ORIGINAL

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

In the Matter of	)	
	)	
PROMEDICA HEALTH SYSTEM, INC.	)	Docket No. 9346
a corporation.	)	**PUBLIC**
	)	

RESPONDENT PROMEDICA HEALTH SYSTEM, INC.'S

PRE-TRIAL BRIEF

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INTRODUCTION

This is a hospital merger case. The FTC alleges that the joinder of St. Luke's Hospital (St. Luke's) with ProMedica Health System ("ProMedica") violates Clayton Act Section 7, 15 U.S.C. § 18. The ultimate question is whether the joinder of St. Luke's – which admits less than ten commercially-insured patients a day and, at the time of the joinder in September 2010, was in such financial distress that its survivability as a stand-alone community hospital was in doubt – with ProMedica will result in an increase in ProMedica's market power that enables ProMedica to raise rates in contracts it negotiates with commercial insurance companies – large sophisticated purchasers with substantial market power in their own right – above a competitive level for a sustained time. Because the evidence will demonstrate the joinder has not and will not have that effect, this case should be dismissed.[1]

The proper market in which to analyze the competitive effects of the joinder is the market to provide "general acute care inpatient hospital services." This is the market in which both the FTC and the Department of Justice, as well as federal courts, have analyzed "all modern hospital merger cases." *See In re Evanston Nw. Healthcare Corp.*, Dkt. No. 9315, Opinion of the Commission at 56 (FTC Aug. 6, 2007) ("[C]ourts have held repeatedly that acute inpatient hospital

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[1] As a preliminary matter, despite Complaint Counsel's repeated reference to the "findings" and decision of the United States District Court for the Northern District of Ohio in connection with the FTC's application for a preliminary injunction, Judge Katz's decision is entitled to no evidentiary effect in this hearing. Because the limited purpose of a preliminary injunction action is to preserve the *status quo* pending trial, and considering the "haste that is often necessary," the findings of fact made by a court granting a preliminary injunction are not binding at the trial on the merits. *In re R.R. Donnelley & Sons Co.*, No. 9243, 1995 FTC LEXIS 215, at *17 (July 21, 1995) (citing *Univ. of Tex. v. Camenisch*, 451 U.S. 390, 394-95 (1981)); *see A.J. Canfield Co. v. Vess Beverages, Inc.*, 859 F.2d 36, 38 (7th Cir. 1988); *Indus. Bank of Wash. v. Tobriner*, 405 F.2d 1321, 1324 (D.C. Cir. 1968) (district court was only authorized to consider the likelihood of success, and "[t]o the extent that the findings and conclusions of the District Judge purported to settle finally the questions of law and fact raised by the complaint, those findings and conclusions went beyond the determination the judge was called upon to make, and should not be regarded as binding in further proceedings in the trial court"). In fact, the FTC has taken the position that a district judge lacks *any authority* to resolve any issues in a case, and any attempt to grant preclusive effect to a district court's decision would "usurp the Commission's statutory fact-finding role." *R.R. Donnelley & Sons*, 1995 FTC LEXIS 215, at *22.

services are a "cluster of services" that constitute a relevant product market.") (citing *FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir. 1995); *FTC v. Univ. Health., Inc.*, 938 F.2d 1206, 1211-12 (11th Cir. 1991); *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 138-40 (E.D.N.Y. 1997) ; *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1290-91 (W.D. Mich. 1996)).

While the FTC's Complaint alleges that one relevant product market in this case is "general acute-care inpatient hospital services sold to commercial health plans," (Compl. ¶ 12), the precise contours of Complaint Counsel's "product market" are muddled and imprecise, and fail to meet the requirements of Section 7. For example, Complaint Counsel fail to explain or identify the "more sophisticated and specialized tertiary and quaternary services" that are excluded from the "general acute care inpatient services market." (Compl. ¶ 13). Complaint Counsel's economic expert calculates market shares for another "market" that is narrower than the product market the Complaint alleges and includes only those procedures that were performed three or more times at both St. Luke's and at ProMedica. The FTC's economist then conducts a "competitive effects" analysis that purports to measure the alleged "price effects" of the joinder across yet another set of services – including those supposedly excluded from the FTC's and Complaint Counsel's markets. The net effect of Complaint Counsel's shifting product market definition is to elevate unrealistically the competitive significance of St. Luke's, and to distort the likely competitive effects of the transaction.

