complete transformation of leadership was required to bring about changes in quality assurance. (Chassin, Tr. 5389). Before the Merger, there was no effective physician discipline, and the physician leaders were unable to address physician behavior. (Chassin, Tr. 5389-90). The integration of the clinical departments at Evanston Hospital and HPH gave full-time Evanston Hospital clinical chairs the ability to implement quality assurance systems already in place at Evanston Hospital. (Chassin, Tr. 5389-90). Thus, the Merger was necessary to achieving meaningful improvement in quality assurance at HPH. (Chassin, Tr. 5389).

Response to Finding No. 2455:

This finding is irrelevant to the issue of remedy. To the extent it has relevance to the issue of liability, various evidence supports the view that: (1) quality assurance did not significantly improve at HPH after the merger (see CCFF 2209-2231, CCRFF 1414-1459); and (2) the changes in quality assurance made by ENH after the merger were not merger specific because HPH, on its own or with others, could have achieved the same changes (see CCFF 2426-2429; CCRFF 1417-1418).

2456. The HPH nursing issues also could not have been solved before the Merger because HPH lacked a culture – throughout the hospital, through administration, or through physician leadership – that promoted positive nurse/physician relationships. (Krasner Tr. 3739). Solving the cultural issues at HPH with respect to nursing required a change of the hospital systems, administration and physician leadership. (Krasner, Tr. 3739). Support for cultural change had to be pervasive throughout the organization. (Krasner, Tr. 3739). Without the cultural change that ENH brought to HPH, nursing services would not have improved. (Chassin, Tr. 5388). Thus, HPH could have achieved similar improvements by merging with a hospital other than Evanston Hospital only if that hospital had the same kind of collaborative culture. (Chassin, Tr. 5395).

Response to Finding No. 2456:

This finding is irrelevant to the issue of remedy. To the extent it has relevance to

the issue of liability, various evidence supports the view that: (1) nursing quality did not significantly improve at HPH after the merger (*see* CCFF 2138, 2165-2185; CCRFF 1338-1413); and (2) the changes in nursing made by ENH after the merger were not merger specific because HPH, on its own or with others, could have achieved the same changes (*see* CCRFF 1397-1407).

2457. Indeed, even though HPH could have hired a consulting firm to identify problems in nursing, HPH needed the expertise and experience that Evanston Hospital brought to the Merger to change the culture and organizational style of the hospital. (Chassin, Tr. 5389). HPH could not have made those same changes on its own. (Chassin, Tr. 5389).

Response to Finding No. 2457:

This finding is irrelevant to the issue of remedy. To the extent it has relevance to the issue of liability, various evidence supports the view that: (1) nursing quality did not significantly improve at HPH after the merger (*see* CCFF 2138, 2165-2185; CCRFF 1338-1413); and (2) the changes in nursing made by ENH after the merger were not merger specific because HPH, on its own or with others, could have achieved the same changes (*see* CCRFF 1397-1407).

2458. { [REDACTED]
[REDACTED]
[REDACTED] } (Silver, Tr. 3924-25, *in camera*). { [REDACTED]
[REDACTED]
[REDACTED] } (Silver, Tr. 3924-25, *in camera*). { [REDACTED]
[REDACTED] } (Silver, Tr. 3925, *in camera*).

Response to Finding No. 2458:

This finding is irrelevant to the issue of remedy. To the extent it has relevance to the issue of liability, various evidence supports the view that: (1) { [REDACTED]

[REDACTED]

[REDACTED] } (see CCFF 2186-2208, *in camera*); and (2) the changes in the OB/Gyn Department at HPH made by ENH after the merger were not merger specific because HPH, on its own or with others, could have achieved the same changes (see CCFF 2417-2425).

2. The Improvements Made By ENH Could Not Have Been Achieved Through Joint Ventures

2459. The Merger was necessary to produce the extremely high quality cardiac surgery program at HPH today. Cardiac surgery is a highly complex and team-dependant service. In fact, cardiac surgery is probably the most complex and team-dependant service that exists at HPH post-Merger. The close collaboration of all team members – from the perfusionist, to the surgeon, to the physician’s assistant, to the ICU and OR nurses – is absolutely necessary to the performance of high quality cardiac surgery. This collaborative culture did not exist at HPH before the Merger. (Chassin, Tr. 5392).

Response to Finding No. 2459:

This finding is irrelevant to the issue of remedy. To the extent it may have relevance to the issue of liability, various evidence supports the view that: (1)

[REDACTED]

[REDACTED] } (see CCRFF 1565, *in camera*); (2) the changes were not merger specific because HPH had planned to implement a cardiac surgery program and would have implemented such a program in the absence of the merger (see CCRFF 1577); and (3) any cardiac surgery program that HPH would have launched without the merger that resulted in quality at the level of Swedish Covenant Hospital or Weiss Hospital would have been acceptable, according to ENH (see CCRFF 1629).

2460. If the cardiac surgery program at HPH had been launched through an affiliation or joint venture, the program would have been of significantly lesser quality, similar to the

programs at Weiss Hospital or Swedish Covenant Hospital. (Chassin, Tr. 5392-93).

Response to Finding No. 2460:

This finding is irrelevant to the issue of remedy. To the extent it may have relevance to the issue of liability, various evidence supports the view that any cardiac surgery program that HPH would have launched without the merger that resulted in quality at the level of Swedish Covenant Hospital or Weiss Hospital would have been acceptable, according to ENH. (See CCRFF 1629).

2461. Neither Weiss Hospital nor Swedish Covenant Hospital is owned or operated by ENH. (Rosengart, Tr. 4443). Rather, ENH cardiac surgeons practice at these two sites only through an affiliation agreement. (Rosengart, Tr. 4443). As a result, both cardiac programs function independently of ENH. (Rosengart, Tr. 4444, 4489, 4500-01).

Response to Finding No. 2461:

This finding is irrelevant to the issue of remedy. To the extent it may have relevance to the issue of liability, see CCRFF 2459.

2462. Due to this lack of integration, the quality of cardiac surgery performed at HPH is higher than the quality of cardiac surgery performed at the affiliated sites. (Rosengart, Tr. 4504).

Response to Finding No. 2462:

This finding is irrelevant to the issue of remedy. To the extent it may have relevance to the issue of liability, see CCRFF 2459.

2463. The complete integration between Evanston and HPH allows certain cutting edge procedures to be performed at HPH that otherwise would not be performed at an affiliated hospital. (Rosengart, Tr. 4492-93). For example, vein harvesting techniques using periscopes through a one inch incision and bloodless surgery, which is performed only at a handful of hospitals in the country, are performed at HPH but not at Swedish Covenant or Weiss Hospital. (Rosengart, Tr. 4494-96). Dr. Rosengart explained: "We are not doing [advanced surgical techniques] at either Swedish or Weiss. I wouldn't feel comfortable. It really involves a lot of integration of anesthesia and nursing, equipment, resources and things like that, and by virtue of not having that sort of commonality of the team, probably would not – certainly no in – not in the

near future do it at either of those sites.” (Rosengart, Tr. 4493).

Response to Finding No. 2463:

This finding is irrelevant to the issue of remedy. To the extent it may have relevance to the issue of liability, various evidence supports the view that any cardiac surgery program that HPH would have launched without the merger that resulted in quality at the level of Swedish Covenant Hospital or Weiss Hospital would have been acceptable, according to ENH. (See CCRFF 1629).

2464. New technology is also adopted more quickly at HPH because of the common leadership and structure at Evanston Hospital and HPH. For example, when a new stenting technology came out two years ago, Evanston and HPH simultaneously adopted it well ahead of other cardiac programs in the Chicago area. (Rosengart, Tr. 4496-97).

Response to Finding No. 2464:

This finding is irrelevant to the issue of remedy. To the extent it may have relevance to the issue of liability, *see* CCRFF 2459.

2465. Additionally, more private and government funded research takes place at HPH than at affiliated hospitals because the affiliated hospitals maintain separate infrastructure, separate Institutional Review Boards and separate contracting practices. (Rosengart, Tr. 4496).

Response to Finding No. 2465:

This finding is irrelevant to the issue of remedy. To the extent it may have relevance to the issue of liability, *see* CCRFF 2459.

2466. The integration from the Merger also affords HPH’s cardiac surgery program staff access to ENH’s state-of-the-art medical technology. (Rosengart, Tr. 4566).

Response to Finding No. 2466:

This finding is irrelevant to the issue of remedy. To the extent it may have relevance to the issue of liability, *see* CCRFF 2459.

2467. An affiliation/agreement does not afford sufficient control of the cardiac surgery program to ensure quality. For example, HPH is subject to ENH's quality assurance program, but Weiss Hospital and Swedish Covenant Hospital are not. (Rosengart, Tr. 4467-68, 4550).

