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Abbreviations of Terms Used in Respondent's Reply Findings of Fact

1. "AAMC" – Association of American Medical Colleges
2. "ACC" – Ambulatory Care Center
3. "ACOG" – American College of Obstetricians and Gynecologists
4. "ACS" – American College of Surgeons
5. "Advocate Lutheran General" – Advocate Lutheran General Hospital, which is part of the Advocate system
6. "Advocate North Side" – Advocate North Side Health Network
7. "Aetna" – Aetna Inc., including Aetna Health Management, Aetna Health Plans of Illinois, Aetna Health Plans of the Midwest and Aetna U.S. Healthcare of Illinois
8. "AHA" – American Heart Association
9. "AHRQ" – Agency for Healthcare Research and Quality
10. "AMI" – Acute Myocardial Infarction
11. "ASHP" – American Society of Health System Pharmacists
12. "Bain" – Bain & Company
13. "Balanced Budget Act" – Balanced Budget Act of 1997
14. "Blue Cross" – Blue Cross and Blue Shield of Illinois, including Blue Advantage, Blue Choice, Blue Cross and Blue Shield Association, Health Care Service, HMO Illinois (HMOI), and Managed Care Network Preferred (MCNP).
15. "CABG" – Coronary Artery Bypass Grafting
16. "CCN" – the entity before First Health Group acquired CCN in August 2001, and includes Affordable, CCN and Healthcare Compare
17. "CCOP" – Community Clinical Oncology Program
18. "CDSS" – Clinical Decision Support Systems
19. "CEO" – Chief Executive Officer

20. “Children’s Memorial” – Children’s Memorial Hospital
21. “CHRPP” – Chicago Hospital Risk Pooling Program
22. “Cigna” – Cigna Corporation, including CIGNA HealthCare of Illinois, and CIGNA Healthplan of Illinois
23. “CML” – Consolidated Medical Labs
24. “COO” – Chief Operating Officer
25. “CON” – Certificate of Need
26. “Condell” – Condell Medical Center
27. “COTH” – Council of Teaching Hospitals
28. “CPI” – Consumer Price Index
29. “CPOE” – Computerized Physician Order Entry
30. “CPT Codes” – Current Procedural Terminology
31. “CST” – Contraction Stress Tests
32. “Deloitte” – Deloitte Consulting
33. “DRG” – Diagnosis-Related Groups
34. “ED” – Emergency Department
35. “ENH” – Evanston Northwestern Healthcare Corporation, post-Merger
36. “ENT” – Ear, Nose and Throat
37. “Evanston Hospital” – pre-Merger Evanston and Glenbrook Hospitals when referred to in the past tense, and Evanston Hospital alone when referred to in the present tense
38. “Great West” – Great-West Life & Annuity Insurance Company, including One Health Plan of Illinois, One Health Plan, Great-West Healthcare of Illinois and Great-West Healthcare
39. “HCFA” – Healthcare Finance Administration
40. “HCUP” – Healthcare Cost and Utilization Project

41. “Healthcare Foundation” – Healthcare Foundation of Highland Park
42. “HFN” – HFN, Inc.
43. “HHI” – Herfindahl-Hirschman Index
44. “HHS Letter” – Letter from the Department of Health and Human Services, received On July 14, 1999, by Peter Friend, HPH’s Chief Operating Officer
45. “HIPPA” – Health Insurance Portability and Accountability Act of 1996
46. “HMO” – Health Maintenance Organizations
47. “HPH” – Highland Park Hospital
48. “HPH Lab” – Immediate Response or “Stat” Laboratory within HPH
49. “Humana” – Humana, Inc., including Employers Health (EHI), Humana Health Plan, Humana HealthChicago, Humana Insurance and Michael Reese Health Plan
50. “ICU” – Intensive Care Unit
51. “IDPH” – Illinois Department of Public Health
52. “IOM” – Institute of Medicine
53. “IQI” – Mortality Indicators
54. “IRB” – Institutional Review Board
55. “ISMP” – Institute for Safe Medication Practices
56. “IT” – Information Technology
57. “JAMA” – The Journal of the American Medical Association
58. “JCAHO” or “Joint Commission” – Joint Commission for the Accreditation of Healthcare Organizations
59. “Kaufman Hall” – Kaufman Hall & Associates
60. “Lakeland” – Lakeland Health Services
61. “LDRP” – Labor, Delivery, Recovery and Postpartum
62. “Loyola” – Loyola University Medical Center

63. “MCOs” – Managed Care Organizations/Private Payors
64. “MedPAC” – Medicare Payment Advisory Commission
65. “Merger” – Merger of Highland Park Hospital with Evanston and Glenbrook Hospitals on January 1, 2000
66. “Merger Guidelines” – The 1992 Horizontal Merger Guidelines, as amended
67. “NAMM” – North American Medical Management
68. “Network” or “NHN” – Northwestern Healthcare Network
69. “NST” – Nonstress Tests
70. “NIH” – National Institutes for Health
71. “NH North” – A failed attempt by Evanston Hospital, HPH and another hospital to form a three-way hospital merger
72. “North Shore” – Northern suburbs of the Chicago, Illinois metropolitan area where ENH is located
73. “Northwestern Memorial” – Northwestern Memorial Hospital
74. “Northwestern Medical School” – Northwestern Feinberg School of Medicine
75. “NPDB” – National Practitioner Data Bank
76. “NPIC” – National Perinatal Information Center
77. “NRMI” – National Registry of Myocardial Infarction
78. “Ob/Gyn” – Obstetrics and Gynecology
79. “OCT” – Oxytocin Challenge Test
80. “OR” – Operating Room
81. “PACS” – Pictorial Archiving Communication System
82. “PCI” – Percutaneous Coronary Interventions
83. “PCP” – Primary Care Physicians
84. “PHCS” – Private Healthcare Systems

85. “PHO” – Physician-Hospital Organization
86. “PMSA” – Primary Metropolitan Statistical Area
87. “POS” – Point of Service
88. “PPO” – Preferred Provider Organizations
89. “PPONS” – Pulmonary Physicians of the North Shore
90. “Press Ganey” – Press Ganey, Associates, Inc.
91. “PROMIS” – Patient Reported Outcome Measurement Information System
92. “PSI” – Patient Safety Indicators
93. “QA” – Quality Assurance
94. “QI” – Quality Improvement
95. “Respondent” – Evanston Northwestern Healthcare
96. “Resurrection” – Resurrection Medical Center
97. “RFF” – Respondents Proposed Findings of Fact
98. “RFF-Reply” – Respondent’s Replies to Complaint Counsel’s Proposed Findings of Fact
99. “Rush North Shore” – Rush North Shore Medical Center
100. “Rush Presbyterian” – Rush-Presbyterian-St. Luke’s Medical Center
101. “St. Francis” – St. Francis Hospital
102. “STS” – Society of Thoracic Surgery
103. “U.C. Davis” – University of California at Davis
104. “Unicare” – Unicare Life and Health Insurance Company, including Access, Anchor, Prudential, Rush Prudential Health Plans, Rush and WellPoint
105. “United” – United Healthcare of Illinois, which is part of United Health Group, I including Chicago HMO, Metlife, MetraHealth, Share, Travelers and United Healthcare

106. “University of Chicago” – University of Chicago Hospital
107. “VBAC” – Vaginal Birth After a Cesarean Section
108. “VRQC” – Voluntary Review of Quality of Care

Pursuant to the Court's Order on Post Trial Briefs on April 6, 2005, and Rule 3.46 of the Federal Trade Commission Rules of Practice ("Rules"), 16 C.F.R. § 3.46, Respondent Evanston Northwestern Healthcare Corporation ("ENH") hereby submits its Replies to Complaint Counsel's Proposed Findings of Fact.

I. INTRODUCTION

1. Counts I and II of the Complaint allege that Evanston and Highland Park consummated a merger in violation of Section 7 of the Clayton Act. Count I alleges the violation using a structural analysis drawn from the Merger Guidelines,¹ but adapted to the facts of this case in which Complaint Counsel challenges a merger that has already taken place and for which pricing data is available. Count II alleges the violation based on direct evidence of competitive effects of the merger. (See CCFE 83).²

Response to Finding No. 1:

Respondent agrees with this proposed finding to the extent that Counts I and II allege claims against Evanston Northwestern Healthcare ("ENH")³. These allegations, however, have no basis in fact or law. Indeed, Count II, to the extent it alleges that Complaint Counsel can prove a violation of Section 7 based on direct effects alone, has no legal basis. (Resp.'s Pre-Trial Brief at 9-13; Resp.'s Post-Trial Brief at 31-34; Resp.'s Reply Brief at Section I.D.1).

2. "Market power" is the ability of a firm to raise its prices above competitive levels. The term "competitive levels" means a long-term analysis to determine the price that would just allow a firm to break-even or earn "zero economic profit." (See CCFE 104).

Response to Finding No. 2:

Respondent agrees with the definition of market power. However, this proposed finding confuses the definition of "competitive levels." Competitive levels are simply a firm's prices as

¹ U.S. Dept. of Justice & Federal Trade Commission, *Horizontal Merger Guidelines* (1992 rev'd 1997)

² "CCFE" refers to Complaint Counsel's Proposed Findings of Fact.

³ Unless otherwise indicated, the term "Evanston Hospital," when used in the past tense, refers to both Evanston Hospital and Glenbrook Hospital before the Merger. The term "Evanston Hospital," when used in the present tense,

compared to the average of several of its competitors. Competitive levels are the price levels that prevail in a competitive marketplace with free and unfettered competition. Different competitive prices might be measured for different firms. In cases where the marketplace supports more than one price level, a representative price is simply the average of the competitors' prices. For instance, in this case, ENH's competitive price level is the average price of care at several of the major teaching hospital in the Chicago area. (Noether, Tr. 5992).

3. The direct evidence of anticompetitive effects of the merger includes evidence of ENH's post-merger price increases (both absolute price increases and price increases relative to other hospitals in the Chicago area). (See, e.g., CCF 373-745, 822-1337).

Response to Finding No. 3:

This proposed finding is incorrect and misleading to the extent it suggests that price increases alone are sufficient to demonstrate direct evidence of anticompetitive effects of the Merger.

REDACTED

(Baker, Tr. 4702, 4644, 4649-50, 4652-53, *in camera*; Haas-Wilson, Tr. 2677; Noether, Tr. 5904).

REDACTED

(Haas-Wilson, Tr. 2546-47, *in camera*).

REDACTED

(Haas-Wilson, Tr. 2828, *in camera*). To prove anticompetitive effects, Complaint Counsel needed to show that there was not a benign reason for the price increase. (Haas-Wilson, Tr. 2677-78; Elzinga, Tr. 2404).

REDACTED

refers to the current Evanston Hospital alone. The term "ENH" refers to the post-Merger entity (Evanston Hospital, Glenbrook Hospital and Highland Park Hospital).

REDACTED

}; (Noether, Tr. 5989, 5991; Haas-Wilson, Tr.

2823-24, *in camera*).

(Haas-

Wilson, Tr. 2834-35, *in camera*).

REDACTED

REDACTED

(Baker, Tr. 4621, *in camera*;

Noether, Tr. 5990).

Finally, another way for Complaint Counsel to show market power is by a price increase and output reduction. However, the evidence in this case shows that output after the Merger actually increased, rather than decreased. (Noether, Tr. 6217-18). Since Complaint Counsel was not able to show anything other than a price increase, there is no evidence of anticompetitive effects.

4. The direct evidence of anticompetitive effects of the merger includes party admissions. (See CCFF 1346-1461. See also CCFF 1387, 1463-1508).

Response to Finding No. 4:

The proposed finding is incorrect. (RFF-Reply⁴ ¶¶ 1346-1461, 1463-1508). Contrary to Complaint Counsel's assertions, testimony from ENH's executives and ENH's contemporaneous business records are not evidence of market power or anticompetitive effects.

REDACTED

⁴ "RFF-Reply" refers to Respondent's Replies to Complaint Counsel's Proposed Findings of Fact.

REDACTED (Noether, Tr. 6107-08, *in camera*; CX 7, CX 8, CX 9, CX 10). The “Merger integration” process involved a vast number of activities that included the analysis of HPH’s managed care organization (“MCO”) rates and renegotiation with MCOs as part of the need to operate under a single contract for the combined post-Merger entity. (Hillebrand, Tr. 1839-40; Chan, Tr. 659-60, 712, 714, 739). As explained by ENH’s Chief Operating Officer (“COO”), Jeffrey Hillebrand, ENH achieved the price increases noted in these documents precisely because, coincident with the Merger, ENH realized it was not being fairly compensated by many MCOs for its clinical services. (Hillebrand, Tr. 2026).

5. The area adjacent to or contiguous to the three hospital campuses that make up ENH, Evanston Hospital, Highland Park Hospital and Glenbrook Hospital, has been termed a “triangle.” (See CCF 54).

Response to Finding No. 5:

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

6. The North Shore triangle includes the area inside the three points of the hospitals. There are only three hospitals in the triangle - Evanston, Glenbrook, and Highland Park. This constitutes a large geographic area with no hospital other than Evanston, Glenbrook and Highland Park. (See CCF 55).

Response to Finding No. 6:

This proposed finding is misleading. It attempts to downplay the highly competitive environment in which the three ENH hospitals exist. (RFF⁵ ¶¶ 383-507; RFF-Reply ¶¶ 5, 55).

REDACTED

(See CCF 51, *in camera*).

⁵ “RFF” refers to Respondents Proposed Findings of Fact

Response to Finding No. 7:

This proposed finding is misleading because it relies far too heavily on the testimony of MCO witnesses who have little knowledge of the Northern suburbs of the Chicago, Illinois metropolitan area where ENH is located (“North Shore”). Moreover, this testimony is based on pure speculation and hearsay given that none of these “executives” testified at trial or, for that matter, were even identified at trial. Accordingly, this proposed finding should be disregarded. (RFF-Reply ¶¶ 50-51).

8. The merger of Evanston and Highland Park was seen as an opportunity for the hospitals to “join forces and grow together rather than compete with each other.” (See CCF 71).

Response to Finding No. 8:

This proposed finding is inaccurate and misleading. HPH hardly posed a competitive threat to Evanston Hospital, and the two were certainly not each other’s closest substitutes. (RFF ¶¶ 480-481, 538-559; RFF-Reply ¶¶ 47, 48, 57, 58, 61).

Further, the above-cited passage from CX 2 does not refer to hospital services but, rather, to physicians and medical offices. (RFF-Reply ¶¶ 1351, 1357, 1360, 1588). The fact that the referenced statement was made at an HPH Medical Executive Committee meeting confirms that it did not relate to hospital services. (CX 2 at 1; RFF-Reply ¶¶ 1360, 1588).

9. Health plans typically do not contract with all the hospitals in a given geographic area. They engage in selective contracting. Selective contracting is the process by which health plans choose to contract with some, but not all, of the acute care hospitals in a geographic area. The health plan seeks to contract with a sufficient number of hospitals to form an attractive network to offer its potential buyers. At the same time the health plan seeks to contract with fewer than all the hospitals in an area in the hope that the hospitals with which it contracts will offer lower prices, permitting the health plan to keep the premiums or the price at which it sells its products low. (See CCF 195-283).

Response to Finding No. 9:

This proposed finding is misleading and incorrect to the extent that it suggests that MCOs use selective contracting in the Chicago area in choosing which hospitals to include in their

respective networks. (RFF-Reply ¶¶ 195-283). There has never been much selective contracting in the Chicago area. (Noether, Tr. 5981). An analysis of the size of various MCO networks in the Chicago area shows that all MCO networks are very large and fairly inclusive, indicating that MCOs contract with the vast majority of hospitals in the Chicago area. (Noether, Tr. 5982 (*describing* DX 7045); RFF ¶ 991). Further, in the Chicago area, HMO and PPO networks are about the same size. (Noether, Tr. 5982). Traditionally, in a market where there is selective contracting, HMO networks would be smaller than PPO networks. (Noether, Tr. 5982; RFF ¶ 992).

10. Through the process of selective contracting, the health plan seeks to negotiate a lower price with the hospital while the hospital seeks to negotiate for a higher price. A bargain is struck between the two price objectives. The health plan will only include those hospitals in its provider network with which there is this sort of bargain over price. The ability of the health plan to exclude a hospital from its network is a powerful tool and defines each side's bargaining position. (*See* CCFF 196-197, 200).

Response to Finding No. 10:

This proposed finding is misleading and incorrect because there has never been much selective contracting in the Chicago area. The facts presented at trial prove that MCOs aspire to include almost every hospital system in their networks and are disinclined to exclude a hospital at the end of negotiations. Patients demand broad provider networks and are averse to limited networks or utilization restrictions. (RFF ¶ 58). Therefore, the threat of excluding a hospital from its network is *not* a powerful tool that defines bargaining positions in the Chicago area. (RFF-Reply ¶¶ 9, 195-197, 200).

11. Before the merger, if Evanston went into a negotiation with a health plan and asked for what the health plan thought was an extremely high, unreasonable price, that health plan could choose to include Highland Park and other hospitals in the provider network while excluding Evanston Hospital. (*See* CCFF 256). Pre-merger, if it was Highland Park that requested unreasonably high rates, the health plan could have turned instead to Evanston and other hospitals. (*See* CCFF 263).

Response to Finding No. 11:

This proposed finding is based only on speculation. (RFF-Reply ¶¶ 256, 263).

Complaint Counsel did not provide any testimony or evidence from the MCOs suggesting that they excluded Evanston Hospital at the expense of HPH or vice versa.

REDACTED

(RFF-Reply ¶ 256; RFF ¶¶ 975-978, 980-981, *in camera*; RFF ¶

979). In fact, Ron Spaeth, President and Chief Executive Officer (“CEO”) of HPH until the Merger, testified that Evanston Hospital’s presence, or the presence of any other hospital in a MCO’s network, did not make it more difficult for pre-Merger HPH to gain price increases from that MCO. (Spaeth, Tr. 2176). And Mark Newton, pre-Merger HPH’s Vice President for business affairs, and one of Complaint Counsel’s lead witnesses, testified that he never felt excluded from MCO contracts because of Evanston Hospital, other than Humana Inc.’s (“Humana”) staff model product. (Newton, Tr. 457; Spaeth, Tr. 2170-71). Overall, pre-Merger HPH had contracts with virtually all MCOs, with perhaps one or two exceptions. (Newton, Tr. 457).

12. After the merger, when ENH demanded a price that the health plan thought was unreasonably high, the alternative of excluding Evanston but including Highland Park and various other hospitals was no longer possible. The health plan would have to exclude both Evanston and Highland Park or neither hospital. (*See* CCF 257).

Response to Finding No. 12:

This proposed finding is based only on speculation and is contradicted by the evidence.

Complaint Counsel has not presented any testimony or evidence that MCOs (other than Great West Life & Annuity Insurance Company (“Great West”)) even attempted to exclude post-Merger ENH from any of their networks. There is no evidence that Great West, the only MCO

that actually terminated with ENH, lost a single existing customer, nor any sales or revenue, as a result of that termination. (RFF ¶ 802).

13. Evanston and Highland Park were direct competitors before the merger. The merger eliminated the competition between the two competitors. (See CCF 284-301).

Response to Finding No. 13:

This proposed finding is very misleading. Evanston Hospital and HPH did compete, in some respects, for patients. However, the competition was minimal because Evanston Hospital was much larger and offered a much greater breadth and sophistication of services than HPH. Specifically, because HPH did not offer the tertiary services Evanston Hospital offered, such as advanced oncology and cardiac surgery, competition for these services was nonexistent. (CX 6305 at 19 (Stearns, Dep.); Neaman, Tr. 1306; Spaeth, Tr. 2244; RFF ¶ 481). The record is clear: Evanston Hospital and HPH were not each other's closest substitute hospitals from either a product or a geographic perspective. (RFF ¶¶ 480-481, 538-587; RFF-Reply ¶¶ 47, 48, 57, 58, 61, 284, 1417, 1473-1474, 1695, 1697).

14. Health plans were unable to exclude the post-merger ENH from their networks. (See CCF 261-283).

Response to Finding No. 14:

This proposed finding is based only on speculation. (RFF-Reply ¶ 12).

15. Highland Park was already a good hospital before the merger. (See CCF 2295-2352). Highland Park was considered by many as "one of the finest community hospitals in the country." (See CCF 368).

Response to Finding No. 15:

The first sentence of this proposed finding is misleading, and the second sentence is false. Pre-Merger HPH was a typical community hospital and a hospital with many financial and clinical problems, not one of the "finest community hospitals in the country." (RFF ¶¶ 44-49, 1165-2277, 2298-2307, 2319-2413; RFF-Reply ¶¶ 37, 41-43, 2295-2352). Complaint Counsel

relies on the testimony of Newton for this particular statement. But Newton, who has no clinical degrees or experience, lacks the appropriate background and knowledge to convincingly comment on the hospital's quality of care. (Spaeth, Tr. 2282-83; Newton, Tr. 471; RFF-Reply ¶ 1465). Before the Merger, Newton never had primary responsibility for HPH's quality of care. (Newton, Tr. 512-13; Spaeth, Tr. 2283). That responsibility was given to HPH's COO, Peter Friend, who Complaint Counsel decided not to call as a trial witness. (Newton, Tr. 512-13). Newton also was not involved in credentialing pre-Merger HPH's physicians, nor was he responsible for HPH's information technology systems. (Spaeth, Tr. 2283).

16. Absent the merger, Highland Park would have remained a viable competitor. It could have continued as a stand-alone competitor without the merger, and it was an attractive candidate for other mergers. (See CCF 302-372).

Response to Finding No. 16:

This proposed finding is false. (RFF-Reply ¶¶ 302-372). HPH's leadership, including Spaeth and Chairman of the Board Neele Stearns, as well as its financial consultant, Kenneth Kaufman, all concluded that HPH ultimately could not maintain the status quo as an independent hospital. (Newton, Tr. 436-37; Spaeth, Tr. 2141; Kaufman, Tr. 5811, 5818-20; RFF ¶¶ 2301-1204, 2307-2310). Moreover, whether HPH would have found an appropriate merger partner other than Evanston Hospital is speculative. But the fact remains that, after 14 years of looking for a partner, HPH settled on Evanston Hospital because only Evanston Hospital demonstrated both the ability and the will to improve HPH's quality of care and ensure its long-term survival. (Spaeth, Tr. 2273; RFF ¶ 197, 240-249, 2306, 2308-2318; RFF-Reply ¶¶ 370, 1598).

17. The pricing of ENH to health plans following the merger provides direct evidence of anticompetitive effects. (See CCF 373-745, 822-1337).

Response to Finding No. 17:

This proposed finding is false.

REDACTED

(RFF-Reply ¶¶ 373-745, 822-1337; RFF

¶¶ 528-531, 656-923, 1110-1155).

18. ENH raised prices post-merger in various ways, including:
- a. Moving health plans to one contract for all three ENH facilities, *i.e.*, the Evanston or Highland Park pre-merger contract, whichever had the higher rate. (*See* CCF 822-847);
 - b. Adding a premium to the higher of the Evanston or Highland Park contract rates. (*See* CCF 848-880);
 - c. Moving 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* CCF 817-821);
 - d. Adopting in 2000 the higher of the Evanston or Highland Park chargemaster list price for the particular product or service. (*See* CCF 881-903); and
 - e. Increasing the chargemaster rates in the years following the merger. (*See* CCF 918-924, 942-951).

Response to Finding No. 18:

This proposed finding is misleading because none of the above-listed ways in which ENH purportedly changed its rates or raised its prices was the result of market power. Rather, all of these changes were the result of ENH using well-accepted means to bring its rates and prices to levels appropriate for its status as an academic hospital system. (RFF-Reply ¶¶ 817-903, 918-924, 942-951). The evidence at trial proved that MCOs negotiated the terms that it felt were important, but compromised on terms as well.

For instance, MCOs recognized that ENH offered a fully-integrated health care delivery system after the Merger that, just as it had always done with Glenbrook Hospital, justified a unified rate structure. (RFF-Reply ¶¶ 822-830, 881-903). The evidence at trial demonstrated that the adjustments to the chargemaster were wholly unrelated to managed care negotiations. (RFF-Reply ¶¶ 881-903, 918-924, 942-951; RFF ¶¶ 924-964.)

When MCOs merge they desire to use the better of the two existing contracts. (RFF-Reply ¶ 833). Similarly, after the Merger, ENH and the MCOs agreed to use the better of the two existing contracts as a starting point in negotiations. (RFF-Reply ¶¶ 833-847). Some contracts negotiated in 2000 were actually less favorable to ENH than what had been in place before the Merger. (RFF ¶¶ 785-789, 852). Several contracts had not been renegotiated by either hospital in many years, which justified prices above the existing levels at the time of the Merger. (RFF-Reply ¶¶ 848-880). Others were outdated and under-market and required adjustments to be brought to fair market levels. (RFF ¶¶ 738-756, 778-780, 790-795). The parties also negotiated changes in the reimbursement structure; some agreed to shift some rates to discount-off-charges, while others did not. (RFF-Reply ¶¶ 817-821; RFF ¶¶ 750-751).

19. ENH increased its net revenues from health plans by a minimum of \$18 million annually due just to the 2000 managed care contract re-negotiations. (See CCF 1329-1337).

Response to Finding No. 19:

This proposed finding is misleading to the extent it suggests that

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(Noether, Tr. 6107-08, *in camera*; RFF-Reply ¶¶ 1329-1337).

Finally, this proposed finding is misleading to the extent that it ignores the impact of post-Merger improvements in quality on revenue and contract negotiations with MCOs.

20. This \$18 million in additional annualized net revenue includes only six named health plans (out of approximately 35-40 total ENH contracts) and some small PPO contracts. (See CCFF 1333). The \$18 million in additional annualized net revenue does not include:
- a. Any additional revenue from other contracts, such as the January 2001 re-negotiated One Health contract. (See CCFF 1333);
 - b. Any additional annualized revenue achieved through the shifting of health plans to the higher (in terms of rates) of the Evanston or Highland Park pre-merger contracts. (See CCFF 1334, 822-847);
 - c. Any additional annualized revenue achieved through ENH's adoption in 2000 of the higher of the Evanston or Highland Park pre-merger chargemaster rates. (See CCFF 1335, 881-903); and
 - d. Any additional annualized revenue achieved through ENH's chargemaster increases in 2002 and later. (See CCFF 1336, 918-924, 942-951).

Response to Finding No. 20:

This proposed finding is misleading to the extent it suggests that ENH could not have achieved this increased revenue without the Merger. (RFF-Reply ¶ 19; RFF-Reply ¶¶ 822-847, 1333-1334).

Moreover, any changes by ENH to the chargemaster were perfectly appropriate. To maximize Merger-related cost efficiencies, ENH consolidated its chargemaster with HPH's so that the merged entity could have a single billing system and a single process for patient registration and other activities. (Hillebrand, Tr. 1710, 1990; RX 864 at ENH HG 1781). A consolidated chargemaster is the best practice for a hospital system. (Porn, Tr. 5646-47). ENH's "goal" of the 2000 chargemaster transition was to "equalize charges at all three sites." (CX 2239

at 1). However, ENH did not increase its chargemaster prices in 2000 above either the pre-Merger Evanston Hospital or HPH prices. (Hillebrand, Tr. 1712). Further, after the Merger, ENH also learned that, on the whole, its chargemaster contained prices that were under-market. (Porn, Tr. 5648-49, 5650; RX 1244). Thus, in 2002, ENH engaged Deloitte Consulting (“Deloitte”) to perform an analysis regarding its chargemaster. (Porn, Tr. 5650, 5653; RX 1244 at ENH JH 7109). Deloitte recommended that ENH increase its prices in its chargemaster, and emphasized that a “one-time ‘catch-up’ adjustment” was required. (Porn, Tr. 5658; RX 1170 at DC 2008; RFF-Reply ¶¶ 881-903, 918-924, 942-951, 1335-1336; RFF ¶¶ 924-964).

21. The first major chargemaster increase in 2002 raised ENH’s net revenue by \$20 million to \$26 million annually. ENH was not concerned that health plans would switch to other hospitals due to the price increase. (*See* CCFF 942-954).

Response to Finding No. 21:

This proposed finding is misleading to the extent it suggests that ENH could not have so increased its chargemaster without the Merger. The evidence showed that ENH could have made these chargemaster increases regardless of the Merger; the chargemaster increase and the Merger were totally unrelated. (Hillebrand, Tr. 1996; Porn, Tr. 5661).

This proposed finding is further misleading to the extent the second sentence implies that that ENH’s reaction to the chargemaster increase has anything to do with market power. ENH was not concerned that MCOs would switch to other hospitals after the chargemaster increase in 2002, because ENH’s chargemaster, on the whole, was under-market. (RFF-Reply ¶ 20). There is no evidence to the contrary. Moreover, Hillebrand did not anticipate any resistance from the MCOs to the chargemaster pricing changes because he never had a conversation with a MCO about ENH’s chargemaster. (Hillebrand, Tr. 1995). Similarly, Deloitte was not aware of any MCO that had issues with the pricing changes in ENH’s chargemaster. (Porn, Tr. 5665; RFF-Reply ¶¶ 942-954).

22. There is no dispute that ENH raised prices to health plans following the merger. (See CCF 392-502).

Response to Finding No. 22:

This proposed finding is true, but Complaint Counsel's evaluation of price changes in CCF 392-502 is incorrect, inaccurate, misleading and irrelevant. The Illinois Department of Public Health ("IDPH") state data, the Nera data, and the data provided by ENH in response to the Civil Investigative Demand were not suitable data sets to examine to find the appropriate price change. (RFF-Reply ¶¶ 394-464). In addition, the data provided by Aetna Inc. ("Aetna"), Blue Cross and Blue Shield of Illinois ("Blue Cross"), Humana, Great West and United Healthcare of Illinois ("United") were not properly analyzed by Dr. Haas-Wilson. (RFF-Reply ¶¶ 465-493). To be of any relevance, ENH's prices must be case-mix adjusted, and compared to an appropriate control group of hospitals. (RFF-Reply ¶¶ 494-502). Additionally, ENH's price change should not be evaluated by individual MCO but, rather, by the overall average, aggregating across all MCOs. (RFF-Reply ¶¶ 494-502). Finally, a simple examination of price changes, without a consideration of competitive price levels, cannot yield the conclusion that the post-Merger prices were anticompetitive. (RFF-Reply ¶ 392).

23. There is also no dispute that, following the merger, ENH raised prices to health plans relative to other hospitals in the Chicago area. (See CCF 503-579).

Response to Finding No. 23:

This proposed finding is misleading to the extent it suggests that relative price increases (i.e. prices increases at ENH that were greater than price increases at comparison hospitals) are necessarily anticompetitive. The mere existence of a relative price increase is not sufficient to support the conclusion that ENH was exercising market power. (RFF-Reply ¶ 510). This proposed finding is also misleading to the extent it implies that ENH raised prices to *all* MCOs relative to other hospitals in the Chicago area. This is not accurate. Professor Jonathan Baker

found that ENH's prices charged to Blue Cross, as compared to an appropriate control group of hospitals, actually declined.

REDACTED

(RFF-

Reply ¶ 579, *in camera*).

Finally, Complaint Counsel's evaluation of price changes in CCF ¶¶ 503-579 is incorrect, inaccurate, misleading and irrelevant. Dr. Haas-Wilson used over-inclusive control groups when comparing ENH's prices to other hospitals. (RFF-Reply ¶¶ 512-568).

REDACTED

changes.} (Haas-Wilson, Tr. 2859, *in camera*). Further, to be of any relevance, ENH's prices must be case-mix adjusted as compared to the appropriate control group of hospitals. (RFF-Reply ¶¶ 573-578). In addition, ENH's price change should not be evaluated by individual MCO but, rather, by the overall average, aggregating across all MCOs. (RFF-Reply ¶¶ 569, 573-575, 577-579).

24. When hospitals increase their prices, health plans pass the price increases on to their customers. (*See* CCF 1338-1345).

Response to Finding No. 24:

This proposed finding is misleading to the extent it suggests that health plans must pass any cost increases on to consumers. First, MCOs can create incentives to use lower cost providers. For instance, some MCOs have created "tiered" networks, which are broad networks in the aggregate that provide financial incentives for employees to use a limited subset of the network providers that have relatively lower negotiated rates. (RX 1346 at BCBSI-ENH 5536; RX 1613 at 5; RX 1663 at 7; RX 1246 at NMH 3014).

Second, even without changing their networks, MCOs do not need to pass cost increases on to the consumers. Despite complaints of higher prices from providers, the MCOs themselves are making millions of dollars in profits and thus can absorb provider price increases without passing them on to consumers. For instance, Health Care Service Corporation, the parent of Blue Cross, posted net gains of over \$624 million in 2003, \$347 million in 2001 and \$173 million in 2000. (RX 1587 at 7; RX 1198 at 6). Humana is one of the nation's largest publicly traded health benefits companies, based on 2003 revenues of \$12.2 billion. (RX 1743 at 4, 27). In 2003, Private Healthcare Systems ("PHCS") reported that its net revenue climbed to \$153 million, an increase of 6% over 2002. (RX 1615 at 3). Further, PHCS's earnings increased by "an astounding 50%" in 2003. (RX 1615 at 3). Cigna Corporation ("Cigna") posted net income of \$668 million in its 2003 financial statements. (RX 1742 at 54). As of February 2005, United Health Group was worth over \$30 billion, and its Chairman and CEO earned in excess of \$91,953,914 in 2003. (Foucre, Tr. 939; RX 1662 at 225, 227; RFF ¶¶ 173-174). Even the smaller MCOs are making millions of dollars. For instance, First Health, which acquired CCN in August 2001 had net income of \$152,734,000 in 2003, up from \$132,938,000 in 2002, \$102,920,000 in 2001, and \$82,619,000 in 2000. (RX 1661 at 50; RX 1469 at 104).

25. There was no significant quality improvement at Highland Park Hospital due to the merger. (See CCF 2032-2443).

Response to Finding No. 25:

This proposed finding is incorrect. There were many significant quality improvements at HPH due to the Merger. (RFF-Reply ¶¶ 2032-2443; RFF ¶¶ 2446-2482).

26. ENH did not negotiate price increases with health plans on the basis of quality improvements. (See CCF 2470-2496). Indeed, virtually all of the alleged quality improvements occurred after health care contracts were re-negotiated. (See CCF 2444-2469).

Response to Finding No. 26:

This proposed finding is incorrect. MCOs knew that ENH intended to provide quality improvements to HPH. Simultaneous with the execution of the Letter of Intent, Evanston Hospital and HPH sent a press release to MCOs, area employers, elected officials and the press describing the goals of the Merger – specifically, the service enhancements Evanston Hospital planned to make at HPH, including key clinical growth areas such as oncology, cardiac services, obstetrics, fertility, home health, behavioral health and specific projects such as the Kellogg Cancer Care Center. (RX 563 at ENH TH 1568-76; Hillebrand, Tr. 1857-58). For example, RX 564 is the copy of the press release sent to Blue Cross Blue Shield. (RX 564). Hillebrand further testified that, as ENH entered specific negotiations with MCOs, the initiation of cardiac surgery at HPH was a point of discussion during MCO meetings. (Hillebrand, Tr. 1858-59; RFF-Reply ¶¶ 2470-2496).

Finally, after the Merger, ENH developed a single chargemaster, as well as a single Medicare ID number, for all three hospital campuses. This necessitated renegotiations of all of the MCO contracts coincident with the Merger. (Hillebrand, Tr. 1839-40). ENH, however, could not begin its quality improvements to HPH until after the Merger. This explains why many quality improvements occurred after MCO contracts were renegotiated. (RFF-Reply ¶¶ 2444-2469).

27. ENH's non-profit status did not restrain its exercise of market power. (See CCF 2497-2534).

Response to Finding No. 27:

This proposed finding is incorrect. **REDACTED** (Noether, Tr. 5900; Baker, Tr. 4671, 4811, *in camera*). Further, ENH's non-profit status plays a role in ENH's

pricing and is relevant to a competitive effects analysis. (RFF-Reply ¶¶ 2497-2534; RFF ¶¶ 2278-2309).

28. Divestiture, the proposed remedy, is practicable and will restore competition. (See CCF 2560-2566).

Response to Finding No. 28:

This proposed finding is incorrect. Divestiture would not restore any purported competition lost. To the contrary, divestiture would undo the vast quality improvements at HPH because of the Merger, thus potentially harming patients. (RFF-Reply ¶¶ 2560-2580; RFF ¶¶ 2483-2534, 2538-2542).

II. THE MERGING PARTIES

A. Evanston Northwestern Healthcare

29. Evanston Northwestern Healthcare (“ENH”) is a non-profit corporation organized, existing and doing business under, and by virtue of, the laws of Illinois, with its office and principal place of business located at 1301 Central Street, Evanston, Illinois 60201. (Complaint, ¶ 4; Answer to Complaint, ¶ 4). Prior to merging with Lakeland Health Services in 2000 (CX 501), ENH was comprised of Evanston Hospital, Glenbrook Hospital, ENH Medical Group, ENH Research Institute and ENH Homecare Services. (CX 84 at 6). The Evanston Northwestern Healthcare name was adopted in 1997. (CX 681 at 1). (Generally, pre-merger ENH is referred to below as “Evanston” and post-merger ENH is referred to as “ENH”).

Response to Finding No. 29:

This proposed finding is incomplete because it fails to mention ENH’s longstanding affiliation with Northwestern Feinberg School of Medicine (“Northwestern Medical School”), ENH’s status as a teaching and academic medical institution, and ENH’s historical commitment to high-end clinical research. (RFF ¶¶ 1-9, 12, 24-27, 30).

30. Evanston’s operating revenue in fiscal year 1998 was \$441 million. The corporation had an investment portfolio balance of \$700 million and \$400 million of long-term debt. (CX 84 at 16; RX 691 at ENH JH 007546).

Response to Finding No. 30:

This proposed finding is incomplete and outdated because it does not fully detail the financial pressures Evanston Hospital experienced in the late 1990s – especially from the Balanced Budget Act of 1997, which reduced Medicare reimbursements to the hospital starting in late 1998, and which eventually turned the hospital’s operating income from positive to negative. (RFF ¶¶ 105, 110-112, 624, 627-630, 633-634). This proposed finding is further incomplete because it omits the facts that: (1) Evanston Hospital’s investment income likewise came under significant financial pressure around the turn of the century; and (2) the hospital’s non-operating income decreased from \$71 million in 1997 to \$59 million in 1998, and was

projected to level off at approximately \$45 million for the next three years before gradually increasing in 2002-2004. (RFF ¶¶ 643-645).

31. According to a 1999 Evanston presentation to the board of directors, 51% of Evanston's revenue came from managed care, 34% from Medicare, 3% from Medicaid and 12% from other sources. (CX 84 at 8).

Response to Finding No. 31:

Respondent has no specific response to the 1999 figures. However, at the start of trial in February 2005, nearly 50% of ENH's revenue came from government sources such as Medicare and Medicaid. (RFF ¶¶ 13-14).

32. Evanston and Glenbrook Hospitals had a total of 596 licensed beds and 481 staffed beds in fiscal year 1998. There were 33,808 admissions and 152,820 patient days during this period. (CX 84 at 7, 16). Two 1999 Evanston strategic documents describe Evanston as having a medical staff of approximately 1,100 physicians serving both hospitals. (CX 84 at 7; CX 681 at 1).

Response to Finding No. 32:

This proposed finding is incomplete because it fails to mention the academic nature of ENH's medical staff. At the time of the Merger, all 350 to 400 physicians employed by ENH Faculty Practice Associates held faculty appointments at Northwestern Medical School. (Neaman, Tr. 1287-88). ENH's Faculty Practice Associates is unique in the Chicago area. Loyola Medical Center ("Loyola"), the University of Chicago Hospital ("University of Chicago"), Rush University Medical Center and the University of Illinois at Chicago are the only other area institutions with similar faculty practice groups. (Neaman, Tr. 1288). Northwestern Memorial Hospital ("Northwestern Memorial") does not have a similar faculty practice group. (Neaman, Tr. 1288).

33. Prior to the merger, Evanston offered some tertiary services. (Haas-Wilson, Tr. 2491). At the time of the merger, Evanston did not offer quaternary services. (See, e.g., Newton, Tr. 297, 299; Haas-Wilson, Tr. 2665). In the pre-merger period, Evanston offered obstetrical services, including a level III perinatal center (CX 84 at 8; Newton, Tr. 299; Spaeth, Tr. 2083); pediatric services (Spaeth, Tr. 2083); diagnostic services (CX 84 at

15); a skilled nursing facility (CX 84 at 15); psychiatric care (Newton, Tr. 299; Spaeth, Tr. 2088); neurosurgery (CX 84 at 8; Newton, Tr. 299); radiation therapy (Spaeth, Tr. 2083-84); cardiology services, including cardiac surgery (CX 681 at 2; CX 84 at 8); orthopedics (Neaman, Tr. 1292); Level I and Level II trauma centers (CX 84 at 8; CX 681 at 2); and the Kellogg Cancer Care Center (CX 84 at 8).

Response to Finding No. 33:

As an initial matter, Complaint Counsel's proposed finding is supported by the testimony of Newton, a former HPH employee who was employed by ENH for only a few months after the Merger. (Spaeth, Tr. 2285). Moreover, Newton lacks direct knowledge of the types of services offered at Evanston Hospital before the Merger. (Newton, Tr. 460). Therefore, Evanston Hospital employees can more credibly provide this information.

In any event, this proposed finding is inaccurate, incomplete and misleading because it fails to detail the true sophistication of the services Evanston Hospital offered before and at the time of the Merger. Before the Merger, Evanston Hospital offered far more than "some tertiary services." (RFF ¶¶ 30-34).

REDACTED

(RFF ¶ 30, *in camera*).

Additionally, to be clear, Evanston Hospital did offer what Complaint Counsel labels "quaternary services" before the Merger, but the hospital decided to discontinue these services because it did not have sufficient volume to allow its physicians to perform a "first-class" job. (Neaman, Tr. 1295; RFF ¶¶ 33, 1090).

As of early 2005, ENH offered, in addition to its traditional tertiary services, extremely advanced services such as cardio-angiogenesis and medical genetics. (Neaman, Tr. 1377-78).

REDACTED

(RFF ¶¶ 1-9, 12, 24-27, 30, *in camera*).

34. Evanston Hospital, which opened in 1891, is located in Evanston, Illinois. (CX 681 at 1; CX 84 at 7).

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(Ballengee, Tr. 159; RX 2015 at ENHL MO 003489. See also Holt-Darcy, Tr. 1506-07, *in camera*). Evanston 1999 strategic documents reference the hospital's 452 licensed acute care beds and 32 skilled nursing facility beds. (CX 681 at 1; CX 84 at 6).

Response to Finding No. 34:

This proposed finding is inaccurate and misleading because it does not properly characterize Evanston Hospital as a teaching and academic facility. This proposed finding fails to mention Evanston Hospital's historical affiliation with Northwestern Medical School. Nor does this proposed finding mention that, through the ENH Faculty Practice Associates, the 350-400 physicians employed by Evanston Hospital held appointments at the medical school. This proposed finding also overlooks Evanston Hospital's commitment to high-end clinical research through the ENH Research Institute. (RFF ¶¶ 1-3, 9, 24-26, 27, 30; Neaman, Tr. 1287-88; RX 2015 at ENHL MO 3489). : **REDACTED**

¶¶ 9, 30, *in camera*).

REDACTED

(RFF ¶ 30, *in camera*).

Finally, this proposed finding mischaracterizes the trial testimony of Lenore Holt-Darcy, of Unicare, as well as the substance of RX 2015. Holt-Darcy testified **REDACTED**

(Holt-Darcy, Tr. 1506-07, *in camera*).

REDACTED

REDACTED

this explanation closely tracks ENH's CEO Mark Neaman's explanation of what he meant when he stated in RX 2015 that ENH was "somewhere in the middle of [community hospitals, academic medical centers, and multispecialty physician practices in that it] utilizes an element of each." (Holt-Darcy, Tr. 1508, *in camera*; RX 2015). Neaman explained that because Evanston Hospital included Glenbrook Hospital, by definition, the ENH system had an "element" of what community hospitals do. (Neaman, Tr. 1286). As explained in RX 2015, however, Neaman's use of the terms "community" and "academic" to describe the hospitals did not refer to the level or intensity of services offered by those hospitals but, instead, to the individual missions and purposes of those hospitals. Specifically, Neaman stated in this document that community hospitals are "driven by the patient care mission and not-for-profit status [while] academic medical centers...are, by definition driven by the teaching, research and academic missions." (RX 2015 at ENHL MO 3489).

35. Glenbrook Hospital, located in Glenview, Illinois, is a community hospital that was developed and opened by Evanston Hospital in 1977. (CX 84 at 7; Neaman, Tr. 1286; Neaman, Tr. 1292; CX 681 at 1). **REDACTED**

(Holt-Darcy, Tr. 1507, *in camera*).

According to a 1999 document, Glenbrook had 144 licensed acute care beds, 19 of which were leased to Children's Memorial Hospital. (CX 681 at 2).

Response to Finding No. 35:

Respondent agrees with the first sentence of this proposed finding. (RFF-Reply ¶ 34).

However, this proposed finding incorrectly asserts that pre-Merger Glenbrook Hospital did not provide any level of service beyond primary care. Glenbrook Hospital offered a more advanced level of care through its Kellogg Cancer Care Center, its orthopedics Center of Excellence and its focus on movement disorders. (RFF ¶¶ 9, 19, 275, 1078; CX 681 at 2).

Respondent agrees with the third sentence regarding the number of beds at pre-Merger Glenbrook Hospital, but adds that the inpatient unit Children's Memorial Hospital ("Children's Memorial") developed at Glenbrook Hospital closed after 2000. (Hillebrand, Tr. 1768).

B. Lakeland Health Services

36. Lakeland Health Services, Inc. ("LHS", also referred to as Highland Park Hospital or "HPH"), the parent company of Highland Park Hospital prior to the merger, was a non-profit Illinois corporation with its principal place of business located at 718 Glenview Avenue, Highland Park, Illinois 60035. (CX 541 at 1). Before merging with Evanston, Lakeland Health Services was comprised of Highland Park Hospital, Highland Park Hospital Foundation and the for-profit Lakeland Health Ventures, Inc. (CX 84 at 11). LHS was incorporated in 1982 as a holding company. (CX 84 at 12).

Response to Finding No. 36:

Respondent has no specific response.

37. Lakeland Health Service's operating revenue for fiscal year 1998 was \$101 million. The corporation had an investment portfolio balance of \$218 million and \$120 million of debt. (CX 84 at 16).

Response to Finding No. 37:

This proposed finding is misleading because it does not fully describe the financial situation at pre-Merger HPH. As shown during trial and detailed in Respondent's proposed findings of fact, pre-Merger HPH suffered from serious financial problems, including operating income losses in the late 1990s, and it lacked sufficient cash reserves to meet the competitive challenges of the Chicago marketplace. (RFF ¶¶ 44-46, 2298-2413). HPH's 1998 operating revenue was positive only because HPH mixed in its investment income, a practice frowned on in the industry. (RFF ¶¶ 2347-2350). Without investment income, HPH actually lost \$1 million in 1997 and \$7 million in 1998. (RFF ¶ 2351).

38. According to a 1999 document, 45% of LHS's revenue came from managed care, 41% from Medicare, 2% from Medicaid and 12% from other sources. (CX 84 at 13).

Response to Finding No. 38:

Respondent has no specific response.

39. Highland Park Hospital, located in Highland Park, Illinois, first opened in 1918. (CX 1874 at 1; CX 84 at 12).

Response to Finding No. 39:

Respondent has no specific response.

40. In fiscal year 1998, HPH had 188 staffed acute care beds and 28 skilled nursing facility beds. (CX 84 at 16, 11). There were 9,957 admissions and 41,311 patient days during this period. (CX 84 at 16). According to a 1999 document, the hospital had a medical staff of 562 physicians. (CX 84 at 12).

Response to Finding No. 40:

Respondent has no specific response.

41. Prior to the merger, HPH offered obstetrical services, including a level II perinatal center (CX 84 at 13; Newton, Tr. 299); pediatric services (Spaeth, Tr. 2083); diagnostic services (CX 84 at 15); a skilled nursing facility (CX 84 at 15); a fertility center (CX 84 at 13); psychiatric care (Newton, Tr. 299; Spaeth, Tr. 2088); neurosurgery (Newton, Tr. 299); radiation therapy (Spaeth, Tr. 2083-84); cardiology services, including an adult cardiac catheterization lab (CX 84 at 13); an oncology program (CX 699 at 24; Spaeth, Tr. 2084); and a level II trauma center (CX 84 at 13).

Response to Finding No. 41:

This proposed finding is misleading because its cursory description of pre-Merger HPH's services leaves out many important details. Most importantly, HPH's services were extremely limited and deteriorating in quality. (RFF ¶¶ 1233-1555).

Because pre-Merger HPH offered almost no tertiary services, such as cardiac surgery and comprehensive oncology, HPH physicians frequently referred their patients to more sophisticated academic hospitals, such as Evanston Hospital, and Highland Park residents frequently sought care at these hospitals. (RFF ¶¶ 41-43, 1566, 1568, 1577-1778, 1734-1735, 1736, 1742-1748; Spaeth, Tr. 2286). HPH also lacked sophisticated pediatrics, and the

neurosurgeons on HPH's staff desired to perform their cases at Evanston Hospital and not at HPH. (Spaeth, Tr. 2286).

REDACTED

(RFF ¶ 42, *in camera*). But again, pre-Merger HPH lacked the necessary tertiary services, such as sophisticated neonatal intensive care, necessary to address fully these patients' needs.

(Spaeth, Tr. 2286). Pre-Merger HPH's services – most specifically, obstetrics and gynecological services (“Ob/Gyn”) – were also deteriorating in quality. And problems with the physical plant nearly cost HPH its Medicare accreditation. (RFF ¶¶ 1165-2277). Over 1,000 of Respondent's proposed findings of fact detail HPH's limited and/or troubled clinical services and ENH's successful efforts to expand and enhance these services. (RFF ¶¶ 1165-2277).

42. Highland Park Hospital was a “strong community hospital” prior to the merger. (CX 852 at 5; CX 874 at 5; Spaeth, Tr. 2095). The quality of care at HPH until the merger with Evanston in 2000 was “very good, if not excellent.” (Newton, Tr. 376). The hospital was well-respected in the community and considered by many to be one of the “finest community hospitals in the country.” (Newton, Tr. 301).

Response to Finding No. 42:

The first sentence of this proposed finding is misleading. While Evanston Hospital did regard HPH as a “strong community hospital” as seen in Evanston Hospital documents from early 1999, Evanston Hospital's opinion of HPH changed dramatically as 1999 progressed. By the time the Merger due diligence was completed, Evanston Hospital realized that HPH was not “strong” but, to the contrary, suffered from numerous financial problems. Evanston Hospital's due diligence of HPH demonstrated that HPH suffered from negative operating income, it improperly used investment earnings to bolster its financial statements, it had a severely constrained debt capacity and it required tens of millions of dollars to repair its deteriorating facilities. (RFF ¶¶ 44-49, 1512-1514, 1530-1548, 2236-2413).

The remainder of this proposed finding is simply false. Pre-Merger HPH was a typical community hospital, but it could not properly be characterized as providing “very good, if not excellent” quality of care. Nor was HPH considered to be one of the “finest community hospitals in the country.” Complaint Counsel relies on the testimony of Newton, pre-Merger HPH’s Vice President for business affairs, for these statements. But Newton, who has no clinical degree or experience, lacks sufficient background and knowledge to convincingly comment on the hospital’s quality of care. (Spaeth, Tr. 2282-83; Newton, Tr. 471). **REDACTED**

(Newton, Tr. 512-13, *in camera*; Spaeth, Tr. 2283). **REDACTED**

(Newton, Tr. 512-13, *in camera*). Newton also was not involved in credentialing pre-Merger HPH’s physicians, nor was he responsible for HPH’s information technology systems. (Spaeth, Tr. 2283).