Complaint Counsel compound these mistakes by also alleging, contrary to the market defined in any other hospital merger case, a separate product "market" for "inpatient obstetrical services." But the rationale for the "cluster market" of all general acute care inpatient services in a hospital merger case is that while "the treatments offered to patients within this cluster of services are not substitutes for one another . . . the services and resources that hospitals provide tend to be similar across a wide range of primary, secondary, and tertiary inpatient services."

California v. Sutter Health Sys., 130 F. Supp. 2d 1109, 1119 (N.D. Cal. 2001). The Complaint's allegation that "no other hospital services are reasonably interchangeable with inpatient obstetrical services," (Compl. ¶ 14), is therefore irrelevant to the proper definition of the cluster of services purchased by commercial health plans. No commercial health plan separately contracts for the small subset of low-risk labor and delivery services that St. Luke's offers. Those services are not separately bought or sold by any participant in the market. There is no independent "market" for inpatient OB services, and the FTC's focus on them is wrong as a matter of law. There is no basis here to depart from the market definition that has been used in "all modern hospital merger cases."

As to the geographic component of the relevant market definition, the Complaint alleges that Lucas County, Ohio is the relevant geographic market (Compl. ¶ 16). But much of Complaint Counsel's expert's analysis of the competitive effects of the transaction inexplicably and inappropriately analyzes a much smaller geographic area – limited to a few zip codes immediately surrounding St. Luke's. The geographic market must "both 'correspond to the commercial realities' of the industry and be economically significant." *Brown Shoe Co. v. United States*, 370 U.S. 294, 336-37 (1962). There is no legal basis for Complaint Counsel's focus on the restricted and narrow geographic area immediately surrounding St. Luke's.

Even if Complaint Counsel's market definitions met the requirements of Section 7, they cannot prevail in this case because they cannot demonstrate that the joinder is likely substantially to lessen competition by increasing ProMedica's market power such that it will be able to extract supracompetitive rates from the large, sophisticated commercial insurers who are the "consumers" at issue here. Complaint Counsel rely on their market share calculations to argue that the joinder is "presumptively unlawful." But market shares are only meaningful if they are a

predictor of the ability of a competitor to exercise market power in the future. Here, St. Luke's treats a very small volume of commercially insured patients (approximately 10 per day), and the addition of those patients to ProMedica simply is not sufficient to confer upon ProMedica market power to extract supracompetive rates.

Beyond "market shares," the court must examine the "structure, history and probable future" of the market to determine whether high market shares indicate there are likely to be anticompetitive effects from the transaction. *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 498 (1974). Here, Mercy Health Partners ("Mercy") and University of Toledo Medical Center ("UTMC") will continue to act as competitive constraints on ProMedica, and other market dynamics, including excess capacity and the potential for "re-positioning" by Mercy in southwest Toledo, will further constrain ProMedica. While Complaint Counsel's economist claims to have constructed a "model" that shows that ProMedica has "market power" that it could use to increase rates as a result of the joinder, the model does not withstand scrutiny. Indeed, an examination of the real world market dynamics in a properly defined market will reveal that ProMedica does not have, nor does this transaction give it, market power sufficient to raise prices to supracompetitive levels. Complaint Counsel therefore cannot prove a Section 7 violation.

FACTUAL BACKGROUND

A. Hospitals Located in Toledo

Eight hospitals operate within close proximity to one another in Lucas County. Drive times to and between hospitals are short, and patients can and do select from several competing hospitals within 20 minutes of their homes. RX-0071 (Guerin-Calvert 4/29/11 Report) ¶¶ 47-54.