Response to Finding No. 2467:

This finding is irrelevant to the issue of remedy. To the extent it may have relevance to the issue of liability, various evidence supports the view that any cardiac surgery program that HPH would have launched without the merger that resulted in quality at the level of Swedish Covenant Hospital or Weiss Hospital would have been acceptable, according to ENH. (See CCRFF 1629).

2468. Further, ENH has not been able to resolve issues with the administration, resources and the ability to obtain necessary upgrades at Weiss Hospital. Consequently, surgeries performed at Weiss Hospital are kept more basic, and patients with complex cases are transferred to Evanston Hospital. (Rosengart, Tr. 4503-04).

Response to Finding No. 2468:

This finding is irrelevant to the issue of remedy. To the extent it may have relevance to the issue of liability, various evidence supports the view that any cardiac surgery program that HPH would have launched without the merger that resulted in quality at the level of Swedish Covenant Hospital or Weiss Hospital would have been acceptable, according to ENH. (See CCRFF 1629).

2469. Outcome data confirms that the quality of cardiac surgery performed at HPH since the Merger is of a higher quality than that done by hospitals with cardiac surgery programs opened through affiliation with ENH. (Rosengart, Tr. 4502-05). Moreover, the length of stay for cardiac surgery patients is longer at Swedish Covenant Hospital than at HPH. (Rosengart, Tr. 4501).

Response to Finding No. 2469:

This finding is irrelevant to the issue of remedy. To the extent it may have

relevance to the issue of liability, various evidence supports the view that any cardiac surgery program that HPH would have launched without the merger that resulted in quality at the level of Swedish Covenant Hospital or Weiss Hospital would have been acceptable, according to ENH. (See CCRFF 1629).

3. The Geographic Proximity Of Evanston Hospital To HPH Was Essential To Improving The Quality At HPH

2470. HPH could not have achieved similar improvements by merging with a hospital that was not in close geographic proximity to HPH. (Chassin, Tr. 5395).

Response to Finding No. 2470:

This finding is irrelevant to the issue of remedy. To the extent it has relevance to the issue of liability, various evidence supports the view that the changes made by ENH after the merger were not merger specific because HPH, on its own or with others, could have achieved the same changes. (See CCF 2294-2443). In any event, Respondent claims that there are four hospitals closer in driving time to HPH than Evanston (RFF 394), which, assuming, *arguendo*, closeness is important, raises other merger possibilities.

2471. The relatively close geographic proximity of Evanston Hospital to HPH enables physicians to rotate between the HPH and Evanston Hospital campuses – as occurs in the pathology, radiology, emergency and cardiac surgery departments. (Chassin, Tr. 5395-96). It also allows specialists to move back and forth between the HPH and Evanston Hospital campuses. (Chassin, Tr. 5395-96).

Response to Finding No. 2471:

This finding is irrelevant to the issue of remedy. To the extent it has relevance to the issue of liability, various evidence supports the view that the changes made by ENH after the merger were not merger specific because HPH, on its own or with others, could

have achieved the same changes. (See CCFF 2294-2443). In any event, Respondent claims that there are four hospitals closer in driving time to HPH than Evanston (RFF 394), which, assuming, *arguendo*, closeness is important, raises other merger possibilities.

4. The Merger Enabled HPH To Make Quality Improvements And Offer Services That Are Not Generally Offered By, And/Or Not Feasible For, Community Hospitals

2472. Some, but certainly not all, of the HPH quality improvements that would not have occurred absent the Merger are summarized below.

Response to Finding No. 2472:

This finding is irrelevant to the issue of remedy. In addition, Respondent cites no support for this finding. This is contrary to the judge's April 6, 2005, Order on Post Trial Briefs stating that each proposed finding shall have a valid and correct cite to the record. To the extent this finding has relevance to the issue of liability, various evidence supports the view that the changes made by ENH after the merger were not merger specific because HPH, on its own or with others, could have achieved the same changes. (See CCFF 2294-2443).

a. ENH Upgraded HPH To The Epic System

2473. { [REDACTED] } (Romano, Tr. 3162, *in camera*).

Response to Finding No. 2473:

This finding is irrelevant to the issue of remedy. To the extent it has relevance to the issue of liability, various evidence supports the view that the changes made by ENH to HPH's information system after the merger were not merger specific because HPH, on

its own or with others, could have achieved the same changes. (See CCFF 2403-2415).

2474. Indeed, no community hospital has deployed an enterprise grade electronic medical record system such as Epic. (Wagner, Tr. 3999-4000). Those hospitals smaller than HPH that are installing Epic are part of a larger hospital system. (Wagner, Tr. 4000).

Response to Finding No. 2474:

This finding is irrelevant to the issue of remedy. To the extent it has relevance to the issue of liability, various evidence supports the view that the changes made by ENH to HPH's information system after the merger were not merger specific because HPH, on its own or with others, could have achieved the same changes. (See CCFF 2403-2415).

2475. Moreover, the majority of community hospitals today do not have an electronic medical record that includes CPOE systems. (Romano, Tr. 3334).

Response to Finding No. 2475:

This finding is irrelevant to the issue of remedy. To the extent it has relevance to the issue of liability, various evidence supports the view that the changes made by ENH to HPH's information system after the merger were not merger specific because HPH, on its own or with others, could have achieved the same changes. (See CCFF 2403-2415).

b. ENH Vastly Improved HPH's Oncology Services

2476. The Merger allowed HPH's oncology department to offer facilities, oncology services, research trials and new equipment that typically are not found in community hospitals. (Chassin, Tr. 5369, 5371; Dragon, Tr. 4370-71; RX 1723). See, Section VIII.D.2.d., *supra*.

Response to Finding No. 2476:

This finding is irrelevant to the issue of remedy. To the extent it may have relevance to the issue of liability, various evidence supports the view that: (1) { [REDACTED] }
[REDACTED] } (see CCFF 2140-2142,

2255-2263; CCRFF 1724, *in camera*); and (2) the changes were not merger specific because HPH, on its own or with others, could have achieved the same changes (*see* CCFF 2374-2380; CCRFF 1724-1725, *in camera*).

2477. Community hospitals typically do not: (1) have centers similar to the Kellogg Cancer Care Center; (2) have multidisciplinary site-specific oncology conferences to discuss patient treatment; (3) offer coordinated ancillary and support services, such as psycho-social support, oncology pharmacy services and dietary services – directly on-site; (4) offer the range of sub-specialty care that ENH brought to HPH after the Merger; (5) perform the level of research that is required to receive funding from the National Cancer Institute for clinical and cancer prevention research; or (6) have CT/PET scan machines, which are latest generation of positive emission tomography scanning devices. (Neaman, Tr. 1352; Dragon, Tr. 4325, 4344-48, 4370-71; RX 1341 at ENH TH 975). Many of these services are offered only in academic teaching hospitals. (Dragon, Tr. 4322-23; Chassin, Tr. 5371).

Response to Finding No. 2477:

This finding is irrelevant to the issue of remedy. To the extent it may have relevance to the issue of liability, various evidence supports the view that: (1) { [REDACTED] } (see CCFF 2140-42, 2255-63; CCRFF 1724, *in camera*); and (2) the changes were not merger specific because HPH, on its own or with others, could have achieved the same changes (*see* CCFF 2374-2380; CCRFF 1724-25, *in camera*).

2478. After the Merger, HPH was able to: open the Kellogg Cancer Care center, have its patients included in weekly multidisciplinary site-specific care conferences, offer coordinated ancillary and support services on-site, offer access to a broad range of sub-specialists, receive additional funding from the National Cancer Institute that gave HPH patients access to a broader range of treatment and prevention research trials, and purchase a CT/PET scan machine. (Chassin, Tr. 5369, 5371; Dragon, Tr. 4370-71; RX 1723). *See* Section VIII.D.2.d., *supra*.

Response to Finding No. 2478:

This finding is irrelevant to the issue of remedy. To the extent it may have relevance to the issue of liability, various evidence supports the view that: (1) { [REDACTED] }

[REDACTED] } (see CCFF 2140-2142, 2255-2263; CCRFF 1724, *in camera*); and (2) the changes were not merger specific because HPH, on its own or with others, could have achieved the same changes (see CCFF 2374-2380; CCRFF 1724-1725, *in camera*).

2479. All of the improvements made by ENH to oncology services at HPH post-Merger caused the American College of Surgeons to change its designation of HPH's oncology program from a community oncology program to an academic hospital cancer center. (Dragon, Tr. 4360-61).