Finally, this proposed finding ignores the numerous quality of care problems at pre-Merger HPH identified by the experts and physicians who testified in this case. These witnesses explained that pre-Merger HPH had significant quality problems across numerous departments, ineffective quality assurance programs, weak quality improvement programs, a dysfunctional nursing culture, and, again, a series of deficiencies in the physical plant that affected patient safety and put the hospital’s Medicare certification in jeopardy. (RFF ¶¶ 1165-2277).

43. Prior to the merger, HPH had a strong balance sheet with a significant amount of cash. (Noether, Tr. 6035 ; Kaufman, Tr. 5860).

Response to Finding No. 43:

This proposed finding is incomplete and misleading because it ignores the relevance of pre-Merger HPH’s balance sheet. 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. (RFF ¶ 2366). Pre-Merger HPH's strategic financial consultant Kaufman advised against using HPH's cash or even the investment dollars on hospital improvements. (RFF ¶ 2368). Kaufman concluded that because HPH had no revenue from operations, its strong balance sheet was only thing keeping the hospital from mere survival. (RFF ¶ 2368). Unable to spend this money on improvements, HPH's "strong balance sheet," therefore, was of little value to the hospital. (RFF ¶¶ 2366, 2368-2370).

Dr. Noether confirmed Kaufman's conclusions, similarly testifying that HPH's cash was not sufficient to continue to prop up its operating income, make the capital expenditures necessary to keep the hospital competitive, and to service the over \$100 million debt Complaint Counsel noted in its proposed finding number 37. (RFF ¶¶ 2410). Complaint Counsel offered no expert testimony to rebut Kaufman and Dr. Monica Noether, Respondent's Economic Expert, on this issue. (RFF ¶ 2413).

44. The Highland Park Hospital Foundation was the philanthropic arm of Lakeland Health Services. (CX 84 at 11). "It was an entity that raised funds from the community . . . for reinvestment for philanthropic purposes back into Highland Park Hospital." (Newton, Tr. 283). On December 31, 1998, the Foundation had approximately \$67,000,000 in assets. (CX 628 at 4).

Response to Finding No. 44:

This proposed finding is incomplete in that it fails to mention that, as the 1990s progressed, the HPH Foundation had more and more difficulty raising funds because members of the Highland Park community were not as interested in supporting a community hospital as they were in supporting an academic hospital. (Styer, Tr. 4963-64). This proposed finding is also misleading because it fails to explain that the HPH Foundation's "reinvestments" into HPH never came close to covering the hospital's requests to the Foundation. (RFF ¶ 2427).

45. Lakeland Health Ventures were for-profit entities owned by Lakeland Health Services. These entities were: Lakeland Primary Care Associates, physician practice management

services, real estate ventures and joint ventures, including a fitness center and a mail order pharmacy. (CX 681 at 3).

Response to Finding No. 45:

This proposed finding is incomplete because it does not detail Lakeland Health Ventures' financial problems. These joint ventures, all run by Newton, were failures and in 1999, lost more than \$2 million. (RFF ¶¶ 310, 2335, 2371-2375).

C. The North Shore

1. Location

46. The North Shore region of the Chicago area includes communities along Lake Michigan north of Chicago, starting at Evanston and extending to Highland Park and further north. The North Shore consists of communities starting at Evanston and encompassing Wilmette, Winnetka, Kenilworth, Highland Park, Lake Forest, Glencoe and other communities in the area. (Ballengee, Tr. 162-63; Holt-Darcy, Tr. 1425-1427; Mendonsa, Tr. 484-85 (“starting in Evanston, moving up to Wilmette, Winnetka, Kenilworth, Highland Park, Glencoe, that kind of area.”)).

Response to Finding No. 46:

Respondent has no specific response.

47. A person traveling up the North Shore from Chicago “would stop at Evanston” first and then “Highland Park would be the next hospital.” (Holt-Darcy, Tr. 1426). Evanston and Highland Park Hospitals compete for patients from people living in between the two communities. (Holt-Darcy, Tr. 1426; Neary, Tr. at 600-01; CX 1 at 3-5; CX 2 at 7).

Response to Finding No. 47:

This proposed finding is inaccurate and misleading.

REDACTED

(RFF ¶ 389, *in camera*).

REDACTED

(RFF ¶ 390, *in camera*; RFF ¶ 560). Complaint

Counsel also fails to mention that a person can quickly travel from Rush North Shore to HPH and to Lake Forest on Interstate 94 and Highway 41. (Neaman, Tr. 1304; Spaeth, Tr. 2241). Therefore whether a person traveling north from Evanston Hospital would first come across HPH is of no relevance given the reality of the Chicago area geography.

Complaint Counsel's assertion that Evanston Hospital and HPH competed for some patients living in between the two communities is equally misleading. Evanston Hospital and HPH competed, in some respects, for patients. However, the competition between the two hospitals was minimal because Evanston Hospital was much larger and offered a much greater breadth and sophistication of services than HPH. In short, Evanston Hospital and HPH were not good substitutes for healthcare services. (RFF ¶¶ 480-481, 538-559).

Finally, the documents to which Complaint Counsel cites do not discuss nor identify Evanston Hospital and HPH as competitors for hospital services but, instead, focus solely on the competition between physicians and medical offices. (CX 1 at 3; CX 2 at 7; Spaeth, Tr. 2209, 2213-2214).

48. The North Shore community viewed Evanston and Highland Park as competing hospitals where people on the North Shore could choose either to go north to one or south to the other to receive the same services at the same level. (Ballengee, Tr. at 166, 170-171 ("competitive environment between the two hospitals")).

Response to Finding No. 48:

This proposed finding is inaccurate. Evanston Hospital and former HPH executives with far more knowledge of the North Shore than Ballengee testified at trial that members of the

North Shore community – specifically, members of Highland Park – did not seek care at HPH if they were “really sick.” (RFF ¶ 43; Spaeth, Tr. 2233-35 (testimony of Spaeth, who lived and worked in the North Shore since 1972)). Because HPH did not offer the tertiary services Evanston Hospital offered, such as advanced oncology and cardiac surgery, competition for these services was nonexistent. (RFF ¶ 481 (Testimony of Neele Stearns, who spent 20 years at HPH, and Mark Neaman, lived or worked in the North Shore since 1973); CX 6305 at 19 (Stearns, Dep.); Neaman, Tr. 1306)). Consequently, physicians with admitting privileges at HPH referred patients to Evanston Hospital for many tertiary services. (Spaeth, Tr. 2244; Neaman, Tr. 1306). The expert testimony in this case confirms that members of the North Shore community did not view Evanston Hospital and HPH as substitutes for healthcare services. (RFF ¶ 47). This evidence far outweighs Complaint Counsel’s reliance on a single person with no background in marketing, or significant experience living or working in the North Shore area. (Ballengee, Tr. 203-04).

49. The North Shore area also roughly corresponds to the Evanston-Highland Park Hospital Combined Core Service Area (“CCSA”), which includes the towns of Deerfield, Highland Park, Fort Sheridan, Highwood, Lake Forest, Glencoe, Northbrook, Glenview, Golf, Kenilworth, Techny, Wilmette, Winnetka, Evanston and Skokie. This area spans a densely populated suburban corridor that runs for about 15 miles north-south along the shore of lake Michigan, and extends roughly ten miles west of the Lake. (CX 348 at 2; CX 360 at 7; CX 359 at 16; CX 84 at 21).

Response to Finding No. 49:

This proposed finding is misleading, irrelevant and partially false.

REDACTED

(RFF ¶¶ 478-479, 499-504, 506, *in camera*; RX 1331 at ENHE DL 11882-83, *in camera*). Spaeth confirmed that hospital administrators typically look to their service area to determine their respective hospitals’ market shares. (Spaeth, Tr. 2156). As of early 2005, ENH

received only half of its patients from the “core” market. (Neaman, Tr. 1307-8; RFF ¶ 502). With only half of its business coming from the “core,” ENH could not survive alone on that subset of its overall service area. Therefore the term “core” is of no relevance.

This proposed finding is false because it incorrectly describes the North Shore as “densely populated.” None of the documents cited by Complaint Counsel contains the word “densely,” or any similar term, to describe the North Shore. (CX 348 at 2; CX 360 at 7; CX 359 at 16; CX 84 at 21). On the other hand, Hillebrand, a 40-year North Shore resident, testified that the North Shore communities are not densely populated. (Hillebrand, Tr. 1825, 2030). Instead, these communities are suburban, bedroom communities with single family homes and sizable plots of land and a limited retail environment. (RFF ¶ 4). The Mayor of Highland Park, Michael Belsky, testified that Highland Park itself is typical of these North Shore communities in that residential property makes up 98% of the city’s tax base and in that Highland Park is a bedroom community dependent on the greater Chicago area. (Belsky, Tr. 4889).

2. Socio-Economic Demographics

50.

REDACTED

(Mendonsa, Tr. 516-17, *in camera*; Foucre, Tr. 901-02; Newton, Tr. at 360; Neary, Tr. 602).

Response to Finding No. 50:

This proposed finding is false, incomplete and misleading. Again, Complaint Counsel asserts that the North Shore is a “densely” or “heavily” populated area, this time relying on the testimony of Jillian Foucre of United. (Foucre, Tr. 901-2). Foucre, however, does not live in the North Shore and, by her own admission, she lacks a “sense of [this] geography.” (Foucre, Tr. 941).

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

As to Complaint Counsel’s final assertion regarding “senior executives and decision makers,” there is no evidence that the North Shore has more of these people than any other affluent community in the Chicago area.

51.

REDACTED

(Mendonsa, Tr. 517, *in camera* ; Foucre, Tr. at 902; Newton, Tr. 360).

Response to Finding No. 51:

This proposed finding is misleading because it too relies heavily on the testimony of witnesses who have little knowledge of the North Shore and is based on speculation. (RFF-Reply ¶ 50).

REDACTED

(Mendonsa, Tr. 475;

Mendonsa, Tr. 556, *in camera*; RFF-Reply ¶¶ 228-29, 244).

52.

REDACTED

} (Newton, Tr. at 327, 352; Mendonsa, Tr. 516, *in camera*, Neary, Tr. at 602)

Response to Finding No. 52:

This proposed finding is misleading because the North Shore, including Highland Park, is not uniformly affluent. (RFF-Reply ¶ 50). This proposed finding is also irrelevant because the

presence or absence of professionals in a given area has no demonstrated connection to the issues in this case. (RFF-Reply ¶ 50).

53. The Combined Core Service Area of Evanston and Highland Park, which roughly corresponds to the North Shore area, had a population of 363,000 at the time of the merger, with an average household income of \$122,975. (CX 360 at 12).

Response to Finding No. 53:

This proposed finding is misleading because it glosses over the fact that both Evanston and Highland Park are not uniformly affluent communities. (RFF-Reply ¶ 50).

3. Other Hospitals

The Hospitals in the Triangle Area on the North Shore

54. The area adjacent to or contiguous to the three hospital campuses that make up ENH, Evanston Hospital, Highland Park Hospital and Glenbrook Hospital, has been termed a “triangle.” (Haas-Wilson, Tr. 2452; 2667; Newton, Tr. 351-52; Foucre, Tr. 901-903; Ballengee, Tr. 168; Holt-Darcy, Tr. 1425-1427).

Response to Finding No. 54:

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

55. The North Shore triangle is a contiguous area that includes the area inside the three points of the hospitals. There are only three hospitals in the triangle – Evanston, Glenbrook, and Highland Park. This constitutes a large geographic area with no hospital other than Evanston, Glenbrook and Highland Park. (Haas-Wilson, Tr. 2452, 2667; Foucre, Tr. 902; Ballengee, Tr. 167-68, 184. *See also* Mendonsa, Tr. 543-44 ;
) , *in camera*).

REDACTED

Response to Finding No. 55:

This proposed finding is false because the only party that has “termed” this area a “triangle” is Complaint Counsel itself. (RFF-Reply ¶¶ 5, 54). This proposed finding is also

misleading because it attempts to downplay the highly competitive environment in which the three ENH hospitals exist. (RFF ¶¶ 383-507; RFF-Reply ¶ 47).

Hospitals Identified by Respondent's Documents Relating to the Merger

56. Some of the Respondent's documents defining the service area of Respondent hospitals are based on patient flow data. A geographic area that is identified on the basis of patient flow data will be larger than the actual geographic market of an acute care hospital, and will erroneously understate the market shares of the merging hospitals. (Elzinga, Tr. 2393-94). These documents show that there was a substantial competitive overlap between Evanston and Highland Park before the merger and few other strong competitors. (*See, e.g.*, CX 84; CX 1876; CX 359). This close competitive overlap between Evanston and Highland Park was clear to health plans, too. (Ballengee, Tr. 156, 162; Neary, Tr. 600-01).

Response to Finding No. 56:

This proposed finding is false, inaccurate and misleading. Dr. Kenneth Elzinga testified that "the use of the Elzinga-Hogarty Test with patient flow analysis typically generate[s] an area that is actually larger geographically than the actual market is." (Elzinga, Tr. 2393-94). However, Dr. Noether explained that the Elzinga-Hogarty analysis focuses exclusively on in-flow and out-flow ratios based on patient flow data to quantify a relevant geographic market. This was not what Dr. Noether was attempting to do. (Noether, Tr. 5947-48). She explained that what she was analyzing was what the hospitals actually consider themselves. Hospitals look at what kinds of patient travel patterns are evident, and use this information to consider the likely dimensions of geographic competition. (Noether, Tr. 5948). Further, patient travel patterns are relevant to the MCO – the customer in this case. For a MCO to be able to compete, it has to have a network that is attractive to enrollees, who are the ultimate patients. Therefore, patient preferences have to be taken into account by the MCO. To understand patient preferences, patient travel patterns are one piece of evidence to examine. (Noether, Tr. 5948).

57. Reports produced for the Evanston and Highland Park boards in 1999, as part of the merger process, highlighted the competitive overlap between Highland Park and Evanston. Internal presentations showed that ENH (44%) and Highland Park (11%)

together comprised a 55% share of the combined core service area of the two hospitals. (CX 84 at 21 (Evanston Northwestern Healthcare and Lakeland Services Proposed Merger, Presentation to the Board of Directors, June 25, 1999); CX 1876 at 18 (Lakeland Health Services, Inc. and Evanston Northwestern Healthcare: Proposed Merger, Presentation to the Board of Directors, Lakeland Health Services, Inc., June 28, 1999); CX 359 at 16 (Evanston Northwestern Healthcare and Lakeland Services Proposed Merger, Presentation to the Executive Committee, April 14, 1999). (Hillebrand, Tr. 1792-94).

Response to Finding No. 57:

This proposed finding is misleading and irrelevant.

REDACTED

REDACTED

(RFF

¶¶ 499-504, 506; CX 350 at 2; RX 1331 at ENHE DL 11884, *in camera*). Spaeth confirmed that hospital administrators typically look to their service area to determine their respective hospitals' market shares. (Spaeth, Tr. 2156). As of early 2005, ENH received only half of its patients from the "core" market. (Neaman, Tr. 1307-8; RFF ¶ 502). With only half of its business coming from the "core," ENH could not survive alone on that subset of its overall service area. For this reason, ENH focuses on its 50+ Zip code service area. (RFF-Reply ¶ 49). Therefore, the term "core" is not at all relevant.

This proposed finding is also misleading because it describes a "competitive overlap" that simply never existed. As previously shown, Evanston Hospital and HPH were not comparable hospitals and, therefore, did not significantly compete for the same patients and services. (RFF-Reply ¶ 48). Evanston Hospital's solid market share in HPH's "core" communities was the result of HPH physicians referring their patients to Evanston Hospital for the advanced care HPH simply could not provide. (Spaeth, Tr. 2302-03).

58. Reports produced for the Evanston and Highland Park boards in 1999, as part of the merger process, downplayed the competitive importance of other hospitals in the North Shore and beyond. The only hospitals besides Evanston, Glenbrook and Highland Park that Evanston specifically identified as having a share in the Combined Core Service

Area were: Rush North Shore (14%), Lutheran General (7%), St. Francis (7%), and Lake Forest (3%). (CX 84 at 21 (Evanston Northwestern Healthcare and Lakeland Services Proposed Merger, Presentation to the Board of Directors, June 25, 1999); CX 1876 at 18 (Lakeland Health Services, Inc. and Evanston Northwestern Healthcare: Proposed Merger, Presentation to the Board of Directors, Lakeland Health Services, Inc., June 28, 1999); CX 359 at 16 (Evanston Northwestern Healthcare and Lakeland Services Proposed Merger, Presentation to the Executive Committee, April 14, 1999)). ENH Executives also told PHCS⁶ that excluding from the network St. Francis, Rush North Shore, and Condell would not justify a lower rate because those hospitals were not viewed by ENH as significant competitors. (Ballengee, Tr. at 181-82).

Response to Finding No. 58:

This proposed finding is misleading and irrelevant because the term “core” is used to describe only a subset of ENH’s overall and more important service area – *i.e.*, the area from which it gets roughly 80% of its patients and because numerous other ENH documents in evidence show the specific shares of tens of hospitals that compete in this service area. (RFF-Reply ¶¶ 49, 57, 59; CCFF ¶ 60).

This proposed finding is also false because

REDACTED

(Hillebrand, Tr. 1746; RFF ¶¶ 570-572, 575-576; RFF ¶¶ 573-574, *in camera*; RX 1331 at ENHE DL 11881, *in camera*, (*describing* “RNS” as a “key competitor”)). Moreover, Evanston Hospital has long viewed St. Francis as an important competitor as well. (RFF ¶ 477).

REDACTED

⁶ “PHCS” refers to Private Healthcare Systems.

(RFF ¶¶ 570-572, 575-576; RFF ¶¶ 573-574, *in camera*). St. Francis itself saw Evanston Hospital as its strongest competitor to the north. (RFF ¶ 463).

REDACTED

(RFF ¶ 477; Hillebrand, Tr. 2005; RX 1331 at ENHE DL 11881, *in camera*).

REDACTED

(RFF ¶ 577, *in camera*).

Hillebrand could not accept PHCS's exclusion offer because the product offered by PHCS, a PPO, cannot by definition accommodate any exclusions. (Hillebrand, Tr. 1746, 1894). And even if Hillebrand could have accepted the offer, it would have been futile because Ballengee's superiors did not support the exclusion approach. (Hillebrand, Tr. 1894).

59. Evanston's December 7, 1999, Presentation to Standard and Poor's, Strategic and Capital Structure Review, identified few hospitals by name as competitors. It refers to the Combined Core Service Area of Evanston and Highland Park as the "Service Area and Competition." Besides the three merging hospitals, Evanston's presentation to Standard and Poors identifies the market share of only Rush North Shore (14%), Lutheran General (7%), St. Francis (7%), and Lake Forest (3%) within Evanston's Combined Core Service Area with Highland Park. (RX 704 at ENH HL 001631).

Response to Finding No. 59:

This proposed finding is misleading and irrelevant because the term "core" is used to describe only a subset of ENH's overall and more important service area – *i.e.*, the area from which it gets roughly 80% of its patients. (RFF-Reply ¶¶ 49, 57; CCFE ¶ 60). This is made clear in the cited document, where ENH's and LHS's respective "core service areas" fall under the overall and separate title of "service area and competition." (RX 704 at ENH HL 1631 (emphasis added)).

This proposed finding is further misleading because numerous other ENH documents in evidence show the specific shares of tens of hospitals that compete in ENH's service area. For example, RX 1361 shows the total market shares of the Advocate, Resurrection, Rush, Vista and

the University of Chicago hospital systems in ENH's 50 zip code service area along with the shares of these systems' individual hospitals. (RX 1361 at ENHE DL 6610-11). RX 1361 also includes the shares of Northwest Community, Condell, Swedish Covenant, Northwestern Memorial, Lake Forest and close to 20 other hospitals with in the 50 zip code service area. (RX 1361 at ENHE DL 6610-12). While the three ENH hospitals account for 16.6% of the service area, the shares of the 62 other hospitals (including the 5 major hospital systems previously mentioned) that make up the remaining 83.4% of the service area are each individually listed and recorded by RX 1361. (RX 1361 at ENHE DL 6610-15).

60. Before the merger, in Evanston and Highland Park's overall service area consisting of 50 zip codes, typically the only other individual hospitals Evanston showed with specific shares (beyond those stated in the CCSA) were Condell and Northwest Community. (CX 84 at 25 (Evanston Northwestern Healthcare and Lakeland Services Proposed Merger, Presentation to the Board of Directors, June 25, 1999); CX 1876 at 15 (Lakeland Health Services, Inc. and Evanston Northwestern Healthcare: Proposed Merger, Presentation to the Board of Directors, Lakeland Health Services, Inc., June 28, 1999; RX 704 at ENH HL 001632).

Response to Finding No. 60:

This proposed finding is misleading because numerous ENH documents in evidence show the specific shares of tens of hospitals that compete in the 50 zip code service area. (RFF-Reply ¶ 59).

ENH agrees with Complaint Counsel, however, that Evanston Hospital's and HPH's overall service area did, indeed, consist of 50 zip codes.

61. Before the merger, Highland Park regarded Evanston, Lake Forest, Condell, and Rush North Shore as competing hospitals. (Newton, Tr. 406-07; Spaeth, Tr. 2088, 2127, 2139-40, 2107, 2157, 2163)

Response to Finding No. 61:

This proposed finding is misleading. HPH did regard the above-listed hospitals as competitors, but some of these hospitals were more important competitors than others.

Specifically, Lake Forest and Condell were regarded by pre-Merger HPH as far more important competitors than Evanston Hospital. (RFF ¶ 580). This view was confirmed by all MCO representatives who testified at trial, further confirmed by HPH's negotiators and documents from various other MCOs as well as by Lake Forest's own internal documents. (RFF ¶¶ 577-587).

Hospitals Identified by the Respondent's Management Documents After the Merger

62. After the merger, for ENH's overall 50 zip code service area (which is larger than the CCSA), ENH's "Market Dashboard" listed as "Top Competitors" only Lutheran, Northwest Community, Condell, St. Francis and Swedish Covenant. (RX 1430 at ENHE F16 00 6171 (2003 FY); RX 1300 at ENHMN003108-09 (FY 02); CX 350 at 2 (2002)).

Response to Finding No. 62:

This proposed finding is misleading. (RFF-Reply ¶ 60).

63. In a 2002 report, there were just six hospitals with a 5% or greater share in ENH's 50 zip code area. These hospitals were: Lutheran General with 9.1%, Northwest Community Hospital with 7.1%, Condell Medical Center with 5.7%, St Francis with 5.6%, Swedish Covenant with 5.3%, and Rush North Shore with 5.0%. (RX 1361 at ENHE DL 006610-11).

Response to Finding No. 63:

This proposed finding is misleading because it fails to mention that RX 1361 also lists the shares of the various hospital systems in ENH's service area. Because Complaint Counsel has repeatedly referred to the combined market shares of the hospitals that make up the ENH system, it is only fair to compare the ENH system's total share to those of other systems. Therefore, a fair and complete comparison shows that in ENH's service area the Resurrection system has the largest market share with 17.7%, the ENH system is second at 16.4%, the Advocate system is third with 14.4%, the Rush and Vista systems follow with 6.5% and 6.0% respectively, and the University of Chicago hospitals finish last with 3.3%. (RX 1361 at ENHE DL 6610-11). Moreover, Evanston Hospital's individual share of the 50 zip codes is only 9.4%, only slightly

larger than Advocate Lutheran General's 9.1% and Northwest Community's 7.1%. (RX 1361 at ENHE DL 6610-11). Therefore, the ENH system is not even the market leader in its own service area.

64. In a September 2002 ENH management committee discussion document, "Positioning for Growth," ENH listed the specific shares within its 50 zip code area of only the following hospitals: Lutheran General (9.5%), Northwest Community (7.1%), Condell (5.7%), Swedish Covenant (5.3%), Rush North Shore (4.9%), St. Francis (4.9%), Northwestern Memorial Hospital (3.9%) and Lake Forest Hospital (2.9%). (RX 1331 at ENHE DL 011877, at 83).

Response to Finding No. 64:

This proposed finding is misleading because

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REDACTED

(RX 1331 at ENHE DL 11883, *in camera*).

65. Most of the hospitals that draw patients from ENH's overall service area have no significant market presence on the North Shore. For example, in 2002, there were 24 hospitals that had less than a 5% market share in ENH's 50 zip code service area. Twenty of these hospitals had less than a 3% market share. (RX 1361 at ENHE DL 011883).

Response to Finding No. 65:

This proposed finding refers to a nonexistent page in RX 1361. In any event, this proposed finding is misleading and irrelevant.

REDACTED

REDACTED

(RX 1331 at ENHE DL 11883, *in camera*). By this

standard, Complaint Counsel implicitly concedes that the addition of HPH's market share to Evanston's was of little significance.

Finally, this proposed finding is confusing. CCFF ¶¶ 53, 58 appear to equate Evanston Hospital and HPH's Combined Core Service Area with the entire North Shore region, but now proposed CCFF ¶ 65 seems to expand the North Shore to include all 50 Zip codes of ENH's service area. This is yet another example of Complaint Counsel failing to understand and properly define the relevant geography of this case.

66.

REDACTED

1303, Foucre, Tr. 933-34; RX 1503, *in camera*).

(Neaman, Tr.

Response to Finding No. 66:

This proposed finding is misleading and incomplete. It does not explain that the above-mentioned hospital systems exert a competitive restraint on ENH regardless of how many of these systems' member hospitals are located in ENH's service area.

REDACTED

(RX 1361 at ENHE DL 6610-11; RX 1331 at ENHE DL 11883, *in camera*).

ENH's internal documents also reveal that many of the individual hospitals in these systems have managed to capture a share of ENH's service area. For example, all eight hospitals in the Resurrection System have a share of ENH's service area, seven of the nine Advocate hospitals have a share, three of the five Rush hospitals have a share, and both of the Vista and University of Chicago hospitals have a share of ENH's service area. (RX 1361 at ENHE DL 6610-11).

Downtown Teaching Hospitals Considered a Separate Group by ENH

67. Before the merger, in communications with board members, Evanston and Highland Park did not identify specific downtown hospitals as competitors. For example, reports produced for the Evanston and Highland Park Boards in 1999 as part of the merger process aggregated all the downtown teaching hospitals as a single entry with a 7% market share in the Combined Core Service Areas of the hospital and 4.7% market share in the overall service areas of the two hospitals. (CX 84 at 21, 25 (Evanston Northwestern Healthcare and Lakeland Services Proposed Merger, Presentation to the Board of Directors, June 25, 1999); CX 1876 at 18, 15 (Lakeland Health Services, Inc. and Evanston Northwestern Healthcare: Proposed Merger, Presentation to the Board of Directors, Lakeland Health Services, Inc., June 28, 1999).

Response to Finding No. 67:

This proposed finding is misleading because the trial testimony and documents in evidence from numerous sources show that the downtown hospitals, particularly Northwestern Memorial, competed with Evanston Hospital and HPH and continue to compete with ENH. (RFF ¶¶ 43, 397, 404, 434, 455-56, 458-459, 477, 489, 490, 548, 563-565, 567-568, 1074, 1735, 2290-2291). Other Merger documents shared with Evanston Hospital Board members also explain that out of the 33,888 admissions in the combined core service area, over 15,000 were admitted to hospitals other than Evanston Hospital, Glenbrook Hospital, and HPH. Specifically, 16% of these 15,000 patients went to the downtown hospitals. (CX 359 at 18).

68. Before the merger, in communications with Standard and Poors, Evanston lumped all the downtown teaching hospitals together with a 7% market share in the Combined Core Service Areas of the two hospitals and a 4.7% market share in the overall service area. (RX 704 at ENH HL 001631-32).

Response to Finding No. 68:

This proposed finding is misleading because the trial testimony and documents in evidence from numerous sources show that the downtown hospitals, particularly Northwestern Memorial, competed with Evanston Hospital and HPH and continue to compete with ENH. (RFF-Reply ¶ 67).

III. THE MERGER

69. On more than one occasion, Evanston and Highland Park considered merging. For example, there were some “pre-merger discussions” in May 1997. (Spaeth, Tr. 2202). A merger was one of several strategies Mr. Spaeth and Mr. Neaman considered in order for the two hospitals to “align” themselves. (Spaeth, Tr. 2202-03; CX 1861 at 1-2).

Response to Finding No. 69:

This proposed finding is incomplete and misleading. It fails to explain that HPH considered, yet rejected, arrangements short of a merger, such as clinical joint ventures. (RFF-Reply ¶¶ 1595-1596). It further fails to explain that HPH considered numerous other hospitals with which to align but, after a long and careful search, decided on Evanston Hospital. (RFF-Reply ¶ 1598). Only Evanston Hospital demonstrated both the ability and the will to improve HPH’s quality of care and ensure its long-term survival. (RFF-Reply ¶ 1598).

70. The merger discussions that resulted in the actual merger started in late 1998 or early 1999. (CX 1 at 2; CX 2 at 7).

Response to Finding No. 70:

Respondent has no specific response.

71. This merger was seen as an opportunity for the hospitals to “join forces and grow together rather than compete with each other.” (CX 2 at 7)

Response to Finding No. 71:

This proposed finding is inaccurate and misleading. HPH hardly posed a competitive threat to Evanston Hospital, and the two were certainly not each other’s closest substitutes. (RFF ¶¶ 480-481, 538-559; RFF-Reply ¶¶ 47, 48, 57, 58, 61).

Moreover, the cited passage from CX 2 does not refer to hospital services but, rather, to physicians and medical offices. (RFF-Reply ¶¶ 1351, 1355, 1357, 1360, 1588). The fact that the referenced statement was made at an HPH Medical Executive Committee meeting further confirms that it did not relate to hospital services. (CX 2 at 1; RFF-Reply ¶¶ 1360, 1588).

72. The merging parties, including Evanston Northwestern Healthcare, Lakeland Health Services, and Highland Park Hospital, signed a letter of intent to merge effective July 1, 1999. (Neaman, Tr. 1328; RX 567 at ENH MN 001365).

Response to Finding No. 72:

Respondent has no specific response.

73. The merger agreement was finalized on October 29, 1999. (CX 501 at 16).

Response to Finding No. 73:

Respondent has no specific response.

74. Kaufman, a consultant hired by Highland Park Hospital, estimated the value of Highland Park around the time of the merger to be approximately \$272 million. This figure includes \$100 million in capital avoidance and accounts for \$120 million in long-term debt. (CX 1875 at 1).

Response to Finding No. 74:

This proposed finding is misleading because it does not fully describe the financial situation at pre-Merger HPH. As shown during trial and detailed in Respondent's proposed findings of fact, pre-Merger HPH suffered from serious financial problems, including operating income losses in the late 1990s, and it lacked sufficient cash reserves to meet the competitive challenges of the Chicago marketplace. (RFF ¶¶ 44-46, 2298-2413). HPH's 1998 operating revenue was positive only because HPH mixed in its investment income, a practice frowned on in the industry. (RFF ¶¶ 2347-2350). Without investment income, HPH actually lost \$1 million in 1997 and \$7 million in 1998. (RFF ¶ 2351).

This proposed finding is further misleading because it fails to explain that \$130 million of the \$272 million in value consisted of HPH's cash on hand. But despite this cash on hand and additional investment money, HPH's funds were still insufficient to meet the competitive challenges of the Chicago marketplace. (RFF ¶ 2366). In fact, Kaufman advised against using

HPH's cash or even the investment dollars on hospital improvements. (RFF ¶¶ 2366, 2368-2370).

Dr. Noether confirmed Kaufman's conclusions, similarly testifying that HPH's cash was not sufficient to continue to prop up its operating income, make the capital expenditures necessary to keep the hospital competitive, and to service the over \$100 million debt Complaint Counsel noted in its proposed finding. (RFF ¶ 2410). Complaint Counsel offered no expert testimony to rebut Kaufman and Dr. Noether on this issue. (RFF ¶ 2413).

Finally, the \$100 million in capital avoidance, the amount of money ENH would have to spend without the Merger to establish a facility similar to HPH in Lake County, turned out to be an incorrect figure. (CX 1875 at 1). As of February 2005, ENH had already spent over \$120 million on capital improvements at HPH and has committed to spending another \$45 million. (RFF ¶ 1518). Because Evanston Hospital took on a hospital with far more severe quality and financial problems than initially expected, this \$100 million in capital avoidance became irrelevant. (RFF-Reply ¶¶ 37, 41-45).

75. In April 1999, Evanston and Highland Park signed an agreement to develop a cardiac surgery program at Highland Park Hospital. (Rosengart, Tr. 4527-30; CX 2094). In November 1999, the state approved a certificate of need for an open heart surgery program at Evanston and Highland Park. (Newton, Tr. 423).

Response to Finding No. 75:

Respondent has no specific response.

76. Deloitte, a consultant hired by Evanston Northwestern Healthcare, stated in May of 1999 that an external buyer might purchase Lakeland Health Services for \$70-94 million. Deloitte also stated that "When added to their investment fund (after retiring long-term debt) the result is \$162-\$186 million in proceeds." (RX 536 at ENH HJ 000323).

Response to Finding No. 76:

This proposed finding is incomplete and misleading. Because the cited Deloitte report was issued in May 1999, it came before the due diligence unearthed the full extent of HPH's financial and quality problems. (RFF ¶¶ 1536-1548, 2336-2404). To remedy these problems and bring HPH up to ENH's standards, between January 2000 and February 2005, ENH poured more than \$120 million into capital expenditures at HPH and has committed another \$45 million. (RFF-Reply ¶ 74). Given that ENH will eventually spend at least \$165 million in capital expenditures alone, it is clear that HPH was not the lucrative purchase this proposed finding implies.

77. In the fall of 1999, executives of Evanston and Highland Park met with Bain and developed a pricing strategy linked to the merger of Evanston and Highland Park. During these pre-merger meetings, the Evanston and Highland Park executives and consultants from Bain exchanged pricing information and discussed how to leverage the merger of the two hospitals to obtain higher rates and convert fixed rate contracts to discount off charges. (See CCFF 1497-1504, 1509-1530).

Response to Finding No. 77:

This proposed finding is very misleading. (RFF-Reply ¶¶ 1497-1504, 1509-1530). First, Evanston Hospital hired Bain to help with its MCO contracting strategies sometime after August 1999, but well before Bain's "Initial Review" presentation on October 29, 1999, the same day the Agreement and Plan of Merger was signed. (Neaman, Tr. 1159-60; CX 2072 at 1; RX 651; RX 652). Therefore, Bain's contracting advice from the Summer of 1999 through 2000 was not contingent on the Merger. (Hillebrand, Tr. 1847; RX 2047 at 24-25 (Ogden, Dep.); RFF ¶ 705). Bain advised Evanston Hospital to seek higher rates regardless of whether the Merger was consummated. (Neaman, Tr. 1347; RFF ¶ 705).

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(RFF ¶¶ 996-998,

in camera). Kim Ogden, who was the Bain representative responsible for the ENH Merger project (but was no longer employed by Bain or any other party involved in this case when she testified) explained that Bain eventually found that HPH was too small to make a difference to MCOs. (RX 2047 at 3, 38 (Ogden, Dep.)). Ogden further testified that, while Bain thought the Merger provided several benefits to ENH, “[w]e weren’t trying to renegotiate based on a changed position because of the merger. We said we need to renegotiate because we don’t have a contract. You haven’t negotiated with us in five years. Here is who Evanston is, and it really was overwhelmingly a focus on Evanston” and what Bain thought was “fair market value.” (RX 2047 at 32 (Ogden, Dep.)). Ogden continued, explaining that HPH was a “tiny hospital” and the Merger did not change ENH’s “position in the marketplace at all.” (RX 2047 at 33 (Ogden, Dep.)). So the “leverage” that ENH had with MCOs after the Merger was a function of where they had been paid before the Merger, and ENH’s position as a major-sized hospital (even without HPH). (RX 2047 at 41 (Ogden, Dep.)). Therefore, what made ENH’s post-Merger contracting efforts successful was the application of “better people and a better process.” (RX 2047 at 33 (Ogden, Dep.)).

78. In the merger agreement, the parties agreed that Lakeland Health Services and Highland Park Hospital would be merged into Evanston Northwestern Healthcare (CX 501 at 17) and that Lakeland Health Services and Highland Park Hospital would no longer exist as separate corporations. (CX 501 at 17).

Response to Finding No. 78:

Respondent has no specific response.

79. The merger was consummated on January 1, 2000. (*See, e.g.*, CX 501 at 17).

Response to Finding No. 79:

Respondent has no specific response.

IV. PROCEDURAL HISTORY

A. Investigation and Complaint

1. Investigation

80. ENH was first notified of the Federal Trade Commission investigation in a letter dated November 6, 2001. The letter was addressed to Mark Neaman, President and Chief Executive Officer of ENH, from Attorney Oscar Voss of the FTC. (Neaman, Tr. 1269; CX 20 at 1).

Response to Finding No. 80:

Respondent has no specific response.

81. The pre-Complaint investigation period ended with the issuance of the Complaint on February 10, 2004, in the matter of Evanston Northwestern Healthcare Corporation, *et al.* (Complaint, February 10, 2004). Respondents answered the Complaint in a filing dated March 17, 2004. (Respondents' Answer to Complaint, March 17, 2004). Subsequent to their initial filing, Respondents amended their answer to the Complaint on July 12, 2004. (*See* Respondents' First Amended Answer, July 12, 2004). Respondents amended their answer again in January 2005. (*See* Respondents' Second Amended Answer, January 11, 2005).

Response to Finding No. 81:

Respondent has no specific response.

82. Discovery during the post-Complaint investigation included subpoenas for depositions, subpoenas for documents, requests for admissions and interrogatories. The FTC requested and obtained pertinent information and documents from Respondents. (*See, e.g.,* CX 5940 at 1-46; Complaint Counsel's First Request for Production of Documents Issued to Evanston Northwestern Healthcare, February 24, 2004). Information and documents were also sought by Respondents and turned over by the FTC. (*See, e.g.,* Respondent Evanston Northwestern Healthcare Corporation's First Request For Production of Documents, April 23, 2004). In addition, the post-Complaint discovery necessitated the production of information and documents from third parties, such as hospitals and health plans. (*See, e.g.,* CX 5910 at 1-28).

Response to Finding No. 82:

Respondent has no specific response.

2. Counts of the Complaint

83. Both Counts I and II of the Complaint allege that Evanston and Highland Park consummated a merger in violation of Section 7 of the Clayton Act. Count I alleges the violation using a structural analysis drawn from the Merger Guidelines, but adapted to the facts of this case in which Complaint Counsel challenges a merger that has already taken place and for which pricing data is available. (Complaint ¶ 16-18). Count II alleges the violation based on direct evidence of competitive effects of the merger, which gave ENH market power. (Complaint ¶ 28-31) Count III concerns physician price fixing, and on April 5, 2005, the Commission issued a non-final consent order regarding that count for public comment. (Complaint ¶33-44). *Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc.*, Docket No. 9315, April 5, 2005.

Response to Finding No. 83:

Respondent agrees with this proposed finding to the extent that Counts I and II allege claims against ENH, and Count III alleged a claim against ENH Medical Group, Inc. These allegations, however, have no basis in fact or law. Indeed, Count II, to the extent it alleges that Complaint Counsel can prove a violation of Section 7 based on direct effects alone, has no legal basis. (Resp.'s Pre-Trial Brief at 9-13, Resp.'s Post-Trial Brief at 31-34, Resp.'s Reply Brief at Section I.D.1). Count III has been settled.

a. Count I

84. Count I of the complaint discusses the relevant product market, geographic market, and market concentration HHIs. It alleges that the the [sic] merger resulted in a post-merger HHI increase in excess of 500 points to a level exceeding 3000 points. Based largely on market shares and concentration figures, Count I concludes that the merger was anticompetitive and lessened competition. (Complaint ¶ 16-18).

Response to Finding No. 84:

Respondent agrees with this proposed finding only to the extent that Count I alleges a product market, a geographic market, market concentration Herfindahl-Hirshman Indexes ("HHIs") and a violation of Section 7. These allegations, however, have no basis in fact or law.

The Market Structure Analysis in Count I is Based on the Merger Guidelines Approach

85. The Merger Guidelines poses the following question to define the relevant product market:

If, in response to the price increase, the reduction in sales of the product would be large enough that a hypothetical monopolist would not find it profitable to impose such an increase in price, then the Agency will add to the product group the product that is the next-best substitute for the merging firm's product The price increase question is then asked for a hypothetical monopolist controlling the expanded product group. This process will continue until a group of products is identified such that a hypothetical monopolist over that group of products would profitably impose at least a "small but significant and nontransitory" increase in price ["SSNIP"], including the price of a product of one of the merging firms.

(Section 1.11 of the 1992 Merger Guidelines). There is a comparable question for defining the relevant geographic market (Section 1.21 of the Merger Guidelines).

Response to Finding No. 85:

Respondent has no specific response.

86. Under the Merger Guidelines approach, once a market has been defined under the SSNIP test, the market shares of the merging firms are used to predict whether a proposed merger might be anticompetitive. In most merger cases, because the merger under analysis has not yet been consummated, the Merger Guidelines approach, including the market definition, is a predictive or inferential exercise, with no post-merger evidence to examine. (Elzinga, Tr. 2360).

Response to Finding No. 86:

Respondent has no specific response.

87. Based on the principles laid out in the Merger Guidelines, and applying the hypothetical monopolist test, the product market is general acute care inpatient services, including primary, secondary and tertiary services, because ENH successfully over the long term raised the prices of that product. (Haas-Wilson, Tr. 2666-67; *see generally*, Neaman Tr. 1210-11; Hillebrand, Tr. 1756; Spaeth Tr. 2083-88; Holt-Darcy, Tr. 1422-23).

Response to Finding No. 87:

This proposed finding is inaccurate and misleading. Under the Horizontal Merger Guidelines, the product market is not defined "because" there is a price increase. Rather, for product market, the relevant inquiry begins with the products "produced or sold" by the merging

firms. (1992 Horizontal Merger Guidelines, §1.11; Noether, Tr. 5905-06).

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

camera :

REDACTED

374, *in camera*

REDACTED

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

88. Based on the principles of the Merger Guidelines, and, in particular, the hypothetical monopolist test, the relevant geographic market in this case includes the area contiguous to the three hospitals of ENH, which includes the campuses of Highland Park, Evanston and Glenbrook Hospitals, because ENH successfully raised its prices in a significant way over the long term and customers did not turn to alternative sellers located outside of the geographic area. (Haas-Wilson, Tr. 2452, 2667). This is a roughly triangular area. (Newton, Tr. 351-52; Chan, Tr. 939-40; Foucre, Tr. 901-903; Ballengee, Tr. 168; Holt-Darcy, Tr. 1425-1427)

Response to Finding No. 88:

This proposed finding is inaccurate and misleading. The appropriate geographic market in this case includes, at least, the merging hospitals, Rush North Shore, St. Francis, Advocate Lutheran General, Resurrection, Lake Forest Hospital and Condell. (Noether, Tr. 5928, 5960; RFF-Reply ¶ 54).

In addition, under the Horizontal Merger Guidelines, for geographic market, the relevant inquiry begins with an identification of the “next best substitutes” for the merging firms. (1992 Horizontal Merger Guidelines, § 1.21; Noether, Tr. 5928). Under the Guidelines, Dr. Haas-

Wilson's market would only make sense if Evanston Hospital and HPH were next best substitutes in geographic terms. (Noether, Tr. 5932). Evanston Hospital and HPH were not next best geographic substitutes. (Noether, Tr. 5932; RFF ¶¶ 387-484).

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

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

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(Baker, Tr. 4704, *in camera*). Finally, the term "triangle," as used in reference to the three ENH hospitals, was invented by Complaint Counsel and does not appear in any of the relevant documents. (RFF-Reply ¶ 54).

89. The only hospitals in the relevant geographic market are the three ENH Hospitals. (Haas-Wilson, Tr. 2452, 2667). Accordingly, the post-merger HHIs in this market would be 10,000, "which is 100 squared, if you had a single monopolist in the market." (Noether, Tr. 5963).

Response to Finding No. 89:

This proposed finding is inaccurate and misleading because the HHI calculations are based on an inappropriate, and unprecedented, geographic market comprised of only the merging

hospitals. This market is not supported by logic or the Guidelines methodology. (RFF-Reply ¶¶ 1645-1646). Consequently, these HHI calculations are meaningless.

90.

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Dr. Noether acknowledged that the post-merger HHIs are at what the Merger Guidelines terms the highly concentrated level “over 1900, increasing by about 300 from pre-merger levels” (Noether Tr, at 5963).

Response to Finding No. 90:

This proposed finding is misleading because it ignores that Dr. Noether’s estimate of concentration levels using her minimum market was necessarily conservative. (RFF-Reply ¶ 1724). For example, there are some hospitals outside of this minimum market that place substantial competitive constraint on hospitals in the market. (Noether, Tr. 5929, 5930-31). In addition, this finding ignores testimony that even this very conservative market is not concentrated relative to the types of transactions that “typically are challenged as likely to cause anticompetitive effects.” (Noether, Tr. 5963).

b. Count II

Determining Competitive Effects of the Merger Through Direct Evidence

91. Count II alleges that the merger is anticompetitive because it resulted in anticompetitive price increases. (Complaint ¶ 28-31).

Response to Finding No. 91:

Respondent agrees with this proposed finding only to the extent that Count II alleges that the Merger was anticompetitive. This allegation, however, has no basis in fact or law.

92. For purposes of Count II, direct evidence of anticompetitive effects demonstrates the existence of market power. (Elzinga, Tr. 2355, 2363; Haas-Wilson, Tr. 2482).

Response to Finding No. 92:

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

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

REDACTED

(Haas-Wilson, Tr. 2834-36, *in camera*; RFF ¶¶ 1053, 1059-1061; RFF ¶¶ 1054-1058, 1062-1064). Consequently, it is impossible to conclude that the post-Merger price changes were anticompetitive based on a simple examination of price changes, without a consideration of competitive price levels.

REDACTED

(Noether, Tr. 5989, 5991;

Haas-Wilson, Tr. 2833-34, *in camera*). **REDACTED**

(Haas-Wilson, Tr. 2823-24, *in camera*).

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

Respondent's experts provided the only empirical analysis of price levels, and that analysis demonstrated that ENH was not pricing at competitive levels before the Merger. The post-Merger price increases were not anticompetitive under that analysis but, instead, were consistent with the learning about demand benign explanation for the price increases. (RFF ¶¶ 1110-1164).

Finally, Complaint Counsel admits that "ENH did not see a decrease in the number of managed care admissions as a result of ENH's price increases in 2000." (CCFF ¶ 1653).

Consequently, there is no support for a finding of direct evidence of anticompetitive effects.

93. After a merger has been consummated, an economist can rely on direct evidence such as price behavior in the marketplace after the merger was consummated, evidence from the merging parties themselves after the merger took place, (*i.e.*, how they assessed the merger), and the assessment of the consequences of the merger by people who buy in the marketplace, rather than inferential data based on market definition and share. (Elzinga, Tr. 2362; Haas-Wilson, Tr. 2468).

Response to Finding No. 93:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶ 92).

94. Dr. Haas-Wilson used a list of potential explanations to guide her analysis of how to design the empirical model that she used to evaluate her “testable hypotheses.” Her methodology was designed to test specifically which of the potential explanations derived from economic theory “can or cannot explain the price increase.” (Haas-Wilson, Tr. 2481).

Response to Finding No. 94:

Respondent has no specific response.

95. If one eliminates the hypothesis that post-merger evidence of price increases is due to benign market forces, such as increases in market demand or increases in costs in the market, then the post-merger evidence of price increases is explicable by the market power that the two firms have in combination that they may not have had when they were independent centers of initiative in the marketplace. (Elzinga, Tr. 2365; Haas-Wilson, Tr. 2467; 2480-81).

Response to Finding No. 95:

Respondent has no specific response except to note that Complaint Counsel did not eliminate at trial the hypothesis that post-Merger evidence of price increases is due to benign market forces.

96. Where there is direct evidence of anticompetitive effects of a merger proved through empirical study, there is no need to engage in the full process outlined in the Merger Guidelines for investigations where the merger has not yet occurred. (Haas-Wilson, Tr. 2468; Elzinga, Tr. 2355, 2362-63).

Response to Finding No. 96:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶ 92).

97. Where an analyst has persuasive post-merger evidence about the consequences of a merger, it is not necessary to define a relevant product or geographic market. If one has direct evidence that a merger is anticompetitive, one would rely on that direct evidence of anticompetitive effects rather than rely on the inferential evidence based on market definition and share. (Elzinga, Tr. 2355, 2363).

Response to Finding No. 97:

This proposed finding is irrelevant and misleading. (RFF-Reply ¶ 92).

Count II Identifies Direct Evidence of Anticompetitive Effects Related to the Merger

98. Dr. Haas-Wilson, complaint counsel's economic expert, applied economic theory to systematically identify a number of potential explanations for the price increase at ENH after the merger. (Haas-Wilson, Tr. 2480).

Response to Finding No. 98:

This proposed finding is misleading to the extent it suggests that the list of potential explanations that Dr. Haas-Wilson identified is an exhaustive list of potential explanations for the post-Merger price increase. **REDACTED**

(Haas-Wilson, Tr. 2486-89, 2681-83; Baker, Tr. 4650-53, *in camera*; RFF ¶ 523).

99. Using economic theory, Dr. Haas-Wilson made a list of ten potential explanations for the "large, post-merger price increase at ENH," a list which is reflected in DX 7024. (Haas-Wilson, Tr. 2480-81).

Response to Finding No. 99:

This proposed finding is misleading. (RFF-Reply ¶ 98).

100. **REDACTED**

(Haas-Wilson, Tr. 2734, *in camera*).

Response to Finding No. 100:

This proposed finding is incorrect. Dr. Haas-Wilson was not able to rule out the nine potential explanations she identified. (RFF-Reply ¶¶ 594-595, 597-599, 602-608). In particular,

she was not able to rule out learning about demand or post-Merger improvements in quality. (RFF-Reply ¶¶ 597-599, 737). This proposed finding is also misleading to the extent it suggests that the nine, non-market power explanations identified by Dr. Haas-Wilson are the only potential explanations for the price increase. **REDACTED**

(Haas-Wilson, Tr. 2486-89, 2681-83; Baker, Tr. 4650-53, *in camera*; RFF ¶ 523).

101.

REDACTED

(CX 3 at 1; CX 1879 at 3-4; CX 1 at 3; CX 2 at 7; CX 4 at 1,2, 9; CX 1566 at 9; Neaman, Tr. 1138, *in camera*); (CX 5 at 5; CX 6 at 7; CX 2070 at 3; CX 12 at 2; CX 13 at 1; CX 16 at 1; and CX 17 at 2), (CX 1099, *in camera*; CX 1519 at 1-2, *in camera*; CX 30 at 1; CX 23 at 2; CX 24 at 2; CX 26 at 1, CX 25 at 9; CX 31 at 1).

Response to Finding No. 101:

This proposed finding is incorrect. The cited ENH documents do not illustrate that Evanston Hospital and HPH sought, or obtained, market power through the Merger. Instead, these documents emphasize that the primary goals of the Merger were to improve the quality of care for the Evanston Hospital and HPH communities, to bolster the financial health of HPH and to generate much needed cost savings. (RFF ¶¶ 259-297).