The market is characterized by the presence of two large hospital systems, ProMedica and Mercy, and a large academic medical center, UTMC, which offers primary, secondary and

sophisticated tertiary and quaternary care services. Each of these three large competitors provides a full range of patient services, with the exception only of certain women's services at UTMC. Collectively the three systems account for the vast majority of patient volumes and revenues, including commercial revenues and volumes, in Lucas County. St. Luke's is the smallest of the four Toledo-based hospital systems.

To understand the differences between St. Luke's and the two large system competitors, it is useful to look at their relative size, measured by billed charges. ProMedica and Mercy are similar in size. In 2009, across all general acute care inpatient services, ProMedica had $295 million in billed charges; Mercy had $245 million. In contrast, St. Luke's had billed charges of $50 million. *See* RX-0071-13 (Guerin-Calvert Report) ¶ 21.

1. ProMedica Health System, Inc.

ProMedica is a high-quality, not-for-profit integrated healthcare system based in Toledo, Ohio. ProMedica's family of hospitals in the region includes three general acute-care hospitals located in Lucas County, Ohio: The Toledo Hospital ("TTH"), Bay Park Community Hospital ("Bay Park"), and Flower Hospital ("Flower"). The three hospitals serve all of Lucas County as well as patients from the surrounding area.

The Toledo Hospital is ProMedica's flagship hospital, located in downtown Toledo. Widely recognized as the premier healthcare facility in northwest Ohio, TTH offers a broad array of primary, secondary, and tertiary-level services, including trauma care, cardio-vascular surgery, and advanced obstetrics services. TTH is the largest of ProMedica's three hospitals in Lucas County with 794 registered beds, of which 660 are currently staffed and in use. RX-0192 (Oostra Decl.) ¶ 4. TTH also houses Toledo Children's Hospital, a 151-bed pediatric hospital, on its campus. *Id.*

Flower Hospital is a community hospital located in Sylvania, Ohio on the western edge of Toledo proper. Flower offers some tertiary services, particularly for oncology. It has 297 registered beds (only 262 staffed). *Id.*

Bay Park Hospital is a community hospital located in Oregon, Ohio, just east of downtown Toledo. Bay Park has 86 registered beds (86 staffed). *Id.*

ProMedica operates four other hospitals located beyond the Toledo metropolitan area and has a 50 percent interest in Lima Memorial Health System in Lima, Ohio. *Id.* ¶ 5. It also owns and operates an insurance company, Paramount Health Care ("Paramount"), and a physician practice group, ProMedica Practice Group ("PPG"). *Id.* ¶ 3. Paramount offers health insurance products including commercial PPO and HMO plans and managed Medicare plans to seniors.[2] PPG employs about 250 physicians, evenly split between primary care physicians and specialists who are situated throughout the Toledo area. ProMedica also owns several ambulatory surgery, imaging, lab, and other medical offices, located across Toledo. *Id.*

2. St. Luke's Hospital

St. Luke Hospital ("St. Luke's" or "SLH") is a general acute-care hospital located in Maumee, Ohio on the southwestern edge of Toledo. While it has 302 registered beds, it only

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[2] Throughout their Pre-Trial Brief, Complaint Counsel seek to create the impression that ProMedica's ownership of Paramount gives it the incentive and ability to engage in anticompetitive conduct. There is no basis for Complaint Counsel's suggestion that there is something anticompetitive about ProMedica's relationship with Paramount. It is not illegal to be a vertically integrated health care provider, as ProMedica is. If delivery of integrated services, including health insurance products is a desirable and efficient way to conduct business, other competitors are free to start insurance subsidiaries. Nor is there any obligation for ProMedica or Paramount to contract with every hospital in Toledo. Just as { } excluded ProMedica from its network for decades, Paramount has elected to operate using a narrow network of hospitals that currently excludes Mercy and in the past excluded St. Luke's. That conduct is neither "unfair" nor "anticompetitive." In fact, hospital providers offer significant discounts to insurers for narrow networks – as { }. *See* PX02212-001 ({ } document discusses significant discount { } for exclusivity and the additional reimbursement { } opened its network to ProMedica).