Response to Finding No. 2479:

This finding is irrelevant to the issue of remedy. To the extent it may have relevance to the issue of liability, various evidence supports the view that: (1) [REDACTED] [REDACTED] } (see CCFF 2140-2142, 2255-2263; CCRFF 1724, *in camera*); and (2) the changes were not merger specific because HPH, on its own or with others, could have achieved the same changes (see CCFF 2374-2380; CCRFF 1724-1725, *in camera*).

c. ENH Improved HPH's ICU Services By Adding The Services Of Intensivists

2480. Intensivist programs such as the one instituted at HPH after the Merger are not common in community hospitals (such as HPH before the Merger). (Chassin, Tr. 5329).

Response to Finding No. 2480:

This finding is irrelevant to the issue of remedy. To the extent it may have relevance to the issue of liability, various evidence supports the view that: (1) intensive care at HPH after the merger did not significantly improve (see CCFF 2273-2278; CCRFF 1672); and (2) the changes were not merger specific because HPH, on its own or

with others, could have achieved the same changes (see CCFF 2394-2402; CCRFF 1677).

2481. The Leapfrog Group conducted a survey that tallied the number of hospitals reporting intensivist programs. (Chassin, Tr. 5329-30). Only 6 out of 37 hospitals reporting to LeapFrog in Illinois had intensivist programs, and three of those six hospitals were the ENH hospitals. (Chassin, Tr. 5330; Romano, Tr. 3324).

Response to Finding No. 2481:

This finding is irrelevant to the issue of remedy. To the extent it may have relevance to the issue of liability, various evidence supports the view that: (1) intensive care at HPH after the merger did not significantly improve (see CCFF 2273-2278; CCRFF 1672); and (2) the changes were not merger specific because HPH, on its own or with others, could have achieved the same changes (see CCFF 2394-2402; CCRFF 1677).

d. ENH Provided Much-Needed Improvements To HPH's Ob/Gyn Services

2482. [REDACTED]

[REDACTED] } (Silver, Tr. 3889-90, *in camera*). [REDACTED]

[REDACTED] } (Silver, Tr. 3890, *in camera*).

Response to Finding No. 2482:

This finding is irrelevant to the issue of remedy. To the extent it may have relevance to the issue of liability, various evidence supports the view that (1) [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (see CCFF 2186-2208, *in camera*; CCRFF 1233-1333); and (2) the changes were not merger specific because HPH, on its own or with others, could have achieved the same changes (see CCFF 2417-2425).

B. Divestiture Is Not A Proper Remedy Because It Would Erode Quality Of Care Improvements Resulting From The Merger And Thus Harm Consumers

2483. The divestiture of HPH would likely erode a number of the improved quality and increased services achieved as a result of the Merger. (Chassin, Tr. 5139, 5397). Accordingly, the proposed remedy of divestiture, if imposed, would harm – *not* benefit – consumers. (Noether, Tr. 6037). There could not be divestiture in the inpatient market without harming outpatient quality as well. (Baker, Tr. 4609).

Response to Finding No. 2483:

This and all of Respondent's findings in Section X(B) are irrelevant to the issue of divestiture. Section X(B) of Respondent's remedy findings argues that divestiture "would erode quality of care improvements" and thus harm consumers. Again, a discussion of remedy assumes, *arguendo*, that Respondent did not prevail on the liability question. Among other things, this would mean that the Court found that quality improvements either did not occur, or were not significant, and that they did not outweigh the anticompetitive harm created by the merger. Thus, even if a divestiture were to erode *all* of the alleged quality improvements at HPH, divestiture could not, on balance, harm consumers. This is because the divestiture would also eliminate the anticompetitive harm that exceeded the quality benefits. Without waiving these objections, Complaint Counsel responds below as appropriate to Respondent's remedy findings. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (see CCFF 2560, 2567-2580, *in camera*).

This finding is irrelevant to the issue of remedy. In addition, various evidence supports the view that divestiture would not have a significant impact on quality at HPH

even if relevant. { [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] } (Romano, Tr.

3193, *in camera*; see also CCFF 2560, 2567-2580).

2484. The maintenance of changes in quality improvements at HPH depend on the continued benefits of the relationship derived from ENH. (Chassin, Tr. 5402-03). Maintaining quality improvement is a continuous process that requires a large amount of input from a variety of different skills. (Chassin, Tr. 5403). For example, exposure to subspecialists with knowledge of clinical advancements and the continual monitoring and updating of protocols are quality improvement areas that are constantly changing. (Chassin, Tr. 5403).

Response to Finding No. 2484:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). While “quality improvement is a continuous process,” this process existed at HPH pre-merger and would likely continue post-divestiture. (See, e.g. CCFF 2295-2383). And while clinical protocols are certainly always changing, HPH pre-merger maintained and updated similar “critical pathways,” some of which were incorporated into ENH’s “protocols.” (O’Brien, Tr. 3559-60). In addition, { [REDACTED]

[REDACTED]
[REDACTED] } (Romano, Tr. 3170-71, *in camera*). It is unlikely that

divestiture would effect the use and development of such protocols.

2485. Further, clinical protocols are mechanisms for resolving problems in health care treatment that similarly need to be constantly updated and modified pursuant to current knowledge. (Rosengart, Tr. 4560). Using a protocol developed in the past without constant minding and attention likely will decrease the quality of care provided. (Rosengart, Tr. 4560). If HPH were divested from ENH and HPH retained the protocols extended to the hospital after the Merger, this would adversely affect the facility. (Rosengart, Tr. 4560-61).

Response to Finding No. 2485:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, the cited source does not say what the two last sentences of Respondent's finding claims. The cited source does not say that quality of care will likely decrease if past protocols are used or the such use would adversely affect the post-divestiture HPH. Rather, Dr. Rosengart stated that "using yesterday's protocol today is a huge negative," but without explaining what that means. (Rosengart, Tr. 4560). Finally, { [REDACTED] [REDACTED] [REDACTED] } (Romano, Tr. 3170-71, *in camera*). It is unlikely that divestiture would effect the use and development of such protocols.

2486. ENH, which has substantial subspecialty clinical expertise that was brought to HPH after the Merger, is the source of HPH's quality improvements. (Chassin, Tr. 5403). If one were to cut off HPH's continuous exposure to ENH's subspecialists and its continual monitoring and updating of protocols, HPH quality would begin to atrophy, thus adversely affecting consumers. (Chassin, Tr. 5403).

Response to Finding No. 2486:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, the cited source does not say what the last sentence of Respondent's finding claims. Dr. Chassin does not say anything about consumers being adversely affected if quality were to begin to atrophy at HPH after getting cut off from ENH.

2487. Like all communities, healthcare is very important to Highland Park residents. (Belsky, Tr. 4899). Accordingly, the Mayor of Highland Park, Michael Belsky, agreed to represent the Highland Park community before the FTC in this action. He wanted to do his part to assure that the major investments made in the community by ENH were successfully

completed. (Belsky, Tr. 4899, 4923). Mayor Belsky believes that the Merger benefitted HPH with an improved physical plant and has improved HPH's services. (Belsky, Tr. 4905). He is concerned that a possible divestiture of HPH by ENH would make continued improvements to HPH's facilities and services more uncertain. (Belsky, Tr. 4912-13). As mayor, Belsky believes that the Highland Park community wants certainty as to the continued improvement of HPH. (Belsky, Tr. 4913).

Response to Finding No. 2487:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, Michael Belsky, the mayor of Highland Park, lacks credibility. For example, he has no formal medical training, has no experience in managing hospitals or healthcare institutions, and has no background in assessing hospital quality. (Belsky, Tr. 4913-14).

2488. Also, as discussed in Section IV.E, the Healthcare Foundation was established as a part of the Merger to support HPH and to enhance healthcare in other areas of the community. (Styer, Tr. 4969-70). As the Chairman of the Healthcare Foundation, James Styer, who testified at trial, believes that if ENH were forced to divest HPH it would be a "tragedy" because the Merger has transformed HPH into a "wonderful" facility. (Styer, Tr. 4995).

Response to Finding No. 2488:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, James Styer, the president of the Healthcare Foundation of Highland Park, lacks credibility. For example, he has no education or training in hospital or medical administration and has no experience in managing hospitals. (Styer, Tr. 4998). Also, the finding is misleading and incomplete in implying that the foundation is a benefit of the merger. HPH already had a comparable foundation before the merger. (See CCFF 325-334). Finally, Complaint Counsel's Proposed Order requires ENH to divest the assets it acquired in the merger, including any additions and improvements. (See CCFF 2560; Complaint Counsel's Proposed Order ¶ I.O.).

2489. The Healthcare Foundation took formal action to express its concerns about a possible divestiture of HPH as a result of this litigation by sending ENH's Chairman of the Board, Homer Livingston, a letter in August 2004. (RX 1714 at HFHP 105-06; Styer, Tr. 4996; Belsky, Tr. 4905-06). The letter expressed the Healthcare Foundation's concern that the current litigation might unravel all of the improvements the Merger brought to HPH, including the construction of a new ambulatory care center, creation of a picture archiving system as well as an implementation of an expensive electronic medical record system. ENH also enhanced the emergency department, catheterization labs and radiology equipment, among other improvements. (RX 1714 at HFHP 105; Styer, Tr. 4996; Belsky, Tr. 4907-08). Mayor Belsky, who serves on the Healthcare Foundation's Board of Directors, gave Styer his approval to send the letter expressing concern about this litigation. (RX 1714 at HFHP 110; Belsky, Tr. 4907).