Nor do the cited ENH documents somehow reveal that ENH used market power after the Merger. The documents, instead, confirm that, as a result of the Merger, ENH learned about its true value in the market as an academic hospital. (RFF ¶¶ 656-703, 726-737, 1002).

Respondent addresses below the documents and testimony at issue as they are used by Complaint Counsel in the following proposed findings of fact.

102. In addition to the empirical research of Dr. Haas-Wilson and the numerous documents illustrating ENH's exercise of market power, there is significant testimony from present and former executives of the merging parties that is consistent with a finding that the merger created market power. (Neaman, Tr. 1036, 39, 1200, 1202-04, 1207-09, 1211-12; Hillebrand, Tr. 1705, 1709-10, 1711-13, 1718-22, 1751, 1754-55, 1757-58, 1764, 1811-17, 2036; Spaeth, Tr. 2210-11; Newton, Tr. at 351-52, 354, 359-62, 363-65, 366-67; Chan, Tr. 694-97, 703-06, 709-10, 834, 839-41, 844-45).

Response to Finding No. 102:

This proposed finding is incorrect. The cited testimony does not show that Evanston Hospital and HPH sought, or obtained, market power through the Merger or that ENH used market power after the Merger. Rather, the cited testimony from present ENH executives confirms that the primary goals of the Merger were to improve the quality of care for the Evanston Hospital and HPH communities, to bolster the financial health of HPH and to generate much needed cost savings. The cited testimony from present ENH executives further confirms that, as a result of the Merger, ENH learned about its true value in the market as an academic hospital. Finally, the cited testimony from former ENH employees, Newton and Chan, should be disregarded. (RFF-Reply ¶ 1465).

Respondent addresses below the testimony at issue as they are used by Complaint Counsel in the following proposed findings of fact.

103. Thus, the January 1, 2000, merger between Evanston Hospital and Highland Park Hospital enhanced the market power of ENH, and, after that merger, "the merged entity exercised market power." (Haas-Wilson, Tr. 2451).

Response to Finding No. 103:

This proposed finding is inaccurate. Dr. Haas-Wilson failed to rule out all potential explanations for the price increase, both the nine she identified and those she did not consider. Nor was she able to explain away the evidence demonstrating that the price increases can be explained by pro-competitive forces. Accordingly, Complaint Counsel did not meet its ultimate burden in this case through Dr. Haas-Wilson's testimony (or otherwise) of showing that the Merger resulted in the enhancement and exercise of market power. (Noether, Tr. 6216; RFF ¶¶ 656-923; RFF-Reply ¶ 740).

104. "Market power" is the ability of a firm to raise its prices above competitive levels. The term "competitive levels" means a long-term analysis to determine the price that would just allow a firm to break-even or earn "zero economic profit." (Haas-Wilson, Tr. 2451).

Response to Finding No. 104:

Respondent agrees with the definition of market power. However, this proposed finding confuses the definition of "competitive levels." Competitive levels are the price levels that prevail in a competitive market place with free and unfettered competition. Where the marketplace supports more than one price level, a representative price is simply the average of the competitors' prices. For instance, in this case, ENH's competitive level is the average of the price of care at several of the major teaching hospitals in the Chicago area. (Noether, Tr. 5992).

c. Count III and the Count III Settlement

105. Count 3 relates to physician price fixing by the ENH Medical Group and Highland Park physicians. The Commission accepted the settlement of Count III for public comment on April 5, 2005. (*Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc.*, Docket No. 9315, April 5, 2005,

Response to Finding No. 105:

This proposed finding is irrelevant because Count III settled and was not at issue in this trial. It is also misleading because Count III related to alleged, not actual, price fixing by the ENH Medical Group and the group of independent Highland Park physicians.

B. The Hearing

1. Schedule

106. The hearing began in Washington, D.C., on February 10, 2005. The last witness testified on April 7, 2005. (Tr. 1-6372).

Response to Finding No. 106:

Respondent has no specific response.

107. The total number of hearing days as of May 1, 2005, was 29. (Tr. 1-6372).

Response to Finding No. 107:

This proposed finding is inaccurate. The total number of hearing days was 30, not 29. (Tr. 1-6372, Volumes I - XXX).

2. Witnesses

108. Complaint Counsel called sixteen witnesses. These witnesses included health plans, present and former employees of Evanston and Highland Park, and an employee of the state of Illinois. Complaint Counsel also called four experts, three in the field of economics and one in the field of quality of care. (Tr. 1-6372).

Response to Finding No. 108:

Respondent has no specific response except to note that Complaint Counsel did not call a single representative from two of the most important MCOs in the Chicago market: Blue Cross and Humana. Complaint Counsel also failed to call a single employer, the market actor Complaint Counsel argues is the crucial linchpin between MCOs, hospitals and patients. (Final Pretrial Conference, Tr. 22-23).

109. Respondent called nineteen witnesses. These witnesses included ENH employees such as nurses, physicians, and administrators, as well as two of ENH's consultants and the mayor of Highland Park. Respondent also called three experts, two in the field of economics and one in the field of quality of care. Respondent did not call any health plans or other customers as witnesses. (Tr. 1-6372).

Response to Finding No. 109:

This proposed finding is misleading because Complaint Counsel likewise did not call a single employer or representative from two of the most important MCOs in the Chicago market. Complaint Counsel, of course, carries the ultimate burden in this case.

3. Exhibits

110. Complaint Counsel introduced into evidence approximately 880 exhibits (referred to as CXs). (JX 1; Tr. 1-6372).

Response to Finding No. 110:

Respondent has no specific response.

111. Respondent introduced into evidence approximately 700 exhibits (referred to as RXs). (JX 1; JX 2; Tr. 1-6372).

Response to Finding No. 111:

Respondent has no specific response.

112. Exhibits from both Respondent and Complaint Counsel were admitted during court room proceedings and through several joint exhibits (referred to as JXs). There are seven JXs, which are marked as JX 1 to JX 7. However, JX 4 was replaced by JX 7. (JX 7).

Response to Finding No. 112:

Respondent has no specific response.

113. The CX and RX exhibits consist mainly of documents from the Respondent's files. The remaining documents were for the most part obtained from third parties. (*See, e.g.*, JX 1).

Response to Finding No. 113:

Respondent has no specific response.

V. INTERSTATE COMMERCE

114. At all times relevant to the Complaint, Respondent, which is located in Evanston, Illinois, was and is engaged in interstate commerce and activities affecting interstate commerce in the delivery of health care services (as the parties have stipulated). (Stipulation Regarding Interstate Commerce, 8/30/04).

Response to Finding No. 114:

Respondent agrees with the above stated terms of the August 30, 2004 Stipulation

Regarding Interstate Commerce.

115. Respondent received combined payments for the delivery of health care services well in excess of \$10 million in each year from 1999 through 2003 from the following companies and/or their subsidiaries:
- a. Aetna, with its corporate headquarters in Hartford, Connecticut.
 - b. Cigna, with its corporate headquarters in Philadelphia, Pennsylvania.
 - c. Humana, with its corporate headquarters in Louisville, Kentucky.
 - d. United, with its corporate headquarters in Minneapolis, Minnesota.
 - e. Private Healthcare Systems, with its corporate headquarters in Waltham, Massachusetts.
 - f. Great-West, with its corporate headquarters located in Greenwood Village, Colorado.
 - g. Preferred Plan, with its corporate headquarters located in Stow, Ohio.

(Stipulation Regarding Interstate Commerce, 8/30/04).

Response to Finding No. 115:

Respondent agrees with the above stated terms of the August 30, 2004 Stipulation

Regarding Interstate Commerce.

116. "At all times relevant to the Complaint, Respondent ENH and the ENH Faculty Practice Associates (the ENH-employed physician group), have received and continue to receive in the aggregate significant payments from the federal Medicare Program, 42 U.S.C. §§ 1395 *et seq.*, and the federal/state Medicaid program, 42 U.S.C. §§ 1396 *et seq.*" (Stipulation Regarding Interstate Commerce, 8/30/04).

Response to Finding No. 116:

Respondent agrees with the above stated terms of the August 30, 2004 Stipulation

Regarding Interstate Commerce.

117. “At all times relevant to the Complaint, ENH, through its operations at Evanston Hospital, Glenbrook Hospital, and Highland Park Hospital, has engaged and continues to engage in commerce and in activities affecting commerce, as the term ‘commerce’ is defined by Section 1 of the Clayton Act. 15 U.S.C. § 12” (as the parties have stipulated). (Stipulation Regarding Interstate Commerce, 8/30/04).

Response to Finding No. 117:

Respondent agrees with the above stated terms of the August 30, 2004 Stipulation

Regarding Interstate Commerce.

VI. HEALTH CARE INDUSTRY BACKGROUND

A. Qualifications of Deborah Haas-Wilson

118. Complaint Counsel's expert witness, Dr. Deborah-Haas Wilson, provided, among other trial testimony, her expert opinion on the background of the health care industry and the dynamics of competition within the marketplace. (Haas-Wilson, Tr. 2453-67).

Response to Finding No. 118:

Respondent has no specific response.

119. Dr. Haas-Wilson is a professor of economics at Smith College. She received her Bachelor Degree from the University of Michigan in Ann Arbor in economics, and she received a Ph.D. in economics from the University of California at Berkeley. Her fields of specialization for her Ph.D. were applied microeconomics with an emphasis in industrial organization and public finance. Dr. Haas Wilson's dissertation for her Ph.D. was a theoretical and empirical analysis of the effect of commercial practice restrictions in the market for ophthalmic goods and services. (Haas-Wilson, Tr. 2433-34).

Response to Finding No. 119:

Respondent has no specific response.

120. Dr. Haas-Wilson has published articles in professional journals, including the Journal of Law and Economics, the Review of Economics and Statistics, the Journal of Health Economics, Journal of Economic Perspective, Journal of Political Economics, and Health Services Research. (Haas-Wilson Tr. 2435-37).

Response to Finding No. 120:

Respondent has no specific response.

121. She is a full professor at Smith and has taught courses in introductory microeconomics, industrial organization and antitrust policy, a seminar in regulation and deregulation of industry, and a senior seminar in Smith's public policy program. (Haas-Wilson, Tr. 2435).

Response to Finding No. 121:

This finding is misleading to the extent that it suggests that Dr. Haas-Wilson had a full-time teaching schedule in the Fall 2004 semester, during the time her rebuttal report was written.

Dr. Haas-Wilson only taught one course at Smith College that semester. (Haas-Wilson, Tr. 2672).

122. Dr. Haas-Wilson wrote a book titled *Managed Care and Monopoly Power: The Antitrust Challenge*, which was funded by the Robert Wood Johnson Foundation. It was published by Harvard University Press in 2003. (Haas-Wilson, Tr. 2436-38 (referring to DX 7052)).

Response to Finding No. 122:

Respondent has no specific response.

123. Dr. Haas-Wilson's book, *Managed Care and Monopoly Power: The Antitrust Challenge*, is "a synthesis about what is known, particularly from an economic perspective, about application of the antitrust laws in markets for healthcare services; in particular markets for hospital services, physician services and healthcare financing." (Haas-Wilson, Tr. 2438).

Response to Finding No. 123:

This proposed finding is misleading to the extent that it suggests that Dr. Haas-Wilson's book is the sole authority of what is known about the application of antitrust laws in markets for healthcare services, in particular markets for hospital services, physician services and healthcare financing. In fact, Dr. Haas-Wilson, in her testimony, relied on a work by Robert Town and Gregory Vistnes, called "Hospital Competition in HMO Networks," just one of many works on the topic. (CCFF ¶ 206). **REDACTED**

(Noether, Tr.

5891; RX 1912 at 5, *in camera*).

124. Dr. Haas-Wilson spent four years as a member of one of the research study sections at the Agency for Healthcare Policy and Research. That is the study section that reviews applications that come in to the federal government for federal funding of research. (Haas-Wilson, Tr. 2438).

Response to Finding No. 124:

Respondent has no specific response.

125. Dr. Haas-Wilson currently serves as an advisory member to the Petris Center on Healthcare Markets at the University of California, Berkeley. (Haas-Wilson, Tr. 2438).

Response to Finding No. 125:

Respondent has no specific response.

126. Dr. Haas-Wilson is a peer reviewer for several economic journals. (Haas-Wilson, Tr. 2438).

Response to Finding No. 126:

Respondent has no specific response.

B. Relationships Between Employee, Employer, Health Plan and Hospital

127. In order to understand the competitive dynamics of healthcare markets, it is necessary to understand the institutional relationships in healthcare. These markets are distinguishable from other markets in the United States economy. (Haas-Wilson, Tr. 2453).

Response to Finding No. 127:

Respondent has no specific response.

128. There are four different institutional relationships relevant to understanding the competitive dynamics of hospital services. These institutional relationships are between: (1) hospitals and managed care organizations (health plans); (2) managed care organizations and employers; (3) employers and employees; and (4) employees and hospitals. (Haas-Wilson, Tr. 2456, 2460-61, 2462-64 (discussing DX 7026)).

Response to Finding No. 128:

REDACTED

This proposed finding is incomplete because

(Haas-Wilson, Tr. 2803, *in camera*; RFF ¶ 385). Even though MCOs may be the purchasers in the first instance of hospital services, they construct hospital networks to create plans that are attractive to their customers, the employers. (Elzinga, Tr. 2407). The employers, in turn, are driven to provide a plan that is attractive to their employees,

because employees may consider health care benefits in deciding where to accept employment. (Elzinga, Tr. 2407). Therefore, MCOs must take patient preferences into consideration in constructing their hospital networks. (Elzinga, Tr. 2407-08; RFF ¶ 386).

129. The first institutional relationship related to competition for hospital services is the institutional relationship between hospitals and health plans. This relationship is referred to as “first-stage” competition in the economics literature. (Haas-Wilson, Tr. 2456)

Response to Finding No. 129:

Respondent has no specific response.

130. The first institutional relationship between hospitals and health plans is particularly important because it is through this relationship that hospital prices are determined. (Haas-Wilson, Tr. 2456). Hospitals sell their services to health plans, and the health plans should be thought of as the consumer in this first-stage competition. (Haas-Wilson, Tr. 2456-2457; Noether, Tr. 5906).

Response to Finding No. 130:

This proposed finding is incomplete as hospitals have different prices with other classes of customers, including Medicare/Medicaid patients and self-pay patients. The prices for Medicare/Medicaid patients are determined by the federal government. (Haas-Wilson, Tr. 2455; Neaman, Tr. 1317-18; CCFF ¶ 167). Self-pay patients pay for services based on the hospital’s chargemaster, the hospital’s list prices. (Porn, Tr. 5685; CCFF ¶ 179).

131. The health plan puts together its network of health care providers by choosing which hospitals will be included in its different plans’ networks, as well as which physician organizations and which other ancillary healthcare providers will be included in the provider networks that are offered as part of the health plan. (Haas-Wilson, Tr. 2456-57).

Response to Finding No. 131:

Respondent has no specific response, except to the extent that this proposed finding implies that MCOs use selective contracting in the Chicago area. (RFF-Reply ¶¶ 138, 218).

132. There are generically three types of hospitals: community, tertiary, and advanced teaching. Community has the basic services such as delivering babies and surgical procedures. Tertiary facilities offer more complex services (as well as basic services).

Advanced teaching facilities offer the highest level services, including transplants, burn centers and hyperbaric centers. (Ballengee, Tr. 158-59).

Response to Finding No. 132:

This proposed finding is inaccurate. Ballengee's testimony is not supported by any documents or other testimony, and in reality, this three-way distinction has been made up by Complaint Counsel for this litigation. **REDACTED**

(Holt-Darcy, Tr. 1589, *in camera*). A community hospital offers services that are relatively simple, such as medical, surgical and maternity. (Ballengee, Tr. 158). **REDACTED**

(Neary, Tr. 622; Foucre, Tr. 935; Foucre, Tr. 1112, *in camera*; Mendonsa, Tr. 565, *in camera*). **REDACTED**

(Ballengee, Tr. 158-59; Holt-Darcy, Tr. 1590, *in camera*; RFF ¶¶ 99-104).

Even if there were three distinctions as asserted in this proposed finding, ENH would still fit squarely within the highest category. For instance, a document authored by Ballengee at PHCS as far back as August 28, 1995, identified the Evanston Hospital Corporation, which included Glenbrook Hospital, as an "advanced teaching" hospital. (RX 107 at GWL 859).

133. All hospitals, including tertiary facilities, "offer a core of basic services," *i.e.*, a tertiary hospital offers more complex services as well as the basic services of a community hospital. (Noether, Tr. 6159-60).

Response to Finding No. 133:

The proposed finding is incomplete. While all hospitals offer basic services, different hospitals offer somewhat different mixes of these services. (Noether, Tr. 6159).

134. The second institutional relationship related to competition for hospital services is the institutional relationship between the health plans and employers. Health plans sell their product, such as HMO and PPO products, to prospective buyers or employers. In the employment-based healthcare insurance system found in the United States, the employer selects which products of health plans to offer as a fringe benefit to employees. (Haas-Wilson, Tr. 2460-61 (discussing DX 7026)).

Response to Finding No. 134:

Respondent has no specific response.

135. Viewed from the standpoint of this second institutional relationship, health plans compete with each other to offer provider networks that are both more attractive to employees and that have a low “premium” or price. (Haas-Wilson, Tr. 2461).

Response to Finding No. 135:

This proposed finding is incomplete. MCOs “compete on many factors.” (Haas-Wilson, Tr. 2461). To be attractive to employers, MCOs must provide adequate networks that span the range of basic and specialty services that employers demand, have good quality reputations, and be geographically convenient to employees and their families. (Noether, Tr. 5936-37, 5944-45).

136. Consumers prefer a broader choice of hospitals in a health plan, and all products have financial incentives for the enrollee to use hospitals that are within the network. (Haas-Wilson, Tr. 2461).

Response to Finding No. 136:

Respondent has no specific response.

137. All health plan products have financial incentives to use within-network providers, although they vary in how “harsh” those incentives are. (Haas-Wilson, Tr. 2462).

Response to Finding No. 137:

Respondent has no specific response.

138. There is a trade-off between broader networks and lower prices. Health plans with better networks tend to have higher prices, and health plans with worse networks have lower prices. (Haas-Wilson, Tr. 2462).

Response to Finding No. 138:

This proposed finding is misleading to the extent it suggests that MCOs use selective contracting in the Chicago area. There has never been much selective contracting in the Chicago area. (Noether, Tr. 5981). An analysis of the size of MCO networks in the Chicago area shows that all MCO networks are very large and fairly inclusive, which demonstrates that MCOs contract with the vast majority of hospitals in the Chicago area. (Noether, Tr. 5982 (*describing* DX 7045); RFF ¶ 991). Further, in the Chicago area, HMO and PPO networks are about the same size. (Noether, Tr. 5982). Traditionally, in a market where there is selective contracting, HMOs would be smaller than PPOs. (Noether, Tr. 5982; RFF-Reply ¶ 218; RFF ¶ 992).

139. The third institutional relationship related to competition for hospital services is the institutional relationship between employers and their employees. Employers who choose to offer health insurance to their employees are offering this health insurance coverage as a form of compensation to their employees. Nevertheless, the employee still bears the cost of the health insurance because economic theory shows that the cost of that insurance is “shifted back” to the employee in the form of lower wages. (Haas-Wilson, Tr. 2463 (discussing DX 7026)).

Response to Finding No. 139:

This proposed finding is misleading to the extent it suggests that MCOs must pass any cost increases on to employers, which then pass those increases on to employees. First, MCOs can create incentives for employees to use lower cost providers. For instance, some MCOs have created “tiered” networks, which are broad networks in the aggregate that provide financial incentives for employees to use a limited subset of the network providers that have relatively lower negotiated rates. (RX 1346 at BCBSI-ENH 5536; RX 1613 at 5; RX 1663 at 7; RX 1246 at NMH 3014). Second, employers have vehicles available to them to control total insurance costs. (Dorsey, Tr. 1471-72). A cafeteria plan, for example, could achieve cost savings. (Dorsey, Tr. 1471-72). In a cafeteria plan, employees pay a higher out-of-pocket fee to access a

more expensive provider, and a lower out-of-pocket fee to access a less expensive provider.

(Dorsey, Tr. 1471; RFF ¶ 62).

140. The fourth institutional relationship related to competition for hospital services is the institutional relationship between employees and hospitals. When an employee covered under an employer-based health insurance plan needs hospitalization, the employee will, together with his or her physician, select the hospital from which to get care. Frequently, the employee, because of the financial incentive offered by the health plan, will choose a hospital in the network. (Haas-Wilson, Tr. 2463-64 (discussing DX 7026)).

Response to Finding No. 140:

This proposed finding is incomplete. Patients evaluate hospital quality, to the extent that they can, as one of the dimensions by which they choose hospitals. (Noether, Tr. 6011; RFF ¶ 325).

141. Hospitals compete, although not on price, to attract patients who are covered by the health plans with which the hospital has contracts. (Haas-Wilson, Tr. 2464). This competition for patients after the hospital has entered into contracts with health plans is called “second stage competition.” (Haas-Wilson, Tr. 2465).

Response to Finding No. 141:

This proposed finding is incomplete. To attract patients, hospitals compete, in part, on the quality of care delivered. (Noether, Tr. 6011). “Patients are made better off when quality is improved, and they certainly use quality to the extent that they can evaluate it as one of the dimensions by which they choose hospitals.” (Noether, Tr. 6011).

142. The four institutional relationships related to competition for hospital services have changed over time as a result of the increasing prevalence of managed care. Prior to managed care, most people were covered by “indemnity-based” insurance. Under indemnity-based insurance, these four different institutional relationships would not have existed as is the case today under managed care competition. (Haas-Wilson, Tr. 2463-65).

Response to Finding No. 142:

Respondent has no specific response.

143. Before, under indemnity insurance, the enrollee of the health plan generally had insurance coverage for all hospitals and physician organizations. Under indemnity insurance, the individual covered by insurance could select any hospital, and the insurance company would reimburse the individual for the cost of care according to the plan benefits. So, under indemnity insurance, the customer of the hospital would be the individual patient, in contrast to under managed care, where the health plan acts as the consumer in first-stage competition. (Haas-Wilson, Tr. 2465-66).

Response to Finding No. 143:

Respondent has no specific response.

144. Under indemnity insurance, hospitals did not have to compete to be part of a network, so there was not the same kind of competition as there is under managed care. Because there was no competition for a place in the provider network under indemnity insurance, hospitals were not competing on price to get contracts with health insurance companies. (Haas-Wilson, Tr. 2466).

Response to Finding No. 144:

This proposed finding is incorrect to the extent it suggests that MCOs use selective contracting in the Chicago area, and that hospitals compete to be part of a MCO network. There has never been much selective contracting in the Chicago area. (RFF-Reply ¶¶ 138, 218).

Hospital Price Increases Ultimately Borne By Consumers

145. Health plan representatives confirmed that employees ultimately bear the cost of higher health care prices.

REDACTED

(Ballengee, Tr. 239, *in camera*; Mendonsa, Tr. 483; Dorsey, Tr. 1450).

Response to Finding No. 145:

This proposed finding is misleading and speculative to the extent it suggests that MCOs must pass any cost increases on to consumers. First, MCOs can create incentives to use lower cost providers. For instance, recently some MCOs have created “tiered” networks, which are broad networks in the aggregate that provide financial incentives for employees to use a limited

subset of the network providers that have relatively lower negotiated rates. (RX 1346 at BCBSI-ENH 5536; RX 1613 at 5; RX 1663 at 7; RX 1246 at NMH 3014; RFF ¶ 61).

Second, even without changing their networks, MCOs do not need to pass cost increases on to the consumers. Despite complaints of higher prices from providers, the MCOs themselves are making millions of dollars in profits and thus can absorb provider price increases without passing them on to consumers. For instance, Health Care Service Corporation, the parent of Blue Cross, posted net gains of over \$624 million in 2003, \$347 million in 2001 and \$173 million in 2000. (RX 1587 at 7; RX 1198 at 7). Humana is one of the nation's largest publicly traded health benefits companies, based on 2003 revenues of \$12.2 billion. (RX 1743 at 4, 27). In 2003, PHCS reported that its net revenue climbed to \$153 million, an increase of 6% over 2002. (RX 1615 at 3). Further, PHCS's earnings increased by "an astounding 50%" in 2003. (RX 1615 at 3). Cigna posted net income of \$668 million in its 2003 financial statements. (RX 1742 at 54). As of February 2005, United Health Group was worth over \$30 billion, and its Chairman and CEO earned in excess of \$91,953,914 in 2003. (Foucre, Tr. 939; RX 1662 at 225, 227; RFF ¶¶ 173-174). Even the smaller MCOs are making millions of dollars. For instance, First Health, which acquired CCN in August 2001, had net income of \$152,734,000 in 2003, up from \$132,938,000 in 2002, \$102,920,000 in 2001, and \$82,619,000 in 2000. (RX 1661 at 50; RX 1469 at 104).

Third, Complaint Counsel did not call one single employer to discuss whether costs would be passed on to employees.

146. Unexpected price increases have "a direct impact on [a self-insured customer's] bottom line" and will adversely affect the profitability of the self-insured's business. (Mendonsa, Tr. 483).

Response to Finding No. 146:

This proposed finding is misleading and speculative. Self-insured employer groups have vehicles available to them to control total insurance costs. (Dorsey, Tr. 1471-72). A cafeteria plan, for example, could achieve cost savings. (Dorsey, Tr. 1471-72). In a cafeteria plan, employees pay a higher out-of-pocket fee to access a more expensive provider, and a lower out-of-pocket fee to access a less expensive provider. (Dorsey, Tr. 1471; RFF ¶ 62).

147. The only choice a self-insured customer or large employer group has in the event of unforeseen increases in expenses is to pass on the costs to its employees. (Mendonsa, Tr. 483-4; Ballengee, Tr. 239)

Response to Finding No. 147:

This proposed finding is misleading. (RFF-Reply ¶ 146).

148. **REDACTED** (Mendonsa, Tr. 549, *in camera*).

Response to Finding No. 148:

This proposed finding is misleading to the extent it suggests that MCOs must pass any cost increases on to consumers. (RFF-Reply ¶ 145). The proposed finding is also speculative in assuming that employers will raise deductibles and co-payments in response to a price increase from a provider. The testimony is not from an employer but, rather, a representative of a MCO. Complaint Counsel did not call any employer to testify that it raised deductibles or co-payments in response to ENH's price increase. Mendonsa's testimony concerning his understanding of the business practice of a third-party should be given no weight.

149. In its contract negotiation advice, Bain advised ENH that "PHCS's PPO business is largely 'cost pass through'" and that rate increases from ENH to PHCS "will not hit [PHCS's] margins directly." (CX 67 at 39).

Response to Finding No. 149:

This proposed finding is misleading and irrelevant because PHCS is different from MCOs like Cigna, Aetna and United. (Ballengee, Tr. 204). PHCS is not an insurance company like these other MCOs. Rather, its customers are insurance companies. (Hillebrand, Tr. 1892; Ballengee, Tr. 143, 204). Therefore, PHCS does not share the financial risk with its customers for healthcare costs. (Ballengee, Tr. 144). This was the point of Bain’s advice in this proposed finding. Thus, this proposed finding is also misleading to the extent that it suggests that PHCS’s customers – insurance companies – must pass any cost increases on to consumers. (RFF-Reply ¶ 145).

150. In response to ENH’s rate increases to PHCS in 2000, PHCS’s customers “had to raise their rates significantly in – the premiums to accommodate the increased rates at Evanston.” (Ballengee, Tr. 196-97).

Response to Finding No. 150:

This proposed finding is misleading. First, it is not necessary for MCOs to pass any cost increases on to consumers. (RFF-Reply ¶ 145, 149). Second, the testimony of Ballengee is based, in particular, on discussions with only one employer, Trustmark. (Ballengee, Tr. 196-97). Complaint Counsel did not call any witness from Trustmark, or any employers at all, to testify about increased premiums. Ballengee’s testimony concerning her understanding of the business practice of a third-party thus should be given no weight.

151. “The big impact” of health plans passing on large increases to their smaller business customers is “small insureds dropping coverage altogether and people not having insurance.” (Mendonsa, Tr. 483-4).

Response to Finding No. 151:

This proposed finding is misleading. First, it is not necessary for MCOs to pass any cost increases on to consumers. (RFF-Reply ¶ 145). Second, it is misleading to the extent it suggests

that any small insureds dropped its coverage in response to price increases from ENH. Neither Mendonsa nor any other trial witness offered testimony that small insurers dropped their coverage after the Merger in response to ENH's price increases.

C. Government Payment System Versus Commercial Insurance Versus Uninsured

152. In the United States, the majority of people with private health insurance have their health insurance purchased through their employer. Not everyone is covered by employer-based healthcare insurance. There is a large sector of public health insurance, including the Medicare and Medicaid programs. (Haas-Wilson, Tr. 2454).

Response to Finding No. 152:

Respondent has no specific response.

153. For both ENH and Highland Park, the major components of their revenue were Medicare and commercial health plans. Medicaid and the uninsured comprised a very small segment of their revenue. (Newton, Tr. 301; Neaman, Tr. 1312).

Response to Finding No. 153:

Respondent has no specific response.

1. Differences and Similarities Among the Three Payment Systems

Government Payment System (Including Medicare, Medicaid, and State Programs)

154. Public health insurance programs cover a portion of patients who are not covered through employer-based health insurance. (Haas-Wilson, Tr. 2454).

Response to Finding No. 154:

Respondent has no specific response.

155. Medicare and Medicaid are primary components of the public health insurance sector. (Haas-Wilson, Tr. 2454).

Response to Finding No. 155:

Respondent has no specific response.

156. The Medicare program “is a federal health insurance program that provides health insurance for the elderly and those individuals suffering from . . . kidney failure and needing renal dialysis.” (Haas-Wilson, Tr. 2454).

Response to Finding No. 156:

Respondent has no specific response.

157. The Medicaid program is “a joint federal/state program” under which “individuals of low income receive health insurance coverage.” (Haas-Wilson, Tr. 2454).

Response to Finding No. 157:

Respondent has no specific response.

158. Medicare and Medicaid accounted for about 40 to 45% of ENH’s gross revenue. (Neaman, Tr. 1312).

Response to Finding No. 158:

Respondent has no specific response.

159. For pre-merger Highland Park, the Medicaid program was a “de minimis” element of revenues. Medicare comprised about 45% of Highland Park’s business and managed care another 45%. “[E]ssentially, the major payer mix was commercial and Medicare.” (Newton, Tr. 301).

Response to Finding No. 159:

Respondent has no specific response

Commercial Insurance: Managed Care and Other Programs

160. In the United States the majority of people with private health insurance have their health insurance purchased through their employer. (Haas-Wilson, Tr. 2454).

Response to Finding No. 160:

Respondent has no specific response.

161. Traditional indemnity insurance was the dominant form of commercial reimbursement in the 1980s. Indemnity insurance was insurance “where benefits were given to subscribers. Prices weren’t negotiated with the insurer.” Instead, the insurance company would pay the benefit on behalf of the patient. (Hillebrand, Tr. 1831-32).

Response to Finding No. 161:

Respondent has no specific response.

162. Managed care plans grew in importance, crowding out traditional indemnity insurance. Managed care became “the predominant form of commercial health insurance.” (Hillebrand, Tr. 1832).

Response to Finding No. 162:

Respondent has no specific response.

Uninsured or Self Pay

163. Those people who do not have health insurance, either through public sector or commercial plans, are referred to as “uninsured.” (Haas-Wilson, Tr. 2454).

Response to Finding No. 163:

Respondent has no specific response.

164. After Medicare, Medicaid and the top health plans, there remained for ENH approximately 10% of gross revenues that fall into a separate category. (Neaman, Tr. 1312).

Response to Finding No. 164:

Respondent has no specific response.

165. Most of this 10% increment was charity care, although there were a small number of self-pay patients in that mix as well. (Neaman, Tr. 1312).

Response to Finding No. 165:

Respondent has no specific response.

166. Self-pay patients were a very small component of pre-merger Highland Park’s business. (Newton, Tr. 301).

Response to Finding No. 166

Respondent has no specific response.

2. Hospital Prices Under the Three Payment Systems

Government Payment System

167. The prices in public health insurance programs are not determined by competitive market forces. The prices are determined by the government. (Haas-Wilson, Tr. 2455).

Response to Finding No. 167:

Respondent has no specific response.

168. The federal government unilaterally sets the rates for Medicare reimbursements. There is no negotiation between providers and the federal government to establish reimbursement rates. (Neaman, Tr. 1317-18).

Response to Finding No. 168:

Respondent has no specific response.

169. The Federal Medicare program pays a case rate on the basis of Diagnosis Related Group (“DRG”), which is “a grouping of inpatients into hundreds of separate categories based on their diagnoses and the procedures they undergo while hospitalized.” (Amended Glossary of Terms at 9, April 22, 2005). The DRG is “a method of payment in which the reimbursement for inpatient hospital services is set based on the DRG into which a patient is classified. As a general rule, the amount of payment will not vary if the hospital renders significantly greater or less services in treating the patient than is the estimated average, or if the hospital incurs costs that are greater or less than the typical cost incurred by hospitals.” (Amended Glossary of Terms at 9, April 22, 2005).

Response to Finding No. 169:

Respondent has no specific response, except to note that: (1) the definition of DRG and DRG reimbursement is found on page 6 of the Amended Glossary of Terms; and (2) this glossary, by its terms, was submitted to the Court as a reference only and not as an admission by either party.

Commercial Insurance: Managed Care and Other Programs

170. **REDACTED**

(See, e.g., Holt-Darcy, Tr. 1521, *in camera*; Ballengee, Tr. 229, *in camera*; Ballengee, Tr. 227, *in camera*).

Response to Finding No. 170:

Respondent has no specific response.

171. **REDACTED**

(See, e.g., Ballengee, Tr. 174-76 (describing PHCS negotiations with ENH); Mendonsa, Tr. 535-36, *in camera*; Dorsey, Tr. 1434-38 (describing One Health negotiations with ENH); Foucre, Tr. 886-87 (describing United negotiations with ENH); Holt-Darcy, Tr. 1503-04, *in camera*.)

REDACTED

Response to Finding No. 171:

Respondent has no specific response. For a detailed account of ENH's negotiations with Aetna, Great West, PHCS, Unicare and United see RFF ¶¶ 738-756, 790-808, 827-848, 853-923.

172. Under the per diem reimbursement, the fixed rate per day is an all-inclusive amount for each day that the patient is in the hospital, regardless of the amount of services or the costs or charges for the services that actually must be rendered to that patient. (Amended Glossary of Terms at 9, April 22, 2005).

Response to Finding No. 172:

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

173. **REDACTED**

(Ballengee, Tr. 229, *in camera*).

Response to Finding No. 173:

Respondent has no specific response.

174. **REDACTED**

(Spaeth, Tr. 2129-30; Holt Darcy 1537-39, *in camera*; Mendonsa 525, *in camera*)

Response to Finding No. 174:

Respondent has no specific response.

175. A discount off charges contract is an arrangement by which health plans pay a percentage discount off of the hospital's chargemaster list price for each component of a service rendered. (Chan, Tr. 667; Amended Glossary of Terms at 6, April 22, 2005).

Response to Finding No. 175:

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

176. Charges are the published prices for services provided by a hospital. These rates are found in the hospital's "chargemaster," which reflects tens of thousands of predetermined itemized amounts (list prices) to be billed for each good or service the hospital provides. Each hospital maintains its own chargemaster. (Amended Glossary of Terms at 4, April 22, 2005; Neaman, Tr. 1349; Hillebrand, Tr. 1710; Chan, Tr. 674; H. Jones, Tr. 4143).

Response to Finding No. 176:

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

Uninsured or Self Pay

177. Uninsured patients generally are treated "as a matter of charity or treated at zero price." (Elzinga, Tr. 2401).

Response to Finding No. 177:

Respondent has no specific response.

178. About 10% of ENH's gross revenue falls outside of commercial insurance and Medicare/Medicaid. Most of that 10% are patients who have no insurance and do not pay their bills. ENH writes these patients off as charity care. "Every once in a while, there's a few people that pay cash, not very often, but every once in a while, there is." (Neaman, Tr. 1312).

Response to Finding No. 178:

Respondent has no specific response.

179. Self-pay patients pay for services based on the hospital's chargemaster, which are essentially list prices. (Porn, Tr. 5685).

Response to Finding No. 179

Respondent has no specific response.

D. Types of Commercial Health Plan Products

1. HMO

180. Traditionally, health maintenance organizations (“HMOs”) are managed care plans that “contrac[t] with a limited number of hospitals, doctors, and other providers, and which specifies that an enrollee of the HMO will bear a significant portion of (and possibly, all) fees for services that he or she receives from a provider with which the HMO does not contract.” (Amended Glossary of Terms at 7, April 22, 2005).

Response to Finding No. 180:

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

181. HMO products tend to have more narrow networks of hospitals than PPO products. (Haas-Wilson, Tr. 2460).

Response to Finding No. 181:

This finding is inaccurate, for in the Chicago area, HMO and PPO networks are about the same size. (Noether, Tr. 5982). For example,

REDACTED

(Holt-Darcy, Tr. 1584-85, *in camera*).

182. An HMO product is an “insured product, meaning that the insurance company takes the risk. For any utilization or healthcare dollars that are spent, the insurance company pays those dollars.” (Neary, Tr. 585).

Response to Finding No. 182:

Respondent has no specific response.

183. With HMO products, consumers are essentially “lock[ed]-in” to the network. If patients obtain services out of the network, they receive no benefit. (Mendonsa, Tr. 477).

Response to Finding No. 183:

Respondent has no specific response.

2. PPO

184. A preferred provider organization (“PPO”) is a managed care plan that “contracts with a group of hospitals, doctors, and other health care providers that usually is somewhat

larger than the groups with which an HMO may contract.” Enrollees generally are offered a financial incentive to obtain care from preferred providers, but may use outside providers at additional cost. (Amended Glossary of Terms at 10, April 22, 2005).

Response to Finding No. 184:

This proposed finding is inaccurate to the extent that it implies that, in the Chicago area, a PPO product includes more hospitals in its network than an HMO product. (RFF-Reply ¶ 181). Moreover, the referenced glossary, by its terms, was submitted to the Court as a reference only and not as an admission by either party.

185. PPO products tend to include more hospitals in their networks than do HMO products. (Haas-Wilson, Tr. 2460).

Response to Finding No. 185:

This proposed finding is inaccurate. (RFF-Reply ¶ 181).

186. With PPO products, the health plan provides a higher in-network benefit. The health plan does provide benefits if a patient chooses to obtain services outside the network, but the benefits are relatively lower than if the patient remains in-network. (Mendonsa, Tr. 477-78).

Response to Finding No. 186:

Respondent has no specific response.

3. Other Products Offered by Health Plans

187. A point of service plan (“POS”) is a managed care plan that “contracts with a limited number of hospitals, doctors, and other providers and extends terms of coverage to enrollees based on terms that will vary depending on the provider from which the enrollee seeks care.” (Amended Glossary of Terms at 10, April 22, 2005).

Response to Finding No. 187:

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

188. A point of service plan is a variation of the PPO. “A point of service product is one where the in-network benefit or the higher benefit is accessed if [a patient] utilize[s] a

primary care physician as opposed to just in and out of network, but there is an out-of-network benefit in that product.” (Mendonsa, Tr. 479).

Response to Finding No. 188:

Respondent has no specific response.

189. With POS products, like with PPO products, the companies “that contracted with the insurance company are responsible ultimately for the payment of [healthcare services].” (Neary, Tr. 586).

Response to Finding No. 189:

Respondent has no specific response.

190. Managed care plans generally fall within the broad HMO, POS, and PPO categories. “Nevertheless, the different types of managed care plans are difficult to distinguish because, over time, the managed care organizations have modified each type of plan to incorporate different elements of the other plans that consumers demand.” (Amended Glossary of Terms at 8, April 22, 2005).

Response to Finding No. 190:

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

4. Self Insurance

191.

REDACTED

(Haas-Wilson, Tr. 2571, *in camera*).

Response to Finding No. 191

Respondent has no specific response.

VII. SELECTIVE CONTRACTING

A. Competition in the Health Care Marketplace

1. Differences Between First and Second Stage Competition

192. The first institutional relationship related to competition for hospital services is between hospitals and health plans. This relationship is referred to as “first-stage” competition in the economics literature, and it is particularly important because it is through this competitive dynamic that hospital prices are determined. (Haas-Wilson, Tr. 2456).

Response to Finding No. 192:

Respondent has no specific response other than to point out that Dr. Haas-Wilson’s testimony was limited to “health economics literature” rather than to economics literature more broadly as this proposed finding suggests.

193. The institutional relationship between employees and hospitals is often referred to as “second-stage competition” in the economics literature. Second-stage competition is the competition among hospitals for patients based on non-price variables. (Haas-Wilson, Tr. 2463-65).

Response to Finding No. 193:

Respondent has no specific response.

194. Hospitals compete for the employees’ business but not necessarily on price. Instead, hospitals compete on non-price variables. Where the employee has a fixed deductible or fixed co-pay, *e.g.*, a co-pay of \$100 a day, the employee’s out-of-pocket costs will not vary by hospital. Consequently, at that point, hospitals do not really compete for patients on the basis of price. (Haas-Wilson, Tr. 2463-65).

Response to Finding No. 194:

Respondent has no specific response.

2. The Process of Selective Contracting

195. Health plans typically do not contract with all the hospitals in a given geographic area. Instead, they engage in selective contracting – the process by which health plans negotiate with hospitals. A health plan seeks to put together an attractive network for potential buyers, while at the same time keeping premiums (*i.e.* the prices at which it sells its products) low. (Haas-Wilson, Tr. 2457).

Response to Finding No. 195:

This proposed finding is misleading to the extent that it implies the practice of selective contracting was prevalent in the Chicago area. There never was much selective contracting in the Chicago area. (Noether, Tr. 5981). To the contrary, MCOs generally included most of the approximately 90 to 100 acute care hospitals in the Chicago area in their networks. (Ballengee, Tr. 154; Mendonsa, Tr. 484 (there are approximately 90 to 100 acute care hospitals in the Chicago area); CCFF ¶ 220 (PHCS has 75 Hospitals in its network); CCFF ¶ 226 (Aetna has “about” 88 hospitals in its network); CCFF ¶ 232 (One Health contracted with “roughly 105 hospitals”); CCFF 238, *in camera* **REDACTED** CCFF ¶ 243 (United contracted with “approximately” 98 hospitals); RFF ¶ 993). At least one MCO, Unicare, testified that **REDACTED**

(Holt-Darcy, Tr. 1584, *in camera*; RFF ¶ 994).

196. Through the process of selective contracting, the health plan seeks to negotiate a lower price with the hospital while the hospital seeks to negotiate for a higher price. A bargain is struck between the two price objectives. (Haas-Wilson, Tr. 2457-58).

Response to Finding No. 196:

This proposed finding is misleading to the extent it suggests that selective contracting governs the bargaining process between MCOs and hospitals in the Chicago area. (RFF-Reply ¶ 195).

197. The health plan will only include those hospitals in its provider network with which there is this sort of bargain over price. (Haas-Wilson, Tr. 2457-58).

Response to Finding No. 197:

This proposed finding is misleading to the extent it suggests that selective contracting governs the bargaining process between MCOs and hospitals in the Chicago area. (RFF-Reply ¶ 195).

3. Relative Bargaining Power in the Selective Contracting Process

198. In first-stage competition, the relative bargaining positions of the hospital and the health plan determine to a large extent the outcome of the negotiation. (Haas-Wilson, Tr. 2469-70).

Response to Finding No. 198:

This proposed finding is misleading because it ignores many factors, other than bargaining position, that can impact the outcome of the negotiations between hospitals and MCOs. **REDACTED**

(Haas-Wilson Tr. 2745-46, 2754, 2755-56;

in camera; RFF ¶ 526).

199. The bargaining position of the hospital and the health plan in first-stage competition depends on the alternatives available to each. (Haas-Wilson, Tr. 2470).

Response to Finding No. 199:

This proposed finding is misleading to the extent it ignores the many factors, besides the alternatives available, that can impact the outcome of the negotiations between hospitals and MCOs. (RFF-Reply ¶ 198).

200. The ability of the health plan to exclude a hospital from its network is a powerful tool that defines each side's bargaining position. (Haas-Wilson, Tr. 2470; Noether, Tr. 6189).

Response to Finding No. 200:

This proposed finding is misleading because it is not supported by the testimony of Dr. Noether. **REDACTED.**

REDACTED

(Noether, Tr. 6189, *in camera*; RFF-Reply ¶ 195).

201. When a health plan is putting together its provider network, if one hospital is asking for what appears to be a particularly high and unreasonable price, the health plan will look at its alternatives. (Haas-Wilson, Tr. 2470).

Response to Finding No. 201:

This proposed finding is misleading to the extent it ignores other factors that might influence MCO decisions about network composition. For example, initially Great-West rented its provider network from PHCS. In the mid-1990s, Great West decided to build its own network. To minimize disruption to its subscribers, Great West sought to mirror the PHCS network. (Dorsey, Tr. 1460-61). **REDACTED**

(RX 718, *in camera*; RX

773, *in camera*; CX 176, *in camera*; CX 5907, *in camera*). In addition, this proposed finding is misleading to the extent it suggests that the practice of selective contracting was prevalent in Chicago. (RFF-Reply ¶ 195).

202. One alternative for the health plan in constructing a network is to exclude hospitals that ask for the particularly high and unreasonable price, and to include other hospitals as substitutes. (Haas-Wilson, Tr. 2470).

Response to Finding No. 202:

This proposed finding is misleading to the extent it ignores factors other than price that influence MCO decisions about network composition. (RFF-Reply ¶ 201). This proposed finding is also misleading to the extent it suggests that the practice of selective contracting was prevalent in Chicago. (RFF-Reply ¶ 195).

203. In constructing its network, the health plan can also choose to pay for the higher priced hospital, but the health plan would most likely only pay for the higher priced hospital when suitable alternatives do not exist. (Haas-Wilson, Tr. 2470).

Response to Finding No. 203:

This proposed finding is misleading to the extent it ignores factors other than price that might influence MCO decisions about network composition. (RFF-Reply ¶ 201-202). This proposed finding is also misleading to the extent it suggests that the practice of selective contracting was prevalent in Chicago. (RFF-Reply ¶ 195).

204. Hospitals, on the other hand, evaluate how much business a particular health plan is bringing to that hospital. (Haas-Wilson, Tr. 2471).

Response to Finding No. 204:

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

205. If a particular health plan has a large volume of patients (enrollees) that would potentially utilize the hospital's services, the hospital's alternative of not being in the health plan's network is less attractive than where the health plan is small and has few enrollees who use that hospital. (Haas-Wilson, Tr. 2471).

Response to Finding No. 205:

Respondent has no specific response.

206. Dr. Haas-Wilson relied on a paper by R. Town and G. Vistnes called "Hospital Competition in HMO Networks," which was published in the Journal of Health Economics in 2001. (Haas-Wilson, Tr. 2475).

Response to Finding No. 206:

Respondent has no specific response.

207. Town and Vistnes wrote in their 2001 article that ". . . a hospital's bargaining position with a plan, and hence its price depend on the incremental value that hospital brings to the plan's network. A hospital's incremental value, in turn, is a function of the plan's opportunity cost of turning to its next-best alternative network that excludes the hospital.

That opportunity cost depends importantly on how well the alternative network provides the scope of coverage the plan's enrollees want (in terms of both perceived quality and access)." (Haas-Wilson, Tr. 2475 (discussing DX 7048)).

Response to Finding No. 207:

This proposed finding is improper because it is based on hearsay that has not been admitted for the truth of the matter asserted. Complaint Counsel did not include the footnote required by paragraph 10 of the Court's Order dated April 6, 2005, indicating that this testimony was elicited for a purpose other than for the truth of the matter asserted.

208. Town and Vistnes wrote in their 2001 article that "the more important a hospital is to [a health plan's revenues] the greater the hospital's bargaining leverage (or equivalently, the higher the [health plan's] opportunity cost of dropping the hospital from its network), and the higher the resultant negotiated hospital price." (Haas-Wilson, Tr. 2475 (discussing DX 7048)).

Response to Finding No. 208:

This proposed finding is improper because it is based on hearsay that has not been admitted for the truth of the matter asserted. Complaint Counsel did not include the footnote required by paragraph 10 of the Court's Order dated April 6, 2005, indicating that this testimony was elicited for a purpose other than for the truth of the matter asserted.

4. Impact of Hospital Mergers on the Selective Contracting Dynamic

209. A merger that affects the availability of formerly independent hospitals to become part of an alternative network for a health plan can create market power by changing the next-best alternative network available to the managed care. (Haas-Wilson, Tr. 2476).

Response to Finding No. 209:

This proposed finding is misleading to the extent it ignores that, to impact the relative bargaining position of the merged hospitals, the hospitals must be close substitutes on at least some level. (Noether, Tr. 5984-85).

REDACTED

REDACTED

(Haas-Wilson, Tr. 2772,

2798-99, *in camera*; RFF ¶ 968). A review of the record evidence reveals that Evanston Hospital and HPH were not close substitutes on virtually any level before the Merger. (RFF ¶¶ 538-587; CCF ¶¶ 1798-1799).

210. Because bargaining position is related to the development of alternative hospital networks by health plans, a change in market power may occur even if the two merged hospitals are not each other's closest competitors in either the first or second-stage of competition. Thus, it is possible for the merger to change the market power available to the merged entity even if patients do not consider the two hospitals to be next-best alternatives to each other and health plans also do not consider them as next-best alternatives. (Haas-Wilson, Tr. 2476).

Response to Finding No. 210:

This proposed finding is misleading to the extent it is inconsistent with Dr. Haas-Wilson's reliance on Town and Vistnes. (CCFF ¶¶ 207-208). The Town and Vistnes article, cited and relied on by Dr. Haas-Wilson, embodies the concept that "closeness of substitution of different networks with and without a particular hospital in question are important in informing about the bargaining leverage that each party brings to the table." (Noether, Tr. 5984). This view is consistent with the theory that unless the merged hospitals were close substitutes before the Merger, the Merger would have little effect on bargaining dynamics. (Noether, Tr. 5985). In general, a merger of two hospitals that were not close substitutes would not be likely to "change the market power available to the merged entity" in any meaningful way. (CCFF ¶ 210, Noether, Tr. 5985).

B. Health Plans' Perspectives on Selective Contracting

1. The Bases for Competition Between Health Plans

211. Health plans compete on many factors, but the two most important factors are the attractiveness of the network and the price. (Haas-Wilson, Tr. 2461, *see* Noether, Tr. 5936 ("[Managed care organizations] are in the business of competing in part based on the provider networks that they put together."), *see* Noether, Tr. 5948 (The health plan,

“to be able to compete, has to have a network that is attractive to enrollees who are the ultimate patients.”)).

Response to Finding No. 211:

This proposed finding is misleading to the extent that it suggests that the practice of selective contracting was prevalent in Chicago. (RFF-Reply ¶ 195).

212. Consumers prefer a broader choice of hospitals in a health plan. (Haas-Wilson, Tr. 2461).

Response to Finding No. 212:

Respondent has no specific response.

213. Every health plan offers financial incentives so that enrollees will use hospitals that are in the health plan’s network. (Haas-Wilson, Tr. 2461-62).

Response to Finding No. 213:

Respondent has no specific response.

214. If the enrollee of a plan chooses to use a hospital that is outside of the health plan’s network of hospitals, there is a financial penalty (i.e. the enrollee will pay more to use an out-of-network hospital) that normally varies by plan. (Haas-Wilson, Tr. 2461-62).