staffs 222. RX-0194 (Wakeman Decl.) ¶ 5. St. Luke's is primarily a community hospital offering primary, secondary and only some minimal tertiary-care services (in cardiology). *Id.* St. Luke's employs a small number of physicians through its WellCare division. *Id.* ¶ 6. It also owns other medical facilities like an ambulatory surgery center, and other medical offices in southwest Toledo. *Id.* Prior to implementation of the Joinder Agreement, St. Luke's was a subsidiary of OhioCare Health System, Inc. ("OHS"), an Ohio nonprofit corporation that also owned the St. Luke's Hospital Foundation. *Id.* ¶ 3.

3. Mercy Health Partners

Mercy is part of the well-respected and financially strong Catholic Health Partners ("CHP"), a not-for-profit healthcare system headquartered in Cincinnati, Ohio that is comprised of 34 hospitals. RX-0194 (Wakeman Decl.) ¶ 8; RX-0206 (Shook Tr.) 45:11-17. As part of CHP, Mercy operates three hospitals in Lucas County, each located adjacent to a ProMedica hospital: St. Vincent Hospital ("St. Vincent"), St. Charles Hospital ("St. Charles"), and St. Anne's Hospital ("St. Anne's"). St. Vincent is Mercy's largest hospital in Lucas County. Located in downtown Toledo, it staffs 445 of its 568 registered beds and has over 800 physicians on staff. PX02068 (Shook Decl.) ¶ 3; RX-0093 (Guerin-Calvert Decl.) ¶¶ 11, 20. Like the nearby Toledo Hospital, St. Vincent's offers a wide variety of primary, secondary and sophisticated tertiary-care services. It houses a trauma center and a burn unit and offers advanced services in oncology, neurology and cardiac care among other specializations. PX02068 (Shook Decl.) ¶ 3. A children's hospital is also located on the St. Vincent campus. *Id.* ¶ 4; RX-0093 (Guerin-Calvert Decl.) ¶¶ 11 n.48. St. Charles is a community hospital located in Oregon, Ohio near ProMedica's Bay Park Hospital. St. Charles staffs 294 of its 390 registered beds and has 540 physicians on staff. PX02068 (Shook Decl.) ¶ 5; RX-0093 (Guerin-Calvert

Decl.) ¶¶ 11, 20. In addition to general acute-care services, St. Charles offers advanced maternity services. It treats high-risk mothers and newborns and houses a Level II neonatal intensive care unit ("NICU"). PX02068 (Shook Decl.) ¶ 5. St. Charles also offers medical, surgical, rehabilitation, psychiatric and behavioral services. *Id.* St. Anne's is a community hospital located on the western edge of Toledo, near ProMedica's Flower Hospital. St. Anne's has 128 registered beds, of which only 100 are in use. PX02068 (Shook Decl.) ¶ 6; RX-0093 (Guerin-Calvert Decl.) ¶¶ 11, 20.

4. University of Toledo Medical Center

UTMC, a state-owned facility located in southwest Toledo near St. Luke's Hospital, was formed in 2006 when the University of Toledo and the Medical University of Ohio merged. PX02064 (Gold (UTMC) Decl.) ¶ 1. UTMC sets itself apart from its local competitors as the only hospital to offer sophisticated quaternary services, like organ transplants. RX-0194 (Wakeman Decl.) ¶ 9. It employs about 200 physicians in a faculty practice group. RX-0038 (Oostra Tr.) 173:19-20. It has 319 registered beds (225 staffed). PX02064 (Gold (UTMC) Decl.) ¶ 1; RX-0093 (Guerin-Calvert Decl.) ¶ 20. As Lucas County's only academic medical center, UTMC is a teaching hospital focused on its research and educational mission. PX02064 (Gold (UTMC) Decl.) ¶ 2; RX-0093 (Guerin-Calvert Decl.) ¶ 14. It offers specialty care in cardiology, neurology, orthopedics, and oncology. PX02064 (Gold (UTMC) Decl.) ¶ 2; RX-0093 (Guerin-Calvert Decl.) ¶ 14.