Response to Finding No. 2489:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). Moreover, documents created, by individuals or entities connected with Respondent or its foundation, after the FTC complaint was voted out in 2004 lack credibility. (Cf. Foucre, Tr. 924-25, 927 (discussing ENH's request that United send a letter, drafted by ENH's lawyers, to the FTC making representations that United did not believe were warranted). Finally, Complaint Counsel's Proposed Order requires ENH to divest the assets it acquired in the merger, including any additions and improvements. (See CCF 2560; Complaint Counsel's Proposed Order ¶ I.O.).

1. Divestiture Would Have Adverse Quality Of Care Consequences Pertaining To Cardiac Procedures At HPH

a. Divestiture Would Result In The Loss Of Cardiac Surgery At HPH

2490. Divestiture would have an adverse affect on HPH's post-Merger cardiac surgery program. If HPH were divested from ENH, the knowledge retained by the operating room team, the ICU team, and all the various personnel involved in the provision of cardiac surgery would not be retained. (Rosengart, Tr. at 4560).

Response to Finding No. 2490:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, the cited source does not say what Respondent's finding claims. Rather, it is unlikely that divestiture would adversely affect HPH's post-merger cardiac surgery program.

Various evidence supports the view that HPH would continue its cardiac surgery program after a divestiture. 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, 4557-58; CX 2094). [REDACTED]

[REDACTED] } (Romano, Tr. 3060, *in camera*).

[REDACTED] } (Romano, Tr. 3193, *in camera*). If HPH is divested from ENH, the new operating room suite, the equipment used in cardiac surgery, and the clinical protocols also would all remain in place at that hospital. (Rosengart, Tr. 4558-60). ENH currently operates a joint cardiac surgery program with Swedish Covenant Hospital and Weiss Hospital, each pursuant to an affiliation agreement. (See CCFF 2363-2367).

The mortality rates for Swedish Covenant Hospital's open heart surgery program are, according to ENH, within acceptable limits. ENH is also comfortable with its results for open heart surgery at Weiss Hospital. (Rosengart, Tr. 4502-03). Thus, 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 agreed that the arrangement between Swedish Covenant Hospital and ENH is exceeding its quality parameters. (Newton, Tr. 424).

Finally, HPH's rights in the April 1999 contract with ENH to do cardiac surgery at HPH constituted an asset that ENH acquired in the merger. Pursuant to Complaint Counsel's Proposed Order, Respondent would be obligated to divest these rights to an acquirer (*see* Complaint Counsel's Proposed Order ¶ II.A.1.) who could then continue to do cardiac surgery pursuant to the affiliation agreement. Respondent's concerns about cardiac surgery post-divestiture are therefore without merit.

2491. As Commissioner of Health in New York State, Dr. Chassin reviewed the proposals for open heart surgery programs at community hospitals desiring to be affiliated with academic hospitals. (Chassin, Tr. 5614). Based upon Dr. Chassin's review of the volumes of surgeries and those expected to be performed at HPH as a freestanding entity, he concluded that it would be nearly impossible for HPH to maintain a cardiac surgery program as a stand-alone hospital with any reasonable quality if it were cut off from its relationship with ENH. (Chassin, Tr. 5607-08). In addition, if HPH were a freestanding hospital, it would not have the volumes to support having sub-specialists work solely at HPH. (Chassin, Tr. 5599).

Response to Finding No. 2491:

This finding is irrelevant to the issue of remedy. (*See* CCRFF 2483. *See also* CCRFF 2490 (discussing the likelihood of HPH continuing cardiac surgery after divestiture.)) In addition, Respondent is taking inconsistent positions on the issue of cardiac surgery volumes. Respondent denies that low volumes are cause for concern, but then raises low volumes as a concern in the case of divestiture. *See* CCF 2081-2086 (discussing testimony on both sides of the issue). If the Court concludes that the low volumes are a concern, then initiating the cardiac surgery program does not constitute an

improvement in the first place. Should the Court reject that point of view, and conclude that the program is in fact worth keeping, then the low volumes ipso facto are not a problem.

2492. Certain minimum volume requirements should be met to operate a high quality cardiac surgery program. HPH's cardiac surgery program does not function as a stand-alone program and is integrated with Evanston Hospital's program and, as a result, HPH does not suffer from concerns about low volume in the practice of cardiac surgery. But if HPH were not integrated into ENH and operated as a stand-alone program, this would raise concerns about whether the volume of cardiac surgery patients at HPH adversely affects the quality of the program. (Rosengart, Tr. at 4518-21).

Response to Finding No. 2492:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483, 2490-2491).

2493. Specifically, the integrated relationship between ENH and HPH via the Merger is important for the existence of HPH's cardiac surgery. If HPH were working independently as a stand-alone program, like the affiliated programs at Swedish Covenant Hospital and Weiss Hospital, the volume of procedures performed would fall below suggested criteria for quality and, as such, the continued existence of the program and its ability to perform at a high level would be in question. (Rosengart, Tr. 4520-21; Romano, Tr. 3059-60).

Response to Finding No. 2493:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483, 2490-2491).

In addition, one of the cited sources for this finding actually contradicts the finding. {

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3056-

60, *in camera*).

2494. Moreover, with respect to the ability of a larger institution to create high quality at a lower-volume institution, the distance between the two hospitals is critical. (Chassin, Tr. 5616). It is critical because the physicians have to be able to go back and forth on a routine basis to take care of patients and participate in training and educational conferences. (Chassin, Tr. 5616). That kind of interaction diminishes with greater distances. (Chassin, Tr. 5616).

Response to Finding No. 2494:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483, 2490-2491).

2495. If physicians were not able to respond within 30 minutes or so, then there would be patient safety problems in even the direct postoperative care of patients. (Chassin, Tr. 5616). Proximity is so important that the Illinois Health Planning Board imposed a condition on the opening of cardiac surgery and interventional cardiology programs that at least one interventional cardiologist and one cardiothoracic surgeon be required to live within 30 minutes of HPH. (RX 901 at ENH JH 11513). In terms of being an academic partner, ENH is close enough to HPH such that a heart surgery program is possible. (Chassin, Tr. 5622).

Response to Finding No. 2495:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483, 2490-2491).

2496. If it were no longer possible to treat cardiac patients at HPH, a patient presenting to the HPH ED would need to be evaluated, a correct diagnosis made, a correct determination of necessary treatment made, arrangements made for an ambulance transfer, waiting on the arrival of the ambulance, transfer of the patient to the next hospital, re-evaluation, and assembly of a team to perform the procedure. This delay could have life-or-death consequences. (Chassin, Tr. 5623).

Response to Finding No. 2496:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483, 2490-2491).

In addition, this finding is misleading in that it suggests that the entire cardiac surgery program takes place where delay has "life or death consequences." But much of the cardiac surgery touted by ENH is not in fact emergent, such as the example given of the procedure performed on a 93 year old man. (See Rosengart, Tr. 4492-93). As to this surgery, the very geographical convenience which ENH says makes it easy for doctors to

travel between ENH and HPH, would make it similarly easy for patients to make the same trip if there were no cardiac surgery at HPH. ENH has not quantified the volume of cardiac surgery that takes place at HPH which is in fact done on an emergency basis. In any event, Respondent claims that there are 47 hospitals within 30 miles of at least one ENH hospital. (See RFF 387). If true, it is clear that the alternatives for cardiac surgery at HPH and the alternatives for a merger partner for HPH within a certain radius are hardly limited to ENH.

2497. It would be extraordinarily difficult for HPH to have a meaningful relationship with another hospital, such as the meaningful relationship that Dr. Rosengart has created between ENH and HPH, if the distance between the two hospitals were much greater than the distance between ENH and HPH. (Chassin, Tr. 5615). Certainly 20, 30 or 40 miles between HPH and another academic hospital would be too great to make the relationship work. (Chassin, Tr. 5615-16). Therefore, it is unlikely that HPH could maintain a cardiac surgery program with a Chicago area hospital that is further away from HPH, than Evanston Hospital. (Chassin, Tr. 5615-16).

Response to Finding No. 2497:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483, 2490-2491).

In any event, Respondent claims that there are 47 hospitals within 30 miles of at least one ENH hospital (see RFF 387), so, if true, there are alternatives available.

b. Divestiture Would Result In The Loss Of Interventional Cardiology Program at HPH

2498. If there were no cardiac surgery program at HPH, the percutaneous coronary intervention ("PCI") program could not be sustained because elective PCIs could not be done at HPH without cardiac surgical backup. (Chassin, Tr. 5612).