Response to Finding No. 214:

Respondent has no specific response.

215. Health plans also compete on price. (Haas-Wilson, Tr. 2461).

Response to Finding No. 215:

Respondent has no specific response.

216. The price that health plans charge customers is called the insurance premium. (Haas-Wilson, Tr. 2461).

Response to Finding No. 216:

Respondent has no specific response.

217. Health plans compete with each other to keep their premiums low. (Haas-Wilson, Tr. 2461).

Response to Finding No. 217:

This proposed finding is misleading to the extent it suggests that price is the only dimension of MCO competition, and it ignores other dimensions of MCO competition, such as quality and access. (CCFF ¶ 211; RFF-Reply ¶ 212).

218. The more expensive, higher premium plan is often the insurance plan with the better network, while a plan with a low premium is often the insurance plan with the worst network. (Haas-Wilson, Tr. 2462).

Response to Finding No. 218:

This proposed finding is misleading because it relies on vague terms such as “better” and “worst” to describe networks. The composition of networks can vary on many dimensions including: price, access, quality and breadth of services. (Noether, Tr. 5936-37; Hillebrand, Tr. 1834; Mendonsa, Tr. 479; RFF ¶ 56-57). Consequently, without more information, the ambiguity of the words “better” and “worst” renders this proposed finding meaningless.

2. Health Plans’ Criteria for Creating Hospital Networks

219. From the health plans’ perspective, their criteria for placing and retaining a hospital in a network include price, reputation, services offered, and location. (*See, e.g.*, Mendonsa, Tr. 485 (discussing importance of location); Neary, Tr. 587 (discussing importance of competitive prices); Holt-Darcy, Tr. 1421 (discussing importance of licensing and accreditation); Dorsey, Tr. 1451 (discussing importance of offering appropriate level of care and services)).

Response to Finding No. 219:

This proposed finding is incomplete and misleading. (RFF ¶ 63). Licensing and accreditation of a hospital is not an accurate measure of the quality of the institution. While Joint Commission accreditation is a necessary requirement for getting Medicare payments, it is merely a minimum standard. (Holt-Darcy, Tr. 1421; RFF ¶ 1519).

PHCS

220. PHCS has 75 hospitals in its network in the Chicago area. (Ballengee, Tr. 154).

Response to Finding No. 220:

This proposed finding is incomplete. Ballengee testified that PHCS contracted with 75 of the approximately 80 to 85 hospitals in PHCS's Chicago market, thus confirming that PHCS did not engage in selective contracting. (RFF ¶¶ 75-76, 116, 145).

221. When PHCS weighs whether or not to exclude a hospital, it takes into account other hospitals. (Ballengee, Tr. 155-56).

Response to Finding No. 221:

This proposed finding is confusing and misleading. While having an understanding of the location of a hospital and its relative geography to other hospitals is a factor in building a network, to the extent that this finding suggests selective contracting is common in Chicago, it is misleading. (RFF ¶¶ 75-76).

222. "We're looking at comparability or some degree of parity of rates for the services that are being rendered." (Ballengee, Tr. 156).

Response to Finding No. 222:

This proposed finding is vague. **REDACTED**

(RFF ¶ 99, *in camera*).

REDACTED

(RFF ¶ 101, *in camera*).

(RFF ¶ 102, *in camera*).

REDACTED

(RFF

¶¶ 103-104, *in camera*). Consequently, there should be rough parity between academic hospitals, or between community hospitals, but not between academic and community hospitals.

223. PHCS's customers seek hospitals that "provide good services . . . have a breadth of services . . . and . . . have good accessibility to those services within their communities." (Ballengee, Tr. 152).

Response to Finding No. 223:

This proposed finding is misleading. PHCS is not an insurance company like Cigna, Aetna, or United. (RFF ¶ 156). It is a consortium of insurance companies that collectively negotiate hospital rates. (RFF ¶ 156). To the extent this proposed finding suggests that PHCS's customers are employers, it is misleading. PHCS's customers are insurance companies and third-party administrators. PHCS merely wants to create a product that its customers can sell to consumers. (Ballengee, Tr. 152).

224. Prices charged by the hospitals are a factor because PHCS's customers "want to know that they're receiving cost-effective healthcare as well as having the access." (Ballengee, Tr. 153).

Response to Finding No. 224:

This proposed finding is misleading. PHCS's customers are insurance companies and third-party administrators. (Ballengee, Tr. 152). To the extent this proposed finding attempts to directly connect the interests of employers or employees and PHCS, it is misguided. PHCS is at least twice removed from patients. Instead, the true correlation is that PHCS wants to create a product that it can sell profitably to its customers; and PHCS's customers demand a product which they, in turn, can sell profitably to employers.

225. PHCS knows that the location of a hospital matters to its customers because "People do not like to drive by a local hospital and have to go to another hospital." (Ballengee, Tr. 184).

Response to Finding No. 225:

This proposed finding is incorrect and not based on reliable or credible evidence.

Ballengee has no reliable foundation to express the desires of patients or its customers. {Her

REDACTED

(RFF-Reply ¶¶ 223-224; Ballengee, Tr. 171, 180, 183; Ballengee, Tr. 237-38, *in camera*).

The credible evidence in this case is that patients can, and do, travel for medical care. For example, Lake Forest Hospital calculated that its patients are willing to travel, on average, up to 16 minutes for emergency care; 28 minutes to a primary care physician; 31 minutes for outpatient care, and 35 minutes to a hospital for an overnight stay. (RFF ¶ 400). Significant numbers of patients even leave the county for health care and many travel to the downtown hospitals for their care. (RFF ¶¶ 402-404).

Aetna

226. Aetna had a network of about 88 hospitals in the Chicago area at the time of the merger. (Mendonsa, Tr. 484).

Response to Finding No. 226:

Respondent has no specific response.

227. Network composition is “critically vital” to Aetna’s ability to market a network to employers. Aetna has to have the “discounts so [it] can have the right pricing,” and “the proper access to get the business.” (Mendonsa, Tr. 485, 491).

Response to Finding No. 227:

Respondent has no specific response. (RFF ¶ 63).

228. **REDACTED**

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

Response to Finding No. 228:

This proposed finding is vague and misleading. Aetna has a network to “provide access for employees,” whether they are “decision-makers” or not. (Mendonsa, Tr. 485).

229. **REDACTED**

(Mendonsa, Tr. 516-17, *in camera*).

Response to Finding No. 229:

This proposed finding is not based on reliable or credible evidence. Complaint Counsel did not call a single employer witness to testify as to how it makes health plan decisions or the criteria it uses. Nor did Complaint Counsel identify a single employer executive who lives in the North Shore area. **REDACTED**

(RFF-Reply ¶ 1190; Mendonsa, Tr. 547-48, *in camera*).

Mendonsa provided no basis for his conjecture that executives from his customers live in the North Shore area, or that these executives act in their own self-interest (as opposed to the interest of the employees in general) when deciding on which health plan to adopt for employees.

230. **REDACTED**

(Mendonsa, Tr. 485; Mendonsa, Tr. 568, *in camera*. See Mendonsa, Tr. 543,)

REDACTED

in camera).

Response to Finding No. 230:

This proposed finding is not based on reliable evidence. (RFF-Reply ¶ 229). The reliable evidence is that patients, in reality, can and do travel reasonable distances to receive health care. (RFF-Reply ¶ 225).

231. The importance of Aetna's network composition to its business is also communicated to its stockholders in its SEC filings. (RX 1047 at 12; RX 1650 at 12). Stockholders are told that "the most significant factors which distinguish competing health plans" are "comprehensiveness of coverage, cost . . . the geographic scope of provider networks,

and the providers available in such networks and managed care programs.” (RX 1047 at 12; RX 1650 at 12).

Response to Finding No. 231:

Respondent has no specific response. (RFF ¶ 56).

One Health

232. In late 1999, One Health contracted with “roughly 105 hospitals” in Illinois. (Dorsey, Tr. 1430).

Response to Finding No. 232:

Respondent has no specific response.

233. In the development and maintenance of its networks, One Health looked for “price-competitive” hospitals that will give One Health’s employer groups “adequate coverage.” (Neary, Tr. 587).

Response to Finding No. 233:

Respondent has no specific response.

234. Network coverage is adequate when “there [are] enough providers in our network” that allow employer groups to “access the physicians and hospitals that they want to access.” (Neary, Tr. 587).

Response to Finding No. 234:

This proposed finding is incomplete. (RFF ¶ 56).

235. One Health’s network management regularly interfaced with its sales group so that it knows “if the network [is] adequate or if we need[d] to grow the network” to make it marketable to new employer groups. (Dorsey, Tr. 1433-34).

Response to Finding No. 235:

This proposed finding is incomplete. While Dorsey, formerly of One Health, spoke to other employees of One Health, he did not have the reliable foundation to express the desires of customers who may have spoken with the sales group. (Dorsey, Tr. 613-14 (unreliable hearsay statements were admitted over Respondent’s objections)). Complaint Counsel did not call

members of One Health's sales group to testify at trial. Accordingly, this proposed finding should be given no weight because it relies on unreliable hearsay communications from One Health sales group employees to Dorsey.

236. The "only way" that One Health can "stay in business" is to provide "the right number of hospitals, the right level of care, [and] the right number of physicians" to its members. (Dorsey, Tr. 1451).

Response to Finding No. 236:

Respondent has no specific response.

237. If One Health's network composition is inadequate, "No [hospital] membership, no employer groups, no premium. No premium, no need to continue with One Health Plan." (Dorsey, Tr. 1451).

Response to Finding No. 237:

This proposed finding is vague and confusing.

Unicare

REDACTED

238. (Holt-Darcy, Tr. 1583, 1526, *in camera*).

Response to Finding No. 238:

Respondent has no specific response.

239. Unicare considers "geographic need, . . . marketing needs" and "access" when developing its network. (Holt-Darcy, Tr. 1420).

Response to Finding No. 239:

This proposed finding is vague and incomplete. Unicare satisfies geographic need by assuring that its members have "access to the hospital within 30 miles of where they live or where they work." (RFF ¶¶ 385, 387, 460). **REDACTED**

REDACTED

(RFF-Reply ¶ 1281, *in camera*).

240. To ensure that Unicare has sufficient network access, the health plan evaluates its covered lives in a particular area, considers its marketing department's evaluation of need, and verifies that providers are conveniently located near members' places of residence or employment. (Holt-Darcy, Tr. 1420).

Response to Finding No. 240:

This proposed finding is vague and incomplete. Unicare's standard for sufficient access is to assure that there is a hospital within 30 miles of where its members live and work. (RFF-Reply ¶ 239). **REDACTED**

(RFF ¶ 387, *in camera*).

241. Providers in Unicare's network must also meet credentialing criteria for "licensure, JCAHO accreditation, [and] insurance qualifications." (Holt-Darcy, Tr. 1420-21).

Response to Finding No. 241:

This proposed finding is incomplete. Holt-Darcy testified that JCAHO accreditation is a "minimum standard" for assessing a hospital's credentials. (Holt-Darcy, Tr. 1421).

242. JCAHO accreditation is "very" important to Unicare. (Holt-Darcy, Tr. 1421). In fact, Unicare "can't credential a hospital that's not JCAHO . . . accredited" because accreditation by the Joint Commission is "like a minimum standard." (Holt-Darcy, Tr. 1421).

Response to Finding No. 242:

Respondent has no specific response. (RFF-Reply ¶ 241).

United

243. There were approximately 98 hospitals in United's network at the end of 2002. (Foucre, Tr. 881).

Response to Finding No. 243:

Respondent has no specific response.

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

In the matter of)
)

Evanston Northwestern Healthcare)
Corporation,)
)
)

Docket No. 9315

Public Record

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

VOLUME II of XI

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244. For a health plan to market and sell a hospital network, the geographic location of the hospitals is important for two reasons: (1) a consumer's "primary decision-making factor in selecting a hospital is very often the location of the hospital and the distance they have to travel to seek services," and (2) ensuring an adequate network compared to their competitors in the geographies of where decision-makers of key employers reside is also important. (Foucre, Tr. 884-85).

Response to Finding No. 244:

This proposed finding is not based on credible evidence. MCOs do consider patient preferences in terms of travel distance. (RFF ¶¶ 385). However, there is no reliable evidence to support that the residence of "decision-makers" has impact on the marketability of a network. (RFF-Reply ¶¶ 228-229). Complaint Counsel did not call any employer to testify concerning this matter. Any testimony on this issue from MCO representatives necessarily is based on unreliable speculation and/or hearsay.

C. Pre-Merger Competition By ENH and Highland Park for Network Inclusion

245. The ability of the health plan to exclude a hospital from its network is a powerful tool and defines each side's bargaining position. (Haas-Wilson, Tr. 2470; Noether, Tr. 6189).

Response to Finding No. 245:

This proposed finding is misleading and incorrect to the extent that it suggests that MCOs use selective contracting in the Chicago area in choosing which hospitals to include in their respective networks. There has never been much selective contracting in the Chicago area. (Noether, Tr. 5981; RFF ¶¶ 989-994; CCF ¶ 1430; RFF-Reply ¶¶ 1421, 1430). An analysis of the size of various MCO networks in the Chicago area shows that all MCO networks are very large and fairly inclusive, indicating that MCOs contract with the vast majority of hospitals in the Chicago area. (Noether, Tr. 5982 (*describing* DX 7045); RFF ¶ 991). Further, in the Chicago area, HMO and PPO networks are about the same size. (Noether, Tr. 5982). Traditionally, in a

market where there is selective contracting, HMOs are smaller than PPOs. (Noether, Tr. 5982; RFF ¶ 992).

246. Pre-merger, Evanston was concerned about being excluded from health plans' network of providers. (Neaman, Tr. 961).

Response to Finding No. 246:

This proposed finding is misleading because Neaman's concerns reflected pre-Merger Evanston Hospital's negotiation philosophy, not a perceived lack of market power. Specifically, because the hospital's focus was on being in all MCOs' networks rather than negotiating for better rates, the hospital was worried that taking a tougher stand in negotiations would backfire. (RX 2047 at 34 (Ogden, Dep.); RFF ¶ 609). Moreover, during this period, management had no incentive to get more aggressive because it believed Evanston Hospital was getting "good rates." (RX 2047 at 61 (Ogden, Dep.); RFF ¶ 677). Consequently, Evanston Hospital's lead MCO negotiator, Sirabian, carried out the modest goals of ensuring that the hospital would be included in all of the different MCO networks and to continue to build relationships with all MCOs. (Sirabian, Tr. 5700, 5702, 5721; RFF ¶ 605). While exclusion from a MCO network would not have been fatal to Evanston Hospital, it would have obviously been counter to this philosophy and, therefore, would have been a "concern."

247. In order to avoid exclusion from health plan networks, Evanston accepted price decreases in order to maintain access to health plan members as future patients. Evanston also increased the breadth, depth and quality of its services, and strove to control costs to remain in health plan networks. (Neaman, Tr. 961-62).

Response to Finding No. 247:

This proposed finding is misleading. Because pre-Merger Evanston Hospital relied on other sources of income, its management believed it had "good rates." And because the

emphasis was on building relationships with MCOs, the hospital had little reason to aggressively fight price decreases before the late 1990s. (RFF ¶¶ 641-643; RFF-Reply ¶¶ 246, 1767).

This proposed finding also mischaracterizes Neaman's testimony. Neaman did not testify that Evanston Hospital, as a matter of course, increased the breadth, depth and quality of its services, and strove to control costs, to remain in health plan networks. Rather, Neaman testified that, in the *late* 1990s, one way to "remedy [Evanston Hospital's] disadvantage" with MCOs was to increase the breadth, depth and quality of its services, and to control costs. (Neaman, Tr. 961-62). This is precisely what Evanston Hospital and HPH hoped would happen as a byproduct of the Merger. (RFF-Reply ¶¶ 1352, 1361-1362, 1407, 1459-1460, 1569; Newton, Tr. 408).

248. Pre-merger, Highland Park was "routinely concerned" about being excluded from health plans' networks. (Newton, Tr. 303). Avoiding exclusion was an "extremely important issue" to Highland Park because exclusion would "diminish [its] ability to be successful in the market, would diminish [its] ability for patients to come to [Highland Park Hospital]." (Newton, Tr. 303-04; CX 1868 at 3).

Response to Finding No. 248:

This proposed finding is misleading. It is based primarily on Newton's testimony, which was not credible. (RFF-Reply ¶ 1465). Newton's "concerns" apparently did not reflect reality because, as he testified at trial, pre-Merger HPH had contracts with virtually all MCOs, with perhaps one or two exceptions. (Newton, Tr. 457).

Moreover, Newton testified that he never felt excluded from MCO contracts because of Evanston Hospital, other than Humana's staff model product. (Newton, Tr. 457; Spaeth, Tr. 2170-71). Spaeth, Newton's superior, similarly testified that Evanston Hospital's presence, or the presence of any other hospital in an MCO's network, did not make it more difficult for pre-Merger HPH to gain price increases from that MCO. (Spaeth, Tr. 2176).

249. In order not to be excluded, Highland Park was “constrained” in pricing negotiations. Highland Park also had to demonstrate to health plans that it would be an “important member of the network adding value for [the health plans’] enrollees.” (Newton, Tr. 304).

Response to Finding No. 249:

This proposed finding is false, misleading and irrelevant. (RFF-Reply ¶ 248). Indeed, this proposed finding is meaningless without a definition of the term “constrained.” (RFF-Reply ¶ 1470).

250. The quality of the hospital was a key component in adding “value” from the health plans’ perspective. “If the institution had a poor image of quality, then they would not be attractive to enrollees, it would not be attractive to consumers . . . [T]he issue of value or quality is absolutely central in that relationship with the managed care companies.” (Newton, Tr. 304-05).

Response to Finding No. 250:

This proposed finding is misleading to the extent it implies that around the time of the Merger, MCOs valued quality. (Hillebrand, Tr. 1783). **REDACTED**

(Mendonsa, Tr. 565, *in camera*). Specifically, if a hospital with a “poor image of quality” will not be attractive to enrollees, then it follows that a hospital with a high “image of quality,” e.g., an academic teaching hospitals with a good reputation, will be very attractive to enrollees. As a result, any increase in the perceived need to have ENH in a managed care network after the Merger is due to its high “image of quality” – not market power.

251. The threat of exclusion also impacted on how Highland Park managed its costs. Highland Park was “constantly concerned” about its “cost profile” because it “did not have a lot of the flexibility in terms of just raising prices.” (Newton, Tr. 305-06).

Response to Finding No. 251:

This proposed finding is misleading and irrelevant because it is based on Newton's testimony, which was not credible. (RFF-Reply ¶ 1465). Assuming that HPH did have little flexibility in raising its prices, the threat of exclusion was not the reason for such inflexibility. (RFF-Reply ¶ 248). The evidence showed that HPH was concerned about controlling costs, not because it feared exclusion, but because it was not generating sufficient operating income due to cuts from the Balanced Budget Amendment and a general failure to enhance revenue through new services and joint ventures. (Spaeth, Tr. 2263-64, 2305; RX 592A at ENH RS 880; Newton, Tr. 444; RFF ¶ 2333).

252. Highland Park recognized that competition existed for "participation in payer plans," forcing providers to "harness rising costs, reduce excess utilization and improve the quality and access of care delivery." (CX 1868 at 3).

Response to Finding No. 252:

This proposed finding is misleading because the level of competition for "participation in payer plans" was obviously very limited: (1) Pre-Merger HPH had contracts with virtually all MCOs; (2) Newton, with a single exception, never felt excluded from MCO contracts because of Evanston Hospital; and (3) Spaeth confirmed that the presence of any other hospital in a MCO's network did not make it more difficult for pre-Merger HPH to gain price increases from that MCO. (RFF-Reply ¶ 248).

253. Within Highland Park's core service area, the competition for network participation came "mainly from Lake Forest and Evanston." (CX 1868 at 3; Newton Tr. 324-25). The competition from Evanston and other providers to Highland Park's south was "strong and focused, forcing [Highland Park] to pursue a defensive position." (CX 1868 at 3).

Response to Finding No. 253:

This proposed finding is misleading because competition for network participation was obviously very limited. (RFF-Reply ¶¶ 248, 252). Moreover, while Evanston Hospital and HPH

did compete to a limited extent, they were not each other's closest substitute hospitals from both a product and geographic perspective. (RFF ¶¶ 480-481, 538-587; RFF-Reply ¶¶ 47, 48, 57, 58, 61, 1695).

254. In order to maintain a high quality service offering, Highland Park approved plans for developing new clinical services, strengthening medical staff, enhancing quality of care for existing services, and utilizing more sophisticated information technology systems. (See CCF 2345-2356).

Response to Finding No. 254:

This proposed finding is incomplete and misleading. HPH did, indeed, approve many of these plans. But it did not have the ability to carry them out. Despite HPH's cash on hand and additional investment money, HPH's funds were insufficient to meet the competitive challenges of the Chicago marketplace. (RFF ¶ 2236). Pre-Merger HPH's strategic financial consultant, Kaufman, advised against using HPH's cash or even the investment dollars on hospital improvements. (RFF ¶ 2368). Kaufman concluded that because HPH had no revenue from operations, its existing assets were the only thing keeping the hospital from mere survival. (RFF ¶¶ 2366, 2368-2370). Dr. Noether confirmed Kaufman's conclusions, similarly testifying that HPH's cash was not sufficient to continue to prop up its operating income, make the capital expenditures necessary to keep the hospital competitive and to service the over \$100 million in debt. (RFF ¶ 2410). Complaint Counsel offered no expert testimony to rebut Kaufman and Dr. Noether on this issue. (RFF ¶ 2413).

Finally, even if HPH had the ability to implement its plans, these plans would have still failed to meet the hospital's needs. Specifically, the 1999-2003 HPH strategic plan included \$65 million in capital expenditures. (CX 96 at 4; Styer, Tr. 5019). Yet the passage of this strategic plan did not change HPH's need to merge with Evanston Hospital because HPH's capital expenditure needs were far beyond what the plan could provide and because those needs were

immediate in 1999. (Styer, Tr. 5029). In short, the 1999-2003 strategic plan was not sufficient to ensure the healthcare needs of the Highland Park community. (Styer, Tr. 5029-30; RFF-Reply ¶ 341).

D. Impact of Evanston-Highland Park Merger on Selective Contracting Process

1. The Merger Reduced Viable Network Alternatives

255. The merger of Evanston and Highland Park changed the alternatives available to the health plans, thereby affecting the outcome of the bargain between health plans and the merged entity. (Haas-Wilson, Tr. 2472).

Response to Finding No. 255:

This proposed finding is inaccurate. While the Merger changed, to a limited respect, the alternative hospitals available to the MCOs, this change did not affect the outcome of the bargain between MCOs and ENH. Moreover, none of the MCO representatives who testified at trial played Evanston Hospital and HPH off of one another before the Merger. (RFF ¶¶ 974-983). To the contrary, the weight of the evidence demonstrates that Evanston Hospital and HPH were not close substitutes before the Merger. (Noether, Tr. 5985; RFF ¶¶ 538-589). The Town and Vistnes description of bargaining theory, cited by Complaint Counsel and relied on by Dr. Haas-Wilson, is based on the concept that the “closeness of substitution of different networks with and without a particular hospital in question are important in informing about the bargaining leverage that each party brings to the table.” (Noether, Tr. 5984). Consequently, under the rubric of Town and Vistnes, the Merger would have little effect on the bargaining dynamics with MCOs. (Noether, Tr. 5985). In addition, this proposed finding overstates the competitive significance of a reduction in network alternatives. Complaint Counsel’s own expert admitted that

REDACTED

REDACTED

(Haas-Wilson, Tr. 2758-59, *in camera*).

256. Before the merger, if Evanston went into a negotiation with a health plan and asked for what the health plan thought was an extremely high, unreasonable price, that health plan could choose to include Highland Park and other hospitals in the provider network while excluding Evanston Hospital. (Haas-Wilson, Tr. 2472).

Response to Finding No. 256:

This proposed finding, while accurate in theory, is misleading to the extent it suggests that, in practice, MCOs played HPH and Evanston Hospital off of each other before the Merger.

REDACTED

(Ballengee, Tr. 170; Mendonsa, Tr. 562-

63, *in camera*; Holt-Darcy, Tr. 1594, *in camera*; Dorsey, Tr. 1470-71; RFF ¶¶ 975-989). In

addition, **REDACTED**

(Haas-Wilson, Tr. 2788-89, 2793, 2796-98, *in camera*; RFF ¶¶ 980-

981, *in camera*). Finally, former HPH executives (including one of Complaint Counsel's own witnesses) testified that HPH was never excluded from managed care contracts because of Evanston Hospital, and that the presence of Evanston Hospital in the network did not make it more difficult for HPH to gain price increases from HPH. (Newton, Tr. 457; Spaeth, Tr. 2176; RFF ¶¶ 982-983).

257. After the merger, when ENH demanded a price that the health plan thought was unreasonably high, the alternative of excluding Evanston but including Highland Park and various other hospitals was no longer possible. At that point, the health plan would have to exclude both Evanston and Highland Park or neither hospital. (Haas-Wilson, Tr. 2473).

Response to Finding No. 257:

Respondent has no specific response.

258. Selective contracting can occur even where there appear to be a large number of hospitals in a particular network. Excluding specialty hospitals like VA hospitals, children's hospitals, psychiatric and rehabilitation hospitals, there are around 80-85 acute care hospitals in the Chicago area, about 75 of which PHCS contracts with. (Ballengee, Tr. 154). Even contracting with 75 hospitals, PHCS excluded hospitals because their rates were too high relative to comparable hospitals. (Ballengee, Tr. 189-90.) When PHCS evaluates whether to exclude a hospital from its network, it looks at other hospitals to see if they will give PHCS the access that its clients want to the services they are looking for. (Ballengee, Tr. 155). Location plays a role in that evaluation. (Ballengee, Tr. 155-156). When PHCS decided to drop the University of Chicago, it looked to other hospitals that it considered "like" hospitals. (Ballengee, Tr. 155-56, 189-90.) Similarly, Aetna contracts with about 88 out of a total of 100 hospitals in the Chicago area. (Mendonsa, Tr. 484.)

REDACTED

(Mendonsa, Tr. 568-569, *in camera*).

Response to Finding No. 258:

This proposed finding is misleading for several reasons. First, this proposed finding is misleading to the extent that it purports to demonstrate, through only two examples of termination, that selective contracting was prevalent in Chicago. The evidence clearly demonstrated that selective contracting was not prevalent in Chicago. (RFF-Reply ¶ 195). Second, as this proposed finding states, MCOs (such as PHCS) compared "like" hospitals when evaluating network alternatives. (Ballengee, Tr. 155-56, 189-90). As Complaint Counsel itself admits, Evanston Hospital and HPH were not "like" hospitals before the Merger. (CCFF ¶¶ 1798-1799; RFF ¶¶ 538-587). This admission is supported by the evidence, which demonstrates that MCOs did not play Evanston Hospital and HPH off of each other in contract negotiations. (RFF-Reply ¶ 256).

259. Dr. Haas-Wilson also relied on trial testimony from Jane Ballengee of PHCS who testified that PHCS viewed Highland Park and Evanston as competitors. If negotiations with the hospitals were not going well, PHCS could have chosen to include only one of the two hospitals in its network before the merger and worked them against each other.

PHCS' strategy centered on the fact that it could have eliminated one of the hospitals from the network and utilized the other as the alternative hospital. (Haas-Wilson, Tr. 2477-79).

Response to Finding No. 259:

This proposed finding is misleading to the extent that it suggests, contrary to the evidence, that MCOs played Evanston Hospital and HPH off of each other before the Merger. (RFF-Reply ¶ 256).

260. If, before the merger, Evanston had insisted upon a price that the health plan thought was unreasonably high, an alternative to that health plan would be to not include Evanston in the network, but instead, make up an alternative network that included Highland Park and various other hospitals in the Chicago area. (Haas-Wilson, Tr. 2479).

Response to Finding No. 260:

This proposed finding, while accurate in theory, is misleading to the extent it suggests that, in practice, MCOs played HPH and Evanston Hospital off of each other before the Merger.

REDACTED

(Ballengee, Tr. 170; Mendonsa, Tr. 562-63, *in camera*; Holt-Darcy, Tr. 1594, *in camera*; Dorsey, Tr. 1470-71; RFF ¶¶ 975-989). In addition, **REDACTED**

(Haas-Wilson, Tr. 2788-89, 2793, 2796-98, *in camera*; RFF ¶¶ 980-981, *in camera*). Finally, former HPH executives (including one of Complaint Counsel's own witnesses) testified that HPH was never excluded from managed care contracts because of Evanston Hospital, and that the presence of Evanston Hospital in the network did not make it more difficult for HPH to gain price increases from HPH. (Newton, Tr. 457; Spaeth, Tr. 2176; RFF ¶¶ 982-983).

2. Health Plans Were Unable to Exclude the Post-Merger ENH from Their Networks

261. Post-merger, ENH management did not believe that other hospitals would change their prices as a result of ENH's price setting. In making price proposals to health plans, ENH management did not consider the risk of health plans switching to other hospitals. (Neaman, Tr. 1211-12; Newton, Tr. 367, Hillebrand, Tr. 1764-65).

Response to Finding No. 261:

This proposed finding is vague, confusing and misleading. The first sentence appears to relate to the effect of changes to ENH's chargemaster. As was shown at trial, ENH adjusted its chargemaster up to market prices from below-market prices. (RFF ¶¶ 932-964). The chargemaster adjustments were unrelated to the Merger and the health plan renegotiations in 2000. (RFF ¶¶ 962-964).

The second sentence of this proposed finding refers to rates negotiated between MCOs and hospitals. The rates negotiated by hospitals and MCOs are confidential. (Ballengee, Tr. 193-94). Just as ENH did not know, and could not have known, Northwestern Memorial or Advocate Lutheran General's rates with any MCO, other hospitals did not know ENH's rates. Therefore, there is no reason to believe that any other hospital would react to ENH's renegotiations. (Hillebrand, Tr. 1751-52). Since selective contracting or steering is not prevalent in the Chicago market, ENH considered the possibility of a health plan switching to one of ENH's alternatives as unlikely. (RFF ¶¶ 75-76, 974-981). MCOs simply do not play hospitals off of each other in the manner suggested by this proposed finding, at least in the Chicago area. (RFF ¶¶ 974-981).

262.

REDACTED

(See, e.g., Ballengee, Tr. 167 (pre-merger pricing more competitive); Mendonsa, Tr. 568-69, *in camera*

REDACTED

REDACTED

Neary, Tr. 618-19 (One Health discovered that it was unable to market its network without ENH hospitals); Holt-Darcy, Tr. 1529, *in camera*: **REDACTED** Foucre, Tr. 931-34 (United could not market a network without ENH)).

Response to Finding No. 262:

This proposed finding is not supported by the evidence. As an initial matter, the rates proposed by ENH were not anticompetitive. Indeed, they were usually based on the better of the two existing contracts at the time of the Merger. (RFF ¶¶ 715, 888). **REDACTED**

(RFF ¶¶ 726-737, 745, 790, 827, 883, 1110-1136, 1148-1155, *in camera*). MCO's testified that before the Merger, it would have been very difficult to terminate Evanston Hospital. **REDACTED**

(Mendonsa, Tr. 530, *in camera*).

REDACTED

(RFF-Reply ¶¶ 1196-1197, 1200, *in camera*). **REDACTED**

(RFF-Reply ¶ 1204, *in camera*).

While One Health did actually terminate with ENH for a short period, there is no evidence that it lost a single customer as a result of such termination. (RFF ¶ 802). Nor could the One Health witnesses quantify any revenue or sales allegedly lost by the termination. (RFF ¶¶ 802-803).

The citation to the testimony of Holt-Darcy is contradicted by the facts. **REDACTED**

REDACTED

(RFF-Reply ¶¶ 1265-1266, 1301, *in*

camera).

REDACTED

(RFF-Reply ¶ 971, *in camera*).

PHCS

263. When Evanston and Highland Park were separate entities, PHCS could use one hospital and not the other. "If, in fact, the negotiation and the rates were not going well at one hospital . . . , we had the alternative." (Ballengee, Tr. 167).

Response to Finding No. 263:

This proposed finding is not supported by the evidence. To the contrary, it is based solely on speculation. **REDACTED**

(Ballengee, Tr. 257, *in camera*). Regardless, PHCS never played Evanston Hospital off of HPH, or vice versa. (Ballengee, Tr. 170).

264. PHCS "could choose between the two [hospitals] and work them against each other" because they were "competitors" prior to the merger. (Ballengee, Tr. 166-67).

Response to Finding No. 264:

This proposed finding is not supported by the evidence. **REDACTED**

(RFF-Reply ¶ 263, *in camera*). In fact, Evanston Hospital and HPH were not close competitors before the Merger. Evanston Hospital, unlike HPH, was an academic hospital that offered a greater breadth of services, had more beds and had a teaching component. (RFF ¶¶ 540-557). Geographically, St. Francis and Rush North Shore were far closer to Evanston Hospital than HPH. (RFF ¶¶ 389, 570-576). For HPH, its closest competitors from both a product and geographic perspective were Lake Forest Hospital and Condell. (RFF ¶¶ 577-587).

265. According to Ms. Ballengee, “[t]he people would choose either to go north to one or south to the other. They could go either way and receive the same services at the same level.” (Ballengee, Tr. 166).

Response to Finding No. 265:

This proposed finding is misleading. (RFF-Reply ¶ 288).

266. As a result of pre-merger negotiations, PHCS obtained lower prices than Evanston was demanding because PHCS “had a competitive environment between the two hospitals” and “could trade one off for the other.” (Ballengee, Tr. 170).

Response to Finding No. 266:

This proposed finding is unsubstantiated.

REDACTED

(RFF-Reply ¶ 263, *in camera*). In addition, PHCS did not play HPH off of Evanston Hospital, or vice versa, during those negotiations. (RFF-Reply ¶ 263). Ballengee’s testimony is further suspect because PHCS has a motive to use this litigation as a bargaining chip for future negotiations with ENH. (RFF-Reply ¶ 1080).

267. Not including every hospital in its network “allows us to utilize . . . natural competitiveness within the hospitals to negotiate better rates.” (Ballengee, Tr. 156).

Response to Finding No. 267:

This proposed finding is not supported by the record. Selective contracting has not been a tool used by MCOs in the Chicago area. (RFF ¶¶ 75-76). PHCS contracts with the vast majority of the approximately 100 hospitals in the Chicago area. (Ballengee, Tr. 154). And PHCS did not play HPH off of Evanston Hospital. (RFF-Reply ¶ 263). Therefore, the evidence does not show that PHCS excluded hospitals in order to negotiate better rates.

Aetna

268. **REDACTED**

(Mendonsa, Tr. 530, *in camera*).

Response to Finding No. 268:

This proposed finding is not based on reliable evidence but, to the contrary, reflects pure speculation that should be given no weight. **REDACTED**

(RFF-Reply ¶¶ 1178, 1183).

269. There have been times when Aetna has “not gotten business in the past because we didn’t have a facility that a competitor has, even though we showed better prices.” (Mendonsa, Tr. 491-2).

Response to Finding No. 269:

Respondent has no specific response.

270. **REDACTED**

(Mendonsa, Tr. 516, *in camera*).

Response to Finding No. 270:

This proposed finding is incomplete. The fact that employers chose to avoid Aetna because it did not have Northwestern Memorial in its network highlights the fact that selective contracting is not a tool that has been used successfully in the Chicago area. (RFF ¶¶ 75-76). In Chicago, consumers desire broad networks. (RFF ¶ 58). Regardless of the Merger, Aetna and any other MCO would be reluctant to terminate with Evanston Hospital, Glenbrook Hospital, or HPH. **REDACTED**

(Mendonsa, Tr. 530, *in camera*).

Accordingly, the Merger did not adversely affect competition.

271. Aetna's experience in terminating Northwestern Memorial taught the health plan that "miss[ing] significant facilities...compromises our ability to win business and our ability to keep business." (Mendonsa, Tr. 491. *See also* Mendonsa, Tr. 516,

REDACTED

in camera).

Response to Finding No. 271:

This proposed finding is misleading. (RFF-Reply ¶ 270).

272. **REDACTED**

(Mendonsa, Tr. 568-69, *in camera*).

Response to Finding No. 272:

This proposed finding is incomplete. **REDACTED**

(RFF-Reply ¶¶ 1185, 1205, *in camera*). However, selective

contracting is not prevalent. (RFF-Reply ¶ 270).

; (Mendonsa, Tr. 543-44, *in camera*).

273. **REDACTED**

(Mendonsa, Tr. 569, *in camera*).

Response to Finding No. 273:

This proposed finding is misleading and not based on reliable or credible evidence.

REDACTED

(RFF-Reply ¶

1205, *in camera*).

REDACTED

(RFF-Reply ¶¶ 1190, 1195, 1205, *in*

camera).

REDACTED

(RX 780; RFF-

Reply ¶¶ 272, 1205, *in camera*).

274.

REDACTED

(Mendonsa, Tr. 520, *in camera*).

Response to Finding No. 274:

This proposed finding is based on pure speculative testimony admitted over Respondent's objection that should be accorded no weight. (Mendonsa, Tr. 518-20, *in camera*). **REDACTED**

(RFF-Reply ¶¶ 1197-1198, *in camera*).

REDACTED

(RFF-Reply ¶ 1197, *in camera*).

One Health

275. Prior to the merger, One Health's network contained "some subset" of the hospitals in the North Shore because "the premise behind a hospital discounting their prices or a physician discounting their prices is that they are going to get something in return, and that would be additional membership or patients going to their office or hospital." (Neary, Tr. 587-8).

Response to Finding No. 275:

This proposed finding is misleading to the extent that it implies that selective contracting was prevalent in Chicago. (RFF-Reply ¶¶ 267, 270). One Health contracted with at least 105 hospitals in Illinois. (RFF-Reply ¶ 232; CCF ¶ 232).

276. Before the merger, One Health's selectivity in choosing hospitals for its network forced hospitals to compete harder for the health plan's business. (Neary, Tr. 587-88).

Response to Finding No. 276:

This proposed finding is not supported by the evidence. (Neary, Tr. 587-88). The cited testimony reflects that One Health aimed to include all hospitals and physicians that patients “want to access” in its network. (Neary, Tr. 587-88). This is consistent with the testimony of other MCOs.

REDACTED

(Holt-Darcy, Tr. 1584, *in camera*). Consumers demand broad provider networks with few restrictions from health plans. (RFF ¶ 58).

277. The relative bargaining strength of One Health during hospital renegotiations depended upon the amount of business that the health plan is bringing a hospital, whether the hospital was currently in or out of the network, the competitive position of the hospital, and the availability of network and non-network-alternatives in the area offering similar services. (Neary, Tr. 589).

Response to Finding No. 277:

Respondent has no specific response except to note that selective contracting has not played a role in managed care contracting in Chicago. (RFF-Reply ¶¶ 267, 270).

278. After receiving ENH’s May 2000 price increase demands, One Health terminated ENH because it believed the increases to be “excessive” but was forced to return to the negotiating table – in a weakened negotiating position – because it could not market its network without the ENH hospitals. (Neary, Tr. 609-11, 615-16, 618-19).

Response to Finding No. 278:

This proposed finding is false and not supported by the record. According to One Health, ENH’s price proposal was not “that shocking.” (RFF ¶ 797). Nevertheless, One Health decided to allow the contract to lapse. (RFF ¶ 799). One Health believed it could have a sellable network after the Merger. (RFF ¶ 801). There is no evidence demonstrating that, after ENH left One Health’s network, it lost a single customer or sales opportunity. (RFF ¶¶ 802-803).

Unicare

279. **REDACTED**

(Holt-Darcy, Tr. 1518-9, *in camera*).

Response to Finding No. 279:

This proposed finding is misleading, speculative and based on unreliable evidence. There are many alternatives to the ENH hospitals. (RFF-Reply ¶¶ 1266, 1297-1298). Moreover,

REDACTED

(RFF-Reply ¶¶

1281-1282, *in camera*).

(RFF-Reply ¶¶

1281-1282, *in camera*).

(RFF-Reply ¶¶ 1281-1282, *in camera*).

280. **REDACTED**

(Holt-Darcy, Tr.

1517-8, *in camera*).

Response to Finding No. 280:

This proposed finding is misleading, speculative and based on unreliable evidence. There are many alternatives to the ENH hospitals. (RFF-Reply ¶¶ 279; 1266, 1297-1298).

281. **REDACTED**

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

Responsive to Finding No. 281:

This proposed finding is inaccurate. (RFF-Reply ¶ 1301).

REDACTED

(RFF-Reply ¶¶ 1265-1266).

REDACTED

REDACTED

(RFF ¶ 871, *in camera*).

282. **REDACTED**

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

Response to Finding No. 282:

This proposed finding is misleading. (RFF-Reply ¶ 1302).

REDACTED

(RFF-Reply ¶ 1266, *in*

camera).

REDACTED

(RFF-Reply ¶¶ 1232, 1254, *in camera*).

United

283. United could have had a network that did not include certain hospitals (such as hospitals in the Rush or Advocate system that are spread out over a larger geographic area), but United could not market a network without ENH, a system that “is not geographically dispersed.” (Foucre, Tr. 931-34).

Response to Finding No. 283:

This proposed finding is not based on reliable or credible evidence.

REDACTED

(RFF-Reply ¶ 971,

in camera).

REDACTED

(RFF-Reply ¶¶ 967, 978, 999, *in camera*). Foucre’s testimony is

unsubstantiated lay opinion, speculation and not supported by credible evidence. When listing her responsibilities at United, Foucre did not identify any role with respect to marketing plans.

(Foucre, Tr. 878-79).

In the time since the Merger, United terminated with both the Rush System (which includes Rush North Shore) and Advocate (which includes Advocate Lutheran General). (Foucre, Tr. 933-34). United acknowledged that Advocate Lutheran General is the most comparable alternative to Evanston Hospital in the geographic area. (RFF ¶ 565). United further recognized that Rush North Shore is only approximately three miles from Evanston Hospital and competes with it. (Foucre, Tr. 941). Consequently, United's reluctance to attempt to market a network without either Advocate Lutheran General or Rush North Shore or Evanston Hospital, in a market averse to selective contracting and limited networks, is unrelated to the consequences of the Merger. (RFF-Reply ¶¶ 267, 270).

VIII. DIRECT EVIDENCE OF ANTICOMPETITIVE EFFECTS: ELIMINATION OF A DIRECT COMPETITOR

A. Evanston and Highland Park Were Direct Competitors Before the Merger

284. Evanston and Highland Park were direct competitors before the merger. (*See, e.g.*, Ballengee, Tr. 166-68; Neary, Tr. 600-601; CX 1868 at 3; Newton, Tr. 325; Neaman, Tr. 1046; Spaeth, Tr. 2088).

Response to Finding No. 284:

This proposed finding is misleading, not supported by the cited evidence, and incomplete. Respondent agrees that HPH and Evanston Hospital were among each other's competitors before the Merger, but they were not each other's closest competitors.

REDACTED

(Ballengee, Tr. 211-14; Mendonsa, Tr. 484;

Mendonsa, Tr. 561-62, *in camera*; Holt-Darcy, Tr. 1597, *in camera*; Foucre, Tr. 1114-15, *in camera*; RX 1208 at UHCENH 3380, *in camera*; Dorsey, Tr. 1478-80; Neary, Tr. 631; RFF ¶¶ 455-456, 459, *in camera*; RFF ¶¶ 457-458). For instance, Ballengee testified that Advocate Lutheran General, Rush North Shore, St. Francis and Lake Forest Hospitals were "significant" competitors. (Ballengee, Tr. 211-12). Newton testified that Lake Forest Hospital was HPH's "main competitor." (Newton, Tr. 325; CX 1868 at 3). Spaeth's testimony confirms that Lake Forest Hospital was HPH's most significant competitor in addition to Condell, Rush North Shore, Advocate Lutheran General and Evanston Hospital. (Spaeth, Tr. 2162-63, 2239-40).

Moreover, the cited testimony by Neaman does not relate to Complaint Counsel's proposed finding. (Neaman, Tr. 1046). The referenced testimony refers to the benefits of the Merger on the physicians who practice in the geography and the community, not competition between HPH and Evanston Hospital. (Neaman, Tr. 1046; CX 2 at 7).

285.

REDACTED

(RX 1912 at 20, *in camera*;
Newton, Tr. 351-52; Foucre, Tr. 901-903; Ballengee, Tr. 167-68; Holt-Darcy, Tr. 1425).

Response to Finding No. 285

This proposed finding is misleading. There is no geographic, legal, nor economic significance to this “triangle.” (RX 1912 at 20, *in camera*). The term “triangle” was invented by Complaint Counsel for use in this case and is not used by any witness other than those prepared by Complaint Counsel. Further, the term does not appear in any of Respondent’s documents. The only geographic area of significance in the instant matter is the properly-defined geographic market substantiated by the trial record, existing case law and the *Merger Guidelines*. (RFF ¶¶ 383-498). This proposed finding is also misleading because the citation to the trial transcript of Ballengee does not support nor relate to the text of this proposed finding. (Ballengee, Tr. 167-68).

286. There are no other hospitals located between Highland Park and Evanston. (Ballengee, Tr. 168). The driving time between the two hospitals ranges from 15 to 30 minutes. (Rosengart, Tr. 4445-46; Spaeth, Tr. 2157; Noether, Tr. 5934).

Response to Finding No. 286:

This proposed finding is misleading.

REDACTED

(RX 1912 at 20-21, *in camera*; RFF ¶¶ 389-390, 393-394, *in camera*).

REDACTED

(RX 1912 at 21, *in camera*; RFF ¶ 388, *in camera*).

As indicated by Dr. Rosengart’s testimony, he was merely estimating driving time between all of his sites and Evanston Hospital (Weiss, Swedish Covenant, and HPH) as “approximately 15 minutes.” (Rosengart, Tr. 4446). Spaeth’s estimate, which is most consistent with Dr. Noether’s analysis, is accurate and reliable. (Spaeth, Tr. 2157; Noether, Tr. 5934).

287. Before the merger, the core service areas of Evanston (including Glenbrook) and Highland Park overlapped. (Neaman, Tr. 1058-59; Neary, Tr. 601-2; Spaeth, Tr. 2088, 2157-58; CX 1 at 3-5; CX 359 at 16; CX 350 at 2). Highland Park's internal documents indicate its concern with the overlapping areas. (CX 105 at 1; CX 360 at 5).

Response to Finding No. 287:

This proposed finding is incomplete and confusing. Respondent agrees that there was some overlap in the service areas of Evanston Hospital (including Glenbrook Hospital) and HPH. (Spaeth, Tr. 2157-58; RFF ¶ 396).

REDACTED

(Noether, Tr. 5943-44; RX 1912 at 54, *in camera*; RFF ¶ 397, *in camera*).

REDACTED

} (Noether, Tr. 5945; RX 1912 at 54, *in camera*; RFF ¶ 398, *in camera*).

One document cited by Complaint Counsel shows that Evanston Hospital was *not* in HPH's "core" subset of its service area but, instead, was further south in HPH's "South" market. (CX 1 at 5). And Neary, who was not an ENH employee with access to its complete admissions data, is not a reliable source in defining the core service areas of Evanston Hospital or HPH. (Neary, Tr. 581-86). CX 105 at 1 references concerns regarding physician sites in Vernon Hills, not hospital competition. (CX 105 at 1). Importantly, the very page cited by Complaint Counsel describes Rush North Shore as a "sizable competitor" building market share in both Evanston Hospital's and HPH's core service areas. (CX 360 at 5).

288. Prior to the merger, Evanston and Highland Park Hospitals competed for patients from the people living in between the two communities. (Holt-Darcy, Tr. 1426; Neary, Tr. 600-01). In fact, a patient could "choose to go north to one [hospital] or south to the other." (Ballengee, Tr. 166).

Response to Finding No. 288:

This proposed finding is misleading.

REDACTED

(RFF ¶¶ 393-394, *in camera*, RFF ¶¶ 400-404).

289. Highland Park was a community hospital before the merger. (Ballengee, Tr. 159; Newton, Tr. 383; Neaman, Tr. 1286). Glenbrook was also a community hospital prior to the merger. (Neaman, Tr. 1286).

Response to Finding No. 289:

Respondents have no specific response.

290. The merging hospitals also overlapped in hospital services (Newton, Tr. 299; Neary, Tr. 601-02). Patients “could go either way [to Highland Park or Evanston] and receive the same services at the same level.” (Ballengee, Tr. 166).

Response to Finding No. 290:

This proposed finding is misleading and not supported by the record. Respondent agrees that HPH and Evanston Hospital offered a range of acute services (both inpatient and outpatient services) that had some overlap. (Noether, Tr. 5906; RFF ¶ 373).

REDACTED

(Mendonsa, Tr. 529, *in camera*; Holt-Darcy, Tr. 1505-06, *in camera*; RX 107 at GWL 859; RFF ¶¶ 30-32, *in camera*, RFF ¶31). Moreover, the quality of the services provided at HPH was significantly below that of similar services at Evanston Hospital. (Chassin, Tr. 5191-92, 5286-87; RFF ¶¶ 47-49).

In support of this proposed finding, Complaint Counsel relies on the testimony of Ballengee. But she specifically testified that she did not account for differences in the quality of

care between the hospitals. (Ballengee, Tr. 200-3). Indeed, Ballengee testified that PHCS “attempts to *eliminate* the customer from the actual dollar and cent valuation.” (Ballengee, Tr. 209-10 (emphasis added)). For instance, Ballengee was not aware that, as a result of the Merger, ENH added several important improvements at HPH including: a new cardiology unit capable of providing invasive cardiology to patients, a comprehensive cancer center, an expanded Emergency Department, intensivists in the ICU, a second ER physician on staff at all times, a PET scanner for radiation treatments, and an electronic medical records system (EPIC). (Ballengee, Tr. 200-3).

291. Prior to the merger, ENH offered, among other things, obstetrical services, including a perinatal center (CX 84 at 8; Newton, Tr. 299); diagnostic services (CX 84 at 15); a skilled nursing facility (CX 84 at 15); psychiatric care (Newton, Tr. 299; Spaeth, Tr. 2088); neurosurgery (CX 84 at 8; Newton, Tr. 299); cardiology services (CX 681 at 2; CX 84 at 8); orthopedics (Neaman, Tr. 1292); and a Level II trauma center (CX 84 at 8; CX 681 at 2); and cancer care (CX 84 at 8).

Response to Finding No. 291:

This proposed finding is repetitive and misleading. (RFF-Reply ¶ 33). As an initial matter, Complaint Counsel’s proposed finding is supported by the testimony of Mark Newton, a former HPH employee who was employed by ENH for only a few months after the Merger. (Spaeth, Tr. 2285). Newton lacks direct knowledge of the types of services offered at Evanston Hospital prior to the Merger. (Newton, Tr. 460). Therefore, Evanston Hospital employees can more credibly provide this information.

In any event, this proposed finding is inaccurate, incomplete and misleading because it fails to detail the true sophistication of the services Evanston Hospital offered before and at the time of the Merger.

(RFF ¶¶ 30-32, *in camera*, RFF ¶¶ 33-34).

REDACTED

REDACTED

REDACTED

(Mendonsa, Tr. 529, *in*

camera; Holt-Darcy, Tr. 1505-06, *in camera*; RX 107 at GWL 859; RFF ¶ 30, *in camera*).