B. Competitive Landscape for Inpatient Hospital Services in Toledo

1. Hospital Beds in Lucas County: Oversupply and Underutilization

With eight hospitals serving Lucas County, there is a significant oversupply and underutilization of hospital beds in Toledo. Compared to urban areas of comparable populations,

Toledo has a higher number of beds per capita, more facilities, and a greater number of independent competitors. RX-0071 (Guerin-Calvert Report) ¶ 109. Collectively, the Lucas County hospitals are licensed to operate 2,867 beds. RX-0093 (Guerin-Calvert Decl.) Table 2 at ¶ 20. Mercy and ProMedica account for the largest share of registered beds in the county, with 38 and 40 percent respectively. *Id.*

Only one Lucas County hospital actually *staffs* all of its registered beds; the vast majority use only a fraction of the beds they are licensed to staff. For example, the Mercy hospitals only staff 74 % of their licensed beds. UTMC only staffs 71 % of its licensed beds. *Id.*

Even the number of staffed beds in the area exceeds national averages. There are 3.6 staffed beds per 1,000 people in Toledo, as compared to the national average of 2.7. RX-0093 (Guerin-Calvert Decl.) ¶ 22. This high rate of staffed beds contributes to low utilization rates among all area hospitals. Many Lucas County hospitals have occupancy rates below 50%. *Id.* ¶ 20. Mercy hospitals have an average occupancy rate of only 45.5%. *Id.* St. Luke's rate is 37.5%. *Id.*

Utilization of the excess inpatient acute care bed capacity in Toledo is unlikely to improve in coming years. RX-0071 (Guerin-Calvert Report) ¶ 111. Hospitals and other analysts project a continuing decline in commercial inpatient admissions due to demographic trends and the continued shift of inpatient volumes to outpatient locations. *Id.* ¶ 112. Indeed one hospital competitor in Toledo, in connection with its analysis of St. Luke's as a possible merger partner, specifically noted that the services St. Luke's provides are the type that will increasingly be performed in outpatient setting in the future, and concluded that, "from a community need, all [of St. Luke's inpatient beds] could be eliminated from the Toledo area inventory and not be missed." RX-0254-3.

2. Physicians Practice at All Area Hospitals

Independent and affiliated physician practice groups are a separate competitive factor in the market. Most physicians in Toledo, including those that PPG and St. Luke's employ, have admitting privileges and actively practice at hospitals owned by two or more competing systems (RX-0035 (Hammerling Tr.) 17:2-4); it is not uncommon for physicians in Toledo to have admitting privileges "at all of the hospitals in town" (*Id.* at 18:10), and most are in-network providers with all major payors. RX-0071 (Guerin-Calvert Report) ¶ 32.

3. Payors in the Lucas County Hospital Market

Until recently, the market for commercial payors in Lucas County was characterized by three large health insurance companies – Anthem Blue Cross Blue Shield ("Anthem"), Medical Mutual of Ohio ("MMO") and Paramount – each marketing health insurance products with a "closed" network of hospitals. RX-0038 (Oostra Tr.) 248:16-18; PX02212-001.[3] Prior to 2008, MMO contracted only with Mercy, St. Luke's and UTMC, but not with ProMedica; Anthem and Paramount contracted only with ProMedica and UTMC, but not with Mercy or St. Luke's. RX-0042 (Wachsman Tr.) 51:9-52:2. Between 2005 and 2010, United Healthcare's network in Toledo excluded ProMedica hospitals. RX-0036 (Hanley Tr.) 97:6-9.