Response to Finding No. 2498:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, it is likely that HPH would continue its cardiac surgery program after a divestiture. (See

CCRFF 2490). Even if, *arguendo*, HPH did not continue its cardiac surgery program

after divestiture, { [REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3194, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3073, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3073-74, *in camera*).

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3073-74, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3075, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3075, *in camera*).

2499. Elective PCIs are procedures that can be scheduled in advance for patients who

are not critically ill, who have chronic disease, and who do not need the procedure within minutes or hours. (Chassin, Tr. 5306).

Response to Finding No. 2499:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483).

c. Divestiture Would Result In Loss Of Nursing Improvements Resulting From Improved Cardiac Care At HPH After The Merger

2500. There is a strong relationship between the cardiac surgery program and the skill level of nursing. To maintain a high quality cardiac surgery program, the hospital must employ an intensive nurse training program. (Chassin, Tr. 5603-04; Ankin, Tr. 5068-70).

Response to Finding No. 2500:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). It is also likely that HPH would continue its cardiac surgery program after a divestiture. (See CCRFF 2490). In addition, changes made in nursing would likely remain in place after the divestiture of HPH. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] }

(Romano, Tr. 3196-97 (discussing the clinical areas in DX 7033 at 7, *in camera*), *in camera*). [REDACTED]

[REDACTED] } (Romano, Tr. 3197, *in camera*).

2501. Cardiac surgery is one of the most complex set of procedures performed at HPH, and it requires constant updating of everyone's skills – from the surgeon to the physician assistant and all of the different levels of nursing that are involved in providing care to those patients. (Chassin, Tr. 5603).

Response to Finding No. 2501:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483).

d. Divestiture Would Result In Loss Of ICU Nurse Acuity Gained From The Cardiac Surgery Program

2502. There is a relationship between the quality of ICU services and the maintenance of a cardiac surgery program because the ICU services the joint cardiac surgery and other critical care area for the hospital. (Chassin, Tr. 5604).

Response to Finding No. 2502:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, changes made in intensive care would likely remain in place after the divestiture of HPH.

{ [REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3194-95, *in camera*).

2503. Once the ICU nurses are trained to handle the very sick and complicated cardiac surgery patients, those skills spill over into improving their ability to take care of many other critically ill patients who are in the ICU for other reasons. (Chassin, Tr. 5604; Ankin, Tr. 5068-70).

Response to Finding No. 2503:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483).

e. Divestiture Would Result In A Decline In Quality Of Care For Patients With AMI

i. HPH Would Lose Its Capacity To Treat AMI Patients

2504. Acute myocardial infarction ("AMI") is more commonly known as a heart attack. (O'Brien, Tr. 3528). If HPH lost its cardiac surgery program, HPH would lose its capacity to provide immediate life-saving cardiac surgical interventions in cardiac surgical emergencies. (Chassin, Tr. 5609). As a result, HPH patients with those kinds of emergencies would no longer be able to receive care, and their immediate survival would be threatened by the lack of a cardiac surgery program. (Chassin, Tr. 5609-10).

Response to Finding No. 2504:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, it is likely that HPH would continue its cardiac surgery program after a divestiture. (See CCRFF 2490).

2505. Generally, ambulances take patients with critical emergencies to the nearest hospital and the specific diagnosis of a cardiac surgical emergency – such as a tear in the aorta – would not be apparent to an ambulance or paramedic personnel. (Chassin, Tr. 5613).

Response to Finding No. 2505:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, it is likely that HPH would continue its cardiac surgery program after a divestiture. (See CCRFF 2490).

ii. There Would Be An Increase In Transfers Of Patients With AMI From HPH To Other Hospitals

2506. Without a cardiac surgery program, and without a PCI program, the pattern of increasing transfers *into* HPH of patients with a heart attack would start to be reversed because patients would know that they cannot get their heart attack treated by revascularization at HPH and they would begin to go elsewhere. (Chassin, Tr. 5612).

Response to Finding No. 2506:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, it is likely that HPH would continue its cardiac surgery program after a divestiture. (See CCRFF 2490). Finally, it is not clear the alleged improvements that have resulted in an increase in transfers of heart attack patients into HPH has in fact been a net benefit, since at the same time there has been a deterioration of heart attack care, using both outcome and process measures, at the higher-volume Evanston Hospital. (Romano, Tr. 3007).

2507. Indeed, one should expect to see a re-emergence of heart attack patients being transferred *from* HPH to receive the interventional treatment that they previously could have received, but no longer were able to receive, from the hospital. (Chassin, Tr. 5612-13). See

Section VIII.D.2.b.ii.

Response to Finding No. 2507:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, it is likely that HPH would continue its cardiac surgery program after a divestiture. (See CCRFF 2490). Finally, it is not clear the alleged improvements that have resulted in an increase in transfers of heart attack patients into HPH has in fact been a net benefit, since at the same time there has been a deterioration of heart attack care, using both outcome and process measures, at the higher-volume Evanston Hospital. (Romano, Tr. 3007).

iii. Delays In Transfer Would Harm Patients

2508. A patient with a problem with his aorta who is admitted to a divested HPH with no PCI program would require much more time to be transferred to another hospital than the mere length of the ambulance ride. (Chassin, Tr. 5623).

Response to Finding No. 2508:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, it is likely that HPH would continue its cardiac surgery program after a divestiture. (See CCRFF 2490).

2509. The patient first would need to be evaluated in the HPH ED, a correct diagnosis would have to be made, the physician would have to correctly determine the necessary treatment, arrangements then would have to be made for an ambulance transfer, the ambulance would have to arrive, the ambulance then would have to take the patient to another hospital, the patient would have to be re-evaluated by that hospital, and a new team would have to be assembled to perform the procedure. (Chassin, Tr. 5623).

Response to Finding No. 2509:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, it is likely that HPH would continue its cardiac surgery program after a divestiture. (See

CCRFF 2490).

2510. Accordingly, it is not merely the matter of the ambulance ride as the total time delay between the diagnosis of the emergent condition and the actual implementation of treatment. (Chassin, Tr. 5623-24). This delay would harm patients. (Chassin, Tr. 5623-24).

Response to Finding No. 2510:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, it is likely that HPH would continue its cardiac surgery program after a divestiture. (See CCRFF 2490).

2. Divestiture Would Result In HPH Returning To A Community Hospital Governance Model

2511. Hospital governance places a critical role, at all levels, in providing a structure for effective peer review and quality assurance. (Chassin, Tr. 5211).

Response to Finding No. 2511:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483).

2512. From the top down, the hospital's trustees must have a role in hearing about and then enforcing discipline. A devotion to such a practice must be reflected in the hospital's leadership – including the administrative leadership as well as the nursing and physician leadership. Such leadership is necessary to make peer review and quality assurance work well. (Chassin, Tr. 5211).

Response to Finding No. 2512:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483).

2513. If divestiture were awarded, these administrative functions would have to be recreated. (Noether, Tr. 6038). It 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).

Response to Finding No. 2513:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). Moreover,

the clinical governance model employed by HPH pre-merger was typical of community hospitals, accepted by JCAHO, and, to Mr. Newton's knowledge never posed a problem.

(Newton, Tr. 379-80; Spaeth, Tr. 2315. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Romano, Tr. 3132-33, *in camera*).

Prior to the merger, HPH had appropriate committee structures in place to look at quality issues, peer review issues, and risk management activities. (See CCFE 2210-26). HPH also took disciplinary actions against physicians that included reduction of privileges, suspension of privileges, or removal from staff. (See CCFE 2220). The pre-merger management at HPH also knew when to call in outside experts to address problems after which it immediately began to implement the resulting recommendations. (See CCFE 2223-24).

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (See CCFE 2204, 2205, *in*

camera, 2230-31; Silver, Tr. 3931-32, *in camera*).

a. **Loss Of Integrated Medical Staffs Would Deprive HPH of Clinical, Academic and Research Activities**

i. **Divestiture Would Result In HPH's Loss Of Academic Involvement By HPH Physicians At Evanston Hospital Campus**

2514. If the HPH physicians were to lose the continuous influx of exposure to an academic medical center, including academic teaching, their learning would become impaired because they would no longer be participating in activities that would improve their clinical skills. Those skills, therefore, would begin to stagnate. (Chassin, Tr. 5400-01).

Response to Finding No. 2514:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, various evidence supports the view that academic affiliation does not improve the quality of care. Expert testimony established that { [REDACTED]

[REDACTED]

[REDACTED] (Romano, Tr. 3124-25, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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

{ [REDACTED]

[REDACTED]

[REDACTED] (Romano, Tr. 3124-25, *in camera*). { [REDACTED]

[REDACTED]

[REDACTED] (Romano, Tr. 3125, *in*

camera).