Additionally, to be clear, Evanston Hospital did offer what Complaint Counsel labels “quaternary services” before the Merger, but the hospital decided to discontinue these services because it did not have sufficient volume to allow its physicians to perform a “first-class” job. (RFF ¶¶ 33, 1090). ENH continues to offer sophisticated services such as cardioangiogenesis, which some may consider a quaternary level service. (Neaman, Tr. 1377-78; Rosengart, Tr. 4437, 4496; RFF ¶ 16).292. Before the merger, HPH also offered, among other things, obstetrical services, including a perinatal center (CX 84 at 13; Newton, Tr. 299); diagnostic services (CX 84 at 15); a skilled nursing facility (CX 84 at 15); psychiatric care (Newton, Tr. 299; Spaeth, Tr. 2088); neurosurgery (Newton, Tr. 299); cardiology services (CX 84 at 13); a Level II trauma center (CX 84 at 13); and cancer care (CX 699 at 24).

291. Prior to the merger, HPH also offered, among other things, obstetrical services, including a perinatal center (CX 84 at 13; Newton, Tr. 299); diagnostic services (CX 84 at 15); a skilled nursing facility (CX 84 at 15); psychiatric care (Newton, Tr. 299; Spaeth, Tr. 2088); neurosurgery (Newton, Tr. 299); cardiology services (CX 84 at 13); a Level II trauma center (CX 84 at 13); and cancer care (CX 699 at 24).

Response to Finding No. 292:

This proposed finding is repetitive and misleading to the extent it attempts to equate the services offered at HPH to Evanston Hospital. The evidence is to the contrary. (RFF-Reply ¶ 41). For example, Spaeth testified the cancer care available at HPH before the Merger was not equivalent to the quality and breadth of services available at Evanston Hospital before the Merger. (Spaeth, Tr. 2237-38, 2276). This proposed finding is misleading because its cursory description of pre-Merger HPH’s services leaves out many important details. **REDACTED**

REDACTED

(RFF ¶¶ 41-42, *in*

camera, RFF ¶¶ 43, 47-49).

REDACTED

(RFF ¶¶ 41-42, *in camera*, RFF ¶¶ 43, 1566, 1568, 1577-1578, 1725-1727, 1734-1735, 1736, 1742-1748; Spaeth, Tr. 2286). HPH also lacked sophisticated pediatrics, and the neurosurgeons on HPH's staff desired to perform their cases at Evanston Hospital and not at HPH. (Spaeth, Tr. 2286).

REDACTED

(Hillebrand, Tr. 1944, *in camera*; RFF ¶ 42, *in camera*). But again, pre-Merger HPH lacked the necessary tertiary services, such as sophisticated neonatal intensive care, needed to address these patient needs. (Spaeth, Tr. 2286).

Pre-Merger HPH's services – most specifically, obstetrics and gynecological services – were also deteriorating in quality. And problems with the physical plant nearly cost HPH its Medicare accreditation. (RFF ¶¶ 1165-2277). Over 1,000 of Respondent's proposed findings of fact detail HPH's limited and/or troubled clinical services and ENH's successful efforts to expand and enhance these services. (RFF ¶¶ 1165-2277).

293. Evanston and Highland Park viewed each other as competitors pre-merger. (CX 1868 at 3; Newton, Tr. 325; Neaman, Tr. 1046; Spaeth Tr. 2088; CX 1 at 3).

Response to Finding No. 293:

This proposed finding is not supported by the cited evidence and incomplete. This finding is incomplete to the extent that it omits that testimony from representatives of both

Evanston Hospital and HPH, as well as pertinent documents from these hospitals, emphasized that these hospitals had and have numerous other competitors. (RFF ¶¶ 475-481). One document cited in support of this finding does not reflect the text of the finding. CX 1 at 3 does not discuss nor identify Evanston Hospital and HPH as competitors of each other for hospital services but, instead, focuses solely on the competition between physicians and medical offices. (CX 1 at 3).

294. Pre-merger, Highland Park strategic documents reported that “[w]ithin the hospital’s core, competition is mainly from Lake Forest and Evanston.” (CX 1868 at 3). In fact, as early as 1997, Highland Park believed competition from Evanston was increasing. (Spaeth, Tr. 2108).

Response to Finding No. 294:

This proposed finding is misleading. The weight of the trial evidence demonstrated that pre-Merger HPH competed with a number of hospitals. Spaeth testified that HPH’s primary competition was Lake Forest Hospital and that HPH also competed with Condell, Rush North Shore, Advocate Lutheran General and Evanston Hospital. (Spaeth, Tr. 2239-40; RFF ¶ 476). The author of the document cited by Complaint Counsel, Mark Newton, reported to Spaeth. (Newton, Tr. 282, 322; Spaeth, Tr. 2282).

The evidence also showed that Lake Forest and Condell Hospitals were pre-Merger HPH’s primary competitors. (CX 6305 at 5 (Stearns, Dep.); RX 148 at ENHL TC 7927; Chan, Tr. 730; Krasner, Tr. 3699-3700; RFF ¶ 476). Kaufman, an independent strategic and financial consultant who was hired by HPH before the Merger, testified that pre-Merger HPH’s primary competitors were Lake Forest and Condell. (Kaufman, Tr. 5836; RFF ¶ 483).

Finally, this proposed finding is incomplete and misleading in that it ignores Spaeth’s actual testimony that competition with Evanston Hospital, “Lake Forest and others” was intensifying. (Spaeth, Tr. 2108; RFF ¶ 483).

REDACTED

295.

(See, e.g., Ballengee, Tr. 166; Neary Tr. 600-01; Mendonsa, Tr. 569, *in camera*).

Response to Finding No. 295:

This proposed finding is incomplete and misleading. As discussed in RFF-Reply ¶¶ 296-299,

REDACTED

(RFF ¶¶ 455-457, 459 *in*

camera; RFF ¶ 458).

REDACTED

(Foucre, Tr. 1114-15, *in camera*; RX 1208 at UHCENH 3380, *in camera*; RFF ¶ 456, *in camera*). Holt-Darcy from Unicare testified that “sufficient access” to hospitals by patients means having a hospital in the network “within 30 miles of where [Unicare’s members] live or where they work.” (Holt-Darcy, Tr. 1420 (emphasis added); RFF ¶ 460).

REDACTED

(Mendonsa, Tr. 484; Mendonsa, Tr. 561-62, *in camera*; Foucre, Tr. 1114-15 *in camera*; RX 1208 at UHCENH 3380, *in camera*; RX 712 at PHCS 891; Ballengee, Tr. 213-14; Dorsey, Tr. 1479-80; Neary, Tr. 631; Holt-Darcy, Tr. 1596-98, *in camera*).

296. PHCS relied on Evanston and Highland Park as the “primary” alternatives to each other. (Ballengee, Tr. 166-68).

Response to Finding No. 296:

This proposed finding is incorrect, incomplete and misleading. In its communications with its customers at the time of the Merger, PHCS identified the following hospitals as alternatives to Evanston Hospital and HPH: St. Francis of Evanston, Lake Forest Hospital, Rush

North Shore, Advocate Lutheran General and Holy Family Hospital. (RX 712 at PHCS 891; Ballengee, Tr. 213-214; RFF ¶ 457).

REDACTED

(Ballengee, Tr. 159; Haas-Wilson, Tr. 2491; Haas-Wilson, Tr. 2551-52, *in camera*; RFF ¶¶ 548-549, *in camera*). Since HPH did not perform many of the services offered by Evanston Hospital, it would have been impossible for MCOs to substitute HPH for Evanston Hospital before the Merger. (Noether, Tr. 5917-18).

297.

REDACTED

(Mendonsa, Tr. 530, 569, *in camera*).

Response to Finding No. 297:

This proposed finding is misleading. In fact, this statement by Aetna's representative, Mendonsa, should be given no weight because he

REDACTED

(Mendonsa, Tr. 556, *in camera*). In fact, he was not involved in the Chicago market until May 1997, several months after the last pre-Merger contracts with HPH and Evanston Hospital were negotiated. (Mendonsa, Tr. 475).

REDACTED

(CX 5001 at 2; CX 5007 at 1-2; RFF ¶ 744, *in camera*).

REDACTED

(Mendonsa, Tr. 484; Mendonsa, Tr. 561-62, *in camera*; RFF ¶ 455). Mendonsa also testified that Northwestern Memorial also provides coverage for the North Shore. (Mendonsa, Tr. 530, *in camera*).

298.

REDACTED

Holt-Darcy, Tr. 1517-9, *in camera*).

Response to Finding No. 298:

This proposed finding is misleading because it is not supported by the record.

REDACTED

(Holt-Darcy, Tr. 1584, *in*

camera). Therefore, her testimony as to what constitutes a “marketable network” should be given no weight.

REDACTED

(Holt-Darcy, Tr. 1595-97, *in*

camera; RFF ¶ 459, *in camera*).

299. One Health viewed Evanston and Highland Park as “main competitors” because their services were “comparable,” and the two hospitals drew patients from the same general population. (Neary, Tr. 600-01).

Response to Finding No. 299:

This proposed finding is incorrect and not supported by the evidence. One Health provided its subscribers with a list of alternative hospitals to substitute for Evanston Hospital and HPH after the Merger. This list included Lake Forest Hospital, St. Therese, Victory Memorial, St. Francis and Advocate Lutheran General Hospitals. Neary further explained that Northwestern Memorial and Condell were main alternatives of Evanston Hospital and HPH. (Dorsey, Tr. 1478-80; Neary, Tr. 631; RFF ¶ 458).

This proposed finding also is inconsistent with the expert testimony in this case.

REDACTED

(Haas-Wilson, Tr.

2491; Haas-Wilson, Tr. 2551-52, *in camera*; RFF ¶¶ 548-549, *in camera*). Since HPH did not

perform many of the services that Evanston Hospital could, it would have been impossible for managed care companies to substitute HPH for Evanston Hospital. (Noether, Tr. 5917-18).

300. A goal of the merger was to stop Evanston and Highland Park from competing with each other. The two hospitals strategized to “join forces and grow together *rather than compete with each other.*” (CX 2 at 7 (emphasis added). See also CX 1879 at 3-4 (“Stop competing with each other.”); CX 4 at 1 (Highland Park and Evanston did not want to “d[o] battle with one another” in “a common battle ground”); CX 442 at 5 (“Do not ‘compete with self’ in covered markets”)).

Response to Finding No. 300:

This proposed finding is not supported by the evidence. There was abundant testimony and documentary evidence that *the* primary goal of the Merger was to protect the viability of a community asset (*i.e.*, HPH) and improve the quality of care at that hospital. (RFF ¶¶ 459-497). The context of the quotation from CX 2 at 7 refers to competition among the *physicians* who would be integrated into the ENH Medical Group. (Spaeth, Tr. 2213-14). Similarly, CX 1879 at 3-4 is a bullet point within a summary of Neele Stearn’s discussions of the medical staff and physicians affected by the Merger, not the hospitals. (CX 1879 at 3-4). To the extent these sentences relate to physician competition, they are irrelevant to the instant matter and do not support this proposed finding. Consistent with the primary goal of the Merger to benefit the community, the context of CX 4 at 1 makes it clear that the intent of the Merger was to secure and maximize the “community benefit.” (CX 4 at 1).

301. The merger eliminated the competition between the two competitors by excluding an alternative provider available to health plans. (Haas-Wilson, Tr. 2472-73).

Response to Finding No. 301:

This proposed finding is incomplete in that it ignores the substantial evidence throughout trial that Evanston Hospital and HPH had several competitors that served as alternative providers available to MCOs. (RFF ¶¶ 383-485). In fact, the evidence demonstrated that each hospital

was not the other's closest geographic substitute. (Noether, Tr. 5957, 5951-56; RFF ¶¶ 485-488).

B. Absent the Merger, Highland Park Would Have Remained a Viable Competitor

1. Highland Park Could Have Continued As a Stand-Alone Competitor Without the Merger

a. Respondents Dropped the Failing Firm Affirmative Defense

302. The failing firm question is not an issue in this case. In their Second Amended Answer to Complaint Counsel's Complaint, Respondents dropped the affirmative defense that Highland Park Hospital was a failing firm. (*Compare* Respondents' Answer to Complaint, dated March 17, 2004, at 20 *with* Respondents' Second Amended Answer, dated January 11, 2005, at 21).

Response to Finding No. 302:

Respondent did drop the "failing firm" defense. Nevertheless, a weakened firm analysis, consistent with that in *United States v. General Dynamics*, 415 U.S. 486, 503 (1974), is relevant to the competitive effects analysis – in particular, the future competitive status of HPH if the Merger had not occurred. (Resp.'s Post-Trial Brief at 61-65).

b. Pre-Merger, HPH Had a Strong Balance Sheet and Was Backed by Its Foundation's Assets

303. Highland Park had a strong balance sheet even up to the close of the merger. (Kaufman, Tr. 5860 (Highland Park had a "strong balance sheet")). Highland Park, along with its affiliated corporations, had assets much greater than their long-term debt. At the end of 1999, Lakeland Health Services, Highland Park Hospital's parent, had \$140 million greater in cash and unrestricted investments than long-term debt. (CX 693 at 16-17). Indeed, Highland Park was so well-capitalized that it insisted to ENH during the 1999 merger negotiations that it would contribute \$100 million to the establishment of an independent community foundation. (Kaufman, Tr. 5843; CX 1912 at 2).

Response to Finding No. 303:

This proposed finding is false, incomplete and misleading. HPH's pre-Merger consultant, Kaufman – a consultant who was uniformly well-regarded by the trial witnesses –

concluded, as did Spaeth and the Board of Directors of HPH, that HPH ultimately could not maintain the status quo as an independent hospital. (Newton, Tr. 436-37; Spaeth, Tr. 2141; Kaufman, Tr. 5811, 5818-20; RFF ¶¶ 2301-2304, 2307-2310).

REDACTED

(Kaufman, Tr. 5789-90, 5793-94, 5796, 5798, 5811, 5818, 5828; RFF ¶¶ 2307, 2319-2324, 2326-2335, 2354-2370; RFF ¶ 2325, *in camera*). Complaint Counsel's assertion that HPH was "well-capitalized" is simply false. (Kaufman, Tr. 5843; RFF ¶ 2357). This proposed finding of fact ignores Kaufman's testimony that, while HPH was "appropriately capitalized to be merged," it was not "by extension . . . appropriately capitalized for a status quo situation." (Kaufman, Tr. 5843). HPH's debt-to-capitalization ratio was a "big problem" that affected its debt capacity. (Kaufman, Tr. 5816; RFF ¶¶ 2354-2356, 2358-2362).

304. Lakeland Health Services was the parent corporation of Highland Park Hospital and the pre-merger Highland Park Foundation. (Newton, Tr. 282).

Response to Finding No. 304:

Respondent has no specific response. (RFF ¶ 35).

305. Ken Kaufman is managing partner of Kaufman Hall & Associates, a financial consulting firm primarily servicing non-profit hospital systems. (Kaufman, Tr. 5773).

Response to Finding No. 305:

Respondent has no specific response. (RFF ¶ 2302).

306. Mr. Kaufman and his firm provided financial and strategic consulting services to Highland Park Hospital prior to its merger with ENH. (Kaufman, Tr. 5774). Mr. Kaufman served as transaction counsel to Highland Park during the ENH merger negotiations. His engagement with HPH ended in July 1999. (Kaufman, Tr. 5838-39).

Response to Finding No. 306:

This proposed finding is incomplete. While Kaufman's engagement ended on the signing of the letter of intent in July 1999, Kaufman continued to work on two subsequent projects.

(Kaufman, Tr. 5834). Kaufman performed some modeling for HPH and assisted Harry Jones from ENH in the due diligence process to model the hospitals together. (Kaufman, Tr. 5834).

307. Mr. Kaufman served only as transaction counsel during the merger negotiations. He did not have discussions with Highland Park in 1999 about the status quo, unaffiliated option. (Kaufman, Tr. 5838-39).

Response to Finding No. 307:

This proposed finding is misleading. Kaufman specifically testified, in the pages cited by Complaint Counsel, that if “at any time [he] thought the transaction was not in the best interests of Highland Park, [he] would have told [HPH management]” and would have consulted as to the status quo option. (Kaufman, Tr. 5838-39). However, since the status quo option was untenable, and a merger with Evanston Hospital was in HPH’s best interests, the situation did not arise.

(Kaufman, 5811, 5818; RFF ¶ 2307). Kaufman Hall did some modeling that compared HPH alone versus HPH as part of ENH after the letter of intent. (Kaufman, Tr. 5834). And Kaufman Hall continued its work during the due diligence process. (Kaufman, Tr. 5834).

308. In his role as transaction counsel, 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).

Response to Finding No. 308:

This proposed finding is incomplete and misleading. Kaufman advised HPH that “the financial condition of both parties [was] such that neither require a financial reason” to merge on October 26, 1998, while HPH was still putting its best face on its condition. (CX 1923 at 1-2).

In October 1998, of course, HPH was involved in negotiations and trying to present itself in the best light possible to maintain its negotiating stance in any merger negotiations. Later, Kaufman Hall’s analyses and the due diligence performed by the parties revealed that HPH was “deteriorating” and in a “downward spiral.” (Kaufman, Tr. 5816-17; H. Jones, Tr. 4157; RFF ¶

2336). Among other things, the due diligence analysis revealed, and Kaufman explained at trial, that HPH attempted to downplay its true financial condition to the community and media by off-setting operating losses with investment income. (RFF ¶ 2347-2353).

309. At the end of 1998, Highland Park Hospital had 444 days of cash on hand. (CX 1912 at 1; Newton, Tr. 427-28). This was the equivalent of being able to run a fully functional hospital for 444 days without a penny of additional revenue. (Kaufman, Tr. 5860). The 444 days of cash on hand did not include any pre-merger foundation assets. (Kaufman, Tr. 5860).

Response to Finding No. 309:

This proposed finding is misleading. (RFF ¶ 2365). HPH used its cash resources to shore up its “very weak capital capacity on the operating side” and provide a “cushion” on its balance sheet. (H. Jones, Tr. 4093-94; Kaufman, Tr. 5796, 5806-7, 5809, 5813; RX 408 at ENHL TH 1509; RX 465 at FTC-KHA 2180; RFF ¶¶ 2365-2370). In relative terms, compared to its competitors in the Chicago market, however, this cash “wasn’t a lot of money.” (Kaufman, Tr. 5806-07; RX 465 at FTC-KHA 2179-80; RFF ¶ 2366).

310. In 1999, Mr. Kaufman advised Highland Park that the hospital “has always supported its credit position through exceptional liquidity.” (CX 1912 at 2).

Response to Finding No. 310:

This proposed finding is misleading. (RFF ¶¶ 2365-2366). HPH was required to maintain liquidity because it held a large amount of debt and had poor operating performance. (Kaufman, Tr. 5806; RX 465 at FTC-KHA 2180; RFF ¶¶ 2365-2368).

311. At the end of 1998, Highland Park Hospital had \$133.6 million in cash assets available to contribute to the ENH-HPH merged entity. (Kaufman, Tr. 5842; CX 1912 at 2). This \$133.6 million did not include the pre-merger Highland Park Foundation’s assets. (Kaufman, Tr. 5842; CX 1912 at 2).

Response to Finding No. 311:

This proposed finding is incomplete and misleading. HPH had over \$120 million in debt, required millions of dollars in critical facility improvements after years of insufficient capital investment, and lacked sufficient cash reserves to compete in the Chicago marketplace.

(Kaufman, Tr. 5806-07, 5811, 5814-16; H. Jones, Tr. 4097-99, 4119; RX 465 at FTC-KHA 2179; RX 569 at ENH JH 1215, 1225-26; RFF ¶ 46).

312. After the \$133.6 million contribution to the ENH-HPH merged entity, Lakeland Health Services still would have had \$102 million left over to fund the independent foundation. (Kaufman, Tr. 5842; CX 1912 at 3).

Response to Finding No. 312:

This proposed finding is incomplete and misleading. HPH had over \$120 million in debt, required millions of dollars in critical facility improvements after years of insufficient capital investment, and lacked sufficient cash reserves to compete in the Chicago marketplace.

(Kaufman, Tr. 5806-07, 5811, 5814-16; H. Jones, Tr. 4097-99, 4119; RX 465 at FTC-KHA 2179; RX 569 at ENH JH 1215, 1225-26; RFF ¶ 46).

313. Even if LHS were to contribute the \$102 million to an independent foundation, Mr. Kaufman advised Highland Park that ENH would be receiving “an appropriately capitalized partner.” (Kaufman, Tr. 5843; CX 1912 at 2).

Response to Finding No. 313:

This proposed finding is vague, inaccurate and misleading. Kaufman distinguished HPH’s financial condition as “appropriately capitalized to be merged,” which is different than being “appropriately capitalized for a status quo situation.” (Kaufman, Tr. 5843; RFF-Reply ¶ 303). The evidence at trial demonstrated that HPH was not “appropriately capitalized” but, to the contrary, it was viewed by Evanston Hospital as a “significant turnaround effort.” (H. Jones, Tr. 4101; RX 557 at ENH GW 4253; RFF ¶¶ 2341-2343).

314. Highland Park Hospital and the pre-merger, non-independent Highland Park Foundation constituted the “obligated group” for this long-term debt. In other words, the assets of the foundation and the hospital backed up the long-term debt. (Kaufman, Tr. 5846; CX 413 at 120).

Response to Finding No. 314:

This proposed finding is misleading. HPH was “significantly over-leveraged.” (Kaufman, Tr. 5802, 5806; RX 465 at FTC-KHA 2179; RX 1979 at FTC KHA 2172; RFF ¶¶ 2359-2360). HPH simply could not borrow any more money because capital markets would have realized that its debt service coverage, which was “trending in the wrong direction,” was a “significant warning signal.” (Kaufman, Tr. 5801-02, 5805-06; RX 465 at FTC-KHA 2179; RX 1979 at FTC KHA 2172; RFF ¶¶ 2359-2361). As further proof of its poor financial condition, Lakeland (unlike ENH) could not issue its own debt and had to buy insurance to guarantee repayment to its debt holders. (H. Jones, Tr. 4099; Noether, Tr. 6036; RFF ¶¶ 2362-2364, 2411).

315. At the end of 1998, the obligated group (Highland Park Hospital and the foundation) had \$120 million in long-term debt. (Kaufman, Tr. 5844; CX 1912 at 1). Highland Park’s bond issues in the 1990s accounted for this long-term debt. (Kaufman, Tr. 5844).

Response to Finding No. 315:

This proposed finding is incomplete and lacks appropriate context. HPH was “significantly over-leveraged” to compete in the market. (Kaufman, Tr. 5802, 5805-06; RFF ¶¶ 2351, 2355, 2359-2361). HPH had incurred substantial debt trying to compete in its market in the late 1980s and early 1990s. (Kaufman, Tr. 5802-03; RFF ¶¶ 2358-2359). Indeed, HPH’s bond holders required HPH to purchase bond insurance on its debt. (H. Jones, Tr. 4099; Noether, Tr. 6036; RFF ¶¶ 2362-2364, 2411).

316. When Mr. Kaufman calculated the debt indicators set forth in his February 1999 memorandum to Messrs. Stearns and Spaeth, he did not include the assets of the foundation. (Kaufman, Tr. 5846). Including the entirety of the obligated group’s assets

in the financial calculations would cause the debt indicators to improve compared to indicators that only utilized the hospital assets. (Kaufman, Tr. 5858).

Response to Finding No. 316:

This proposed finding is technically correct, but incomplete and misleading. As Kaufman explained at trial, he never included the assets of the Foundation in his analyses because “the Foundation was a separate organization run by a separate board, and so on a day-to-day basis, it was not consolidated into the financial activity of the organization.” (Kaufman, Tr. 5875). The exclusion of the assets of the Foundation also makes sense given that these assets were not among those that ENH would receive in the Merger. (Styer, Tr. 4969-70; RFF ¶ 262).

317. For example, Mr. Kaufman calculated that, at the end of 1998, Highland Park Hospital had a debt service coverage ratio of 1.8 and a debt to capitalization ratio of 61%. (CX 1912 at 1). These calculations did not take into consideration the foundation assets. (Kaufman, Tr. 5858).

Response to Finding No. 317:

This proposed finding is incomplete and misleading. (RFF ¶ 2361). The finding omits important contextual testimony explaining that the debt service ratio was far below the A-rating, represented “very weak” debt coverage, and was a “significant warning signal” as to the financial condition of HPH. (Kaufman, Tr. 5805-06; CX 1912 at 1; RFF ¶ 2361).

318. In contrast, Highland Park did include the pre-merger foundation assets in its calculations of debt indicators set forth in its 1999 Certificate of Need application to the Illinois Health Facilities Planning Board. (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).

Response to Finding No. 318:

This proposed finding is not supported by the record. There was never any testimony explaining or deriving the figures represented in this proposed finding. As such, there is no way to assess the validity or the significance of the numbers. (Kaufman, Tr. 5859). Moreover, there

was voluminous documentary evidence and live testimony explaining that the debt service ratio was 1.8, that any number below 2 was a “significant warning signal,” and that the national A-rated median was 3.8 in 1999. (Kaufman, Tr. 5805-06; RX 465 at FTC-KHA 2179-80; RFF ¶¶ 2360-2361).

319. Thus, including the entirety of the obligated group’s assets improves the debt service coverage ratio from 1.8 to 2.3, a 40% improvement. (*Compare* CX 1912 at 1 to CX 413 at 119).

Response to Finding No. 319:

This proposed finding is irrelevant. Since the Foundation was a “separate organization” with respect to the operations of HPH, its hypothetical inclusion in HPH’s financials has no bearing on the issues in this case. (Kaufman, Tr. 5875). The testimony of the key financial advisor was that the assets of the Foundation were not consolidated in the financials of the firm nor were they considered by the Board in assessing the financial condition of the hospital. (Kaufman, Tr. 5875; RFF ¶¶ 2297-2298).

320. In addition, Highland Park projected that by 2003 the debt service coverage ratio would improve to 3.1 and the debt to capitalization ratio to 39%. (CX 413 at 119).

Response to Finding No. 320:

This finding is not supported by the evidence at trial. Time and again, Respondent showed that HPH’s projections were overly optimistic and could not withstand scrutiny. For example, HPH propped-up its financials by including investment income as operating revenue. (Kaufman, Tr. 5796, 5811; H. Jones, Tr. 4093-94; RX 408 at ENHL TH 1509; RFF ¶¶ 2347-2350). HPH’s projections were unrealistic and unreliable for a variety of other reasons as well. HPH ignored historical trend lines. (H. Jones, Tr. 4112; RX 514 at FTC-KHA 1669; RFF ¶ 2393). The HPH projections also made aggressive assumptions inconsistent with its actual performance. (RX 539 at DC 7657; RFF ¶ 2398).

321. At the end of 1998, Highland Park Hospital and its affiliated corporations had a total of about \$235 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 merged entity. (Kaufman, Tr. 5842, 5844).

Response to Finding No. 321:

This proposed finding is incomplete, insufficient and misleading. HPH held \$120 million in debt and needed to make millions of dollars in critical facility improvements that were necessary to ensure patients' safety. (Kaufman, Tr. 5806-07, 5811, 5814-16; H. Jones, Tr. 4097-99, 4119; RX 465 at FTC-KHA 2179; RX 569 at ENH JH 1215, 1225-26; RFF ¶ 46).

322. If HPH and its corporate parent had used these funds to pay off the entirety of its long-term debt of \$120 million at the end of 1998, they would have been entirely debt-free and still would have had about \$115 million in cash and unrestricted investments. (Kaufman, Tr. 5844).

Response to Finding No. 322:

This proposed finding is not supported by the evidence. Kaufman explained that Complaint Counsel's arithmetic improperly assumed that the "Foundation assets were equal to the hospital assets." (Kaufman, Tr. 5844). Some assets held by the Foundation were "restricted to a specific purpose." (CX 6321 at 61). Kaufman explained during trial that if HPH had spent its cash or investment assets, the hospital "would have nothing at all, because they had no [revenue from] operations." (Kaufman, Tr. 5809; RFF ¶¶ 2368-2369). Those funds on the balance sheet were "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; RFF ¶ 2368). As a result, if HPH had spent its resources paying its debt, it would have actually resulted in a *deterioration* of its balance sheet. (Kaufman, Tr. 5876-77; RFF ¶¶ 2368-2369). In fact, if HPH dipped into its investments, it would have nothing left to offset its substantial operating losses. (Kaufman, Tr. 5813, 5876-77; RFF ¶¶ 2368-2369). Dr. Noether similarly concluded that

HPH, even with its cash and investments, could not afford to service its debt, make its required capital expenditures and support its operations. (Noether, Tr. 6035; RFF ¶ 2410).

323. Because it had sufficient cash flow for its projected capital needs, Highland Park management believed that \$100 million “are justifiably excluded from the merger and left with the Community Foundation.” (CX 1903 at 1).

Response to Finding No. 323:

This proposed finding is false and contrary to the evidence. The evidence in this case demonstrated that HPH did not have sufficient cash flow to meet its capital needs. HPH nearly lost its Medicare certification because of its inability to meet even the minimum standards of the Department of Health and Human Services. (RX 545 at ENH JH 011578; RFF ¶¶ 1512-1513, 2451). The regulators determined that “the deficiencies are significant and limit [HPH’s] capacity to render adequate care and ensure the health and safety of [its] patients. (RX 545 at ENH JH 11578). In addition, HPH’s physical facilities needed millions of dollars in immediate life safety and code compliance improvements. (RX 635 at ENH JH 4002; Neaman, Tr. 1336). Indeed, even if HPH decided to spend every penny of the \$100 million, it would still be “not a lot of money” compared to competitive challenges in the marketplace. (Kaufman, Tr. 5806-07). Dr. Noether thus concluded that HPH, even with its cash and investments, could not afford to service its debt, make its required capital expenditures and support its operations. (Noether, Tr. 6035; RFF ¶ 2410). HPH would have had to do all three of these things to remain competitively significant.

324. Highland Park and its affiliated corporations experienced a decline in long-term debt and an increase in cash and unrestricted investments position from 1998 to 1999. In particular, long-term debt declined from \$120.5 million to \$116.7 million. (CX 693 at 17). Cash and unrestricted investments increased from \$217.8 million to approximately \$260 million. (CX 693 at 16).

Response to Finding No. 324:

This proposed finding is misleading. Kaufman explained that the long term debt of the institution decreased simply because HPH had to amortize its debt: “just like your house, you have to pay off a certain amount of debt each year.” (Kaufman, Tr. 5853-54). Similarly, HPH’s cash and unrestricted investments improved because “the stock market went up,” not because of HPH’s operations. (Kaufman, Tr. 5853-54). The stock market, of course, collapsed in 2000. (Noether, Tr. 6032; H. Jones, Tr. 4107-08). The finding also is misleading to the extent that it implies that HPH’s overall financial position improved from 1998 to 1999. As the evidence abundantly demonstrated, HPH was in a “downward spiral” from 1998 through 1999. (H. Jones, Tr. 4157; RFF ¶¶ 2336-2337, 2341-2342, 2347-2348).

c. Foundation Assets Would Not Have Exited HPH Without The Merger

325. Pre-merger, Highland Park Hospital, through its parent, Lakeland Health Services, was backed by the assets of its foundation. These funds were available for use by the hospital. (Styer, Tr. 4954) (“funds from the pre-merger Foundation went to support the hospital”). The post-merger, independent foundation was established in order to compensate the local community of Highland Park for the loss of control following Highland Park’s merger with Evanston. (Kaufman, Tr. 5855). Highland Park and its corporate affiliates contributed \$100 million for the independent foundation. (CX 501 at 113). Without the merger, the pre-merger foundation’s assets would have remained in the corporate structure of Highland Park, (Kaufman, Tr. 5856) and been used to the benefit of Highland Park Hospital.

Response to Finding No. 325:

This proposed finding is misleading. Before the Merger, the assets of the foundation were being used to offset operations losses at HPH. (Styer, Tr. 4954, 4961, 5001-2; RX 400 at ENH RS 6692; RFF ¶¶ 2426-2428). Without the Merger, HPH would have had to keep chipping away at the foundation’s principal simply to stay afloat in the face of its operational

shortcomings and its downward financial trends. (RFF ¶¶ 2336, 2343, 2347-2348, 2354-2357, 2365-2370, 2385-2386, 2428).

326. The pre-merger Highland Park Hospital Foundation was “responsible for fund raising for and on behalf of Lakeland Health Services, Inc. (“Lakeland”), the Hospital [HPH] and their affiliates.” (CX 6321 at 61).

Response to Finding No. 326:

Respondent has no specific response. (RFF ¶ 36).

327. These raised funds were available to Highland Park Hospital. The foundation “maintains the funds received and distributes the funds based upon the needs of the affiliates, or, if restricted to a specific purpose, the directions of the donor.” (CX 6321 at 61). As the former chairman of the pre-merger foundation testified, “The funds from the pre-merger Foundation went to support the hospital, to fulfill needs.” (Styer, Tr. 4954).

Response to Finding No. 327:

Respondent has no specific response. (RFF ¶¶ 2425-2426).

328. Pre-merger, Highland Park Hospital executives “would bring [the foundation board] various projects that were ongoing in the hospital,” and the foundation members would select specific projects to fund, such as improvements to the hospital’s dialysis center. (Styer, Tr. 4959-60).

Response to Finding No. 328:

Respondent has no specific response.

329. HPH believed a vital part of the ENH merger was to compensate the local community of Highland Park for the loss of control following the merger. (Kaufman, Tr. 5855).

Response to Finding No. 329:

This proposed finding is an exaggeration and thus misleading. While dedicating a well-endowed foundation for the benefit of the community was a “key issue[]” of the Merger negotiations, this proposed finding describing the foundation as “vital” is an overstatement. (RX 465 at FTC-KHA 2179; RFF ¶ 2432).

330. The establishment of a separate post-merger foundation to serve Highland Park was designed to compensate the community for the loss of control. (Kaufman, Tr. 5855-56).

Response to Finding No. 330:

This proposed finding is incomplete. One of the goals of the Merger was to “put together a foundation for the benefit of the community.” (Kaufman, Tr. 5831). In part, the foundation served to compensate the community for the loss of control of a community, not-for-profit asset to a larger not-for-profit entity. (Kaufman, Tr. 5855-56).

331. If there was no merger, there would be no loss of control and hence no need to compensate the community. (Kaufman, Tr. 5856).

Response to Finding No. 331:

Respondent has no specific response. (RFF-Reply ¶¶ 329-330).

332. The foundation was in fact established as an independent entity with \$100 million in total net unrestricted assets. (CX 501 at 113). Highland Park and its affiliated corporations contributed these assets at the time of the foundation’s formation. (Neaman, Tr. 1260).

Response to Finding No. 332:

This proposed finding is not supported by the evidence. The foundation was established with \$60 million from the old HPH Foundation and another \$40 million from Evanston Hospital. (Styer, Tr. 4969-70; RFF ¶ 262). The \$100 million Healthcare Foundation corpus was to be used to support HPH and enhance healthcare in other areas of the community. (Styer, Tr. 4969-70; RFF ¶ 262).

333. The post-merger, independent foundation was renamed Healthcare Foundation of Highland Park. (RX 2037 at HFHP 001351; Styer, Tr. 4951).

Response to Finding No. 333:

Respondent has no specific response. (RFF ¶ 262).

334. If there was no merger, the \$100 million foundation contribution would have remained in the corporate structure of Highland Park and its affiliated companies and would not have been spun off to a separate entity. (Kaufman, Tr. 5856).

Response to Finding No. 334:

This proposed finding is inaccurate, not supported by the record and misleading.

Kaufman's testimony was that, but for the Merger, he assumed the corporate structure of Lakeland Hospital and the pre-Merger foundation would have remained the same. (Kaufman, Tr. 5856). The post-Merger foundation was created using approximately \$40 million from ENH. (RFF ¶ 262). HPH would not have had access to those funds absent the Merger.

d. HPH's Management and Board Believed That HPH Was Financially Strong Pre-Merger

335. Both the Highland Park management and board believed that Highland Park was financially strong in 1999 and for the foreseeable future. (CX 1055 at 3 (Highland Park "can remain financially strong over the foreseeable future.")). The management and board contemplated that Highland Park's income would grow (CX 1055 at 2 (projecting increased net revenues)); its debt would decline (CX 1903 at 1 (projecting reduction in long-term debt)), and its operating margin would increase from 1999 into the future (CX 1055 at 2 (setting forth higher operating margin forecasts)). They also believed that Highland Park would be able to make necessary capital investments, as well as create new strategic initiatives to further increase operating revenue. (CX1903 at 1, 3 (outlining \$79 million in planned capital expenditures as well as \$28 million for strategic initiatives)).

Response to Finding No. 335:

This proposed finding is false, misleading and contrary to the weight of the evidence presented in this case. First, the testimony and exhibits admitted into evidence conclusively demonstrated that HPH's financial condition was rapidly deteriorating in 1999. Kaufman advised the HPH Board that its "financial momentum" was "trending downward." (Kaufman, Tr. 5798-99; RFF ¶ 2322).

Second, this proposed finding ignores pertinent evidence. Complaint Counsel cites one sentence of one document from March 1999 in an attempt to demonstrate HPH's entire financial state going forward. (CX 1055 at 2). However, as shown in Court, in June and July of 1999, HPH's operating revenues were \$4.7 million under its budget. (RX 609 at EY 19; H. Jones, Tr.

4121; RFF ¶¶ 2329-2330). Earnings were negative and trending more negative by the summer of 1999. (H. Jones, Tr. 4093; Kaufman, Tr. 5798-99; RFF ¶¶ 2341-2342). And multiple witnesses acknowledged that HPH, because it was a not-for-profit hospital, was probably not going to go bankrupt in the immediate future, but, without any doubt, it could no longer maintain the status quo. (H. Jones, Tr. 4117, 4157; Kaufman, Tr. 5811, 5818-20, 5828, 5874; CX 6305 at 7, 11 (Stearns, Dep.); RFF ¶¶ 2307, 2336).

Third, Complaint Counsel cites projections that never came to fruition and, in fact, were proven unrealistic and remarkably false. (H. Jones, Tr. 4096-97, 4112-13). HPH's operating margin was in a "downward spiral," capital expenditures were insufficient to compete in the marketplace, and once the stock market crashed, HPH could no longer prop itself up using investment income. (H. Jones, Tr. 4097-99, 4157; Kaufman, Tr. 5789-90, 5806-7, 5811, 5814; RFF ¶¶ 2336, 2347, 2354, 2365-2366, 2376-2379).

Finally, the projections concerning HPH's debt are not material. As a natural course of its debt, HPH projected that it would pay off some of its long-term debt according to its amortization schedules. (Kaufman, Tr. 5853-54; RFF-Reply ¶ 324).

336. The Highland Park board had assessed the financial position of the hospital and felt it was acceptable. Highland Park was not planning to file for bankruptcy before the merger. It never considered filing for bankruptcy. (Spaeth, Tr. 2308).

Response to Finding No. 336:

This proposed finding is misleading. While Respondent agrees that HPH did not plan to file for bankruptcy in the immediate future, HPH "did not have a rosy future on that site." (Spaeth, Tr. 2307-8; RFF-Reply ¶ 335). To the contrary, HPH's Board doubted that it could even survive in the marketplace and knew that the hospital under-served its community. (Kaufman, Tr. 5781-82, 5819-20; CX 6305 at 4 (Stearns, Dep.); RFF ¶¶ 2298-2300). HPH was

in a “downward spiral” financially and was “wobbly and getting wobblier.” (H. Jones, Tr. 4157; Kaufman, Tr. 5816-17; RFF ¶ 2336). HPH attempted to enact cost-cutting measures, but as time progressed, instead of trimming the fat, it began cutting into its backbone: patient care, such as nursing and radiology. (Spaeth, Tr. 2263-64, 2305; RX 592A at ENH RS 880).

337. Mr. Spaeth testified that he never heard anyone on the board say that Highland Park should consider filing for bankruptcy. In addition, Mr. Spaeth had never heard anyone on the board say that they needed to think about closing the hospital. (Spaeth, Tr. 2308).

Response to Finding No. 337:

This proposed finding is misleading. Although HPH was not in danger of immediate bankruptcy, it was in a “downward spiral” that threatened its viability in the future. (H. Jones, Tr. 4157; RFF-Reply ¶¶ 335-336).

338. Mr. Stearns, Highland Park’s Chairman of the Board, testified that he believed that Highland Park was not in danger of exiting the market for at least ten years. (CX 6305 at 5 (Stearns, Dep.)).

Response to Finding No. 338:

This proposed finding is misleading. As the evidence demonstrated, HPH’s precarious financial position led the HPH Board of Directors to seek a merger partner that could assure the competitive viability of the hospital for the community. (CX 6305 at 4, 7, 11 (Stearns, Dep.); Kaufman, Tr. 5781-82, 5786-87; RFF ¶¶ 2298-2300, 2308-2310). Harry Jones testified that once HPH depleted its cash and investments in approximately six years, HPH would surely exit the market. (H. Jones, Tr. 4170-71). Moreover, HPH was unable to invest sufficient amounts of money into its capital to preserve itself for the long-term as a competitor. (Kaufman, Tr. 5814-16).

339. Before the merger, HPH “historically achieved strong financial results compared to the median for not-for-profit hospitals.” (CX 545 at 3).

Response to Finding No. 339:

This proposed finding is overbroad and misleading. HPH maintained a balance sheet that may have appeared to be strong by holding above-average amounts of cash. (Kaufman, Tr. 5860). But HPH's overall financial results were distorted by its non-standard accounting practice of including investment income as operating revenue. (H. Jones, Tr. 4093-94; Kaufman, Tr. 5811; RFF ¶¶ 2347-2350). HPH was experiencing a "significant operating loss" in the late 1990s. (Kaufman, Tr. 5811). Further, several key indicators used by capital markets indicated that HPH's financials were well below the medians that would be considered an A-rating. (Kaufman, Tr. 5803-6; RX 465 at FTC-KHA 2179-80; RFF ¶¶ 2327-2328). Specifically, HPH was far below the median of A-rated hospitals in terms of its operating margin, excess margin (which includes investment income), debt service coverage, and debt-to-capitalization ratio. (Kaufman, Tr. 5803-6; RX 465 at FTC-KHA 2179-80; RFF ¶¶ 2327-2328).

340. At the March 23, 1999 meeting, the Lakeland finance and planning committee concluded that Highland Park "can remain financially strong over the foreseeable future." (CX 1055 at 3; Newton, Tr. 432-34; Spaeth, Tr. 2147).

Response to Finding No. 340:

This proposed finding is vague and misleading. Complaint Counsel places far too much weight on a single sentence devoid of supporting financial data or historical trend lines. (CX 1055 at 3; RFF-Reply ¶¶ 335-339). In any event, Spaeth clarified the cited sentence in Court when he explained that "was [the committee's] view *at the time*." (Spaeth, Tr. 2147 (emphasis added)).

The preceding sentence of the cited document conforms with the evidence in this case. This sentence reflects that the committee questioned "the long term viability of the organization should affiliation discussions not reach fruition." (CX 1055 at 3). The Court thus should rely on

the overwhelming evidence that HPH's overall financial condition was trending downward and that HPH was unable to sustain itself as an independent community hospital. (H. Jones, Tr. 4093, 4157-58; Kaufman, Tr. 5816-17; RFF ¶¶ 2336-2337; CX 6034 at 5 (Livingston, Dep.); RFF ¶ 2337).

341. Highland Park's 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." The plan also set aside \$65 million for "[h]ospital construction, routine capital and information technology" investments, and a small amount for Lakeland Health Ventures. The combined budget was in excess of \$100 million. (Newton, Tr. 430-31; CX 545 at 3; CX 1055 at 2).

Response to Finding No. 341:

This proposed finding is irrelevant, exaggerated, misleading and devoid of context. HPH's financial plan for improvements was based on its "reverse hockey stick" projections and wishful thinking. (H. Jones, Tr. 4096-97). And even if the \$100 million materialized, it was not necessarily "a lot of money" relative to other hospitals' capital expenditures. (Kaufman, Tr. 5806-07; RFF ¶ 2366). In any event, these budgeted amounts would not have paid for new brick-and-mortar improvements for patients but, instead, simply equaled the amount of annual expenses for the depreciation of HPH's assets. (H. Jones, Tr. 4098). This low level of capital expenses is proof that HPH lacked sufficient cash flow and reserve assets to improve successfully patient care in its facilities and adequately compete in the marketplace. (H. Jones, Tr. 4098-99; Kaufman, Tr. 5814-15; RFF ¶ 2379). That is, \$65 million, or even \$75 million, "wasn't going to begin to get at the problems" that were occurring at HPH. (Kaufman, Tr. 5826; Styer, Tr. 5029; RFF ¶¶ 2381-2382).

342. According to Highland Park's 1999-2003 financial plan, "Cash and investments are forecasted to grow from \$238 million in 1998 to \$323 million in 2003." (CX 1055 at 3).

Response to Finding No. 342:

This proposed finding is irrelevant, devoid of context and misleading. The proposed finding reflects a highly speculative forecast that did not come to fruition. As it turned out, the stock market did not sustain the type of growth required for HPH's projections. While 1998 and 1999 was a "wonderful time to be in the market," the market "tank[ed]" in 2000. (Kaufman, Tr. 5853-54; H. Jones, Tr. 4107-8).

343. HPH also forecasted that its investments would generate a return of \$28 million in incremental net revenues in 2003, reaching HPH's "market share target." (CX 1055 at 2).

Response to Finding No. 343:

This proposed finding is irrelevant, devoid of context and misleading. HPH's forecasts of future growth are unreliable and irrelevant. As noted above, the stock market crashed in 2000, thus rendering these forecasts unrealistic. (Kaufman, Tr. 5853-54; H. Jones, Tr. 4107-8; RRF-Reply ¶ 342). Kaufman testified at length that HPH had a difficult time turning a "dollar of revenue into any kind of profitability." (Kaufman, Tr. 5794-95; RFF ¶ 2321). Moreover, revenues from the actual operations continued in a downward trend in the late 1990s. (Kaufman, Tr. 5811; RFF ¶ 2320).

344. The 1999-2003 Highland Park financial plan emphasized that "[e]xisting cash and investments are available to fund strategic initiatives and generate new programs." (CX 545 at 3).

Response to Finding No. 344:

This proposed finding is irrelevant, devoid of context and misleading. While Respondent agrees that HPH had cash available to fund some activities, it did not have the wherewithal to make the extensive improvements and initiatives required to remain a competitor in the market. (Noether, Tr. 5902, 6026-27; RFF ¶ 2405). In fact, HPH's projected capital improvement plan

would have actually driven it out of business by rapidly depleting its investment balance. (H. Jones, Tr. 4136-37; RX 603 at KHA 32; RFF ¶¶ 2384-2386). If HPH had spent its investments, it would no longer be able to subsidize its operations with investment earnings. (H. Jones, Tr. 4136-37; RX 603 at KHA 32; RFF ¶¶ 2384-2386).

345. Mr. Spaeth testified that Highland Park's "strong financial results" and ability to fund strategic initiatives and generate new programs through "existing cash and investments" was correct as of March 1999. (Spaeth, Tr. 2135; CX 545).

Response to Finding No. 345:

This proposed finding is irrelevant, misleading, duplicative and, as described above, devoid of context. (RFF-Reply ¶¶ 335, 339-340, 344).

346. On March 23, 1999, Lakeland's finance and planning committee approved the 1999-2003 Strategic Plan and Financial Plan. (Spaeth, Tr. 2146; CX 1055 at 3).

Response to Finding No. 346:

Respondent has no specific response.

347. At the April 30, 1999, Highland Park Hospital board meeting, the board members approved the 1999-2003 Strategic Plan and Financial Plans. (CX 96 at 4; Spaeth, Tr. 2155) The board members did not express doubt about Highland Park's ability to generate the \$100 million required to fund the projects. (Newton, Tr. 430-32).

Response to Finding No. 347:

This proposed finding is incomplete and unsupported by the evidence. When the Board approved the plans, it was based on assumptions. (CX 96 at 4). But the assumptions made in HPH's plans were unrealistic, especially in light of the collapse of the stock market in 2000 and the impact of the Balanced Budget Act on HPH's finances. (Noether, Tr. 6031).

This proposed finding is unsupported by the evidence because Newton only testified as to whether he, as an individual, doubted HPH's ability to raise the money required to fund the projects. (Newton, Tr. 432). In fact, Newton acknowledged that the Board doubted, debated and

considered alternatives, or other options, and that specific initiatives required further review by the Board. (Newton, Tr. 431-32). Newton did not even recall the Board specifically approving the plans. (Newton, Tr. 430).

348. Highland Park's 1999-2004 Financial Plan projected that cash and investments would increase by \$48 million from 1999-2004, and that long-term debt would be reduced by \$24.3 million, excluding amortization. (CX 1903 at 1).

Response to Finding No. 348:

This proposed finding is irrelevant, misleading and duplicative. (RFF-Reply ¶ 342).

349. Highland Park's financial forecasts established that it had sufficient cash flow for both the planned capital expenditures and the strategic initiatives. (CX 1903 at 1).

Response to Finding No. 349:

This proposed finding is inaccurate, incomplete and misleading. The Merger due diligence review revealed that HPH's level of capital expenditures would yield insufficient cash flow and inadequate reserve assets. (H. Jones, Tr. 4098-99; RFF ¶ 2379). Cash flows were forecasted to be positive only because of overly-optimistic expectations from investment earnings. (RX 363 at FTC-KHA 2357; RFF ¶ 2401). Dr. Noether's analysis confirmed that cash flows at HPH were insufficient for HPH to make the \$100 to \$200 million in required improvements. (Noether, Tr. 6033-34; RFF ¶ 2406).

350. The 1999-2004 financial plan included planned capital expenditures of \$79 million. These expenditures were comprised of "primarily routine capital for equipment and facility improvements, construction for renovation of patient care areas, information system enhancements and physician development." (CX 1903 at 1).

Response to Finding No. 350:

This proposed finding is irrelevant, misleading, devoid of context and repetitive. (RFF-Reply ¶ 341; CCF ¶ 341).

351. The financial plan also included an additional \$28 million in planned expenditures for "Strategic/Master Plan Initiatives." These initiatives included development of a cath lab,

additional parking, and additional facilities for oncology and radiation therapy. (CX 1903 at 1, 3).

Response to Finding No. 351:

This proposed finding is misleading and incomplete. The evidence at trial demonstrated that even if HPH were able to finance its capital expenditure plans, the planned expenditures would be insufficient to maintain HPH as a viable long-term competitor. Kaufman testified, with respect to HPH's level of investment in capital, that "we didn't think that with what was happening in the Chicago market at that point, that that level of investment would be sufficient to sustain their competitive position over time." (Kaufman, 5814-15; RFF ¶ 2379). While HPH certainly planned to make some investments, it was incapable of making sufficient improvements to remain competitive in the market. (H. Jones, Tr. 4098; Kaufman, Tr. 5814-15; RFF ¶ 2379). And while HPH may have wished for the ability to renew its tired and deteriorating physical plant and to install new facilities, like a new cath lab or better cancer care, the fact of the matter is that the Merger was necessary to make these wishes come true. (Spaeth, Tr. 2274-76).

e. HPH's 1999 Operating Results Were Distorted Due to Merger-Related Expenses

352. Lakeland Health Services, including Highland Park Hospital, showed an operating loss in 1999. This was primarily attributable to writing down in value a variety of assets and accruing expenses in anticipation of the Evanston merger. (Newton, Tr. 412-13).

Response to Finding No. 352:

This proposed finding is inaccurate, incomplete and not supported by the evidence. First, Newton – to the extent his testify on the subject of HPH's finances should be given any weight given that he was not HPH's Chief Financial Officer – stated that HPH's losses were attributable not only to accrual of expenses, but also primarily caused by the impact of the Balanced Budget

Act. (Newton, Tr. 412-13). Any suggestion that Merger-costs alone were the cause of HPH's dismal operating performance is misguided because most of the expenses had to be accrued even in the absence of a Merger. (Noether, Tr. 6031, 6180-81, 6207; RFF ¶ 2408).