Insurers in Toledo historically have been able to offer a hospital network that was attractive to area employers by including one, but not necessarily both of the multi-hospital systems. *Id.* at 75:12-20; PX01910 (Randolph Tr.) 64:25-65:8. Paramount and Anthem offered

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[3] Other payors in the market include United Healthcare, Cigna, Aetna, and FrontPath, a consortium of area employers who negotiate jointly for health coverage for their employees. RX-0042 (Wachsman Tr.) 46:4-24, 151:5-7.

an attractive network comprised of *only* ProMedica hospitals and UTMC. *See, e.g.*, PX01903 (Hanley Tr.) 74:3-8. Neither insurer deemed St. Luke's essential to its network. *See* RX-0036 (Hanley Tr.) 84:11-18 (discussing fact that Paramount did not lose significant membership when St. Luke's left the network); PX01905 (Wachsman Tr.) 110:17-23 (same); RX-0040 (Randolph Tr.) 152:23-153:17 (loss of St. Luke's from Paramount network had minimal impact on Paramount, even for patients in Maumee, since UTMC's practice plan was a "very viable alternative to for the employers."). Similarly, MMO successfully marketed health plans with a network that did not include any ProMedica hospitals. (*See* RX-0042 (Wachsman Tr.) 51:13-24; RX-0036 (Hanley Tr.) 75:9-20.

Payors and hospitals bargain over a complex set of price and non-price terms. RX-0029 ({ } Tr.) 14:20-15:25; RX-0023 ({ } Tr.) 20:21-22:23; 26:5-17; RX-0012 ({ } Tr.) 37:8-22; RX-0013 ({ } Tr.) 77:3-14; RX-0027 ({ } Tr.) 32:6-15; PX02244; RX-0766. With regard to price, they bargain over the relative cost of different types of services (e.g., inpatient vs. out-patient; imaging; lab; etc.) RX-0023 ({ } Tr.) 26:5-27:5; RX-0012 ({ } Tr.) 36:22-39:1; RX-0013 ({ } Tr.) 75:15-21; RX-0027 ({ } Tr.) 31:11-32:3. Moreover, payors offer different health plans or products (e.g., HMO and PPO) and can and do bargain with providers over the relative costs of services in one plan versus another. *See* PX02212-001 (describing the fact that a shift in business from { } PPO plan to its HMO plan has resulted in a steady decline in the hospital's yield from { } business," thereby justifying a "rate increase" to Toledo area hospitals). *See also* PX01905 ({ } Tr). 154:2-156:1 (discussing same facts).

{ } experience is that employers are primarily concerned with a particular plan's total cost and range of benefits. PX01910; RX-0040 ({ } Tr.) 65:22-66:6. The

next most important issues are whether the employees' individual primary care physicians are participating providers in the plan (PX01910; RX-0040 ({ } Tr.). 66:13-17), and the location of the most frequently used services (e.g., pharmacy). *Id.* at 66:18-22. The inclusion of a particular hospital in a payor's network is "pretty far down the list" of contracting concerns, "especially in a community like Toledo where . . . you can go from one end of town to the other in 20 minutes." PX01910; RX-0040 ({ } Tr.) 67:1-11; *see also* RX-0093 (Guerin-Calvert Decl.) ¶ 17.

Complaint Counsel's case vastly oversimplifies the complexity of these negotiations, creating a misleading impression of the true nature of competition in the market for hospital services in Lucas County. Viewed in the context of the actual structure and dynamics of the market, the joinder of ProMedica and St. Luke's does not violate Section 7.

C. St. Luke's Pre-Joinder Financial Viability

1. St. Luke's Pre-Joinder Financial Condition Was Weak and Deteriorating

Prior to its joinder with ProMedica, St. Luke's and its parent OhioCare experienced significant operating losses in each of the years 2007 through 2009, and for the eight months ending August 31, 2010 as shown in the table below. PX01006, PX01013, PX01265, PX01008 (OhioCare and St. Luke's Financial Statements); RX-0056 (Den Uyl Report) ¶¶ 15-17 and Table1.