[REDACTED]

[REDACTED]

(Romano, Tr. 3118, *in camera*). [REDACTED]

[REDACTED] (Romano, Tr. 3118,
3124, *in camera*). [REDACTED]

[REDACTED]

[REDACTED]

(Romano, Tr. 3117, 3121-22, 3123, 3214, 3218-22, *in camera*).

ii. **Divestiture Would Result In HPH's Loss Of Research Partnerships With Physicians At Evanston Hospital**

2515. If HPH were to be returned to a stand-alone hospital, it would lose the kinds of conferences and partnerships among physicians at the three hospitals. These conferences and partnerships focus on the development of multidisciplinary treatment plans for individual patients and, on the quality assurance side, look at individual complications and individual difficult cases to make decisions that could never be made at a free-standing community hospital. (Chassin, Tr. 5598-99; Ankin, Tr. 5053-54).

Response to Finding No. 2515:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, various evidence supports the view that academic affiliation does not improve the quality of care. (See CCRFF 2514). In any event, HPH was an attractive candidate for other mergers (see CCF 368-372) even before ENH allegedly improved it.

2516. These types of multidisciplinary discussions cannot be accessed through regular educational conferences because those types of conferences tend to be straightforward lectures and didactic seminars. (Chassin, Tr. 5598-99).

Response to Finding No. 2516:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition,

various evidence supports the view that academic affiliation does not improve the quality of care. (See CCRFF 2514).

iii. Divestiture Would Result In HPH's Loss Of Department Conferences And Case Consultation

2517. More information can be shared among physicians at department conferences within the same hospital than if physicians merely attend the conference as a visitor from another hospital. (Chassin, Tr. 5598-99). The conferences that are held in which medical staff members of many, unaffiliated hospitals attend are pretty much straightforward lectures. (Chassin, Tr. 5599).

Response to Finding No. 2517:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, various evidence supports the view that academic affiliation does not improve the quality of care. (See CCRFF 2514). In any event, if Respondent is correct that in-house conferences are better for a hospital than conferences at another hospital, then it is hard to see how post-divestiture HPH would suffer at all from having in-house conferences.

2518. In contrast, the kinds of conferences that are routinely held now involving physicians from HPH and Evanston and Glenbrook Hospitals are multi-disciplinary, patient care-focused conferences to develop treatment plans for individual patients. (Chassin, Tr. 5599). With respect to quality assurance, these conferences within ENH are multidisciplinary quality assurance conferences that look at individual complications and difficult cases to make decisions that would never be made in conferences involving separate institutions. (Chassin, Tr. 5599).

Response to Finding No. 2518:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, various evidence supports the view that academic affiliation does not improve the quality of care. (See CCRFF 2514).

3. Divestiture Would Result In HPH's Loss Of ENH Quality Improvement And Quality Assurance Programs

2519. Upon divestiture, it would be likely that the cardiac surgery team at HPH would not be able to perform at the high level it does today. (Chassin, Tr. 5401).

Response to Finding No. 2519:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, it is likely that HPH would continue its cardiac surgery program with acceptable quality after a divestiture. (See CCRFF 2490).

2520. The integrated nature of the cardiac surgery program between ENH and HPH that was created after the Merger requires that every member of the cardiac surgery team continuously interact with every other member of the team. (Chassin, Tr. 5401). This involves continuous participation in learning and developing new protocols, new evidence-based methods of taking care of patients. (Chassin, Tr. 5401).

Response to Finding No. 2520:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, it is likely that HPH would continue its cardiac surgery program with acceptable quality after a divestiture. (See CCRFF 2490).

2521. If that close relationship were severed, the skills of the combined group, ENH and HPH, would start to atrophy at the HPH site. (Chassin, Tr. 5401).

Response to Finding No. 2521:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, it is likely that HPH would continue its cardiac surgery program with acceptable quality after a divestiture. (See CCRFF 2490).

2522. Moreover, if HPH were to return to a stand-alone hospital, it would not be able to continue the preoperative gynecologic surgical review program because it would not have the department leadership provided by ENH. (Silver, Tr. 3861-62).

Response to Finding No. 2522:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition,

various evidence supports the view that (1) [REDACTED] [REDACTED] } (see CCFF 2186-2208; CCRFF 1233-1333); and (2) the changes were not merger specific because HPH, on its own or with others, could have achieved the same changes (see CCFF 2417-2425). Any change in clinical governance from a paid department chairperson to the pre-merger rotating department chairperson method (which is typical of community hospitals) does not preclude HPH from submitting decision to operate to some form of peer review, if it deems such review to be appropriate.

4. Divestiture Would Result In HPH's Loss Of The Benefits Of Epic

2523. As discussed in Section VIII.D.2.h, the community served by the ENH hospitals benefits from the use and deployment of Epic at those hospitals. (Wagner, Tr. 3989). The value of Epic to the community is enhanced and improved by greater participation in the system. That is, the more institutions, the more physicians and the more caregivers looking at the same data and having access to patients' electronic records, with the system's safety features, the better the outcomes for the patients. (Wagner, Tr. 3989-90).

Response to Finding No. 2523:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, it is likely that HPH would continue to use the EPIC information system after a divestiture. The use of electronic medical records by hospitals has increased recently among community hospitals. (Wagner, Tr. 4067-69). Other hospitals have purchased the EPIC electronic medical record system, and systems similar to it. (Wagner, Tr. 4066-68).

[REDACTED]

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

[REDACTED]

[REDACTED] } (Romano, Tr. 3161-62, *in camera*). [REDACTED]
[REDACTED] } (Romano, Tr. 3162, *in camera*). [REDACTED]
[REDACTED] } (Romano, Tr. 3162-63, *in camera*). [REDACTED]
[REDACTED] } (Romano, Tr. 3162-63, *in camera*). [REDACTED]
[REDACTED] } (Romano, Tr. 3162-65, *in camera*). [REDACTED]
[REDACTED] } (Romano, Tr. 3165, *in camera*). [REDACTED]
[REDACTED] } (Romano, Tr. 3197, *in camera*).

A post-divestiture HPH would be well positioned to continue using EPIC. For example, Complaint Counsel's Proposed Order requires ENH to provide transitional services (in connection with services that had been consolidated on a corporate-wide basis) to an acquirer for a period not to exceed 12 months (Complaint Counsel's Proposed Order ¶ II.G.). Among other things, this would allow an acquirer time to address and implement its own computer system. Second, the Proposed Order requires ENH to grant a non-exclusive license to an acquirer of HPH to all intellectual property related to ENH's hospital business (Complaint Counsel's Proposed Order ¶ II.D.). This license would include access to information involving EPIC workflows, data center, information services procedures, and training procedures. This would complement the

fact that HPH's employees and physicians are already trained in EPIC.

Finally, Respondent has presented no evidence showing what the EPIC license itself costs (that is, the license only, not counting other installation and training costs). Thus, Respondent cannot argue that it would be too expensive for an acquirer to obtain its own license.

2524. The value of Epic to the community is diminished when physicians and hospitals cease to use the same Epic database. (Wagner, Tr. 3990).

Response to Finding No. 2524:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, it is likely that HPH would continue to use the EPIC information system after a divestiture. (See CCRFF 2523).

2525. The Merger increased the value of ENH's implementation of Epic by increasing the number of participants, sites of care, and providers of care. (Wagner, Tr. 3961-62). ENH's deployment and use of Epic at HPH benefited patients in the Highland Park community as well as other communities. (Wagner, Tr. 3990-91).

Response to Finding No. 2525:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, it is likely that HPH would continue to use the EPIC information system after a divestiture. (See CCRFF 2523).

2526. ENH owns the license to use Epic, which is non-assignable. This means that the license could not be assigned to HPH if it were divested from ENH. (Wagner, Tr. 3991). Thus, HPH would not be able access the data stored in ENH's Epic database through any sort of cost-sharing arrangement in the event that divestiture were ordered. (Wagner, Tr. 4080). If HPH were no longer part of the ENH system, it would need to purchase a separate license to use Epic. (Wagner, Tr. 3991).

Response to Finding No. 2526:

This finding is irrelevant to the issue of remedy. (*See* CCRFF 2483). In addition, it is likely that HPH would continue to use the EPIC information system after a divestiture. (*See* CCRFF 2523). Finally, Complaint Counsel's Proposed Order requires ENH to grant a license to an acquirer of HPH to all intellectual property relating to the HPH hospital business, which would include any information relating to HPH patients (*see* Complaint Counsel's Proposed Order ¶ II.D.). Thus, contrary to the third sentence of this finding, an acquirer of HPH would have the right to the data stored in ENH's Epic database to the extent that such data relates to HPH's business.