Indeed, Newton's testimony on the subject should be disregarded altogether since he did not participate in the extensive due diligence analyses of HPH's finances. Nor was he responsible for HPH's finances before the Merger. (Spaeth, Tr. 2283; H. Jones, Tr. 4104). The reliable evidence in this case confirms that HPH showed a declining year-after-year trend in operations well before the Merger. (Kaufman, Tr. 5811; RFF ¶ 2320).

353. Highland Park Hospital assumed more than \$9.6 million in various merger-related accruals for executive compensation as part of the merger. Total merger-related costs were estimated at \$11 million. (CX 1720 at 39).

Response to Finding No. 353:

This proposed finding is irrelevant and misleading. Even excluding Merger-related accruals, Lakeland showed a year-to-date operating loss of over \$4.6 million dollars, as compared to its "break even budget," by October 1999. (RX 2013 at ENH RS 6097; Spaeth, Tr. 2307; RFF ¶ 2335). The majority of the nonrecurring costs accrued during the Merger were year-end adjustments that needed to be accounted for *even if* the Merger did not occur. (H. Jones, Tr. 4181; RFF ¶ 2344). It was HPH's practice to accrue certain items at the end of its fiscal year instead of monthly, so it was not out-of-the-ordinary to have substantial accruals added to the books at the end of every year. (H. Jones, Tr. 4181).

354. On June 29, 1999, Highland Park replaced the employment agreements of the top executives at Highland Park. These new agreements replaced earlier ones and "offered additional retention bonuses as well as enhanced severance agreements." (CX 534 at 3). The amount required to cover these additional bonuses and severance agreements totaled \$8 million. (CX 534 at 3; Neaman, Tr. 1257-58)).

Response to Finding No. 354:

This proposed finding is irrelevant and misleading. This proposed finding is irrelevant because the accrual of executive compensation would have occurred even if there were no Merger. (H. Jones, Tr. 4113-14, 4119-20, 4181; RFF ¶ 2344). The changes to the executive compensation occurred six months before the Merger, were not contingent on nor specific to the Merger and, therefore, are completely unrelated to the Merger. (H. Jones, Tr. 4119-20, 4181; RFF ¶ 2344).

355. As of July 31, 1999, Highland Park's operating margin was a deficit of \$1.6 million due to "nonrecurring" or "one-time" costs from the merger with ENH. Without these non-recurring merger costs, Highland Park's operating margin would have been a surplus of \$1 million. (Hillebrand, Tr. 1777-80; CX 517 at 2-5).

Response to Finding No. 355:

This proposed finding is false, misleading, unreliable and contrary to the evidence. The document cited in support of the finding was never recognized by any of the ENH executives who testified in Court. (Hillebrand, Tr. 1777; H. Jones, Tr. 4152-53). Instead, each of the live trial witnesses was able to reliably testify, subject to cross examination, that HPH's operating margin was negative and was "deteriorating significantly," notwithstanding Merger costs. (Neaman, Tr. 1347; Hillebrand, Tr. 1778-79; Kaufman, Tr. 5811, 5798-99; RX 1979 at FTC KHA 2172; H. Jones, Tr. 4093; RFF ¶¶ 2320-2322, 2329). Further, reliable analysis proved that, as of June 1999, HPH's negative net margin was approximately \$2 million. (RX 609 at EY 19; H. Jones, Tr. 4121; RFF ¶ 2329).

f. Highland Park Could Have Continued As a Stand-Alone Competitor Without the Merger

356. Highland Park's board and management consistently contemplated and made plans for a stand-alone, "status quo" option in which Highland Park would not merge with another hospital. (CX 1055 at 1 (Highland Park strategic and financial plans "developed assuming no affiliation with another provider were to occur"); Spaeth, Tr. 2145-46 (plans

set forth goals for “going forward without a merger”); CX 1869 at 5-6 (outlining benefits of stand-alone growth strategy)). Highland Park’s stand-alone strategic plans projected continued growth and financial strength. (CCFF 335-351). In addition, Highland Park emphasized that it did not have a financial need to merge with ENH. (CX 1923 at 2 (Highland Park does not “require a financial reason” for the merger)).

Response to Finding No. 356:

This proposed finding is incomplete and misleading. Respondent agrees that HPH prepared for a “status quo” option as a last resort. However, HPH’s Board and management knew that a merger was the more prudent option for the hospital and its community. (Kaufman, Tr. 5811, 5818, 5820-21; RFF ¶¶ 2307-2318). Put simply, HPH could not improve the quality of the organization and bring a higher level of services to meet the demands of its community on its own. (Kaufman, Tr. 5828-29; CX 6305 at 11 (Stearns, Dep.); RFF ¶ 2315). As discussed above, the sources relied on by Complaint Counsel are unreliable, irrelevant and against the weight of the evidence. (RFF-Reply ¶¶ 335-351).

357. In the fall of 1998, Highland Park contemplated both a merger strategy as well as an independent, stand-alone growth strategy. (CX 1869 at 5-6).

Response to Finding No. 357:

This proposed finding is inaccurate. The HPH Board began considering a Merger strategy as early as 1996. (RX 198). HPH hired Kaufman Hall Associates to examine its long-term future in November 1996. (Kaufman, Tr. 5780, RX 198 at FTC KHA 713; RFF ¶ 2305). The engagement letter outlines that, as early as 1996, HPH began to compare the “status quo” with other options. (RX 198 at FTC KHA 713; Kaufman, Tr. 5818-19; RFF ¶ 2305). The HPH Board made its evaluation of how to move forward in 1997 through the middle of 1998. (Kaufman, Tr. 5818-19).

358. Highland Park believed that the benefits of an independent growth strategy were “[i]ndependence, [c]ontrol [and] [l]ocal [f]lavor.” (CX 1869 at 5).

Response to Finding No. 358:

This proposed finding is incomplete. HPH emphasized “local control” and concern for the community throughout its discussions relating to a merger, as well. (Kaufman, Tr. 5786-87, 5817, 5830-31; RFF ¶ 2306).

359. In his role as transaction counsel, Mr. Kaufman advised the Highland Park board and management that “[t]he 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).

Response to Finding No. 359:

This proposed finding is incomplete, devoid of context and misleading. During the Merger negotiations, the HPH Board was concerned that the media and the community would perceive the reasons for the Merger to be financial. (Kaufman, Tr. 5840). However, as was made abundantly clear at trial, HPH’s financial condition was such that its long-term outlook in the absence of a Merger was not “rosy.” (Spaeth, Tr. 2307-8; Kaufman, Tr. 5811, 5818, 5828; RFF ¶¶ 2298-2300, 2307).

360. Highland Park was prepared to proceed with the status quo, unaffiliated option if the ENH merger talks failed. (Kaufman, Tr. 5838).

Response to Finding No. 360:

This proposed finding is incomplete and misleading. (RFF-Reply ¶ 356).

361. Mr. Stearns, Highland Park’s Chairman of the Board, testified that he believed that Highland Park was not in danger of exiting the market for at least ten years. (CX 6305 at 5 (Stearns, Dep.)).

Response to Finding No. 361:

This proposed finding is misleading. (RFF-Reply ¶ 338).

362. If the merger with ENH had not closed, HP had “the financial wherewithal to sustain [itself].” HP management and board believed that “[t]here was no urgency to have an alternative immediately available.” (CX 6305 at 11 (Stearns, Dep.)).

Response to Finding No. 362:

This proposed finding is misleading. (RFF-Reply ¶¶ 338, 356).

363. From Highland Park management's perspective, pursuing the stand-alone, independent option in 1998-99 "was absolutely a viable alternative for Highland Park." (Newton, Tr. 319-20).

Response to Finding No. 363:

This proposed finding is irrelevant and false because it is based only on Newton's own speculation, which should be given no weight. (RFF-Reply ¶ 1465). Nevertheless, even assuming this finding has some relevance, it is still misleading. (RFF-Reply ¶¶ 338, 356).

364. Highland Park could remain independent due to a variety of factors. It had a quality medical staff with significant coverage over a range of about 45 specialties. It had a broad primary care network. It was efficient in managed care activities. (Newton, Tr. 320).

Response to Finding No. 364:

This proposed finding is irrelevant and false because Newton cannot speak for HPH management. (RFF-Reply ¶ 1465). Nevertheless, even assuming this finding has some relevance, it is still misleading. HPH suffered from serious financial and quality of care problems. (RFF-Reply ¶¶ 41-42, 338, 356).

365. The Highland Park community also strongly supported the hospital. Fund raising and donor support were strong, and the donor base was wealthy. (Newton, Tr. 320-21). For example, one fund-raising campaign conducted in the 1990s raised more than \$10 million for the development of new surgical suits. (Newton, Tr. 321). Another campaign raised funds for Highland Park Hospital's dialysis center, which was established in 1998. (Styer, Tr. 4959-60).

Response to Finding No. 365:

This proposed finding is inaccurate and misleading because HPH's donor support and fundraising were dwindling in the late 1990s. (RFF-Reply ¶ 44). Moreover, this finding relies

on baseless ethnic stereotypes promoted by Newton, thus further eroding his credibility as a witness. (Newton, Tr. 321; RFF-Reply ¶ 1465).

366. At the March 23, 1999 meeting, the Lakeland finance and planning committee concluded that based on the 1999 strategic and financial plans, Highland Park “can remain financially strong over the foreseeable future.” (CX 1055 at 3; Newton, Tr. 432-34; Spaeth, Tr. 2147). These plans were “developed assuming no affiliation with another provider were to occur.” (CX 1055 at 1; Spaeth, Tr. 2145-46 (plans set forth goals for “going forward without a merger”)).

Response to Finding No. 366:

The proposed finding is contrary to the weight of the evidence presented in this case and is misleading. (RFF-Reply ¶¶ 335, 340, 356).

367. Highland Park proposed a year 2000 budget in October 1999. The budget was prepared assuming no merger with ENH would take place; “therefore, no merger-related impact [was] included.” (CX 397 at 1). The proposed budget for 2000 anticipated “dramatic improvement over 1999’s results.” (CX 397 at 1). For example, the budget projected net revenue increases of more than \$6.3 million in 2000 for the hospital. (CX 397 at 3).

Response to Finding No. 367:

This proposed finding is not supported by the evidence at trial. (RFF-Reply ¶ 320).

HPH’s projections were unrealistic and unreliable for a variety of reasons, including the fact that they ignored historical trend lines. (H. Jones, Tr. 4112; RX 514 at FTC-KHA 1669; RFF ¶ 2393). The projections also made aggressive assumptions inconsistent with HPH’s actual performance. (RX 539 at DC 7657; RFF ¶¶ 239, 2398). For instance, HPH’s actual 1996 to 1998 volume as measured by discharges decreased by 1%, yet the cited budget projections assumed 1.3% growth in admissions for 2000. (CX 397 at 4).

This proposed finding is further misleading because it fails to explain that, even with the projected increase in net revenue, HPH would still only have an operating margin of roughly \$1 million. (CX 397 at 4). Moreover, the combined net margin for Lakeland, HPH’s parent company, was projected to be only \$.7 million. (CX 397 at 3). And even with the referenced

“dramatic” improvements, the 2000 budget allotted less than \$10 million for capital expenditures, far less than what was needed to remedy the hospital’s problems. (CX 397 at 8; Kaufman, Tr. 5826; RFF ¶ 2381).

2. Highland Park Was an Attractive Candidate for Other Mergers

368. Highland Park was considered by many as “one of the finest community hospitals in the country.” (Newton, Tr. 301).

Response to Finding No. 368:

This proposed finding is false and based on nothing more than speculation by Newton, who was not a credible witness. Given that this proposed finding does not even reference those who purportedly hold this “consider[ation]” of HPH, it should be disregarded in its entirety as pure conjecture and hearsay. (RFF-Reply ¶¶ 42, 1465).

369. Highland Park viewed itself as an attractive partnership candidate and considered other partners besides ENH. In the fall of 1998, Highland Park contemplated a number of potential merger partners, besides Evanston, including Northwest Community, Lake Forest and Condell. (CX 1869 at 6). Highland Park also had a strong balance sheet (CCFF 303-324), was backed by its foundation’s assets (CCFF 314-322), had an “attractive service area” (CX 6305 at 51 (Stearns, Dep.)), and anticipated positive growth in capital investments, strategic initiatives and operating margin (CCFF 339-351). (cross reference)).

Response to Finding No. 369:

This proposed finding suffers from numerous problems. HPH did not have a strong balance sheet. (RFF-Reply ¶¶ 303-324). The HPH Foundation’s assets provided little support for HPH’s financial position. (RFF-Reply ¶¶ 314-322). And HPH’s “*anticipated* positive growth in capital investments, strategic initiatives and operating margin” was based on faulty and unrealistic projections. (RFF-Reply ¶¶ 320, 339-351, 367 (emphasis added)).

This proposed finding is further misleading because it fails to explain the long and searching process pre-Merger HPH went through to find an appropriate merger partner. (RFF-

Reply ¶ 1598). According to both Spaeth and Stearns, HPH rejected, or was rejected by, all potential merger candidates, save Evanston Hospital. For example, discussions between Northwestern Memorial and HPH did not progress beyond initial stages because Northwestern Memorial was not responsive to HPH's inquiries and because HPH doubted Northwestern Memorial's ability to deliver what HPH thought its community needed. (Spaeth, Tr. 2270-71; RFF ¶¶ 244, 287). Spaeth spoke with Advocate Lutheran General senior executives about linking but, after initial discussions, HPH determined that Advocate Lutheran General was not the best fit because Advocate Lutheran General's religious affiliation might have affected patient care in the Highland Park community. (Spaeth, Tr. 2271-72; RFF ¶ 245). HPH also approached Lake Forest Hospital from time to time, but Lake Forest Hospital was not interested or not available, in part, because of its affiliation with Rush-Presbyterian. (CX 6305 at 12 (Stearns, Dep.); RFF ¶ 285). In the late 1990s, Condell did not have the financial and clinical wherewithal to be an attractive merger partner to HPH. CX 6305 at 12 (Stearns, Dep.); RFF ¶ 286). Aside from NH North discussions in 1996 and 1997, there is no evidence that HPH and Northwest Community approached one another a second time. HPH did briefly consider merging with a for-profit hospital, but HPH's board felt very strongly that HPH should remain a community hospital and not become part of a for-profit corporation. (Spaeth, Tr. 2272; RFF ¶ 246).

370. If the ENH merger had not closed, Highland Park was prepared "to continu[e] to explore other options," meaning "other partnership options." (CX 6305 at 11 (Stearns, Dep.)).

Response to Finding No. 370:

This proposed finding is supported only by speculation because the ultimate success of exploring other options remains a mystery. But the fact remains that, after 14 years of considering other partnership options, HPH settled on Evanston Hospital because only Evanston Hospital demonstrated both the ability and the will to improve HPH's quality of care and ensure

its long-term survival. (Spaeth, Tr. 2273; RFF ¶¶ 197, 240-249, 2306, 2308-2318; RFF-Reply ¶ 1598).

371. According to Highland Park's chairman of the board, Highland Park "had at least some contact with other institutions and . . . would have pursued those more aggressively had this – the merger with Evanston not gone through." (CX 6305 at 11-12 (Stearns, Dep.)).

Response to Finding No. 371:

This proposed finding is supported only by speculation. (RFF-Reply ¶ 370).

372. Highland Park had "an attractive service area," and therefore, it "would be attractive to other partnership candidates." (CX 6305 at 12 (Stearns, Dep.)).

Response to Finding No. 372:

This proposed finding is supported only by speculation. HPH is located in an attractive area, Lake County. But whether that fact alone would have led to successful discussions with another institution after a fourteen-year search is pure conjecture. (RFF-Reply ¶ 370).

IX. DIRECT EVIDENCE OF ANTICOMPETITIVE EFFECTS: THE PRICING OF ENH TO HEALTH PLANS FOLLOWING THE MERGER WITH HIGHLAND PARK PROVIDES DIRECT EVIDENCE OF ANTICOMPETITIVE EFFECTS

A. Introduction to the Data Relied Upon by Dr. Haas-Wilson

373. Dr. Haas-Wilson used four different data sources in her empirical analysis to examine whether prices increased at ENH after the merger. The four data sources were: (1) data from the Universal Dataset from the Illinois Department of Public Health (“IDPH Universal Dataset”); (2) data from the economic consulting firm NERA submitted to the FTC on behalf of ENH; (3) data submitted directly by ENH in response to an FTC Civil Investigative Demand (“CID”); and (4) commercial payer claims data. (Haas-Wilson, Tr. 2495-2500 (referring to DX 7025)).

Response to Finding No. 373:

This proposed finding is misleading to the extent it suggests that an analysis of NERA and CID data would have any independent relevance or significance. These data contain only price information for the ENH hospitals and, therefore, cannot provide a basis for relative price calculations. (CCFF ¶¶ 385, 386). Only relative price changes, not absolute price changes, are relevant to the analysis in this case.

REDACTED

(Baker, Tr. 4702, 4644, 4649-50,

4653, *in camera*; Haas-Wilson, Tr. 2677 *in camera*; Noether, Tr. 5904; RFF ¶¶ 315, 519).

REDACTED

(Baker, Tr. 4639-43, *in camera*).

REDACTED

(Haas-Wilson, Tr. 2677-78; Elzinga, Tr. 2404; Baker, Tr. 4649-50, *in camera*; Noether, Tr. 5903-04; RFF ¶¶ 316-317, 319, 521-522).

Finally, Dr. Haas-Wilson admitted that :

REDACTED

(Haas-Wilson, Tr. 2834-36, *in camera*; RFF ¶¶ 1053-1064). Consequently, it is impossible to conclude that the post-Merger price changes were anticompetitive based on a simple examination of price changes, without a consideration of competitive price levels.

1. Data from the IDPH Universal Dataset

374.

REDACTED

REDACTED

2582-83, *in camera*).

(Haas-Wilson, Tr. 2500; Haas-Wilson, Tr.

Response to Finding No. 374:

Respondent has no specific response.

375. The IDPH Universal Dataset includes the hospital's "list prices" for each procedure which reflect each hospital's chargemaster. The Universal Dataset does not include information on the actual transaction prices that hospitals charge health plans. (Haas-Wilson, Tr. 2500).

Response to Finding No. 375:

Respondent has no specific response.

376.

REDACTED

(Haas-Wilson, Tr. 2527, *in camera*).

Response to Finding No. 376:

Respondent has no specific response.

377.

REDACTED

(Haas-Wilson, Tr. 2527-28,

in camera).

(Haas-Wilson, Tr. 2527).

REDACTED

(Haas-Wilson, Tr. 2529, *in*

camera).

Response to Finding No. 377:

This proposed finding is misleading

REDACTED

REDACTED

(Haas-Wilson, Tr. 2529, *in camera*).

378.

REDACTED

REDACTED

(Haas-Wilson, Tr. 2529, *in camera*).

Response to Finding No. 378:

Respondent has no specific response other than to point out that Dr. Haas-Wilson did not make any effort to compare the estimated prices she generated using this data to the actual prices paid.

379.

REDACTED

{Haas-Wilson, Tr. 2529, *in camera*).

Response to Finding No. 379:

Respondent has no specific response.

380.

REDACTED

(Haas-Wilson, Tr.

2529-30, *in camera*).

Response to Finding No. 380:

Respondent has no specific response.

381.

REDACTED

(Haas-Wilson, Tr. 2531-32, *in camera*).

REDACTED

REDACTED

(Haas-Wilson, Tr. 2532, *in camera*; CX 6279 at 7, *in camera*).

Response to Finding No. 381:

This proposed finding is misleading to the extent it suggests that any of these “categories of payers” are representative of the MCO customer at issue in this case. (Compl. ¶ 16; Noether, Tr. 5906).

2. Data Submitted by the Economic Consulting Firm NERA on Behalf of ENH

382. NERA, an economic consulting firm hired by ENH, submitted data to the FTC, on ENH’s behalf. (Haas-Wilson, Tr. 2498).

Response to Finding No. 382:

Respondent has no specific response.

383. The NERA data reported actual negotiated prices for ENH’s fiscal years from 1999 through 2001. (Haas-Wilson, Tr. 2498).

Response to Finding No. 383:

Respondent has no specific response.

384. **REDACTED**
(Haas-Wilson, Tr. 2498). **REDACTED**
(Haas-Wilson, Tr. 2499; CX 6279 at 4 (**REDACTED**), *in camera*).

Response to Finding No. 384:

This proposed finding is misleading because Great West is one of the “five payors” referred to in the first sentence.

REDACTED

REDACTED

(Noether, Tr. 6050, *in camera*).

385. The NERA data include information only on ENH. There was no data on prices at other hospitals. (Haas-Wilson, Tr. 2498-99).

Response to Finding No. 385:

Respondent has no specific response.

3. Data Submitted by ENH in Response to a Civil Investigative Demand Issued by the Federal Trade Commission

386. ENH submitted data in response to a CID issued by the Federal Trade Commission. The CID response data was similar to the NERA data. The CID response data reported actual negotiated prices for ENH's fiscal years from 1999 through 2002. (Haas-Wilson, Tr. 2499-500).

Response to Finding No. 386:

Respondent has no specific response.

387. **REDACTED**
(Haas-Wilson, Tr. 2498). **REDACTED**
(CX 6279 at 5 (**REDACTED**), *in camera*).

Response to Finding No. 387:

This proposed finding is misleading to the extent that the "five payors" referred to in the first sentence include Great West. (Reply-RFF ¶ 384).

388. The CID response data, however, have information over a longer period of time than the NERA data, including data for ENH fiscal year 2002. (Haas-Wilson, Tr. 2499-500).

Response to Finding No. 388:

Respondent has no specific response.

4. Claims Data Submitted by Health Plans

389. **REDACTED**
(Haas-Wilson, Tr. 2510, *in camera*).

Response to Finding No. 389:

This proposed finding is inaccurate because One Health/Great West did not provide useable data. (Reply-RFF ¶ 384).

390. The claims data from health plans had data on a patient by patient basis. (Haas-Wilson, Tr. 2496).

Response to Finding No. 390:

This proposed finding is misleading because it implies that the claims data provided aggregate information by patient. Although, as Dr. Haas-Wilson suggested, the data provided information about patients,

REDACTED

(Haas-Wilson, Tr. 2495; Noether, Tr. 6050, in camera).

REDACTED

(Noether, Tr.

6052-53, in camera; RFF 1102, in camera).

391. The claims data contained information about the diagnosis of the patient and the actual amount paid for the procedure. (Haas-Wilson, Tr. 2496-97).

REDACTED

(Haas-Wilson, Tr. 2510, in

camera).

Response to Finding No. 391:

This proposed finding is inaccurate because

REDACTED

(Noether, Tr. 6050, in camera; RFF ¶ 1098, in camera).

B. There is No Dispute That ENH Raised Prices to Health Plans Following the Merger with Highland Park

392. Regardless of the data source that is used, or the methodology used to “clean” or manipulate the data, all the evidence shows that following the merger with Highland Park, ENH raised the prices of inpatient acute care hospital services to health plans. (CCFF 394-502).

Response to Finding No. 392:

This proposed finding is misleading to the extent that it implies that there is any competitive significance to absolute price increases.

REDACTED

(Baker, Tr. 4702,

4644, 4649-50, 4653, *in camera*; Haas-Wilson, Tr. 2677 *in camera*; Noether, Tr. 5904; RFF ¶¶ 315, *in camera*, 519, *in camera*).

REDACTED

REDACTED

(Baker, Tr. 4639-43,

in camera).

REDACTED

(Haas-Wilson, Tr. 2677-78; Elzinga, Tr. 2404; Baker, Tr. 4649-50, *in camera*; Noether, Tr. 5903-04; RFF ¶¶ 316-317, 319, 521-522).

REDACTED

(Baker, Tr. 4617-20, 4646, 4795-96, *in camera*; Haas-Wilson, Tr. 2637, *in camera*; RFF ¶¶ 1003-1011).

Finally, Dr. Haas-Wilson admitted that

REDACTED

REDACTED

(Haas-Wilson, Tr. 2834-36, *in camera*; RFF ¶¶ 1053-1064). Consequently, it is impossible to conclude that the post-Merger price changes were anticompetitive based on a simple examination of price changes, without a consideration of competitive price levels.

393. All four of the separate data sources show prices to managed care organizations increased at ENH after the merger. (Haas-Wilson, Tr. 2500-01).

Response to Finding No. 393

This proposed finding is misleading to the extent it implies that

REDACTED

(Reply-RFF ¶ 392, *in camera*).

1. **The Data from the IDPH Universal Dataset and the Data from the Medicare Cost Reports Show That ENH Raised Prices to Health Plans, Taken As a Whole, Following the Merger with Highland Park**

394.

REDACTED

REDACTED

(Haas-Wilson, Tr. 2530-31, *in camera*).

Response to Finding No. 394:

Respondent has no specific response.

395.

REDACTED

REDACTED

(Haas-Wilson, Tr. 2531-32, *in camera*).

Response to Finding No. 395:

This proposed finding is misleading and incomplete to the extent that

REDACTED

REDACTED

(CCFF ¶ 375; Haas-Wilson, Tr.

2500; Baker, Tr. 4646-47, *in camera*; RFF ¶ 1016).

396.

REDACTED

REDACTED

(Haas-Wilson, Tr. 2532, *in camera*).

Response to Finding No. 396:

This proposed finding is misleading to the extent it suggests that any of these “groupings” are representative of the MCO customer at issue in this case. (Compl. ¶ 16; Noether, Tr. 5906).

397.

REDACTED

REDACTED

(Haas-Wilson, 2527-29, *in camera*. See also CCFF 376-380).

Response to Finding No. 397:

This proposed finding is misleading to the extent that :

REDACTED

REDACTED

(CCFF ¶ 375; Haas-Wilson, Tr. 2500; Baker, Tr. 4646-47, *in camera*; RFF ¶ 1016). In addition, Dr. Haas-Wilson did not make any effort to compare the estimated prices she generated using this data to the actual prices paid.

398.

REDACTED

REDACTED

(CX 6279 at 7, *in camera*).

Response to Finding No. 398:

This proposed finding is misleading to the extent that it implies that there is any competitive significance to an absolute price increase. (Reply-RFF ¶ 392). **REDACTED**

REDACTED

REDACTED

(Reply-RFF ¶ 395, *in camera*).

This proposed finding is also misleading to the extent it suggests that the price increases for the “all patient” group provides any information about the price increases experienced by the MCO customer at issue in this case. (Reply-RFF ¶ 396).

REDACTED

REDACTED

(Reply-RFF ¶ 392, *in camera*).

399.

REDACTED

REDACTED

(CX 6279 at 7, *in camera*).

Response to Finding No. 399:

This proposed finding is misleading. (RFF-Reply ¶ 398). In addition, this proposed finding is misleading to the extent that it relies on “price per day.”

REDACTED

REDACTED

(Baker, Tr. 4628-29, *in camera*).

400.

REDACTED

REDACTED

(CX 6279 at 7, *in camera*).

Response to Finding No. 400:

This proposed finding is misleading to the extent that it implies that there is any competitive significance to an absolute price increase. (Reply-RFF ¶ 392). **REDACTED**

REDACTED

REDACTED

(Reply-RFF ¶ 395, *in camera*).

This proposed finding is also misleading to the extent it suggests that the price increases for the “commercial and self-paying patients” group provides any information about the price increases experienced by the MCO customer at issue in this case. (Reply-RFF ¶ 396).

REDACTED

REDACTED

(Reply-RFF ¶

392, *in camera*).

401.

REDACTED

REDACTED

(CX 6279 at 7, *in camera*).

Response to Finding No. 401:

This proposed finding is misleading. (RFF-Reply ¶ 400). In addition, this proposed finding is misleading to the extent that it relies on “price per day.”

REDACTED

REDACTED

(Baker, Tr. 4628-29, *in camera*).

402.

REDACTED

REDACTED

(CX 6279 at 7, *in camera*).

Response to Finding No. 402:

This proposed finding is misleading to the extent that it implies that there is any competitive significance to an absolute price increase. (Reply-RFF ¶ 392).

REDACTED

REDACTED

(Reply-RFF ¶ 395, *in camera*).

This proposed finding is also misleading to the extent it suggests that the price increases for the “commercial, self-paying, self-administered, and HMO patients” group provides any information about the price increases experienced by the MCO customer at issue in this case. (Reply-RFF ¶ 396).

REDACTED

REDACTED

(CCFF ¶ 396, *in camera*).

REDACTED

(CCFF ¶¶ 398 (30% for “all patients”), 402 (26% for “commercial, self-paying patients, self-administered and HMO,” *in camera*)). Given that Medicare and Medicaid reimbursements were decreasing during this time period after the passage of the Balanced Budget Act, one would have expected the precise opposite. This suggests a flaw in Dr. Haas-Wilson’s analysis. (Neaman, Tr. 1314).

REDACTED

REDACTED

(Reply-RFF ¶ 392, *in camera*).

403.

REDACTED

REDACTED

(CX 6279 at 7, *in camera*).

Response to Finding No. 403:

This proposed finding is misleading. (RFF-Reply ¶ 402).

REDACTED

REDACTED

Medicare and Medicaid patients.} (CCFF ¶ 396, *in camera*).

REDACTED

REDACTED

(CCFF ¶¶ 399 (48% for “all patients”), 403 (46% for “commercial, self-paying patients, self-administered and HMO”, *in camera*). Given that Medicare and Medicaid reimbursements were decreasing during this time period after the passage of the Balanced Budget Act, one would have expected the precise opposite. This suggests a flaw in Dr. Haas-Wilson’s analysis. This proposed finding is misleading because

REDACTED

REDACTED

(Reply-RFF ¶ 392, *in*

camera).

Finally, this proposed finding is misleading to the extent that it relies on “price per day.”

REDACTED

REDACTED

(Baker, Tr. 4628-

29, *in camera*).

404.

REDACTED

REDACTED

(Haas-Wilson, Tr. 2533 (referring to DX

7012, *in camera*), *in camera*).

Response to Finding No. 404:

This proposed finding is misleading to the extent it suggests that “Chicago medical care CPI” is a meaningful point of comparison.

REDACTED

(Haas-Wilson,

Tr. 3038-39, *in camera*).

REDACTED

(Haas-Wilson, Tr.

3038-39, *in camera*).

2. The Data Provided by NERA Shows That ENH Raised Prices to Most Health Plans, Following the Merger with Highland Park

405.

REDACTED

(Haas-Wilson, Tr. 2519, *in camera*).

Response to Finding No. 405:

Respondent has no specific response.

406.

REDACTED

REDACTED

(CX 6279 at

4, *in camera*).

Response to Finding No. 406:

This proposed finding is misleading to the extent that **REDACTED**

(Reply-RFF ¶ 392).

REDACTED

(Baker, Tr. 4702, 4644, 4649-50, 4653, *in camera*; Haas-Wilson, Tr. 2677 *in camera*; Noether, Tr. 5904; RFF ¶¶ 315, 519). In addition, this finding is misleading to the extent that it suggests

that a payor-by-payor analysis is appropriate in this case. Instead,

REDACTED

REDACTED

(Baker, Tr. 4648, 4662-

63, *in camera*; Noether, Tr. 6058-59, *in camera*). In addition, this finding is misleading to the extent it suggests that the consideration of inpatient-only prices is appropriate. **REDACTED**

REDACTED

(Spaeth, Tr. 2299-2300;

Ballengee, Tr. 144-45, 200; Mendonsa, Tr. 556, *in camera*; Hillebrand, Tr. 1862; Foucre, Tr. 1122-23, *in camera*; Holt-Darcy, Tr. 1585, *in camera*; RFF ¶¶ 369-374).

REDACTED

REDACTED

(Noether, Tr. 6113, *in camera*).

This finding is also misleading to the extent it considers only price changes. Dr. Haas-Wilson admitted that {

REDACTED

REDACTED

(Haas-Wilson, Tr.

2834-36, *in camera*; RFF ¶¶ 1053-1064). Consequently, it is impossible to conclude that the post-Merger price changes were anticompetitive based on a simple examination of price changes, without a consideration of competitive price levels.

Finally, this proposed finding is misleading to the extent that it relies on "price per day."

REDACTED

(Baker, Tr. 4628-

29, *in camera*).

407.

REDACTED

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 407:

This proposed finding is misleading to the extent that it implies that there is any competitive significance to an absolute price increase. (Reply-RFF ¶ 392). **REDACTED**

REDACTED

(Baker,

Tr. 4702, 4644, 4649-50, 4653, *in camera*; Haas-Wilson, Tr. 2677 *in camera*; Noether, Tr. 5904; RFF ¶¶ 315, 519, *in camera*). In addition, this finding is misleading to the extent that it suggests that a payor-by-payor analysis is appropriate in this case. Instead,

REDACTED

REDACTED

(Baker, Tr. 4648, 4662-

63, *in camera*, Noether, Tr. 6058-59, *in camera*). In addition, this finding is misleading to the extent it suggests that the consideration of inpatient-only prices is appropriate. **REDACTED**

REDACTED

(Spaeth, Tr. 2299-2300;

Ballengee, Tr. 144-45, 200; Mendonsa, Tr. 556, *in camera*; Hillebrand, Tr. 1862; Foucre, Tr.

1122-23, *in camera*; Holt-Darcy, Tr. 1585, *in camera*; RFF ¶¶ 369-371, 374, *in camera*; RFF ¶¶

372-373).

REDACTED

REDACTED

(Noether, Tr. 6113, *in camera*).

This finding is also misleading to the extent it considers only price changes. Dr. Haas-Wilson admitted that

REDACTED

REDACTED

(Haas-Wilson, Tr.

2834-36, *in camera*; RFF ¶¶ 1053-1064). Consequently, it is impossible to conclude that the post-Merger price changes were anticompetitive based on a simple examination of price changes, without a consideration of competitive price levels.

408.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 408:

This proposed finding is misleading. (RFF-Reply ¶ 406).

409.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 409:

This proposed finding is misleading. (RFF-Reply ¶ 407).

410.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 410:

This proposed finding is misleading. (RFF-Reply ¶ 406).

411.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 411:

This proposed finding is misleading. (RFF-Reply ¶ 407).

412.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 412:

This proposed finding is misleading. (RFF-Reply ¶ 406).

413.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 413:

This proposed finding is misleading. (RFF-Reply ¶ 407).

414.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 414:

This proposed finding is misleading. (RFF-Reply ¶ 406).

415.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 415:

This proposed finding is misleading. (RFF-Reply ¶ 407).

416.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 416:

This proposed finding is misleading. (RFF-Reply ¶ 406).

417.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 417:

This proposed finding is misleading. (RFF-Reply ¶ 407).

418.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 418:

This proposed finding is misleading. (RFF-Reply ¶ 406).

419.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 419:

This proposed finding is misleading. (RFF-Reply ¶ 407).

420.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 420:

This proposed finding is misleading. (RFF-Reply ¶ 406).

421.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 421:

This proposed finding is misleading. (RFF-Reply ¶ 407).

422.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 422:

This proposed finding is misleading. (RFF-Reply ¶ 406).

423.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 423:

This proposed finding is misleading. (RFF-Reply ¶ 407).

424.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 424:

This proposed finding is misleading. (RFF-Reply ¶ 406).

425.

REDACTED

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 425:

This proposed finding is misleading. (RFF-Reply ¶ 407).

426.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 426:

This proposed finding is misleading. (RFF-Reply ¶ 406).

427.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 427:

This proposed finding is misleading. (RFF-Reply ¶ 407).

428.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 428:

This proposed finding is misleading. (RFF-Reply ¶ 406).

429.

REDACTED

REDACTED

(CX 6279 at 4, *in camera*).

Response to Finding No. 429:

This proposed finding is misleading. (RFF-Reply ¶ 407).

430.

REDACTED

REDACTED

(Haas-Wilson, Tr. 2520-22

(referring to DX 7009, *in camera*), *in camera*).

REDACTED

(Haas-Wilson, Tr.

2521-22 (referring to DX 7009, *in camera*), *in camera*).

Response to Finding No. 430:

This proposed finding is misleading to the extent it suggests that “Chicago medical care CPI” is a meaningful point of comparison.

REDACTED

(Haas-Wilson,

Tr. 3038-39, *in camera*).

REDACTED

(Haas-Wilson, Tr.

3038-39, *in camera*).

431.

REDACTED

(Haas-Wilson, Tr. 2522-23, *in camera*; Ballengee, Tr. 179).

Response to Finding No. 431:

This proposed finding is misleading to the extent it implies that the calculations done by Ballengee were based on accurate and complete data.

REDACTED

REDACTED

(Ballengee, Tr. 261-62, *in camera*)

432.

REDACTED

REDACTED

(Haas-Wilson, Tr. 2519-20,

in camera; CX 6279 at 4, *in camera*).

Response to Finding No. 432:

This proposed finding is misleading. (RFF-Reply ¶¶ 406-431).

3. **The Data Provided by ENH in Its Response to the Civil Investigative Demand Shows That ENH Raised Prices to Most Health Plans, Following the Merger with Highland Park**

433.

REDACTED

(Haas-Wilson, Tr. 2523, *in camera*).

REDACTED

REDACTED

(Haas-Wilson, Tr. 2523-24, *in camera*).

Response to Finding No. 433:

Respondent has no specific response.

434.

REDACTED

REDACTED

at 5, *in camera*).

(Haas-Wilson, Tr. 2525, *in camera*; CX 6279

Response to Finding No. 434:

Respondent has no specific response.

435.

REDACTED

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 435:

This proposed finding is misleading to the extent that it implies that there is any competitive significance to an absolute price increase. (Reply-RFF ¶ 392). **REDACTED**

REDACTED

(Baker,

Tr. 4702, 4644, 4649-50, 4653, *in camera*; Haas-Wilson, Tr. 2677 *in camera*; Noether, Tr. 5904; RFF ¶¶ 315, 519). In addition, this finding is misleading to the extent that it suggests that a

payor-by-payor analysis is appropriate in this case. Instead,

REDACTED

REDACTED

(Baker, Tr. 4648, 4662-63, *in*

camera; Noether, Tr. 6058-59, *in camera*). This finding also is misleading to the extent it suggests that the consideration of inpatient-only prices is appropriate. **REDACTED**

REDACTED

(Spaeth, Tr. 2299-2300; Ballengee,

Tr. 144-45, 200; Mendonsa, Tr. 556, *in camera*; Hillebrand, Tr. 1862; Foucre, Tr. 1122-23, *in camera*; Holt-Darcy, Tr. 1585, *in camera*; RFF ¶¶ 369-371, 374 *in camera*; RFF ¶¶ 372-373).

REDACTED

REDACTED

(Noether, Tr. 6113, *in camera*).

This finding is further misleading to the extent it considers only price changes. Dr. Haas-Wilson admitted that

REDACTED

REDACTED

REDACTED

(Haas-Wilson, Tr.

2834-36, *in camera*; RFF ¶¶ 1053, 1059-1061; RFF ¶¶ 1054-1058, 1062-1064, *in camera*).

Consequently, it is impossible to conclude that the post-Merger price changes were anticompetitive based on a simple examination of price changes, without a consideration of competitive price levels.

Finally, this proposed finding is misleading to the extent that it relies on "price per day."

REDACTED

REDACTED

(Baker, Tr. 4628-

29, *in camera*).

436.

REDACTED

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 436:

This proposed finding is misleading to the extent that it implies that there is any competitive significance to an absolute price increase. (Reply-RFF ¶ 392). **REDACTED**

REDACTED

(Baker,

Tr. 4702, 4644, 4649-50, 4653, *in camera*; Haas-Wilson, Tr. 2677 *in camera*; Noether, Tr. 5904; RFF ¶¶ 315, 519). In addition, this finding is misleading to the extent that it suggests that a payor-by-payor analysis is appropriate in this case. Instead,

REDACTED

REDACTED

REDACTED

(Baker, Tr. 4648, 4662-63, *in*

camera; Noether, Tr. 6058-59, *in camera*). In addition, this finding is misleading to the extent it suggests that the consideration of inpatient-only prices is appropriate. **REDACTED**

REDACTED

(Spaeth, Tr. 2299-2300; Ballengee,

Tr. 144-45, 200; Mendonsa, Tr. 556, *in camera*; Hillebrand, Tr. 1862; Foucre, Tr. 1122-23, *in camera*; Holt-Darcy, Tr. 1585, *in camera*; RFF ¶¶ 369-372, 374, *in camera*; RFF ¶¶ 372-373).

REDACTED

(Noether, Tr. 6113, *in camera*).

This finding is also misleading to the extent it considers only price changes. Dr. Haas-Wilson admitted that

REDACTED

REDACTED

REDACTED

(Haas-Wilson, Tr.

2834-36, *in camera*; RFF ¶¶ 1053, 1059-1061; RFF ¶¶ 1054-1058, 1062-1064, *in camera*).

Consequently, it is impossible to conclude that the post-Merger price changes were anticompetitive based on a simple examination of price changes, without a consideration of competitive price levels.

437.

REDACTED

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 437:

This proposed finding is misleading. (RFF-Reply ¶ 435).

438.

REDACTED

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 438:

This proposed finding is misleading. (RFF-Reply ¶ 436).

439.

REDACTED

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 439:

This proposed finding is misleading. (RFF-Reply ¶ 435).

440.

REDACTED

REDACTED

camera).

(CX 6279 at 5, *in*

Response to Finding No. 440:

This proposed finding is misleading. (RFF-Reply ¶ 436).

441.

REDACTED

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 441:

This proposed finding is misleading. (RFF-Reply ¶ 435).

442.

REDACTED

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 442:

This proposed finding is misleading. (RFF-Reply ¶ 436).

443.

REDACTED

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 443:

This proposed finding is misleading. (RFF-Reply ¶ 435).

444.

REDACTED

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 444:

This proposed finding is misleading. (RFF-Reply ¶ 436).

445.

REDACTED

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 445:

This proposed finding is misleading. (RFF-Reply ¶ 435).

446.

REDACTED

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 446:

This proposed finding is misleading. (RFF-Reply ¶ 436).

447.

REDACTED

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 447:

This proposed finding is misleading. (RFF-Reply ¶ 435).

448.

REDACTED

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 448:

This proposed finding is misleading. (RFF-Reply ¶ 436).

449.

REDACTED

REDACTED

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 449:

This proposed finding is misleading. (RFF-Reply ¶ 435).

450.

REDACTED

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 450:

This proposed finding is misleading. (RFF-Reply ¶ 436).

451.

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 451:

This proposed finding is misleading. (RFF-Reply ¶ 435).

452.

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 452:

This proposed finding is misleading. (RFF-Reply ¶ 436).

453.

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 453:

This proposed finding is misleading. (RFF-Reply ¶ 435).

454.

REDACTED

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 454:

This proposed finding is misleading. (RFF-Reply ¶ 436).

455.

REDACTED

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 455:

This proposed finding is misleading. (RFF-Reply ¶ 435).

456.

REDACTED

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 456:

This proposed finding is misleading. (RFF-Reply ¶ 436).

457.

REDACTED

REDACTED

(CX 6279 at 5, *in camera*).

Response to Finding No. 457:

This proposed finding is misleading. (RFF-Reply ¶ 435).

458.

REDACTED

REDACTED

REDACTED

camera).

(CX 6279 at 5, in

Response to Finding No. 458:

This proposed finding is misleading. (RFF-Reply ¶ 436).

459.

REDACTED

REDACTED

(CX 6279 at 5, in camera).

Response to Finding No. 459:

This proposed finding is misleading. (RFF-Reply ¶ 435).

460.

REDACTED

REDACTED

(CX 6279 at 5, in camera).

Response to Finding No. 460:

This proposed finding is misleading. (RFF-Reply ¶ 436).

461.

REDACTED

REDACTED

(CX 6279 at 5, in camera).

Response to Finding No. 461:

This proposed finding is misleading. (RFF-Reply ¶ 435).

462.

REDACTED

REDACTED

(CX 6279 at 5, in camera).

Response to Finding No. 462:

This proposed finding is misleading. (RFF-Reply ¶ 436).

463.

REDACTED

REDACTED

(Haas-Wilson,

Tr. 2526 (referring to DX 7007, *in camera*), *in camera*).

Response to Finding No. 463:

This proposed finding is misleading to the extent it suggests that “Chicago medical care CPI” is a meaningful point of comparison.

REDACTED

REDACTED

(Haas-Wilson,

Tr. 3038-39, *in camera*).

REDACTED

(Haas-Wilson, Tr.

3038-39, *in camera*)

464.

REDACTED

(Haas-Wilson,

Tr. 2524-25, *in camera*; CX 6279 at 4, *in camera*).

Response to Finding No. 464:

This proposed finding is misleading. (RFF-Reply ¶¶ 435-463).

- 4. The Commercial Payer Claims Data Provided by Aetna, Blue Cross, Humana, and United Shows That ENH Raised Prices to Most Health Plans Following the Merger with Highland Park**

465.

REDACTED

REDACTED

(Haas-Wilson, Tr. 2510-11, *in camera*).

Response to Finding No. 465:

Respondent has no specific response to the extent that this proposed finding accurately describes the methodology employed by Dr. Haas-Wilson. This proposed finding is misleading, however, to the extent that it implies that the methodology employed by Dr. Haas-Wilson to analyze the commercial payer claims data was appropriate in this case. In particular, this finding is misleading because it suggests that analyzing the data “by type of plan within payer” is appropriate. First,

REDACTED

(Haas-Wilson, Tr. 2853, *in camera*; Mendonsa, Tr. 557, *in camera*; Holt-Darcy, Tr. 1541, 1586-87, *in camera*; Hillebrand, Tr. 1861-62, 2019; RX 844 at ENH JL 2023, *in camera*). This suggests that, at the very least, the plans should be aggregated for each MCO. Second,

REDACTED

REDACTED

(Baker, Tr. 4648, 4662-63, *in camera*; Noether, Tr. 6058-59, *in camera*). Finally,

REDACTED

REDACTED

(Spaeth, Tr. 2299-2300; Ballengee, Tr. 144-45, 200; Mendonsa, Tr. 556, *in camera*; Hillebrand, Tr. 1862; Foucre, Tr. 1122-23, *in camera*; Holt-Darcy, Tr. 1585, *in camera*; Noether, Tr. 6113, *in camera*; RFF ¶¶ 369-371, 374, *in camera*; RFF ¶¶ 372-373).

466.

REDACTED

REDACTED

2511 (referring to DX 7010, *in camera*), *in camera*).

(Haas-Wilson, Tr.

Response to Finding No. 466:

This proposed finding is misleading to the extent that

REDACTED

REDACTED

REDACTED

(Baker, Tr. 4636-37, *in camera*; Haas-

Wilson, Tr. 2511, *in camera*; RFF ¶ 1028, *in camera*).

467.

REDACTED

(Haas-Wilson, Tr. 2524-25, *in camera*).

Response to Finding No. 467:

This proposed finding is misleading to the extent that it implies that there is any competitive significance to an absolute price increase. (Reply-RFF ¶ 392).

REDACTED

(Baker,

Tr. 4702, 4644, 4649-50, 4653, *in camera*; Haas-Wilson, Tr. 2677 *in camera*; Noether, Tr. 5904; RFF ¶¶ 315, 519, *in camera*). In addition, this proposed finding is misleading to the extent that it suggests that a plan-by-plan analysis for prices is appropriate in this case.

REDACTED

(Haas-Wilson, Tr. 2853, *in camera*; Mendonsa, Tr. 557, *in camera*; Holt-Darcy, Tr. 1541, 1586-

87, *in camera*; Hillebrand, Tr. 1861-62, 2019; RX 844 at ENH JL 2023, *in camera*). This

suggests that, at the very least the plans should be aggregated within payor. This proposed

finding is also misleading to the extent that it suggests that a payor-by-payor analysis is

appropriate in this case. Instead,

REDACTED

REDACTED

REDACTED } (Baker, Tr. 4648, 4662-63, *in camera*; Noether, Tr. 6058-59, *in camera*). In addition, this finding is misleading to the extent it suggests that the consideration of inpatient-only prices is appropriate. **REDACTED**

REDACTED (Spaeth, Tr. 2299-2300; Ballengee, Tr. 144-45, 200; Mendonsa, Tr. 556, *in camera*; Hillebrand, Tr. 1862; Foucre, Tr. 1122-23, *in camera*; Holt-Darcy, Tr. 1585, *in camera*; RFF ¶¶ 369-371, 374, *in camera*; RFF ¶¶ 372-373). **REDACTED**

REDACTED (Noether, Tr. 6113, *in camera*).

This finding is also misleading to the extent it considers only price changes. Dr. Haas-Wilson admitted that

REDACTED **REDACTED**
(Haas-Wilson, Tr. 2834-36, *in camera*; RFF ¶¶ 1053, 1059-1061; RFF ¶¶ 1054-1058, 1062-1064, *in camera*).

Consequently, it is impossible to conclude that the post-Merger price changes were anticompetitive based on a simple examination of price changes, without a consideration of competitive price levels.

This proposed finding is also misleading to the extent that it relies on “price per day.”

REDACTED } (Baker, Tr. 4628-29, *in camera*).

Finally, this proposed finding is also misleading to the extent the “commercial payer data sets” referenced include the data produced by Great West. **REDACTED**

REDACTED

REDACTED

(Noether, Tr. 6050, *in camera*).

468.

REDACTED

REDACTED

(Haas-Wilson, Tr. 2518, *in camera*).

Response to Finding No. 468:

This proposed finding is misleading. (RFF-Reply ¶ 467).

a. **United**

469.

REDACTED

(Haas-Wilson, Tr. 2511-12 (referring to DX 7010, *in camera*), *in camera*).

Response to Finding No. 469:

Respondent has no specific response to the extent that this proposed finding accurately describes the methodology employed by Dr. Haas-Wilson to define the pre- and post-Merger time periods. This finding is misleading, however, to the extent that it suggests that Dr. Haas-Wilson's methodology was appropriate for her work in this case.

REDACTED

REDACTED

REDACTED

(Baker, Tr. 4636-37, *in camera*; Haas-Wilson, Tr. 2511, *in camera*; RFF ¶ 1028, *in camera*).

470.

REDACTED

REDACTED

REDACTED (CX 6279 at 3, *in camera*).

Response to Finding No. 470:

This proposed finding is misleading. (RFF-Reply ¶ 467). This finding is also misleading to the extent it ignores the data problems that existed with the United data.

REDACTED

(Baker, Tr. 4622, *in camera*). In addition,

REDACTED

(Baker, Tr. 4625-26, 4628, 4806-7, *in camera*; Noether, Tr. 6053-55; RFF ¶¶ 1013-15, 1103, *in camera*).

471.

REDACTED

6279 at 3, *in camera*).

(CX

Response to Finding No. 471:

This proposed finding is misleading. (RFF-Reply ¶¶ 467, 470).

472.

REDACTED

(CX 6279 at 3, *in camera*).

Response to Finding No. 472:

This proposed finding is misleading. (RFF-Reply ¶¶ 467, 470).

473.

REDACTED

REDACTED

(CX 6279 at 3, *in camera*).

Response to Finding No. 473:

This proposed finding is misleading. (RFF-Reply ¶¶ 467, 470).

474.

REDACTED

(CX 6279 at 3, *in camera*).

Response to Finding No. 474:

This proposed finding is misleading. (RFF-Reply ¶¶ 467, 470).

475.

REDACTED

6279 at 3, *in camera*).

(CX

Response to Finding No. 475:

This proposed finding is misleading. (RFF-Reply ¶¶ 467, 470).

b. Aetna

476.