($ millions)	**2007**	**2008**	**2009**	**8/31/10**
Operating Loss (OhioCare)	($8.163)	($12.673)	($20.246)	($7.745)
Margin (OhioCare)	*-6.2%*	*-9.1%*	*-13.0%*	*-6.9%*
Operating Loss (St. Luke's)	($7.698)	($8.976)	($15.167)	($2.702)
Margin (St. Luke's)	*-5.9%*	*-6.6%*	*-10.3%*	*-2.6%*

St. Luke's total operating losses during this time period were more than $31 million and those of its parent more than $48 million. Notably, the largest annual losses, $20 million and $15 million for Ohio Care and St. Luke's respectively were in 2009, a year when all other hospitals in the Toledo area made a profit. RX-0209 (Guerin-Calvert Supplemental Decl., 1/31/11) ¶ 86.

Similarly, St. Luke's and OhioCare's operating margins were negative throughout that time period and significantly lower than comparable hospitals in Ohio and throughout the country. For example, in 2009 St. Luke's operating margin was *negative* 10.3% while the average for all Ohio Hospitals was *positive* 5%. PX01008, PX01005, PX02129 (St. Luke's Financial Statements); RX-0056 (Den Uyl Report) Table 2.

More importantly, in the years leading up to the joinder, St. Luke's was not generating sufficient cash flow from operations to fund its operations and to pay for its capital expenditures. OhioCare's aggregate cash flow losses from 2007 to August 31, 2010 totaled more than $28 million. PX01006, PX01013, PX01265 (OhioCare Financial Statements); RX-1284 (St. Luke's Statement Of Cash Flows for the eight months ended August 31, 2010); RX-0056 (Den Uyl Report) Table 5.

($ millions)	**2007**	**2008**	**2009**	**8/31/10**
Operating Cash Flow less Capital Expenditures	($2.103)	{ }	{ }	{ }

Ongoing cash flow losses like these are not sustainable. RX-0056 (Den Uyl Report) ¶ 22.

St. Luke's generated these negative results despite taking significant measures to reduce its expenditures. The capital expenditures of OhioCare have historically totaled approximately $11 million per year. *See, e.g.*, PX01003 (OhioCare Audited Financials 2007); PX01013 (OhioCare Audited Financials 2008); RX-0056 (Den Uyl Report) ¶ 61. However, in the time

leading up to the joinder, St. Luke's capital expenditures were significantly lower: $7 million in 2009 and $1.8 million in the first eight months of 2010. PX01006 (OhioCare Audited Financials 2009); RX-0674 (OhioCare Balance Sheet August 31, 2010); RX-0056 (Den Uyl Report) ¶ 61. Because it was not generating positive cash flow, St. Luke's restricted its capital expenditures and delayed a number of capital projects {

}. PX02018 (Johnston Decl.) ¶¶ 13-19, 28; RX-0056 (Den Uyl Report) ¶¶ 42, 62 and Table 16.

In addition to reduced capital spending, St. Luke's undertook further cost cutting actions in 2008 and 2009 that included a reduction of salaries for senior management, a freeze on employee salaries and on hiring of non-essential employees, a reduction in paid time off for employees, and the requirement that employees contribute greater amounts to the cost of their health insurance benefits. PX02102 (Wakeman Decl.) ¶ 14; RX-0056 (Den Uyl Report) ¶ 63. Moreover, St. Luke's froze its defined benefit pension plan effective December 31, 2009. PX02102 (Wakeman Decl.) ¶ 14; PX01006 (OhioCare Audited Financials 2009); RX-0056 (Den Uyl Report) ¶ 63. Most of these deferrals and cutbacks were not sustainable, but without them, St. Luke's losses would have been even larger.