2527. There are numerous barriers preventing HPH from maintaining Epic post-divestiture. (Wagner, Tr. 3991-95). First, if any part of the hospital environment were changed, the workflows in Epic must be rebuilt. (Wagner, Tr. 3992-93).

Response to Finding No. 2527:

This finding is irrelevant to the issue of remedy. (*See* CCRFF 2483). In addition, it is likely that HPH would continue to use the EPIC information system after a divestiture. (*See* CCRFF 2523). Finally, after the merger, ENH consolidated HPH staff, consolidated clinical procedures, and moved some clinical and corporate services to locations other than Highland Park Hospital. In particular, ENH discontinued certain corporate functions at HPH (consolidating at Evanston) including, among other things, the information systems department. (Hillebrand, Tr. 1839. *See also* Neaman, Tr. 1345). Because these functions were consolidated post-merger, Complaint Counsel's Proposed Order requires ENH to provide certain services to an acquirer of HPH for a transitional period of time (*see* Complaint Counsel's Proposed Order ¶ II.G.). This would then allow an acquirer to arrange for such services itself (including information systems) or to find

an alternative supplier with minimum disruption to its business. The Proposed Order also requires ENH to grant a non-exclusive license to an acquirer of HPH to all intellectual property related to ENH's hospital business (Complaint Counsel's Proposed Order ¶ II.D.). This license would include access to information involving EPIC workflows, data center, information services procedures, and training procedures.

2528. Second, to maintain Epic if divestiture were ordered, HPH also would have to purchase a data center, hire an information services department to manage and run Epic, develop its own training division and develop their own support team. (Wagner, Tr. 3993-94).

Response to Finding No. 2528:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, it is likely that HPH would continue to use the EPIC information system after a divestiture. (See CCRFF 2523). Finally, Complaint Counsel's Proposed Order requires ENH to provide certain transitional services to an acquirer of HPH. This would allow an acquirer to arrange for such services itself (including information systems) or to find an alternative supplier with minimum disruption to its business. (See CCRFF 2527).

Finally, the Proposed Order also requires ENH to cooperate, and not interfere, with an acquirer to hire key management personnel from among ENH's ranks. (See Complaint Counsel's Proposed Order ¶ II.H.).

2529. Third, HPH currently does not have the infrastructure to run Epic on its own. (Wagner, Tr. 4073). If divestiture were ordered, it would take HPH three to five years to get up and running with Epic on its own. (Wagner, Tr. 3994).

Response to Finding No. 2529:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, it is likely that HPH would continue to use the EPIC information system after a

divestiture. (See CCRFF 2523). Finally, Complaint Counsel's Proposed Order requires ENH to provide certain transitional services to an acquirer of HPH. This would allow an acquirer to arrange for such services itself (including information systems) or to find an alternative supplier with minimum disruption to its business. (See CCRFF 2527).

2530. Finally, if HPH were bought by another hospital system that used Epic, there currently is no way for the two Epic systems to communicate. (Wagner, Tr. 3994-95). Currently, hospitals that use Epic but are in different hospital systems cannot share information that is in their respective Epic databases. (Wagner, Tr. 3994).

Response to Finding No. 2530:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, it is likely that HPH would continue to use the EPIC information system after a divestiture. (See CCRFF 2523). Finally, Complaint Counsel's Proposed Order requires ENH to provide certain transitional services to an acquirer of HPH. This would allow an acquirer to arrange for such services itself (including information systems) or to find an alternative supplier with minimum disruption to its business. (See CCRFF 2527).

5. Divestiture Would Result In A Diminished Ability By HPH To Recruit High-Caliber Physicians And Hospital Administrators

2531. A hospital's status as an academic medical center, or being affiliated with an academic medical center, has a substantial positive impact on the hospital's ability to recruit the highest quality physicians and hospital administrators. (Chassin, Tr. 5600).

Response to Finding No. 2531:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, various evidence supports the view that academic affiliation does not improve quality of care. (See CCRFF 2514).

2532. The impact of being an academic medical center, or being affiliated with one, on

recruiting high-caliber physician leaders is that when most academic hospitals seek to fill leadership positions, they endeavor to find someone interested in staying as current as possible and, in fact, establishing what the new standards of practice will be. (Chassin, Tr. 5600-01). Thus, academic hospitals attract physicians who are interested in research connections with respect to their field, physicians who are interested in establishing the latest and most effective best practices in patient care, and physicians who are interested in establishing the latest and most effective best practices in patient care and in establishing the ongoing process of maintaining those best practices and providing the best quality care. (Chassin, Tr. 5601).

Response to Finding No. 2532:

This finding is irrelevant to the issue of remedy. (See CCRFF 2483). In addition, various evidence supports the view that academic affiliation does not improve quality of care. (See CCRFF 2514).

C. Divestiture Is Not A Proper Remedy Because ENH Cannot “Unlearn” About Its Demand

2533. { [REDACTED]
[REDACTED] }
(Baker, Tr. 4655-56, *in camera*). { [REDACTED]
[REDACTED] } (Baker, Tr. 4656, *in camera*).

Response to Finding No. 2533:

This and all of Respondent's findings in Section X(C)) are irrelevant to the issue of divestiture. In Section X(C)), Respondent argues that divestiture is not a proper remedy because ENH cannot “unlearn” about its demand. Evaluation of a merger remedy, however, begins with the basic premise that the merger violated Section 7. By finding a Section 7 violation, the Court would have rejected Respondent’s “learning about demand” theory. The Court instead would have determined that ENH raised prices significantly above those of the control group because it acquired and exercised market power as a result of the merger. Once the market power explanation has been accepted,

Respondent cannot come back again with "learning about demand." If "learning about demand" did not explain the price increases in the first place when considering liability, it cannot explain the continuation of those price increases for remedy purposes.

Respondent is again simply arguing liability under the heading of remedy. Complaint Counsel objects to this practice. Without waiving this objection, Complaint Counsel responds below as appropriate to Respondent's remedy findings.

This finding is irrelevant to the issue of remedy. To the extent it has relevance to the issue of liability, it is incorrect. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (Haas-Wilson, Tr. 2732-33

(referring to DX 7046), *in camera*). (See, e.g. CCFF 737).

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] }

In any event, Dr. Baker lacked credibility. (See CCFF 1742-1762).

2534. { [REDACTED]

[REDACTED] } (Baker, Tr. 4656, *in camera*).

Response to Finding No. 2534:

This finding is irrelevant to the issue of remedy. (See CCRFF 2533). To the extent it has relevance to the issue of liability, it is incorrect. { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (See CCRFF

284-301).

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (See CCRFF 192-283).

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

(Haas-Wilson, Tr. 2479). { [REDACTED]

[REDACTED]

{ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (See CCF 722-725). [REDACTED]

[REDACTED] (See CCF 245-260). [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

In any event, Dr. Baker lacked credibility. (See CCF 1742-1762).

D. Divestiture Is Not A Proper Remedy Because The Merger Was Between Two Members Of An Approved Network

2535. As discussed in Section III.A, Evanston Hospital and HPH were both part of the Network, which received Hart-Scott-Rodino approval in 1993. (Neaman, Tr. 1360).

Response to Finding No. 2535:

Section X(D) of Respondent's remedy findings argues that divestiture is not a proper remedy because the merger was between two members of an approved network. By invoking facts relating to the relationship between ENH and HPH before the merger, Respondent is arguing the question of liability. Complaint Counsel submits that it is inappropriate to raise liability issues again (under the heading of remedy) because a discussion of remedy assumes, *arguendo*, that Respondent did not prevail on the liability question. Section 7 liability would mean that the Court rejected Respondent's claims on the FTC's ability to challenge the merger. Without waiving this objection, Complaint Counsel responds below as appropriate to Respondent's remedy findings.

This finding is irrelevant to the issue of remedy. *See* CCRFF 300 concerning the FTC's ability to challenge the merger of Evanston and HPH. To the extent that the finding has relevance to the issue of liability, ENH's membership in the Northwestern Healthcare Network does not eliminate ENH's liability under Section 7 of the Clayton Act. (*See* CCFF 2535-2559).

2536. In August 1999, before the Merger, the FTC Pre-Merger Notification Office notified the Network, Evanston Hospital, and Lakeland, the parent company of HPH, that it viewed the Network as already holding the assets of both Evanston Hospital and Lakeland. (RX 586 at 2).

Response to Finding No. 2536:

This finding is irrelevant to the issue of remedy. (*See* CCRFF 2535). *See* CCRFF 298 concerning the FTC's ability to challenge the merger of Evanston and HPH. To the extent that the finding has relevance to the issue of liability, ENH's membership in the Northwestern Healthcare Network does not eliminate ENH's liability under Section 7 of the Clayton Act. (*See* CCFF 2535-2559).