REDACTED

(Haas-Wilson, Tr. 2512 (referring to DX 7010, *in camera*), *in camera*).

Response to Finding No. 476:

This proposed finding is misleading. (RFF-Reply ¶ 469).

477.

REDACTED

REDACTED

(CX 6279 at 3, *in camera*).

Response to Finding No. 477:

This proposed finding is misleading. (RFF-Reply ¶ 467).

478.

REDACTED

(CX 6279 at 3, *in camera*).

Response to Finding No. 478:

This proposed finding is misleading. (RFF-Reply ¶ 467).

479.

REDACTED

(CX 6279 at 3, *in camera*).

Response to Finding No. 479:

This proposed finding is misleading. (RFF-Reply ¶ 467).

480.

REDACTED

(CX 6279 at 3, *in camera*).

Response to Finding No. 480:

This proposed finding is misleading. (RFF-Reply ¶ 467).

c. **Humana**

481.

REDACTED

(Haas-Wilson, Tr. 2511-12 (referring to DX 7010, *in camera*), *in camera*).

Response to Finding No. 481:

This proposed finding is misleading. (RFF-Reply ¶ 469).

482.

REDACTED

(CX 6279 at 3, *in camera*).

Response to Finding No. 482:

This proposed finding is misleading. (RFF-Reply ¶ 467). This finding is also misleading to the extent that it is based on data that do not include price information for capitated plans.

REDACTED

(Haas-Wilson, Tr. 2853, *in camera*; Noether, Tr. 6076-77; RFF ¶ 1029, *in camera*).

REDACTED

6076, *in camera*; RFF ¶ 1128).

(Noether, Tr.

483.

REDACTED

(CX 6279 at 3, *in camera*).

Response to Finding No. 483:

This proposed finding is misleading. (RFF-Reply ¶¶ 467, 482).

484.

REDACTED

6279 at 3, *in camera*). **REDACTED**

(CX

Response to Finding No. 484:

This proposed finding is misleading. (RFF ¶¶ 467, 482).

485.

REDACTED

(CX 6279 at 3, *in camera*).

Response to Finding No. 485:

This proposed finding is misleading. (RFF-Reply ¶¶ 467, 482).

486.

REDACTED

(CX 6279 at 3, *in camera*).

Response to Finding No. 486:

This proposed finding is misleading. (RFF-Reply ¶¶ 467, 482).

487.

REDACTED

(CX 6279 at 3, *in camera*).

Response to Finding No. 487:

This proposed finding is misleading. (RFF-Reply ¶¶ 467, 482).

d. Blue Cross/Blue Shield

488.

REDACTED

(Haas-Wilson, Tr. 2511-2512 (referring to DX 7010, *in camera*), *in camera*).

Response to Finding No. 488:

This proposed finding is misleading. (RFF-Reply ¶ 469).

489.

REDACTED

(Haas-Wilson, Tr. 2511-2512 (referring to DX 7010, *in camera*), *in camera*).

Response to Finding No. 489:

This proposed finding is misleading. (RFF-Reply ¶ 469).

490.

REDACTED

(CX 6279 at 3, *in camera*).

Response to Finding No. 490:

This proposed finding is misleading. (RFF-Reply ¶ 467).

491.

REDACTED

(CX 6279 at 3, *in camera*).

Response to Finding No. 491:

This proposed finding is misleading. (RFF-Reply ¶ 467).

492.

REDACTED

(CX 6279 at 3, *in camera*).

Response to Finding No. 492:

This proposed finding is misleading. (RFF-Reply ¶ 467).

493.

REDACTED

REDACTED

CX 6279 at 3, *in camera*).

Response to Finding No. 493:

This proposed finding is misleading. (RFF-Reply ¶ 467).

5. Dr. Baker's Analysis Confirmed That Prices Went Up at ENH After the Merger with Highland Park

494.

REDACTED

(Baker, Tr. 4631-32, *in camera*).

Response to Finding No. 494:

This proposed finding is incomplete.

REDACTED

(Baker, Tr. 4631-32, *in camera*).

REDACTED

(Baker, Tr. 4632, *in camera*).

REDACTED

(Baker, Tr. 4648, *in camera*).

495.

REDACTED

REDACTED
camera).

, (Baker, Tr. 4633-34, *in*

Response to Finding No. 495:

This proposed finding is misleading

REDACTED

(Baker, Tr. 4633-34, *in camera*).

REDACTED

camera).

(Baker, Tr. 4633, *in*

496.

REDACTED

(Baker, Tr. 4635, *in camera*).

Response to Finding No. 496:

This proposed finding is true, but incomplete.

REDACTED

(Baker, Tr. 4635, *in camera*).

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

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

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

VOLUME III of XI

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497.

REDACTED

(Haas-Wilson, Tr. 2564-65 (referring to DX 7022 at 2, *in camera*), *in camera*).

Response to Finding No. 497:

This proposed finding is misleading and irrelevant to the analysis of ENH's price changes coincident with the Merger.

REDACTED

§ (Baker, Tr. 4744-45, *in camera* (referring to DX 7068 at 43, *in camera*)).

REDACTED

(Baker, Tr. 4641, *in camera*).

REDACTED

(Baker, Tr. 4640, *in camera*).

REDACTED

(Haas-

Wilson, Tr. 2546-47, *in camera*). There is no record evidence regarding Professor Baker's estimates of price changes at individual MCOs that were both case-mix adjusted and compared to a control group of hospitals.

REDACTED

(Baker, Tr. 4648, *in camera*).

498.

REDACTED

(Haas-Wilson, Tr. 2566-67 (referring to DX 7013 at 2, *in camera*), *in camera*; Baker, Tr. 4744-45, *in camera*).

Response to Finding No. 498:

This proposed finding is misleading and irrelevant. (RFF-Reply ¶ 497).

499.

REDACTED

13%.} (Haas-Wilson, Tr. 2569 (referring to DX 7014 at 2, *in camera*), *in camera*).

Response to Finding No. 499:

This proposed finding is misleading and irrelevant. (RFF-Reply ¶ 497).

500.

REDACTED

(Haas-Wilson, Tr. 2573 (referring to DX 7020 at 2, *in camera*), *in camera*).

Response to Finding No. 500:

This proposed finding is misleading and irrelevant. (RFF-Reply ¶ 497).

- b. **Dr. Baker's Analysis Showed a Price Increase When He Combined All the Payers Examined by Him**

501.

REDACTED

(Haas-Wilson, Tr. 2584).

REDACTED

(Haas-Wilson, Tr. 2584-85 (referring to DX 7050 at 2, *in camera*), *in camera*).

Response to Finding No. 501:

This proposed finding is misleading

REDACTED

REDACTED

(Baker, Tr. 4646-

47, *in camera*).

REDACTED

, (Baker, Tr. 4640-42, *in camera*).

REDACTED

(Baker, Tr. 4640, *in camera*).

REDACTED

(Haas-Wilson, Tr. 2546-47, *in camera*).

REDACTED

(Baker, Tr. 4619-20, 4646, 4795-96, *in camera*; Haas-Wilson, Tr.

2637, *in camera*)

REDACTED

(CCFF ¶ 607, *in*

camera).

502.

REDACTED

(Baker, Tr. 4639-40 (discussing DX 8041, *in camera*), *in camera*).

Response to Finding No. 502:

This proposed finding is misleading and overstates

REDACTED

(Baker, Tr. 4640-42, *in*

camera).

REDACTED

(Baker, Tr. 4640, *in camera*).

REDACTED

REDACTED

(Haas-Wilson, Tr. 2546-47, *in camera*).

REDACTED

(Baker, Tr. 4617-19,

4795-96, *in camera*).

REDACTED

12%.} (CCFF ¶ 607).

C. There Is No Dispute That, Following the Merger with Highland Park, ENH Raised Prices to Managed Care Organizations Relative to Other Hospitals in the Chicago Area

1. Relative Price Changes, Not Relative Prices, Is the Appropriate Methodology to Test for Market Power

503. Hospitals services are a differentiated product. (Haas-Wilson, Tr. 2492-93; Noether, Tr. 5910). Consumers are willing and able to pay higher prices for certain aspects of product differentiation. Thus, because prices can vary in the market for a differentiated service for many different reasons, one may not conclude anything about market power by merely using a cross-sectional analysis of hospital prices at a single point in time. (Haas-Wilson, Tr. 2492-93 (example provided in DX 7043)).

Response to Finding No. 503:

This proposed finding is correct as written. However, the citation to Dr. Haas-Wilson's testimony suggests that price level analysis should not be used in examining hospital services, which is not correct.

REDACTED

(Noether, Tr. 5989, 5991; Haas-Wilson, Tr. 2823-24, *in camera*; Baker, Tr. 4621, *in camera*).

504. In contrast, by looking at price changes over time, one can compare the price change at one hospital to the price change at another hospital. Using such an approach, one can conclude there is a change in market power if there is a price increase after having ruled out the other possible explanations for greater price increases at one hospital versus another. (Haas-Wilson, Tr. 2495).

Response to Finding No. 504:

This proposed finding is misleading. Before concluding that post-Merger price increases were caused by the gain and exercise of market power, viable alternatives for the price increases must be evaluated and eliminated. (Haas-Wilson, Tr. 2677-78).

REDACTED

(Baker, Tr. 4649-50, *in camera*; Elzinga, Tr. 2404).

REDACTED

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

camera; Baker, Tr. 4621, *in camera*).

REDACTED

(Haas-Wilson, Tr. 2834-35, *in camera*).

REDACTED

(Baker, Tr. 4621, *in camera*; Noether, Tr. 5990).

2. Whether ENH's Prices Increased Faster Than Other Hospitals Is Determined by Using a Methodology Called Difference in Differences

505.

REDACTED

(Haas-Wilson, Tr. 2546-47 (referring to DX 7027 (showing steps in the process)), *in camera*).

Response to Finding No. 505:

Respondent has no specific response.

506.

REDACTED

(Haas-Wilson, Tr. 2546-47, (referring to DX 7027 (showing steps in the process)), *in camera*).

Response to Finding No. 506:

Respondent has no specific response

507.

REDACTED

(Haas-Wilson, Tr. 2546-48 (referring to DX 7027 (showing steps in the process)), *in camera*).

Response to Finding No. 507:

Respondent has no specific response

508.

REDACTED

(Haas-Wilson, Tr. 2548, *in camera*).

Response to Finding No. 508:

Respondent agrees that these features of a control group are important. This proposed finding is misleading to the extent that

REDACTED

(RFF ¶¶ 1032-1045, *in camera*).

509.

REDACTED

(Haas-Wilson, Tr. 2938-39, *in camera*).

Response to Finding No. 509:

Respondent has no specific response except that this proposed finding is misleading to the extent that it implies that Dr. Noether did not “compare ENH to hospitals with similar characteristics.” (RFF-Reply ¶¶ 703-727).

510.

REDACTED

(Haas-Wilson, Tr. 2552, *in camera*).

Response to Finding No. 510:

This proposed finding is misleading to the extent it suggests that relative price increases (i.e. prices increases at ENH that were greater than price increases at comparison hospitals) are necessarily anticompetitive. Dr. Haas-Wilson concluded that

REDACTED

(Haas-Wilson, Tr. 2828, *in camera*).

REDACTED

(Haas-Wilson, Tr. 2677-78; Elzinga, Tr. 2404; RFF ¶¶ 521-522; RFF ¶ 223,

in camera).

511.

REDACTED

(Haas-Wilson, Tr. 2552-53, *in camera*).

Response to Finding No. 511:

Respondent has no specific response.

3. **Because Multiple Control Groups Assure That the Results Are Not Dependent Upon the Choice of the Control Group, Dr. Haas-Wilson Used Three Control Groups**

512.

REDACTED

(Haas-Wilson, Tr. 2548, *in camera*).

Response to Finding No. 512:

Respondent agrees that these features of a control group are important.

REDACTED

(RFF ¶¶ 1032-1045, *in camera*;

RFF-Reply ¶¶ 513-519).

513.

REDACTED

REDACTED

(Haas-Wilson, Tr. 2548-49, *in camera*).

Response to Finding No. 513:

Respondent has no specific response to the extent this accurately describes the manner in which Dr. Haas-Wilson purported to develop and categorize control groups for use in her analysis. This proposed finding is misleading, however, to the extent it suggests that these control groups were appropriate for use in this analysis. (RFF-Reply ¶¶ 515-517).

514.

REDACTED

(Haas-Wilson, Tr. 2549, *in camera*).

Response to Finding No. 514:

This proposed finding is misleading to the extent it ignores that Dr. Haas-Wilson's control groups are overly broad and overlap substantially with one another. (RFF-Reply ¶¶ 515-17).

515.

REDACTED

(Haas-Wilson, Tr. 2549, *in camera*).

Response to Finding No. 515:

This proposed finding is misleading because Dr. Haas-Wilson did not undertake any analysis to determine whether all of the other Chicago PMSA Hospitals did, in fact, experience similar changes in cost, demand and regulation as ENH.

REDACTED

(Haas-Wilson, Tr. 2865, *in*

camera).

REDACTED

(Noether, Tr. 5989; Noether, Tr. 6109,

in camera).

REDACTED

REDACTED

(Noether, Tr. 6109, *in camera*). As a consequence of this breadth and diversity, it is likely that not all of the hospitals in the Chicago PMSA experienced the same cost, demand and regulation shocks as ENH.

REDACTED

(Noether, Tr. 6109-13, *in camera*; RFF ¶ 1039, *in camera*).

REDACTED

(Haas-Wilson, Tr. 2864-65, *in camera*).

REDACTED

(Baker, Tr.

4647, *in camera*).

516.

REDACTED

(Haas-Wilson, Tr. 2549-50, *in camera*).

Response to Finding No. 516:

This proposed finding is misleading to the extent that it implies that,

REDACTED

REDACTED

(RFF-Reply ¶ 515, *in camera*).

517.

REDACTED

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

Response to Finding No. 517:

This proposed finding is misleading for at least two reasons.

REDACTED

(Haas-Wilson, Tr. 2869-70, *in camera*; Noether, Tr. 6110-11, *in camera*).

REDACTED

(Noether, Tr. 6110-11, *in*

camera).

REDACTED

(Haas-Wilson, Tr. 2870, *in camera*).

518.

REDACTED

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

Response to Finding No. 518:

This proposed finding is misleading to the extent it suggests that the methodology Dr. Haas-Wilson used to select her three *control* groups, drawing a line around the entire Chicago

PMSA and using a non-industry accepted measure of teaching intensity, is less arbitrary. In addition, this proposed finding is misleading to the extent that it contradicts the stated goal in control group selection – to pick control group hospitals

REDACTED

(CCFF ¶ 515, *in camera*).

519.

REDACTED

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

Response to Finding No. 519:

Respondent agrees that HPH and Evanston Hospital were not similar hospitals before the Merger. This proposed finding is misleading, however, to the extent it ignores that, following the Merger, the ENH hospitals priced as a single system, thus making it necessary to have one point of comparison for the entire system.

4. Tests of Statistical Significance Allow the Quantification of the Amount of Confidence One Has in the Results

520.

REDACTED

(Haas-Wilson, Tr. 2553, *in camera*).

Response to Finding No. 520:

Respondent has no specific response.

521.

REDACTED

(Haas-Wilson, Tr. 2553-54, *in camera*).

Response to Finding No. 521:

Respondent has no specific response.

5. **The IDPH Universal Dataset Shows That Prices to Health Plans Went Up Faster at ENH Than at Other Hospitals After the Merger with Highland Park, Regardless of the Control Group Used and Regardless of the Patient Group Used**

522.

REDACTED

(Haas-Wilson, Tr. 2530-31, *in camera*).

Response to Finding No. 522:

Respondent has no specific response.

523.

REDACTED

(Haas-Wilson, Tr. 2532, *in camera*).

Response to Finding No. 523:

This proposed finding is misleading to the extent it suggests that any of these “groupings” are representative of the MCO customer at issue in this case. (Compl. ¶ 16; Noether, Tr. 5906).

524.

REDACTED

(Haas-Wilson, Tr. 2527-29, *in camera*. See also CCFF 376-380).

Response to Finding No. 524.

This proposed finding is misleading to the extent

REDACTED

(CCFF ¶ 375; Haas-Wilson, Tr. 2500; Baker, Tr. 4646-47, *in camera*;

RFF ¶ 1016).

REDACTED

(RFF-Reply ¶¶ 376-380, *in camera*).

- a. **Compared to the Chicago PMSA Hospitals, Prices to Health Plans Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park**

525.

REDACTED

(CX 6279 at 10, *in camera*).

REDACTED

(CX 6279 at 11, *in*

camera).

Response to Finding No. 525:

This proposed finding is misleading to the extent it assumes that

REDACTED

(Reply-RFF ¶¶

395, 524). This proposed finding is also misleading to the extent it suggests that the price increases for the “all patient” group provides any information about the price increases experienced by the MCO customer at issue in this case. (Reply-RFF ¶¶ 396, 523).

REDACTED

(RFF-Reply ¶ 515, *in*

camera). This proposed finding is further misleading to the extent that it relies on “price per day.”

REDACTED

(Baker, Tr.

4628-29, *in camera*).

Finally, this proposed finding is misleading because it focuses only on price changes, without considering whether Evanston Hospital/ENH was pricing at competitive levels. Dr. Haas-Wilson admitted that

REDACTED

REDACTED

(Haas-Wilson, Tr. 2834-36, *in camera*; RFF ¶¶ 1053, 1059-1061; RFF ¶¶ 1054-1058, 1062-1064, *in camera*). Consequently, it is impossible to conclude that the post-Merger price changes were anticompetitive based on a simple examination of price changes, without a consideration of competitive price levels.

526.

REDACTED

(CX 6279 at 10, *in camera*).

REDACTED

(CX 6279 at 11, *in camera*).

Response to Finding No. 526:

This proposed finding is misleading. (RFF-Reply ¶¶ 524-525). This proposed finding is also misleading to the extent

REDACTED

(RFF-Reply ¶¶ 396, 523, *in*

camera).

527.

REDACTED

(CX 6279 at 10, *in camera*).

REDACTED

(CX 6279 at 11, *in camera*).

Response to Finding No. 527:

This proposed finding is misleading. (RFF-Reply ¶¶ 524-525). This proposed finding is also misleading to the extent

REDACTED

REDACTED

(RFF-

Reply ¶¶ 396, 523, *in camera*).

REDACTED

(CCFF ¶ 396, *in camera*).

REDACTED

(CCFF ¶¶ 525 (**REDACTED**),

527, *in camera* (

REDACTED

). Given that Medicare and Medicaid reimbursements were decreasing during this time period after the passage of the Balanced Budget Act, one would have expected the precise opposite. This suggests a flaw in Dr. Haas-Wilson's analysis. (Neaman, Tr. 1314).

- b. **Compared to the Non-Merging Chicago PMSA Hospitals, Prices to Health Plans Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park**

528.

REDACTED

10, *in camera*).

(CX 6279 at

REDACTED

(CX 6279 at 11, *in camera*).

Response to Finding No. 528:

This proposed finding is misleading. (RFF-Reply ¶¶ 524-25). This proposed finding is also misleading because **REDACTED**

(RFF-Reply ¶ 516, *in camera*).

529.

REDACTED

(CX 6279 at 10, *in camera*).

REDACTED

(CX 6279 at

11, *in camera*).

Response to Finding No. 529:

This proposed finding is misleading. (RFF-Reply ¶¶ 524-525, 528). This proposed finding is also misleading to the extent

REDACTED

(RFF-Reply ¶¶ 396,

523, *in camera*).

530.

REDACTED

(CX 6279 at 10, *in camera*).

REDACTED

(CX 6279 at 11, *in camera*).

Response to Finding No. 530:

This proposed finding is misleading. (RFF-Reply ¶¶ 524-525, 528). This proposed finding is also misleading to the extent

REDACTED

(RFF-Reply ¶¶ 396, 523, *in camera*).

REDACTED

REDACTED (CCFF ¶ 396, *in camera*). It is notable, therefore, that Dr. Haas-Wilson found that that the prices increased more for the “all patients” group than the “commercial, self-paying patients, self-administered and HMO” group. (CCFF ¶¶ 528 (**REDACTED**), 530, *in camera* (**REDACTED**)). Given that Medicare and Medicaid reimbursements were decreasing during this time period after the passage of the Balanced Budget Act, one would have expected the precise opposite. This suggests a flaw in Dr. Haas-Wilson’s analysis. (Neaman, Tr. 1314).

c. **Compared to the Chicago PMSA Teaching Hospitals, Prices to Health Plans Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park**

531.

REDACTED

camera). (CX 6279 at 10, *in*

REDACTED

6279 at 11, *in camera*). (CX

Response to Finding No. 531:

This proposed finding is misleading. (RFF-Reply ¶¶ 524-525). This proposed finding is also misleading because **REDACTED**

(RFF-Reply ¶ 517, *in*

camera).

532.

REDACTED

(CX 6279 at 10, *in camera*).

REDACTED

(CX 6279 at 11, *in*

camera)

Response to Finding No. 532:

This proposed finding is misleading. (RFF-Reply ¶¶ 524-525, 531). This proposed finding is also misleading to the extent

REDACTED

(RFF-Reply ¶¶ 396,

523, *in camera*).

533.

REDACTED

(CX 6279 at 10, *in camera*).

REDACTED

(CX 6279 at 11, *in camera*).

Response to Finding No. 533:

This proposed finding is misleading. (RFF-Reply ¶¶ 524-525, 532). This proposed finding is also misleading to the extent

REDACTED

(RFF-Reply ¶¶ 396, 523, *in camera*). The only difference between “commercial, self-paying patients, self-administered, and HMO” and the “all patients” group discussed in CCFF ¶¶ 531 and 533 is that the “all patients” group also includes Medicare and Medicaid patients. (CCFF ¶ 396).

REDACTED

(CCFF ¶¶ 531, *in camera* (

REDACTED

), 533, *in camera* (

REDACTED

REDACTED

). Given that Medicare and

Medicaid reimbursements were decreasing during this time period after the passage of the Balanced Budget Act, one would have expected the precise opposite. This suggests a flaw in Dr. Haas-Wilson's analysis. (Neaman, Tr. 1314).

534. The IDPH Universal Dataset shows that prices to health plans went up faster at ENH than at other hospitals after the merger with Highland Park. This result does not change with the different control groups and does not change with the different patient groups identified in the IDPH Universal Dataset. (CCFF 525-533).

Response to Finding No. 534:

This proposed finding is misleading. (RFF-Reply ¶¶ 524-533).

6. The Commercial Payer Claims Data Shows That, Except for Blue Cross, Prices to Most Health Plans Went Up Faster at ENH Than at Other Hospitals After the Merger with Highland Park, Regardless of the Control Group Used

a. The United Claims Data Shows That Prices to United Went Up Faster at ENH Than at Other Hospitals After the Merger with Highland Park for All Control Groups

535.

REDACTED

Tr. 2512 (referring to DX 7010, *in camera*), *in camera*). (Haas-Wilson,

Response to Finding No. 535:

Respondent has no specific response to the extent that this proposed finding accurately describes the methodology employed by Dr. Haas-Wilson to define the pre- and post-Merger time periods. This finding is misleading, however, to the extent that it suggests that Dr. Haas-Wilson's methodology was appropriate for her work in this case.

REDACTED

REDACTED

(Baker, Tr. 4636-37, *in camera*; Haas-

Wilson, Tr. 2511, *in camera*; RFF ¶ 1028, *in camera*).

- (1) **Compared to the Chicago PMSA Hospitals, Prices to United Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park**

536.

REDACTED

6279 at 8, *in camera*).

(CX

REDACTED

(CX 6279 at 9, *in camera*).

Response to Finding No. 536:

This proposed finding is misleading because it suggests that analyzing the data “by type of plan within payer” is appropriate. First,

REDACTED

(Haas-Wilson, Tr. 2853, *in camera*;

Mendonso, Tr. 557, *in camera*; Holt-Darcy, Tr. 1541, 1586-87, *in camera*; Hillebrand, Tr. 1861-62, 2019; RX 844 at ENH JL 2023, *in camera*). This suggests that, at the very least, the plans should be aggregated for each MCO. Second.

REDACTED

(Baker,

Tr. 4648, 4662-63, *in camera*; Noether, Tr. 6058-59, *in camera*). Finally,

REDACTED

(Spaeth,

Tr. 2299-2300; Ballengee, Tr. 144-45, 200; Mendonso, Tr. 556, *in camera*; Hillebrand, Tr. 1862;

Foucre, Tr. 1122-23, *in camera*; Holt-Darcy, Tr. 1585, *in camera*; Noether, Tr. 6113, *in camera* RFF ¶¶ 369-371, 374, *in camera*; RFF ¶¶ 372-373)

This finding is also misleading to the extent it considers only price changes. Dr. Haas-Wilson admitted that

REDACTED

(Haas-Wilson, Tr.

2834-36, *in camera*; RFF ¶¶ 1053, 1059-1061; RFF ¶¶ 1054-1058, 1062-1064, *in camera*).

Consequently, it is impossible to conclude that the post-Merger price changes were anticompetitive based on a simple examination of price changes, without a consideration of competitive price levels.

This proposed finding is also misleading to the extent that it relies on "price per day."

REDACTED

(Baker, Tr. 4628-

29, *in camera*).

This finding is also misleading to the extent it ignores the data problems that existed with the United data.

REDACTED

(Baker, Tr. 4622, *in*

camera). In addition,

REDACTED

(Baker, Tr. 4625-26, 4628, 4806-7, *in camera*; Noether, Tr. 6053-55, *in camera*; RFF ¶¶ 1013-1015, 1103, *in camera*).

Finally, this proposed finding is also misleading because

REDACTED

(RFF-Reply

¶ 515, *in camera*).

537.

REDACTED

(CX 6279 at 8,

in camera).

REDACTED

(CX

6279 at 9, *in camera*).

Response to Finding No. 537:

This proposed finding is misleading. (RFF-Reply ¶ 536).

538.

REDACTED

(CX

6279 at 8, *in camera*).

REDACTED

(CX 6279 at 9, *in camera*).

Response to Finding No. 538:

This proposed finding is misleading. (RFF-Reply ¶ 536).

- (2) **Compared to the Non-Merging Chicago PMSA Hospitals, Prices to United Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park**

539.

REDACTED

(CX 6279 at 8, *in camera*).

REDACTED

(CX 6279 at 9, *in camera*).

Response to Finding No. 539:

This proposed finding is misleading. (RFF-Reply ¶ 536). This proposed finding is also misleading because :

REDACTED

(RFF-Reply ¶ 516, *in camera*).

540.

REDACTED

(CX 6279 at 8, *in camera*).

REDACTED

(CX 6279 at 9, *in camera*).

Response to Finding No. 540:

This proposed finding is misleading. (RFF-Reply ¶¶ 536, 539).

541.

REDACTED

(CX 6279 at 8, *in camera*).

REDACTED

(CX 6279 at 9, *in camera*).

Response to Finding No. 541:

This proposed finding is misleading. (RFF-Reply ¶¶ 536, 539).

- (3) **Compared to the Chicago PMSA Teaching Hospitals, Prices to United Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park.**

542.

REDACTED

(CX 6279 at 8, *in camera*).

REDACTED

(CX 6279 at 9, *in camera*).

Response to Finding No. 542:

This proposed finding is misleading. (RFF-Reply ¶¶ 536). This proposed finding is also misleading because

REDACTED (RFF-Reply ¶ 517, *in camera*).

543.

REDACTED (CX 6279 at 8, *in camera*).

REDACTED (CX 6279 at 9, *in camera*).

Response to Finding No. 543:

This proposed finding is misleading. (RFF-Reply ¶¶ 536, 542).

544.

REDACTED (CX 6279 at 8, *in camera*).

REDACTED (CX 6279 at 9, *in camera*).

Response to Finding No. 544:

This proposed finding is misleading. (RFF-Reply ¶¶ 536, 542).

- b. **The Aetna Claims Data Shows That Prices to Aetna Went Up Faster at ENH Than at Other Hospitals After the Merger with Highland Park for All Control Groups**

545.

REDACTED
(Haas-Wilson, Tr. 2512 (referring to DX 7010, *in camera*), *in camera*).

Response to Finding No. 545:

This proposed finding is misleading. (RFF-Reply ¶ 535).

(1) **Compared to the Chicago PMSA Hospitals, Prices to Aetna Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park**

546.

REDACTED

(CX 6279 at 8, in

camera).

REDACTED

(CX

6279 at 9, in camera).

Response to Finding No. 546:

This proposed finding is misleading because it suggests that analyzing the data “by type of plan within payer” is appropriate. First,

REDACTED

(Haas-Wilson, Tr. 2853, in camera;

Mendonsa, Tr. 557, in camera; Holt-Darcy, Tr. 1541, 1586-87, in camera; Hillebrand, Tr. 1861-

62, 2019; RX 844 at ENH JL 2023, in camera). This suggests that, at the very least, the plans

should be aggregated for each MCO. Second,

REDACTED

(Baker,

Tr. 4648, 4662-63, in camera; Noether, Tr. 6058-59, in camera). Finally,

REDACTED

(Spaeth,

Tr. 2299-2300; Ballengee, Tr. 144-45, 200; Mendonsa, Tr. 556, in camera; Hillebrand, Tr. 1862;

Foucre, Tr. 1122-23, in camera; Holt-Darcy, Tr. 1585, in camera; Noether, Tr. 6113, in camera

RFF ¶¶ 369-371, 374, in camera; RFF ¶¶ 372-373).

This finding is also misleading to the extent it considers only price changes. Dr. Haas-Wilson admitted that

REDACTED

(Haas-Wilson, Tr. 2834-36, *in camera*; RFF ¶¶ 1053, 1059-1061; RFF ¶¶ 1054-1058, 1062-1064, *in camera*).

Consequently, it is impossible to conclude that the post-Merger price changes were anticompetitive based on a simple examination of price changes, without a consideration of competitive price levels.

This proposed finding is also misleading to the extent that it relies on “price per day.”

REDACTED

(Baker, Tr. 4628-29, *in camera*).

Finally, this proposed finding is also misleading because

REDACTED

(RFF-Reply ¶ 515, *in camera*).

547.

REDACTED

(CX 6279 at 8, *in camera*).

REDACTED

(CX 6279 at 9, *in camera*).

Response to Finding No. 547:

This proposed finding is misleading. (RFF-Reply ¶ 546).

- (2) **Compared to the Non-Merging Chicago PMSA Hospitals, Prices to Aetna Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park**

548.

REDACTED

(CX 6279 at 8, *in camera*).

REDACTED, (CX 6279 at 9, *in camera*).

Response to Finding No. 548:

This proposed finding is misleading. (RFF-Reply ¶ 546). This proposed finding is also misleading to the extent that

REDACTED

(RFF-Reply ¶ 516, *in camera*).

549.

REDACTED

(CX 6279 at 8, *in camera*).

REDACTED

(CX 6279 at 9, *in camera*).

Response to Finding No. 549:

This proposed finding is misleading. (RFF-Reply ¶ 546, 548).

- (3) **Compared to the Chicago PMSA Teaching Hospitals, Prices to Aetna Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park**

550.

REDACTED

(CX 6279 at 8, *in camera*).

REDACTED

(CX 6279 at 9, *in camera*).

Response to Finding No. 550:

This proposed finding is misleading. (RFF-Reply ¶ 546). This proposed finding is also misleading to the extent that

REDACTED

(RFF-Reply ¶ 517, *in camera*).

551.

REDACTED

(CX 6279 at

8, *in camera*).

REDACTED

(CX 6279 at 9, *in camera*).

Response to Finding No. 551:

This proposed finding is misleading. (RFF-Reply ¶ 550).

- c. **The Humana Claims Data Shows That Prices to Humana Went Up Faster at ENH Than at Other Hospitals After the Merger with Highland Park for All Control Groups**

552.

REDACTED

(Haas-Wilson, Tr. 2511-12 (referring to DX 7010, *in camera*), *in camera*).

Response to Finding No. 552:

This proposed finding is misleading. (RFF-Reply ¶ 535).

- (1) **Compared to the Chicago PMSA Hospitals, Prices to Humana Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park**

553.

REDACTED

(CX 6279 at 8,

in camera).

REDACTED

6279 at 9, *in camera*).

REDACTED

(CX

Response to Finding No. 553:

This proposed finding is misleading because it suggests that analyzing the data “by type of plan within payer” is appropriate. First,

REDACTED

(Haas-Wilson, Tr. 2853, *in camera*;

Mendonsa, Tr. 557, *in camera*; Holt-Darcy, Tr. 1541, 1586-87, *in camera*; Hillebrand, Tr. 1861-62, 2019; RX 844 at ENH JL 2023, *in camera*). This suggests that, at the very least, the plans should be aggregated for each MCO. Second,

REDACTED

(Baker,

Tr. 4648, 4662-63, *in camera*; Noether, Tr. 6058-59, *in camera*). Finally,

REDACTED

(Spaeth,

Tr. 2299-2300; Ballengee, Tr. 144-45, 200; Mendonsa, Tr. 556, *in camera*; Hillebrand, Tr. 1862; Foucre, Tr. 1122-23, *in camera*; Holt-Darcy, Tr. 1585, *in camera*; Noether, Tr. 6113, *in camera* RFF ¶¶ 369-371, 374, *in camera*; RFF ¶¶ 372-373).

This finding is also misleading to the extent it considers only price changes. Dr. Haas-Wilson admitted that

REDACTED

(Haas-Wilson, Tr.

2834-36, *in camera*; RFF ¶¶ 1053, 1059-1061; RFF ¶¶ 1054-1058, 1062-1064, *in camera*).

Consequently, it is impossible to conclude that the post-Merger price changes were anticompetitive based on a simple examination of price changes, without a consideration of competitive price levels.

This proposed finding is also misleading to the extent that it relies on "price per day."

REDACTED

(Baker, Tr. 4628-

29, *in camera*).

~~This finding is further misleading to the extent that it is based on data that do not include price information for capitated plans.~~

REDACTED

(Haas-Wilson, Tr. 2853, *in camera*;

Noether, Tr. 6076-77; RFF ¶ 1029, *in camera*).

REDACTED

(Noether, Tr. 6076, *in camera*; RFF ¶ 1128, *in camera*).

Finally, this proposed finding is also misleading because

REDACTED

(RFF-Reply

¶ 515, *in camera*).

554.

in camera).

REDACTED

(CX 6279 at 8,

6279 at 9, *in camera*).

REDACTED

(CX

Response to Finding No. 554:

This proposed finding is misleading. (RFF-Reply ¶ 553).

555.

REDACTED

(CX 6279 at 8,

in camera).

REDACTED

(CX

6279 at 9, *in camera*).

Response to Finding No. 555:

This proposed finding is misleading. (RFF-Reply ¶ 553).

- (2) **Compared to the Non-Merging Chicago PMSA Hospitals, Prices to Humana Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park**

556.

REDACTED

(CX 6279 at 8, *in camera*).

REDACTED

(CX 6279 at 9, *in camera*).

Response to Finding No. 556:

This proposed finding is misleading. (RFF-Reply ¶ 553). This proposed finding is also misleading to the extent that

REDACTED

(RFF-Reply ¶ 516, *in camera*).

557.

REDACTED

(CX 6279 at 8, *in camera*).

REDACTED

(CX 6279 at 9, *in camera*).

Response to Finding No. 557:

This proposed finding is misleading. (RFF-Reply ¶ 553, 556).

558.

REDACTED

(CX 6279 at 8, *in camera*).

REDACTED

9, *in camera*).

(CX 6279 at

Response to Finding No. 558:

This proposed finding is misleading. (RFF-Reply ¶ 553, 556).

- (3) **Compared to the Chicago PMSA Teaching Hospitals, Prices to Humana Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park**

559.

REDACTED

8, *in camera*).

(CX 6279 at

REDACTED

(CX 6279 at 9, *in camera*).

Response to Finding No. 559:

This proposed finding is misleading. (RFF-Reply ¶ 553).

REDACTED

(RFF-Reply ¶ 517, *in camera*).

560.

REDACTED

8, *in camera*).

(CX 6279 at

REDACTED

REDACTED

(CX 6279 at 9, *in camera*).

Response to Finding No. 560:

This proposed finding is misleading. (RFF-Reply ¶ 553, 559).

561.

REDACTED

(CX 6279 at

8, *in camera*).

REDACTED

(CX 6279 at 9, *in camera*).

Response to Finding No. 561:

This proposed finding is misleading. (RFF-Reply ¶ 553, 559).

- d. **The One Health Claims Data Shows That Prices to One Health (Great West) Went Up Faster at ENH Than at Other Hospitals After the Merger with Highland Park for All Control Groups**

562.

REDACTED

(Haas-Wilson, Tr. 2511-12

(referring to DX 7010, *in camera*), *in camera*).

Response to Finding No. 562:

This proposed finding is misleading. (RFF-Reply ¶ 535).

- (1) **Compared to the Chicago PMSA Hospitals, Prices to One Health (Great West) Went Up Faster at ENH Than at the Control Group Hospitals After the Merger with Highland Park**

563.

REDACTED

(CX 6282 at 5, *in camera*).

REDACTED

(CX 6282 at 5, *in camera*).

Response to Finding No. 563:

This proposed finding is misleading because it relies on “unusable” data.

REDACTED

REDACTED

(Noether, Tr. 6050, *in camera*).

This finding is also misleading because it suggests that analyzing the data “by type of plan within payer” is appropriate. First, {

REDACTED

(Haas-Wilson, Tr. 2853, *in camera*;

Mendonsa, Tr. 557, *in camera*; Holt-Darcy, Tr. 1541, 1586-87, *in camera*; Hillebrand, Tr. 1861-62, 2019; RX 844 at ENH JL 2023, *in camera*). This suggests that, at the very least, the plans should be aggregated for each MCO. Second,

REDACTED

(Baker,

Tr. 4648, 4662-63, *in camera*; Noether, Tr. 6058-59, *in camera*). Finally, {

REDACTED

(Spaeth,

Tr. 2299-2300; Ballengee, Tr. 144-45, 200; Mendonsa, Tr. 556, *in camera*; Hillebrand, Tr. 1862; Foucre, Tr. 1122-23, *in camera*; Holt-Darcy, Tr. 1585, *in camera*; Noether, Tr. 6113, *in camera* RFF ¶¶ 369-371, 374, *in camera*; RFF ¶¶ 372-373).

This finding is also misleading to the extent it considers only price changes. Dr. Haas-Wilson admitted that

REDACTED

- a. **Dr. Baker Found Price Increases at ENH That Exceeded the Price Increases at His Control Group for United, Aetna, and Humana**

573.

REDACTED

(Haas-Wilson, Tr. 2564-65 (referring to DX 7022 at 2, *in camera*),
in camera).

Response to Finding No. 573:

This proposed finding is misleading and irrelevant to the analysis of ENH's price changes coincident with the Merger.

REDACTED

(Baker, Tr. 4744-45, *in camera* (referring to DX 7068 at 43, *in camera*)).

REDACTED

(Baker, Tr. 4641, *in camera*). There is no record evidence regarding Professor Baker's estimates of price changes at individual MCOs that were case-mix adjusted.

REDACTED

4648, *in camera*)).

(Baker, Tr.

574.

REDACTED

REDACTED (Haas-Wilson, Tr. 2566-67 (referring to DX 7013 at 2, *in camera*), *in camera*; Baker, Tr. 4744-46, *in camera*).

Response to Finding No. 574:

This proposed finding is misleading and irrelevant to the analysis of ENH's price changes coincident with the Merger. (RFF-Reply ¶ 573).

575. !

REDACTED

(Haas-Wilson, Tr. 2573 (referring to DX 7020 at 2, *in camera*), *in camera*).

Response to Finding No. 575:

This proposed finding is misleading and irrelevant to the analysis of ENH's price changes coincident with the Merger. (RFF-Reply ¶ 573).

576. {Dr. Baker found that the post-merger price increase for Blue Cross did not exceed the post-merger price increase for his control group.} (Haas-Wilson, Tr. 2569 (referring to DX 7014 at 2, *in camera*), *in camera*).

Response to Finding No. 576:

This proposed finding is misleading, inaccurate and incomplete

REDACTED

(Baker, Tr. 4744-45,

in camera (referring to DX 7068 at 43, *in camera*)).

REDACTED

(RFF-Reply ¶ 573).

REDACTED

(Baker, Tr.

4695, *in camera*).

REDACTED

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

camera).

b. **Dr. Baker Found Price Increases at ENH That Exceeded the Price Increases at His Control Group for the Average Price of the Four Payers Analyzed by Him**

577:

(Haas-Wilson, Tr. 2584). **REDACTED**

REDACTED

(Haas-Wilson, Tr. 2584-85 (referring to DX 7050 at 2, *in camera*), *in camera*).

Response to Finding No. 577:

This proposed finding is misleading

REDACTED

REDACTED

(Baker, Tr. 4646-

REDACTED

47, *in camera*).

(Baker, Tr. 4640-42, *in camera*).

REDACTED

REDACTED

(Baker, Tr. 4619-20, 4646, 4795-96, *in camera*; Haas-

Wilson, Tr. 2637, *in camera*).

REDACTED

(CCFF ¶

607, *in camera*).

578.

REDACTED

REDACTED
4640-41 (discussing DX 8041, *in camera*), *in camera*).

(Baker, Tr.

Response to Finding No. 578:

This proposed finding is misleading and overstates ENH's average price increase.

REDACTED
(Baker, Tr. 4641-42, *in camera* (discussing DX
8041, *in camera*)).

REDACTED

REDACTED

(Baker, Tr. 4641, *in camera*).

REDACTED

REDACTED
(Baker, Tr.
REDACTED
4617-19, 4795-96, *in camera*).

(CCFF ¶ 607).

8. Summary

579.

REDACTED

CCFF 535-578).

Response to Finding No. 579:

This proposed finding is misleading to the extent it suggests that ENH had market power because it secured price increases. **REDACTED**

REDACTED

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

REDACTED

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

REDACTED

(Baker, Tr. 4695-96,

4742-43, *in camera*).

D. Dr. Haas-Wilson Considered Eight Alternative Explanations of the Price Increases Besides Increases in Market Power Arising from the Merger and Learning About Demand

1. Price Increases Alone Do Not Establish the Exercise of Market Power, As Alternative Explanations Must Be Rejected

580. It was not feasible to test directly for whether or not market power is the explanation behind the price increase at ENH. (Haas-Wilson, Tr. 2482).

Response to Finding No. 580:

Respondent has no specific response.

581. Because market power cannot be tested directly, “the best available method is to develop this sort of list based on theory and what theory would expect to result in a price increase and then use empirical tests based on available data to be able to either cross these items off the list or, if you’re not able with your empirical test to cross them off, then see what you’re left with at the end of the analysis.” (Haas-Wilson, Tr. 2482).

Response to Finding No. 581:

This proposed finding is misleading to the extent it suggests that it is possible to examine price changes alone, without considering competitive levels, to conclude that relative price increases are the result of anticompetitive market power. The “best available method” requires an evaluation of price changes and price levels. Dr. Haas-Wilson admitted that **REDACTED**

REDACTED

(Haas-Wilson, Tr. 2834-36, *in camera*; RFF ¶¶ 1053, 1059-1061; RFF ¶¶ 1054-1058, 1062-1064, *in camera*). Consequently, it is impossible to conclude that the post-Merger price changes were anticompetitive based on a simple examination of price changes, without a consideration of competitive price levels.

2. There Were Eight Alternative Explanations for the Price Increase to Rule Out Besides Market Power and Learning About Demand

582. It was not possible to test for all possible explanations of the price increase, so it was necessary to look for reasonable explanations that are grounded in economic theory. (Haas-Wilson, Tr. 2481).

Response to Finding No. 582:

This proposed finding is misleading to the extent that it suggests that Dr. Haas-Wilson effectively considered and eliminated all such “reasonable explanations.” (RFF-Reply ¶¶ 594-95, 597-99, 602-08).

583. Dr. Haas-Wilson, drawing upon economic theory, came up with a list of eight potential explanations for the price increase at ENH after the merger other than market power or learning about demand. The “basis for including things in this list was economic theory and what economic theory suggested would be potential explanations for the large post-merger price increase at ENH.” (Haas-Wilson, Tr. 2481 (referring to DX 7024)).

Response to Finding No. 583:

This proposed finding is misleading to the extent it suggests that the “list of eight potential explanations” that Dr. Haas-Wilson developed is an exhaustive list of potential explanations for the post-Merger price increase.

REDACTED

REDACTED

(Haas-Wilson, Tr. 2486-89, 2861-63, 2682-83; Baker, Tr. 4650-53, *in camera*; RFF ¶ 523).

584. The eight plausible explanations of the price increase at ENH aside from market power or learning about demand were: (1) cost increases that affect all hospitals; (2) changes in regulations that affect all hospitals; (3) increases in consumer demand for hospital services; (4) increases in quality at ENH; (5) changes in the mix of patients; (6) changes in the mix of customers; (7) increases in teaching intensity; and (8) decreases in outpatient prices. (Haas-Wilson, Tr. 2482-88 (discussing DX 7024)).

Response to Finding No. 584:

Respondent has no specific response to the extent that these eight factors are potential “plausible explanations for the price increase.” This proposed finding is misleading, however, to the extent it suggests this list includes all the plausible explanations that must be considered and eliminated to facilitate a conclusion that the post-Merger prices were anticompetitive.

585. Dr. Haas-Wilson tested whether any of these potential explanations could explain the price increase at ENH. (Haas-Wilson, Tr. 2481).

Response to Finding No. 585:

This proposed finding is misleading to the extent that it suggests that, contrary to CCFR ¶¶ 580 and 695, Dr. Haas-Wilson was actually able to test all eight of these explanations. (RFF-Reply ¶¶ 583, 594-95, 597-99, 602-08).

3. Dr. Haas-Wilson Was Able to Directly Rule Out Five of the Eight Alternative Explanations of the Price Increase at ENH

586. Dr. Haas-Wilson was able to directly rule out five potential explanations of the price increase at ENH: (1) cost increases; (2) changes in regulations; (3) changes in consumer demand; (4) changes in quality; and (5) declines in outpatient prices. (CCFR 594-595, 597-599, 602-608).

Response to Finding No. 586:

This proposed finding is misleading to the extent it suggests that Dr. Haas-Wilson was effectively ruled out these five potential explanations. She did not. (RFF-Reply ¶¶ 594-595, 597-599, 602-608).

a. Cost Increases

587. Because economic theory suggests that when costs increase in competitive markets, one would expect to see prices increase, Dr. Haas-Wilson tested for whether cost increases in the Chicago area would explain why ENH's prices increased. (Haas-Wilson, Tr. 2482).

Response to Finding No. 587:

This proposed finding is misleading to the extent it suggests that, simply by using her overly broad control groups, Dr. Haas-Wilson effectively ruled out Chicago area cost increases. She did not. (RFF-Reply ¶¶ 515-517).

REDACTED

(Haas-Wilson, Tr. 2681; Baker, Tr. 4652, *in camera*; RFF ¶ 523).

588. An example of a kind of cost increase that could take place in the Chicago area that would lead to a price increase is a shortage of nurses in the Chicago area. If a hospital had to pay higher wages in order to hire nurses, that would be an increase in cost that would affect ENH and all of the hospitals in the area, and potentially lead to a price increase. (Haas-Wilson, Tr. 2482-83).

Response to Finding No. 588:

This proposed finding is misleading. (RFF-Reply ¶ 587).

b. Changes in Regulations

589. Because a change in regulation that affected all hospitals in the Chicago area could potentially explain price increases at all hospitals in the Chicago area, Dr. Haas-Wilson tested for whether changes in regulations would explain why ENH's prices increased. (Haas-Wilson, Tr. 2483).

Response to Finding No. 589:

This proposed finding is misleading to the extent it suggests that, simply by using her overly broad control groups, Dr. Haas-Wilson was able to effectively rule out Chicago area changes in regulation. (RFF-Reply ¶¶ 515-517). In addition, this proposed finding is misleading to the extent that it ignores the possibility that changes in regulation had differing effects on hospitals in the Chicago area and that such idiosyncratic regulation change effects may result in relative price increases. The Balanced Budget Act is one example of a regulation that could impact hospital prices. Dr. Haas-Wilson did not attempt to evaluate whether the Balanced Budget Act impacted all Chicago hospitals in a similar manner. The evidence demonstrates that the Balanced Budget Act did impact hospitals like ENH differently than other hospitals.

(Neaman, Tr. 1315; RFF ¶¶ 627-629).

590. An example of a change in regulation that could affect the prices at hospitals is taken from California. In California, where they are particularly prone to earthquakes, there are regulations requiring hospitals to make sure their buildings are able to withstand earthquakes of certain levels. Such a regulation clearly would increase costs at all hospitals in California and would be expected to lead to higher prices. (Haas-Wilson, Tr. 2483-84).

Response to Finding No. 590:

This proposed finding is misleading. (RFF-Reply ¶ 589).

c. Changes in Consumer Demand

591. Because economic theory suggests that if there are increases in demand over a time period, one would expect those increases in demand in the Chicago area to increase prices at all hospitals in the Chicago area, Dr. Haas-Wilson tested for whether increases in demand would explain why ENH's prices increased. (Haas-Wilson, Tr. 2484).

Response to Finding No. 591:

This proposed finding is misleading to the extent it suggests that simply by using her overly broad control groups, Dr. Haas-Wilson was able to effectively control for increases in

demand. (Reply-RFF ¶¶ 515-517).

REDACTED

(Noether, Tr. 6109, *in camera*). As a consequence of this breadth and diversity, it is likely that not all the hospitals in the Chicago PMSA experienced the same cost, demand and regulation shocks as ENH.

REDACTED

(Noether, Tr. 6109-13, *in camera*; RFF ¶ 1039).

REDACTED

(Haas-Wilson, Tr. 2864-65, *in camera*).

REDACTED

(Baker, Tr. 4647, *in camera*).

592. An example of what could cause an increase in demand that would subsequently affect prices is “[t]o the extent the elderly consume more hospital services than the young, to the extent the population is aging in the Chicago area, that would likely increase demand for hospital services in the Chicago area and could potentially explain, therefore, price increases at all hospitals in the Chicago area.” (Haas-Wilson, Tr. 2484).

Response to Finding No. 592:

This proposed finding is misleading. (RFF-Reply ¶ 591).

REDACTED

(Haas-Wilson, Tr. 2864-65, *in camera*).

REDACTED

REDACTED

(Baker, Tr. 4647,

in camera).

d. The Relative Price Increase at ENH, Compared to Control Groups, Rules Out Changes in Costs, Regulations, and Demand As an Explanation of the Price Increase

593. In her analysis, Dr. Haas-Wilson focused on price increases instead of “price levels” because the market for hospital services can be characterized as a market for a differentiated product as opposed to a product that would be characterized as homogenous. Consumers are willing and able to pay higher prices for certain aspects of product differentiation, e.g., convenient location or reputation. Thus, because prices can vary in the market for a differentiated service for many different reasons, one may not conclude anything about market power by merely using a cross-sectional analysis of hospital prices at a single point in time. (Haas-Wilson, Tr. 2492 (*see* example provided in DX 7043)). In contrast, by looking at price changes over time, one can compare the price change at one hospital to the price change at another hospital. Using such an approach, one can conclude there is change in market power if there is a price increase after having ruled out the other possible explanations for greater price increases at one hospital versus another. (Haas-Wilson, Tr. 2495).

Response to Finding No. 593:

This proposed finding is misleading to the extent that it suggests that because the measurement of price levels presents unique challenges it should not be conducted. Dr. Haas-Wilson admitted that

REDACTED

REDACTED

(Haas-Wilson, Tr.