2537. As such, the FTC Pre-Merger Notification Office did not view the Merger between Evanston Hospital and HPH as an acquisition of assets under the HSR Act. (RX 586 at 2). "This conclusion is not altered by the fact that [the Network] will be dissolved and removed as a member of [ENH] following the effective date of the merger. . . . [A]s long as [the Network] exists and holds the reserved power over appointments to the boards of [ENH] and [Lakeland Health Services] at the time of the merger, the merger will not be reportable." (RX 586 at 2).

Response to Finding No. 2537:

This finding is irrelevant to the issue of remedy. (*See* CCRFF 2535). *See* CCRFF 298-99 concerning the FTC's ability to challenge the merger of Evanston and HPH. To the extent that the finding has relevance to the issue of liability, ENH's membership in the Northwestern Healthcare Network does not eliminate ENH's liability under Section 7

of the Clayton Act. (See CCRFF 2535-2559).

E. Divestiture Is Not A Proper Remedy Because It Would Undo Efficiencies Of The Merger

2538. Harry Jones, as head of the finance department at ENH, was given the responsibility to track the cost savings and revenue enhancements that were achieved after the Merger. (H. Jones, Tr. 4130-31). The various departments at ENH would report their savings to the finance department, which would challenge the expected savings and compile them into a monthly report. (H. Jones, Tr. 4130-31; RX 883). The list prepared by the finance department was not an exact calculation, but rather a "best estimate" of what was achieved. (H. Jones, Tr. 4131; RX 883).

Response to Finding No. 2538:

Section X(E) of Respondent's remedy findings argues that divestiture is not a proper remedy because it would undo efficiencies of the merger. As set forth in the Merger Guidelines, efficiencies analysis comes into play at the liability stage of an evaluation. (Merger Guidelines, § 4). Thus, by invoking matters relating to alleged efficiencies achieved by the merger, Respondent is arguing the question of liability. Complaint Counsel submit that it is inappropriate to raise liability issues again (under the heading of remedy) because a discussion of remedy assumes, *arguendo*, that Respondent did not prevail on the liability question. Section 7 liability would mean, among other things, that the Court rejected any claim by Respondent that merger-specific efficiencies outweighed the merger's anticompetitive harm. Without waiving this objection, Complaint Counsel respond below as appropriate to Respondent's remedy findings.

RFF 2538 is irrelevant to the issue of remedy. To the extent that it has relevance to the issue of liability, Respondent acknowledges that the savings are estimates and points to no evidence that these planned savings were ever actually achieved. In addition,

Respondent has not shown that these are “merger-specific efficiencies” that could only be achieved by the merger between ENH and HPH. (Merger Guidelines, § 4). If either ENH or HPH merged with another entity, it may have been able to realize the savings (such as from consolidating administrative operations) without the anticompetitive effect.

The Anticompetitive Effects of the Merger Outweigh Any Alleged Efficiencies

Respondent has not alleged a cost savings efficiencies defense, despite claiming in RFF 2539 that “[a]pproximately \$12 million . . . was directly tied to savings after the merger.” It makes sense that Respondent has not raised the defense, because the merger resulted in price increases. (See CCRFF 1). Furthermore, merger-related expenses must be subtracted from any alleged merger-related savings, and there were millions of dollars in merger-related expenses. (See, e.g., CCFF 352-354 (concerning the estimated \$11 million in merger-related costs)). Moreover, Respondent has not shown that savings, if any, were actually passed on to consumers.

In any event, even assuming, *arguendo*, that certain efficiencies were achieved and passed on, the anticompetitive impact of the merger substantially outweighed any purported benefits. The entire anticompetitive cost of the merger is not certain, but some facts are clear. First, just from the year 2000 health plan contract re-negotiations alone, ENH increased its net revenues by a minimum of \$18 million annually. (See CCFF 1329-1337). Second, the price increase from shifting all three hospitals to the Evanston or Highland Park pre-merger contract for the particular health plan (whichever contract had the higher rate) gave ENH at least \$10 million annually more. (CCFF 833-842). Third, the 2000 “equalization” of the Evanston and Highland Park chagemasters at whatever

was the higher price for the particular product or service netted ENH at least another \$5 million annually. (CCFF 884-895). (Thus, these three increases netted a minimum of \$33 million a year.) { [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] } (RX 1687 at ENHL BW 027653, *in camera*; CCFF 817-821, 918-924, *in camera*, 930). Based on a document from ENH's files that sets ENH's net at roughly 20% of the gross (CX 45 at 8 (estimating that the net annual impact of the 2002 chagemaster increase of \$102.2 million was \$20-\$26 million)), the four chagemaster increases in 2002-2003 netted about \$39.4 million annually.

2539. The finance department tracked approximately \$36 million in enhancements and savings that were achieved after the Merger. (H. Jones, Tr. 4131). Approximately \$12 million of the total amount was directly tied to savings after the Merger. (H. Jones, Tr. 4131).

Response to Finding No. 2539:

This finding is irrelevant to the issue of remedy. (See CCRFF 2538). To the extent that it has relevance to the issue of liability, Respondent points to no evidence that the savings were ever actually achieved or that they were merger-specific and could not have been achieved through alternative means. (See CCRFF 2538). Mr. Jones testified that these purported savings were "best estimates," not actual measurements. (H. Jones, Tr. 4131).

In addition, the purported savings must be balanced by the costs attributable to the merger. For the year ending September 2001, ENH in its audited financials stated that it

spent \$11 million in “merger-related costs.” (CX 2068 at 24). Lakeland Health Services in its audited financials calculated that it spent \$8.7 million in “merger-related costs” for 1999. (CX 693 at 9). Thus, without counting Evanston’s merger-related costs in 1999 and the combine entity’s costs in 2000 (which were not available in the record), the merger-related costs already outweigh the supposed \$12 million “directly tied to savings after the Merger.”

2540. Several Merger efficiencies contributed to the cost savings of the Merger. (RX 967 at ENH GW 1147-50). ENH saved \$2 million by phasing-out seven senior management positions and twenty-five corporate staff. (RX 967 at ENH GW 1147). The unified pricing structure of the three hospitals resulted in a \$5 million cost improvement. (RX 967 at ENH GW 1147). Another \$2 million was saved by combining advertising and other corporate functions. (RX 967 at ENH GW 1148). ENH also achieved \$400,000 savings by merging human resource benefits and \$900,000 by consolidating information systems staffing. (RX 967 at ENH GW 1148-49).

Response to Finding No. 2540:

This finding is irrelevant to the issue of remedy. (See CCRFF 2538). To the extent that it has relevance to the issue of liability, Respondents point to no evidence that the savings were ever actually achieved or that they were merger-specific and could not have been achieved through alternative means. (See CCRFF 2538). Mr. Jones testified that these purported savings were “best estimates,” not actual measurements. (H. Jones, Tr. 4131).

2541. By adding HPH to a single Medicare provider status after the Merger, ENH realized \$200,000 in cost savings. (RX 967 at ENH GW 1150).

Response to Finding No. 2541:

This finding is irrelevant to the issue of remedy. (See CCRFF 2538). To the extent that it has relevance to the issue of liability, Respondents point to no evidence that

the savings were ever actually achieved or that they were merger-specific and could not have been achieved through alternative means. (See CCRFF 2538). Mr. Jones testified that these purported savings were “best estimates,” not actual measurements. (H. Jones, Tr. 4131).

2542. “One needs to evaluate the benefits and costs associated with a remedy.” (Noether, Tr. 6037). Complaint Counsel's chief economic expert witness, Dr. Haas-Wilson, testified plainly that she offered no opinion on the proper remedy in this case. (Haas-Wilson, Tr. 2441).

Response to Finding No. 2542:

This finding is irrelevant to the issue of remedy. (See CCRFF 2538). The calculation of any purported efficiencies or procompetitive effects allegedly due to the merger is irrelevant in the remedy phase. As set forth in the Merger Guidelines, efficiencies and procompetitive effects analyses come into play at the liability, not remedial, stage. (Merger Guidelines § 4). Once there is a finding of a Section 7 violation, evaluating efficiency benefits is moot.

If Respondent is alleging additional costs associated with the remedy, it has not specified these costs. In any event, the divestiture remedy will restore the competition lost due to the Evanston-Highland Park merger, with improvements, if any, to HPH remaining with HPH. (See CCFF 284-301, 2560-65).

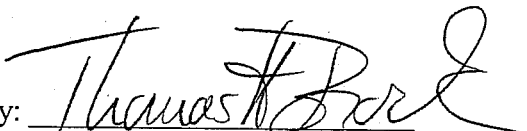
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July 1, 2005

By: 

CERTIFICATE OF SERVICE

I hereby certify that on July 1, 2005, I caused the attached "Complaint Counsel's Proposed Findings of Fact in Reply" to be served upon the persons identified below and in the manner indicated:

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