2834-36, *in camera*; RFF ¶¶ 1053, 1059-1061; RFF ¶¶ 1054-1058, 1062-1064, *in camera*).

Consequently, it is impossible to conclude that the post-Merger price changes were

anticompetitive based on a simple examination of price changes, without a consideration of competitive price levels.

594.

REDACTED

(Haas-Wilson, Tr. 2542-44, *in camera*).

Response to Finding No. 594:

This proposed finding is misleading to the extent that it suggests that Haas-Wilson effectively ruled out changes in cost, demand and regulation simply by using her overly broad control groups. (RFF-Reply ¶¶ 587-592).

595. Prices at ENH rose relative to the prices at other hospitals. (CCFF 579).

REDACTED

(Haas-Wilson, Tr. 2562-63, 2565, 2573-74, 2579, 2583, 2586, *in camera*).

Response to Finding No. 595:

This proposed finding is misleading to the extent that it suggests that Haas-Wilson effectively ruled out all changes in cost, demand and regulation simply by using her overly broad control groups. (RFF-Reply ¶¶ 587-592). Rather, as Dr. Haas-Wilson admitted, idiosyncratic changes in cost, demand and regulation could effect prices at ENH. (Haas-Wilson, Tr. 2681-82).

The evidence suggests that ENH may have experienced demand, cost and regulation forces different than those of the hospitals in Dr. Haas-Wilson's control groups. (RFF-Reply ¶¶ 587-

592, 579).

596.

REDACTED

(Haas-Wilson, Tr. 2562-63, 2565, 2573-74, 2579, 2583, 2586, *in camera*).

Response to Finding No. 596:

This proposed finding is misleading to the extent it suggests that only those cost, demand, and regulation changes that “affect all the hospitals in the control groups similarly” may impact price. Rather, as Dr. Haas-Wilson admitted, idiosyncratic changes in cost, demand and regulation could effect prices at ENH. (Haas-Wilson, Tr. 2681-82). Dr. Haas-Wilson did not effectively rule out these idiosyncratic changes. (RFF-Reply ¶¶ 515-517, 587-592).

e. The Increases in Prices at ENH Relative to Other Hospitals Cannot Be Explained by an Increase in Quality Relative to Other Hospitals

597. If quality is increasing in general, that would lead to potentially higher prices at all hospitals. (Haas-Wilson, Tr. 2485). If quality is increasing at one hospital relative to other hospitals, and the buyers of hospital services value that increase in quality, then that could potentially explain a greater price increase at the first hospital. (Haas-Wilson, Tr. 2485). **REDACTED**

(Haas-Wilson, Tr. 2586, *in camera*).

Response to Finding No. 597:

Respondent has no specific response.

598.

REDACTED

(Haas-Wilson, Tr. 2586-88, *in camera*. See also CCF# 2032-2496).

Response to Finding No. 598:

This proposed finding is misleading to the extent that it suggests that it is appropriate to ignore the analysis conducted by Dr. Chassin and the evidence demonstrating that, in fact, quality did improve on both clinical and non-clinical dimensions. (RFF ¶¶ 325-329, 1165-2277).

This proposed finding is also misleading to the extent it ignores that quality also has non-clinical dimensions which, from an economist’s perspective, are competitively significant. (RFF ¶¶ 324-25). Dr. Haas-Wilson did not conduct an independent analysis of non-clinical quality. (RFF- ¶ 329).

599.

REDACTED

(Haas-Wilson, Tr. 2587-88, 2615, *in camera*).

Response to Finding No. 599:

This proposed finding is conclusory and incorrect. This proposed finding is based on Dr. Haas-Wilson's analysis, which, in turn, was based solely on Dr. Romano's analysis of clinical quality. Dr. Haas-Wilson did not consider Dr. Chassin's analysis of clinical quality and Dr. Noether's opinions on non-clinical quality. (Haas-Wilson, Tr. 2446-47, 2586; Noether, Tr. 6018-19). It is not appropriate to ignore the analysis conducted by Dr. Chassin and the evidence demonstrating that quality did, in fact, improve on both clinical and non-clinical dimensions. (RFF ¶¶ 325-329; 1165-2277).

f. Decreases in Prices of Outpatient Services at ENH Cannot Explain the Increase In Prices at ENH Relative to Control Group Hospitals

600. Though economic theory does not predict that decreases in outpatient services prices would lead to increases in inpatient service prices, some managed care payers indicated they would be concerned about what they paid for all the products that they were purchasing from a hospital. (Haas-Wilson, Tr. 2487)

Response to Finding No. 600:

This proposed finding is misleading to the extent that it misrepresents Dr. Haas-Wilson's testimony. Dr. Haas-Wilson testified that the relationship between outpatient and inpatient prices was "not so much from economic theory but more from reading of the transcripts." (Haas-Wilson, Tr. 2487).

601. To the extent that a managed care organization cares about the total price, a managed care organization might be willing to pay higher prices for inpatient services if they were getting outpatient services at a lower price. It might be willing to trade one off for the other. (Haas-Wilson, Tr. 2487-88).

Response to Finding No. 601:

Respondent has no specific response.

602.

REDACTED

7024), *in camera*).

(Haas-Wilson, Tr. 2607 (referring to DX

Response to Finding No. 602:

Respondent has no specific response.

603.

REDACTED

(Haas-Wilson, Tr. 2607-08, *in camera*).

(Haas-Wilson, Tr. 2608, *in camera*).

Response to Finding No. 603:

Respondent has no specific response.

604.

REDACTED

2614-15, *in camera*)

} (Haas-Wilson, Tr.

Response to Finding No. 604:

This proposed finding is misleading to the extent it suggests that the appropriate way to analyze the price changes is to consider inpatient and outpatient separately. As Complaint Counsel points out in CCF ¶ 601, MCOs care about the “total price.”

REDACTED

(Noether, Tr. 6113, *in camera*).

605.

REDACTED

(Haas-Wilson, Tr. 2610, *in camera*; CX 6279 at 17, *in camera*).

Response to Finding No. 605:

Respondent has no specific response to the extent that this proposed finding accurately describes the methodology employed by Dr. Haas-Wilson. This finding is misleading, however, to the extent that it implies that the methodology employed by Dr. Haas-Wilson to analyze the commercial payer claims data was appropriate in this case. In particular, this finding is misleading because it suggests that analyzing the data “by type of plan within payer” is appropriate. First,

REDACTED

(Haas-Wilson, Tr. 2853, *in camera*; Mendonsa, Tr. 557; Holt-Darcy, Tr. 1541, 1586-87 *in camera*; Hillebrand, Tr. 1861-62, 2019; RX 844 at ENH JL 2023, *in camera*). This suggests that, at the very least, the plans should be aggregated for each MCO.

Second,

REDACTED

(Baker, Tr. 4648, 4662-63, *in camera*; Noether, Tr. 6058-59, *in camera*). Finally,

REDACTED

(Spaeth, Tr. 2299-2300; Ballengee, Tr. 144-45, 200; Mendonsa, Tr. 556, *in camera*; Hillebrand, Tr. 1862; Foucre, Tr. 1122-23, *in camera*; Holt-Darcy, Tr. 1585; *in camera*; Noether, Tr. 6113, *in camera* RFF ¶¶ 369-371, 374, *in camera*; RFF ¶¶ 372-373).

606.

REDACTED

REDACTED

(Haas-Wilson, Tr. 2614-15, *in camera*).

Response to Finding No. 606:

This proposed finding is misleading because Great West is one of the “five payors” referred to in the first sentence.

REDACTED

(Noether, Tr. 6050, *in camera*).

607. The finding that outpatient prices did not decline is consistent with Dr. Baker’s analysis. Dr. Baker estimated that the price increase at ENH for his four payers, relative to his control group, for inpatient and outpatient services combined was 11 to 12%. (Baker, Tr. 4617-4618) Looking at just inpatient services, Dr. Baker that [sic] estimated the price increase at ENH for his four payers, relative to the control group was 9-10%. (Baker, Tr. 4620). This implies that the price of outpatient services at ENH for Dr. Baker’s four payers increased more than the price of inpatient services. (Baker, Tr. 4797).

Response to Finding No. 607:

REDACTED

(Baker, Tr. 4642, *in camera*). Respondent agrees that the implication of Professor Baker’s estimates is that outpatient prices did not decline. (Baker, Tr. 4797). This is not surprising, because Evanston Hospital was under pricing all of its services – including outpatient

– services before the Merger, so it is natural that outpatient services would have risen as well.

(RFF ¶¶ 661, 663, 686, 699, 785-786, 811, 827, 832, 836-836, 908).

608.

REDACTED

camera).

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

Response to Finding No. 608:

Respondent has no specific response.

4. Dr. Haas-Wilson Was Not Able to Rule Out Three of the Eight Alternative Explanations of the Price Increase at ENH Without Additional Analysis

609. Dr. Haas-Wilson was not able to rule out three potential explanations of the price increase at ENH: (1) changes in the mix of patients at ENH; (2) changes in the mix of customers at ENH; and (3) changes in the teaching intensity at ENH, without using multiple regression analysis. (CCFF 610-630).

Response to Finding No. 609:

Respondent has no specific response.

a. Changes in the Mix of Patients at ENH Cannot Be Ruled Out As a Potential Explanation for the Increase in Prices at ENH Without Additional Analysis

610. Not all inpatient hospital stays require the same resources to treat. Patients with more complex conditions may require more resources than patients with less complex conditions. For two patients with the same condition, one may be sicker, requiring more resources to treat than the patient who is less sick. (Haas-Wilson, Tr. 2485).

Response to Finding No. 610:

Respondent has no specific response.

611. The mix of patients that a hospital has will influence the hospital's prices. If the hospital has patients who require more resources to treat than other hospitals, that will impact the hospital's prices. (Haas-Wilson, Tr. 2486).

Response to Finding No. 611:

Respondent has no specific response.

612.

REDACTED

(Haas-Wilson, Tr. 2589, *in camera*).

Response to Finding No. 612:

Respondent has no specific response.

613.

REDACTED

(Haas-Wilson, Tr. 2589-90, *in camera*).

Response to Finding No. 613:

Respondent has no specific response.

614.

REDACTED

(Haas-Wilson, Tr. 2594, *in camera*).

Response to Finding No. 614:

Respondent has no specific response.

(1) Commercial Claims Data

615.

REDACTED

camera; CX 6279 at 13, *in camera*).

(Haas-Wilson, Tr. 2592-93, *in*

Response to Finding No. 615:

This proposed finding is misleading because Great West is one of the “five payors” referred to in the first sentence.

REDACTED

(Noether, Tr. 6050, *in camera*). This finding is also misleading to the extent that it suggests that the “control hospitals” referenced were good controls for ENH. In fact, these control groups were overly broad. (RFF-Reply ¶¶ 515-517).

616.

REDACTED

(Haas-Wilson, Tr. 2590 *in camera*; Haas-Wilson, Tr. 2595-96, *in camera*).

REDACTED

(Haas-Wilson, Tr.2619-20, *in camera*).

Response to Finding No. 616:

This proposed finding is misleading because Great West is one of the “five payors” referred to in the first sentence.

REDACTED

REDACTED

(Noether, Tr. 6050, *in camera*).

(2) The IDPH Universal Dataset

617.

REDACTED (Haas-Wilson, Tr. 2596-98, *in camera*;

CX 6279 at 14, *in camera*).

Response to Finding No. 617:

This proposed finding is misleading to the extent that it suggests that the “control hospitals” referenced were good controls for ENH. In fact, these control groups were overly broad. (RFF-Reply ¶¶ 515-517).

618.

REDACTED

(Haas-Wilson, Tr. 2598-99, *in camera*) **REDACTED**

(Haas-Wilson, Tr. 2619-20, *in camera*).

Response to Finding No. 618:

This proposed finding is misleading to the extent that it ignores the additional fact that

REDACTED

REDACTED

(CCFF ¶ 375; Haas-Wilson, Tr. 2500; Baker, Tr. 4646-47, *in*

camera; RFF ¶ 1016, *in camera*). In addition, Dr. Haas-Wilson did not make any effort to compare the estimated prices she generated using this data to the actual prices paid to MCOs. (RFF-Reply ¶¶ 376-380).

b. Changes in the Mix of Customers at ENH Cannot Be Ruled Out As a Potential Explanation for the Increase in Prices at ENH Without Additional Analysis

619. Mix of customers refers to the different types of organizations that pay for patients at a hospital, whether it is commercial insurance or public health insurance programs, such as the Medicare and Medicaid programs. (Haas-Wilson, Tr. 2486).

Response to Finding No. 619:

Respondent has no specific response.

620. If a hospital has more Medicare and Medicaid patients, that could provide a motivation for the hospital to raise its prices to patients of the managed care organizations, especially when payment under the public programs is lessened. (Haas-Wilson, Tr. 2486).

Response to Finding No. 620:

Respondent has no specific response.

621.

REDACTED

(Haas-Wilson, Tr. 2600, *in camera*).

Response to Finding No. 621:

Respondent has no specific response.

622.

REDACTED

(Haas-Wilson, Tr. 2600, *in camera*).

Response to Finding No. 622:

Respondent has no specific response.

623.

REDACTED

(Haas-Wilson, Tr. 2600, 2602-03, *in camera*).

REDACTED

(Haas-Wilson, Tr. 2619-20, *in camera*).

Response to Finding No. 623:

Respondent has no specific response.

c. Changes in the Teaching Intensity at ENH Cannot Be Ruled Out As a Potential Explanation for the Increase in Prices at ENH Without Additional Analysis

624. Teaching intensity is a measure of how much teaching activity is occurring at a hospital. Some hospitals participate in the training of residents and interns, future doctors. (Haas-Wilson, Tr. 2486-87).

Response to Finding No. 624:

Respondent has no specific response.

625. There is empirical support for the proposition that hospitals that are involved in teaching activity have higher costs than hospitals that are not involved in teaching activity. (Haas-Wilson, Tr. 2487).

Response to Finding No. 625:

Respondent has no specific response.

626. Therefore, those hospitals involved in more teaching may have higher costs than those involved with lesser amounts of teaching activity. (Haas-Wilson, Tr. 2487).

Response to Finding No. 626:

Respondent has no specific response.

627.

REDACTED

(Haas-Wilson, Tr. 2603-04, *in camera*).

Response to Finding No. 627:

Respondent has no specific response.

628.

REDACTED (Haas-Wilson, Tr. 2604, *in camera*).

Response to Finding No. 628:

Respondent has no specific response.

629.

REDACTED (Haas-Wilson, Tr. 2604, *in camera*).

Response to Finding No. 629:

Respondent has no specific response.

630.

REDACTED

(Haas-Wilson, Tr. 2603-04, 2606, *in camera*).

REDACTED (Haas-Wilson, Tr. 2619-20, *in camera*).

Response to Finding No. 630:

Respondent has no specific response.

5. Dr. Haas-Wilson Was Able to Eliminate Five of Her Eight Alternative Causes of the Price Increase at ENH

631. Dr. Haas-Wilson was able to eliminate five of her eight potential causes of the price increase at ENH as causes in fact.} (CCFF 586). The three remaining potential causes of the price increase could not be completely eliminated by her initial analysis, so Dr. Haas-Wilson used multiple regression to test the extent to which they could explain the price increases.} (CCFF 632).

Response to Finding No. 631:

This proposed finding is misleading to the extent that it suggests that Dr. Haas-Wilson was effectively able to eliminate five of her potential eight causes of the prices increases. (RFF-Reply ¶ 586).

E. Multiple Regression Analysis Ruled Out Changes in Patient Mix, Changes in Customer Mix, and Changes in Teaching Intensity As Explanations for the Relative Price Increase Observed at ENH After the Merger with Highland Park

632.

REDACTED

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

Response to Finding No. 632:

This proposed finding is misleading to the extent that it suggests that Dr. Haas-Wilson was effectively able to eliminate five of her potential eight causes of the prices increases. (RFF-Reply ¶ 586).

- 1. Multiple Regression Analysis Allows the Researcher to Measure Simultaneously the Impact of Multiple Independent Variables on a Dependent Variable**

633.

REDACTED

(Haas-Wilson, Tr. 2616, *in camera*).

Response to Finding No. 633:

Respondent has no specific response.

634.

REDACTED

(Haas-Wilson, Tr. 2616, 2619, *in camera*).

Response to Finding No. 634:

Respondent has no specific response.

635.

REDACTED

(Haas-Wilson, Tr. 2619-20, *in camera*).

Response to Finding No. 635:

Respondent has no specific response.

636.

REDACTED

(Dr. Haas-Wilson, Tr. 2620, *in camera*).

Response to Finding No. 636:

Respondent has no specific response.

637.

REDACTED

(Haas-Wilson, Tr. 2620, *in camera*).

Response to Finding No. 637:

Respondent has no specific response.

638.

REDACTED

(Haas-Wilson, Tr. 2621, *in camera*).

Response to Finding No. 638:

Respondent has no specific response.

639.

REDACTED

(Haas-Wilson, Tr. 2621-22, *in camera*).

Response to Finding No. 639:

Respondent has no specific response.

2. **The IDPH Universal Dataset Shows That Changes in Patient Mix, Changes in Customer Mix, and Changes in Teaching Intensity Cannot Explain the Relative Price Increase at ENH Following the Merger with Highland Park, Using Any Control Group and Any Grouping of Patients**

640.

REDACTED

(Haas-Wilson, Tr.

2631-35, *in camera*; CX 6279 at 20, *in camera*).

Response to Finding No. 640:

This proposed finding is misleading. (RFF-Reply ¶ 618).

641.

REDACTED

(Haas-Wilson, Tr. 2530-31, *in camera*).

Response to Finding No. 641:

Respondent has no specific response.

642.

REDACTED

(Haas-Wilson, Tr. 2622-23, *in camera*).

Response to Finding No. 642:

This proposed finding is misleading to the extent that it suggests the methodology that Dr. Haas-Wilson used to case-mix adjust, described above, is the best method. **REDACTED**

REDACTED

(Baker, Tr. 4649, *in camera*).

- a. **For All Patients in the IDPH Universal Dataset, Changes in Patient Mix, Customer Mix, and Teaching Intensity Cannot Explain the Relative Price Increase at ENH Following the Merger with Highland Park**

643.

REDACTED

(CX 6279 at 20, *in camera*).

Response to Finding No. 643:

This proposed finding is misleading to the extent it assumes that Dr. Haas-Wilson's estimates of price change, based on IDPH data – which do not contain actual prices, paid to hospitals by MCOs and patients – are related to the actual price changes. (Reply-RFF ¶¶ 395, 524). This proposed finding is also misleading to the extent it suggests that the price increases for the “all patient” group provides any information about the price increases experienced by the MCO customer at issue in this case. (Reply-RFF ¶¶ 396, 523). This proposed finding is also misleading because it is based on a comparison of ENH with an overly broad control group, all hospitals in the Chicago PMSA. (RFF-Reply ¶ 515). This proposed finding is further misleading to the extent that it relies on “price per day.”

REDACTED

(Baker, Tr. 4628-29, *in camera*).

Finally, this proposed finding is misleading because it focuses only on price changes, without considering whether Evanston Hospital/ENH was pricing at competitive levels. Dr. Haas-Wilson admitted that

REDACTED

REDACTED

(Haas-Wilson, Tr. 2834-36, *in camera*; RFF ¶¶ 1053, 1059-1061; RFF ¶¶ 1054-1058, 1062-1064, *in camera*). Consequently, it is impossible to conclude that the post-Merger price changes were anticompetitive based on a simple examination of price changes, without a consideration of competitive price levels.

644.

REDACTED

(CX 6279 at 20, *in camera*).

Response to Finding No. 644:

This proposed finding is misleading. (RFF-Reply ¶ 643). This proposed finding is also misleading because

REDACTED

(RFF-Reply ¶ 516, *in camera*).

645.

REDACTED

(CX 6279 at 20, *in camera*).

Response to Finding No. 645:

This proposed finding is misleading. (RFF-Reply ¶ 643). This proposed finding is also misleading because

REDACTED

(RFF-Reply ¶ 517, *in camera*).

b. **For Commercially Insured and Self Pay Patients in the IDPH Universal Dataset, Changes in Patient Mix, Customer Mix, and Teaching Intensity Cannot Explain the Relative Price Increase at ENH Following the Merger with Highland Park**

646.

REDACTED

(CX 6279 at 20, *in camera*).

Response to Finding No. 646:

This proposed finding is misleading. (RFF-Reply ¶ 643). This proposed finding is also misleading to the extent it

REDACTED

(RFF-Reply ¶¶ 396, 523, *in camera*).

647.

REDACTED

(CX 6279 at 20, *in camera*).

Response to Finding No. 647:

This proposed finding is misleading. (RFF-Reply ¶¶ 643, 646). This proposed finding is also misleading because

REDACTED

(RFF-Reply ¶ 516, *in camera*).

648.

REDACTED

(CX 6279 at 20, *in camera*).

Response to Finding No. 648:

This proposed finding is misleading. (RFF-Reply ¶¶ 643, 646). This proposed finding is also misleading because

REDACTED

(RFF-Reply ¶ 517, *in camera*).

- c. **For Commercially Insured, Self Pay, HMO, and Self-Administered Patients in the IDPH Universal Dataset, Changes in Patient Mix, Customer Mix, and Teaching Intensity Cannot Explain the Relative Price Increase at ENH Following the Merger with Highland Park**

649.

REDACTED

6279 at 20, *in camera*).

(CX

Response to Finding No. 649:

This proposed finding is misleading. (RFF-Reply ¶ 643). This proposed finding is also misleading to the extent it suggests that

REDACTED

523, *in camera*).

(RFF-Reply ¶¶ 396,

650.

REDACTED

(CX 6279 at 20, *in camera*).

Response to Finding No. 650:

This proposed finding is misleading. (RFF-Reply ¶¶ 643, 649). This proposed finding is also misleading because **REDACTED**

(RFF-Reply ¶ 516, *in camera*).

651.

REDACTED

(CX 6279 at 20, *in camera*).

Response to Finding No. 651:

This proposed finding is misleading. (RFF-Reply ¶¶ 643, 649). This proposed finding is also misleading because

REDACTED

(RFF-Reply ¶ 517, *in camera*).

3. **Commercial Payer Claims Data Shows That Changes in Patient Mix, Customer Mix, and Teaching Intensity Cannot Explain the Relative Price Increase at ENH Following the Merger with Highland Park**

652.

REDACTED

(Haas-Wilson, Tr. 2622, *in camera*; CX 6279 at 18, *in camera*; CX 6279 at 19, *in camera*).

Response to Finding No. 652:

Respondent has no specific response.

653.

REDACTED

REDACTED (Haas-Wilson, Tr. 2623-24, *in camera*, CX 6279 at 18, *in camera*).

Response to Finding No. 653:

Respondent has no specific response.

654.

REDACTED

(Haas-Wilson, Tr. 2624, *in camera*; CX 6279 at 18, *in camera*).

Response to Finding No. 654:

Respondent has no specific response.

655.

REDACTED

(Haas-Wilson, Tr. 2625, *in camera*).

Response to Finding No. 655:

This proposed finding is misleading to the extent that it suggests

REDACTED

(RFF-Reply ¶¶ 515-517, *in camera*).

656.

REDACTED

(Haas-Wilson, Tr. 2625, *in camera*).

Response to Finding No. 656:

This proposed finding is misleading to the extent it suggests that Dr. Haas-Wilson's analytic approach was effective and appropriate and allowed her to "eliminate" changes in patient mix, customer mix and teaching intensity. (RFF-Reply ¶¶ 657-682).

657.

REDACTED

REDACTED

(Haas-Wilson, Tr. 2625, *in camera*; CX 6279 at 18, *in camera*).

Response to Finding No. 657:

This proposed finding is misleading to the extent that it implies that there is any competitive significance to an absolute price increase. (Reply-RFF ¶ 392). As all the testifying experts in this case admit, price increases alone are not competitively significant. (Baker, Tr. 4702, 4644, 4649-50, 4653, *in camera*; Haas-Wilson, Tr. 2677 *in camera*; Noether, Tr. 5904; RFF ¶¶ 315, 519, *in camera*). In addition, this proposed finding is misleading to the extent that it suggests that a plan-by-plan analysis for prices is appropriate in this case.

REDACTED

REDACTED

(Haas-Wilson, Tr. 2853, *in camera*; Mendonsa, Tr. 557; Holt-Darcy, Tr. 1541, 1586-87, *in camera*; Hillebrand, Tr. 1861-62, 2019; RX 844 at ENH JL 2023, *in camera*). This suggests that, at the very least the plans should be aggregated by MCO. This proposed finding is also misleading to the extent that it suggests that a payor-by-payor analysis is appropriate in this case. Instead,

REDACTED

(Baker, Tr. 4648, 4662-63, *in camera*; Noether, Tr. 6058-59, *in camera*). In addition, this proposed finding is misleading to the extent it suggests that the consideration of inpatient-only prices is appropriate.

REDACTED

(Spaeth, Tr. 2299-2300; Ballengee, Tr. 144-45, 200; Mendonsa, Tr. 556, *in camera*; Hillebrand, Tr. 1862; Foucre, Tr. 1122-23, *in camera*; Holt-Darcy, Tr. 1585, *in camera*; RFF ¶¶ 369-371, 374, *in camera*; RFF ¶¶ 372-373).

REDACTED

(Noether, Tr. 6113, *in camera*).

This proposed finding is further misleading to the extent it considers only price changes.

Dr. Haas-Wilson admitted that

REDACTED

(Haas-Wilson, Tr. 2834-36, *in camera*; see also RFF ¶¶ 1053, 1059-1061; RFF ¶¶ 1054-1058, 1062-1064, *in camera*). Consequently, it is impossible to conclude that the post-Merger price changes were anticompetitive based on a simple examination of price changes, without a consideration of competitive price levels.

Finally, this proposed finding is misleading to the extent the calculated price increases are based on a comparison of Evanston Hospital/ENH with an overly broad control groups. (RFF-Reply ¶¶ 515-517).

658.

REDACTED

(Haas-Wilson, Tr. 2625, *in camera*; CX 6279 at 18, *in camera*).

Response to Finding No. 658:

This proposed finding is misleading. (RFF-Reply ¶ 657).

659.

REDACTED

(Haas-Wilson, Tr. 2628, *in camera*;
CX 6282 at 6, *in camera*).

Response to Finding No. 659:

This proposed finding is misleading. (RFF-Reply ¶ 384).

660.

REDACTED

(Haas-Wilson, Tr. 2628-29 (discussing DX 7016, *in camera*), *in camera*).

Response to Finding No. 660:

This proposed finding is misleading to the extent that it suggests that the methodology which Dr. Haas-Wilson used to case-mix adjust, described above, is the best method.

REDACTED

REDACTED

(Baker, Tr. 4649, *in camera*).

a. Aetna

661.

REDACTED

(Haas-Wilson, Tr. 2512 (referring to DX 7010, *in camera*), *in camera*).

Response to Finding No. 661:

This proposed finding is misleading to the extent that,

REDACTED

Baker, Tr. 4636-37, *in camera*; Haas-Wilson, Tr. 2511, *in camera*; RFF ¶ 1028, *in camera*).

662.

REDACTED

(CX 6279 at 18, *in camera*).

Response to Finding No. 662:

This proposed finding is misleading. (RFF-Reply ¶ 657).

663.

REDACTED

(CX 6279 at 18, *in camera*).

Response to Finding No. 663:

This proposed finding is misleading. (RFF-Reply ¶ 657).

664.

REDACTED

(CX 6279 at 19, *in camera*).

Response to Finding No. 664:

This proposed finding is misleading. (RFF-Reply ¶ 657).

b. Blue Cross

665.

REDACTED

(Haas-Wilson, Tr. 2626, *in camera*).

Response to Finding No. 665:

Respondent has no specific response.

c. Humana

666.

REDACTED

(Haas-Wilson, Tr. 2511-12 (referring to DX 7010, *in camera*), *in camera*).

Response to Finding No. 666:

This proposed finding is misleading. (RFF-Reply ¶ 661).

667.

REDACTED

Haas-Wilson, Tr. 2626-27, *in camera*; CX 6279 at 19, *in camera*).

Response to Finding No. 667:

This proposed finding is misleading. (RFF-Reply ¶ 657). This finding is also misleading to the extent that it is based on data that do not include price information for capitated plans.

REDACTED

(Haas-Wilson, Tr. 2853, *in camera*; Noether, Tr. 6076-77, *in camera*; RFF ¶ 1029).

REDACTED

(Noether, Tr. 6076, *in camera*; RFF ¶ 1128).

668.

REDACTED

(Haas-Wilson, Tr. 2626-27, *in camera*; CX 6279 at 19, *in camera*).

Response to Finding No. 668:

This proposed finding is misleading. (RFF-Reply ¶¶ 657, 667).

669.

REDACTED

(CX 6279 at 19, *in camera*).

Response to Finding No. 669:

This proposed finding is misleading. (RFF-Reply ¶¶ 657, 667).

670.

REDACTED

(CX 6279 at 19, *in camera*).

Response to Finding No. 670:

This proposed finding is misleading. (RFF-Reply ¶¶ 657, 667).

671.

REDACTED

(CX 6279 at 19, *in camera*).

Response to Finding No. 671:

This proposed finding is misleading. (RFF-Reply ¶¶ 657, 667).

d. United

672.

REDACTED

(Haas-Wilson, Tr. 2511-12 (referring to DX 7010, *in camera*), *in camera*).

Response to Finding No. 672:

This proposed finding is misleading. (RFF-Reply ¶ 661).

673.

REDACTED

(Haas-Wilson, Tr. 2626-28, *in camera*; CX 6279 at 19, *in camera*).

Response to Finding No. 673:

This proposed finding is misleading. (RFF-Reply ¶ 657). This finding is also misleading to the extent it ignores the data problems that existed with the United data.

REDACTED

(Baker, Tr. 4622, *in camera*). In addition,

REDACTED

REDACTED

26, 4628, 4806-7, *in camera*; Noether, Tr. 6053-55; RFF ¶¶ 1013-1015, 1103, *in camera*).

674.

REDACTED

(Haas-Wilson, Tr. 2627-28, *in camera*; CX 6279 at 19, *in camera*).

Response to Finding No. 674:

This proposed finding is misleading. (RFF-Reply ¶¶ 657, 673).

675.

REDACTED

Response to Finding No. 675:

This proposed finding is misleading. (RFF-Reply ¶¶ 657, 673).

676.

REDACTED

(CX 6279 at 19, *in camera*).

Response to Finding No. 676:

This proposed finding is misleading. (RFF-Reply ¶¶ 657, 673).

677.

REDACTED

(CX 6279 at 19, *in camera*).

Response to Finding No. 677:

This proposed finding is misleading. (RFF-Reply ¶¶ 657, 673).

e. **One Health (Great-West)**

678.

REDACTED

(Haas-Wilson, Tr. 2511-12 (referring to DX 7010, *in camera*), *in camera*).

Response to Finding No. 678:

This proposed finding is misleading. (RFF-Reply ¶¶ 384, 466).

679.

REDACTED

(Haas-Wilson, Tr. 2628, *in camera*; CX 6282 at 6, *in camera*).

Response to Finding No. 679:

This proposed finding is misleading. (RFF-Reply ¶ 657). In addition, this finding is misleading to the extent it relies on Great West data.

REDACTED

accurately reflect prices.} (Noether, Tr. 6050, *in camera*).

680.

REDACTED

(CX 6282 at 6, *in camera*).

Response to Finding No. 680:

This proposed finding is misleading. (RFF-Reply ¶¶ 657, 679).

681.

REDACTED

in camera).

(CX 6282 at 6

Response to Finding No. 681:

This proposed finding is misleading. (RFF-Reply ¶¶ 657, 679).

682.

REDACTED

(CX 6282 at 6, *in camera*).

Response to Finding No. 682:

This proposed finding is misleading. (RFF-Reply ¶¶ 657, 679).

4.

REDACTED

683.

(Baker, Tr. 4631-32, *in camera*).

Response to Finding No. 683:

This proposed finding is incomplete. (RFF-Reply ¶ 494).

684.

REDACTED

(Baker, Tr. 4635, *in camera*).

Response to Finding No. 684:

This proposed finding is incomplete. (RFF-Reply ¶ 496).

685.

REDACTED

(Baker Tr. 4648-49, *in camera*).

(Baker, Tr. 4800, *in camera*).

Response to Finding No. 685:

This proposed finding is incomplete.

REDACTED

REDACTED

(Baker, Tr. 4648-49, *in camera*).

686.

REDACTED

camera).

(Dr. Baker, Tr. 4638, *in camera*).

Response to Finding No. 686:

This proposed finding is incomplete.

(Baker, Tr. 4637-38, 4755, *in camera*).

REDACTED

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

REDACTED

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

REDACTED

(Baker, Tr. 4633, 4638-39, 4662, *in camera*).

687. The control groups chosen by Dr. Noether were biased. (CCFF 1814-1951).

Response to Finding No. 687:

This proposed finding is incorrect. The control groups chosen by Dr. Noether were appropriate for Professor Baker's and her analyses. (RFF-Reply ¶¶ 1814-1951).

688.

REDACTED

(Haas-Wilson, Tr. 2635-36 (referring to DX 7019 at 1, *in camera*), *in camera*; Baker Tr. 4645 (discussing DX 8042, *in camera*), *in camera*).

Response to Finding No. 688:

This proposed finding is misleading

REDACTED

REDACTED

(Baker,

Tr. 4646-47, *in camera*).

REDACTED

(Baker, Tr. 4617-19, 4795-96, *in camera*).

REDACTED

(Baker, Tr. 4619-20, 4646, 4795-96, *in camera*; Haas-Wilson, Tr. 2637, *in camera*).

REDACTED

(Baker, Tr. 4645-46, *in camera*).

689.

REDACTED

(Haas-Wilson,

Tr. 2636-37 (referring to DX 7019 at 2, *in camera*), *in camera*; Baker Tr. 4645-46 (discussing DX 8042, *in camera*), *in camera*).

Response to Finding No. 689:

This proposed finding is incomplete and misleading.

REDACTED

REDACTED

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

(Baker, Tr. 4628, *in*

camera).

(Baker, Tr. 4646, *in camera*).

690.

REDACTED

(Haas-Wilson, Tr. 2630-31

(referring to DX 7018, *in camera*), *in camera*).

Response to Finding No. 690:

This proposed finding is incomplete, inaccurate and misleading.

REDACTED

(Haas-Wilson, Tr. 2853, *in camera*; Noether,

Tr. 6075-77, *in camera*).

REDACTED

(Hillebrand, Tr. 1867; Noether, Tr. 6076-77, *in camera*).

REDACTED

(Hillebrand, Tr. 1863-66; Noether, Tr. 6078-79, *in camera*).

691. Dr. Baker admitted that the pricing pattern of ENH's prices to Humans [sic], Aetna, and United was consistent with ENH obtaining market power through the merger with Highland Park. (Baker, Tr. 4742-43)

Response to Finding No. 691:

This proposed finding is misleading and incomplete. This proposed finding is misleading and incomplete.

REDACTED

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

REDACTED

(Baker, Tr. 4653-54).

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

REDACTED

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

692. Even using Dr. Noether's biased control groups, Dr. Baker's results were consistent with Dr. Haas-Wilson's results. (CCFF 683-691).

Response to Finding No. 692:

This proposed finding is incorrect. First, the control groups chosen by Dr. Noether were appropriate for both Professor Baker's and her analyses – and were not biased. (RFF-Reply ¶¶ 1814-1951).

REDACTED

(Baker, Tr. 4645-46, *in camera*).

REDACTED

(RFF-Reply ¶ 691).

5. Conclusion

693.

REDACTED

(Haas-Wilson, Tr. 2637 (referring to DX 7024), *in camera*).

Response to Finding No. 693:

This proposed finding is misleading to the extent it ignores the data, control group and other methodology issues discussed in greater detail in Respondent's Reply Findings 609-682. (RFF-Reply ¶¶ 609-682).

F. The Learning About Demand Theory Does Not Explain the Price Increases at ENH

694. Changes in information, or learning about demand, is a potential explanation that was put forth by the experts hired by ENH in this case. (Haas-Wilson, Tr. 2488).

REDACTED

(Haas-Wilson, Tr. 2642 (referring to DX 7024), *in camera*).

Response to Finding No. 694:

Respondent has no specific response.

695.

REDACTED

(Haas-Wilson, Tr. 2643, *in camera*).

Response to Finding No. 695:

This proposed finding is misleading to the extent it ignores the fact that Professor Baker had a very explicit test for the learning about demand hypothesis.

REDACTED

(Baker, Tr. 4656-57, *in camera*).

REDACTED

(Baker, Tr. 4657-58, *in camera*).

REDACTED

(Noether, Tr. 6052, *in camera*).

Finally, this proposed finding is misleading to the extent it ignores

REDACTED

(Haas-Wilson, Tr. 2832-

33, *in camera*).

1. **The Pre-Merger Payment Rates in the Highland Park Contracts with Commercial Payers Would Not Teach ENH About the Demand by Payers for Its Services**

696.

REDACTED

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

Response to Finding No. 696:

This proposed finding is misleading because it ignores that there are several different ways to think about price. (Noether, Tr. 647). Negotiated rates or contracted rates are one measure of price. (Noether, Tr. 5988).

REDACTED

(Baker, Tr. 4807-08). Using negotiated rates as a measure of price, it follows that the hospital with the higher negotiated rates would have had higher prices.

697.

REDACTED

(Haas-Wilson, Tr. 2645 (referring to DX 7046, *in camera*), *in camera*).

Response to Finding No. 697:

While it is true that contracted rates and reimbursement rates are two different measures of price and that contracts can be complex, this proposed finding is misleading to the extent it suggests that Evanston Hospital's examination of contracted rates, as influenced by all pertinent contract terms, did not provide information about prices relative to HPH.

REDACTED

(RX 762, *in camera*).

In addition, this proposed finding is misleading to the extent it suggests that the only prices that could have informed ENH about the demand for its services were contracted rates. Both Bain and Chan conducted an evaluation of average reimbursement and concluded, on that basis, that, in many cases, Evanston Hospital's prices were lower than HPH's prices. (RX 684 at BAIN 43; RX 625 at ENH JL 8294).

698.

REDACTED

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

Response to Finding No. 698:

This proposed finding is misleading. (RFF-Reply ¶ 697).

699. Learning about contract rates does not necessarily tell one which hospital has the higher prices. (CCFF 696-698).

Response to Finding No. 699:

This proposed finding is misleading because it ignores the fact there are several ways to measure price. Contract rates are only one of many ways to measure price. (RFF-Reply ¶¶ 696-98; RFF ¶¶ 647-655). In addition, this proposed finding is misleading to the extent it suggests that contract rates were the only manner in which Evanston Hospital/ENH examined prices. (RFF-Reply ¶ 698). Finally, this proposed finding is misleading to the extent it suggests that Evanston Hospital/ENH did not learn about prices, in part, from an examination of HPH's contract rates in this case. It is undisputed that executives at Evanston Hospital/ENH and HPH were surprised to learn that HPH had higher contracted rates than Evanston Hospital, thus confirming that there was something to be learned about prices from contract rates in this

instance. (Sirabian, Tr. 5718; Spaeth, Tr. 2297; Hillebrand, Tr. 1871; Neaman, Tr. 1342, 1344-45).

700.

REDACTED

(Haas-Wilson, Tr. 2646 (discussing DX 7047, *in camera*), *in camera*).

Response to Finding No. 700:

This proposed finding is misleading for several reasons.

REDACTED

(Haas-Wilson, Tr. 2838-39, *in camera*).

REDACTED

REDACTED

(Haas-Wilson, Tr. 2836-39, *in camera*).

Third, this proposed finding is misleading to the extent it ignores the vast majority of the record evidence, which showed that, in many instances, pre-Merger HPH's prices, using both reimbursement amount and contract rates as measures of prices, were actually higher than

Evanston Hospital's prices.

REDACTED

(RX 684 at BAIN 43; RX 762 at ENHL

TC 9917, 9924, 9936, 9942, *in camera*; RX 2047 at 57 (Ogden, Dep.); Hillebrand, Tr. 1892; RFF

¶¶ 677-693). An analysis annual net revenue, conducted by Chan, revealed that for 80% of

HPH's contracts, if HPH had been paid under Evanston Hospital's contracted rates it would have

received \$8 million less than what HPH was currently receiving from MCOs. (RX 674 at ENHL

TC 17915; Chan, Tr. 723-24). Dr. Noether also looked at actual Evanston Hospital and HPH

contracted rates.

REDACTED

(RX 1912 at 34). In addition,

REDACTED

(Noether, Tr. 6084-85, *in camera*).

REDACTED

(RX 1912 at 150-152).

701.

REDACTED

(Haas-Wilson,

Tr. 2646 (discussing DX 7047, *in camera*), *in camera*).

Response to Finding No. 701:

This proposed finding is misleading. (RFF-Reply ¶¶ 697, 699, 700).

702.

REDACTED

(Haas-Wilson, Tr. 2647, *in*

camera. See CCFF 700-701).

Response to Finding No. 702:

This proposed finding is misleading. (RFF-Reply ¶¶ 696-698, 700-701).

2. **The Academic Control Group, Developed by Dr. Noether and Used by Both Dr. Noether and Dr. Baker, Is an Inappropriate Control Group to Compare with ENH**

703.

REDACTED

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

Response to Finding No. 703:

Respondent has no specific response.

704.

REDACTED

(Haas-Wilson, Tr. 2698-2710 (referring to DX 7031, *in camera*), *in camera*).

Response to Finding No. 704:

This proposed finding is misleading to the extent it suggests that the factors used by Dr. Noether in the selection of her control groups (breadth of service, size and teaching intensity) were not appropriate. In addition, this proposed finding is misleading to the extent it suggests that any of the four “differences” referenced are significant, or that an examination of these “differences” suggests that Dr. Noether’s control groups are not appropriate for comparison to ENH. (Reply-RFF ¶¶ 705-725).

- a. **ENH’s Patient Mix Is Very Different from the Patient Mix of Loyola University, Northwestern Memorial, Rush Presbyterian-St. Luke’s, and the University of Chicago**

705.

REDACTED

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

Response to Finding No. 705:

This proposed finding is misleading to the extent it ignores that case mix or patient mix reflects not just the “types of cases treated” but also the volume of patients treated for a particular condition. (Noether, Tr. 6162).

706.

REDACTED

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

Response to Finding No. 706:

Respondent has no specific response.

707.

REDACTED

(Haas-Wilson, Tr. 2699-2700 (referring to DX 7057, *in camera*), *in camera*; RX 1912 at 25).

Response to Finding No. 707:

This proposed finding is misleading to the extent that it overstates the significance of case mix. Because looking at case mix alone can be very misleading, Dr. Noether elected not to use case mix as one of the criteria by which she defined her academic control group. (Noether, Tr. 6212). In addition, this proposed finding is misleading because it overstates the significance of the difference in case mix between ENH and Northwestern Memorial. ENH’s 1.14 is nearly identical to Northwestern Memorial’s 1.18.

708.

REDACTED

(Haas-Wilson, Tr. 2699-70 (referring to DX 7057, *in camera*), *in camera*; RX 1912 at 26, *in camera*).

Response to Finding No. 708:

This proposed finding is misleading to the extent it overstates the significance of case mix index. (Reply-RFF ¶¶ 707).

709.

REDACTED

(Haas-Wilson, Tr. 2700

(referring to DX 7057, *in camera*), *in camera*).

Response to Finding No. 709:

This proposed finding is misleading to the extent it overstates the significance of case mix index. (Reply-RFF ¶¶ 707).

- b. **Dr. Noether's Academic Control Group Inappropriately Compares ENH to Hospitals That Perform Quaternary Services**

710.

REDACTED

(Haas-Wilson, Tr. 2701, *in*

camera).

Response to Finding No. 710:

This proposed finding is misleading to the extent that quaternary services are not clearly defined.

REDACTED

(Noether, Tr. 6001; Haas-Wilson,

Tr. 2876, *in camera*). This definition, however, conflicts with the Complaint,

REDACTED

;(Haas-Wilson, Tr. 2876, *in*

camera).

REDACTED

REDACTED

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

REDACTED

camera).

(Haas-Wilson, Tr. 2879-85, *in camera*).

This proposed finding is also misleading to the extent it ignores that ENH used to offer services such as sophisticated burn treatments and continues to offer services such at cardioangiogenesis. (RFF-Reply ¶ 293).

711.

REDACTED

(Haas-Wilson, Tr. 2701 (referring to DX 7058, *in camera*), *in camera*).

Response to Finding No. 711:

This proposed finding is vague because it does not define the phrase “thought of as different.” In addition this proposed finding is vague and misleading to the extent it ignores the fact that the definition of quaternary services is unsettled. (RFF-Reply ¶ 710).

712.

REDACTED

(Haas-Wilson, Tr. 2702 (referring to DX 7058, *in camera*), *in camera*).

Response to Finding No. 712:

This proposed finding is misleading to the extent that it overstates the significance of these services. Solid organ transplants and extensive burn injuries are a very small portion – .8 of 1% – of the total number of services provided at any of the academic control group hospitals. (Noether, Tr. 6002). In addition, this proposed finding is misleading to the extent it ignores that, at one point, Evanston Hospital did provide extensive burn services (a quaternary service according to Dr. Haas-Wilson’s testimony), but elected to terminate the program because

demand was significantly reduced by the widespread use of fire detectors. (Noether, Tr. 6002-03; Hillebrand, Tr. 2009-10).

c. Most of the Hospitals in Dr. Noether's Academic Control Group Were Not Similar to ENH in Terms of the Overall Inpatient Services They Provide

713.

REDACTED

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

Response to Finding No. 713:

This proposed finding is misleading to the extent it suggests that Dr. Haas-Wilson's measure of breadth of service provides useful information about the similarities between ENH and control group hospitals. This measure is misleading because it places undue weight on higher volume DRGs, such as obstetrics, because it double-counts both mother and baby and, by squaring the sums of the differences, it inappropriately amplifies the differences between hospitals. For example 94% of Dr. Haas-Wilson's measured difference between ENH and Northwestern Memorial was due to obstetrics patients. This demonstrated that Dr. Haas-Wilson's measure is dominated by obstetrics services and really only reflects the size of obstetrics programs at various hospitals, even though obstetrics services account for only 22 out of 520 DRGs. (Noether, Tr. 6004-08; RFF ¶¶ 1083-1084).

714.

REDACTED

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

Response to Finding No. 714:

This proposed finding is misleading to the extent it suggests that Dr. Haas-Wilson's measure of breadth of service provides useful information about the similarities between ENH and control group hospitals. For the reasons discussed in RFF-Reply ¶ 713, this measure is not useful.

715.

REDACTED

(Haas-Wilson, Tr. 2703, *in camera*; CX 6282 at 7 and 8, *in camera*).

Response to Finding No. 715:

This proposed finding is misleading to the extent it suggests that Dr. Haas-Wilson's measure of breadth of service provides useful information about the similarities between ENH and control group hospitals. For the reasons discussed in RFF-Reply ¶ 713, this measure is not useful.

716.

REDACTED

(Haas-Wilson, Tr. 2704-05, *in camera*).

Response to Finding No. 716:

This proposed finding is misleading to the extent that it suggests that Dr. Haas-Wilson's measure of breadth of service provides useful information about the similarities between ENH and control group hospitals. For the reasons discussed in RFF-Reply ¶ 713, this measure is not useful.

717.

REDACTED

(Haas-Wilson, Tr. 2706, *in camera*).

Response to Finding No. 717:

Respondent has no specific response to the first sentence. The second sentence of this proposed finding is misleading to the extent it suggests that Dr. Haas-Wilson's measure of breadth of service is informative. (RFF-Reply ¶ 713).

718.

REDACTED

2707, *in camera*; CX 6282 at 7, 8; *in camera*).

Response to Finding No. 718:

This proposed finding is inaccurate. For the reasons discussed in RFF-Reply ¶ 713, Dr. Haas-Wilson's measure of breadth of service does not provide useful information about the similarities between ENH and other Chicago area hospitals.

- d. **Teaching Intensity, Bed Size, and Public Perception Were All Factors That Cut Against Dr. Noether's Control Group Being an Appropriate Control Group**

719.

REDACTED

2708 (referring to DX 7061, *in camera*), *in camera*).

(Haas-Wilson, Tr.

Response to Finding No. 719:

This proposed finding is misleading to the extent that it suggests that the cut-off employed by Dr. Noether, 0.25 residents per bed, was inappropriate.

REDACTED

REDACTED

(Noether, Tr. 5922, 5995-96; Noether, Tr. 6111, *in camera*).

720.

REDACTED

REDACTED

(Haas-Wilson, Tr. 2708-09, *in camera*; DX 7060, *in camera*).

Response to Finding No. 720:

This proposed finding is misleading to the extent it suggests that the differences described are significant. Dr. Noether used a cut-off of 300 beds to define “major teaching hospital.” Solucient also considers bed size when identifying major academic hospitals, using a cut-off of 400 beds – a definition that ENH also satisfies. (Romano, Tr. 3432). This confirms that Dr. Noether’s cut-off was reasonable. Dr. Haas-Wilson offered no similar evidence to confirm her control group criteria. In addition, this proposed finding is misleading because it ignores evidence suggesting that Advocate Northside actually had around 500 beds, rather than 663 as this finding suggests. (Noether, Tr. 5919-20).

721.

REDACTED

(Haas-Wilson, Tr. 2711-2713 (referring to DX 7051, *in camera*), *in camera*).

Response to Finding No. 721:

This proposed finding is misleading to the extent it suggests that the U.S. News and World Report for 2004 is the only, or best, measure of whether a hospital is “one of the leading Chicago teaching hospitals. Although she relied on one year of U.S. News and World Report, Dr. Haas-Wilson did not realize that the reputational component of the U.S. News Score, which represents one third of the score, was based on a survey of only 150 physicians in a given specialty nationwide, rather than surveys of actual consumers (i.e. the public). (Haas-Wilson, Tr. 2930). Dr. Haas-Wilson was aware of other measures of public perception of quality, such as Solucient’s Top 100 hospital list. (Haas-Wilson, Tr. 2932). And she admitted that Solucient

rankings would be relevant to public perception. (Haas-Wilson, Tr. 2932). She was not, however, aware that Solucient had classified ENH as a major teaching hospital in its rankings, or that ENH had been named to Solucient's Top 100 hospitals lists for the tenth time in 2005. (Haas-Wilson, Tr. 2932). In addition, ENH has received a number of other quality-related awards – such as the National Quality Award, the KLAS and Davies awards and the Leapfrog Award. (Neaman, Tr. 1291; RFF ¶ 3). Although Dr. Haas-Wilson was aware of many of these awards, she was not aware that ENH had received them. (Haas-Wilson, Tr. 3931-33). Finally, Dr. Haas-Wilson ignored that US News & World Report had recognized ENH as one of “America's Best Hospitals” in other years. (RFF ¶ 3).

e. **The Testimony of ENH's Customers Undermines Dr. Noether's Control Group**

722.

REDACTED

(Haas-Wilson, Tr. 2713-14, *in camera*, citing Ballengee, Tr. at 188-189).

Response to Finding No. 722:

This proposed finding is misleading because her testimony was inaccurate. PHCS's own documents categorize pre-Merger Evanston Hospital as an “Advanced Teaching” hospital. (RX 107 at GWL 859). Indeed, Ballengee authored this very document. (RX 107 at GWL 859).

Ballengee inexplicably changed her description of the hospital at trial. This testimony should be given no weight, and her credibility and reliability as a witness be viewed as extremely suspect.

(RFF-Reply ¶ 1080). Further,

REDACTED

(Haas-Wilson, Tr.

2713-14, *in camera*).