Above and beyond its regular capital expenditures, St. Luke's faced a { } investment in a new Electronic Medical Records System ("EMR"). PX02102 (Wakeman Decl.) (Wakeman Decl.) ¶ 26; PX01496 (St. Luke's Eclypsis Cash Flow); PX02108 (Johnston Decl.) ¶ 12; RX-0056 (Den Uyl Report) ¶¶ 35, 38 and Table 8. The American Reinvestment and Recovery Act ("ARRA") required that healthcare providers implement EMR by 2015 or face penalties under Medicare or Medicaid reimbursement. PX02102 (Wakeman Decl.) ¶ 26. In late

2009, St. Luke's had selected Eclypsis to provide its EMR system at an expected cost of { } over seven years, with the largest investment, approximately { }, occurring in the first year. PX01496 (St. Luke's Eclypsis Cash Flow); RX-0056 (Den Uyl Report) *Id.* ¶ 35 and Table 8. St. Luke's expected to incur an additional { } of costs associated with incremental IT personnel and hardware needs over the first three years of the project. RX-0056 (Den Uyl Report) ¶ 38. It was not clear that St. Luke's could fund the EMR system project costs on its own. PX02102 (Wakeman Decl.) ¶ 26; PX02108 (Johnston Decl.) ¶ 12; RX-0022 (Perron Tr.) 113:24-113:25.

St. Luke's also faced large additional contributions into its pension plan in the time period leading up to the joinder and beyond. Although St. Luke's froze its defined benefit plan effective December 31, 2009, it still had the obligation to fully fund the plan to compensate for employee service up to that date. PX02108 (Johnston Decl.) ¶ 11; RX-0056 (Den Uyl Report) ¶ 31. In the years leading up to the joinder, St. Luke's liability associated with the pension had grown and its annual cash contribution increased. RX-0056 (Den Uyl Report) ¶ 31. St. Luke's needed to make ever larger contributions to maintain the required 80% funding level because it had dropped below that level between 2008 and August, 31, 2010. RX-1270 (OhioCare Audited Financials 2009); PX02129 (St. Luke's Hospital Balance Sheet as of August 31, 2010.); RX-0056 (Den Uyl Report) ¶ 32 and Table 7. And at a minimum, St. Luke's would need to contribute { } per year from 2012 through 2014 based on current actuarial estimates. RX-0015 (Arjani Tr.) 120:3-120:23, 125:16-126:11.

St. Luke's consistent operational losses combined with deferred capital expenditures, the need for a new EMR system, and large pension contributions threatened to deplete St. Luke's cash reserves. RX-0056 (Den Uyl Report) ¶ 40. As of August 31, 2010, St. Luke's had

unrestricted reserves of $46 million (less than one-half what they were in 2007). PX01265 (OhioCare Balance Sheet August 31, 2010); RX-0056 (Den Uyl Report) Table 9. However, if St. Luke's continued to operate at a loss and used those reserves to fund its deferred investments, a new EMR system, and its pension fund, they would be depleted rapidly. And that is not even taking into account the age of St. Luke's physical plant, which is significantly older than other hospitals, (RX-0056 (Den Uyl Report) Table 10), or additional planned improvements such as privatizing certain rooms, itself a { } cost. PX00160 (St. Luke's Service Integration Study); RX-0056 (Den Uyl Report) ¶ 43. Relying on *reserve* funds to finance St. Luke's *regular* expenditures and *necessary* investments was not a sustainable strategy.

2. St. Luke's Contracts With Payors Yielded Below Cost and Below Market Reimbursement

Central to St. Luke's financial problems was the fact that in the years preceding the joinder St. Luke's largest commercial payors, { }, did not reimburse St. Luke's at levels sufficient to cover the full cost of the Care St. Luke's provided to their members. RX-0194 (Wakeman Decl.) ¶¶ 15, 20; RX-0115 (Black Decl.) ¶ 9. PX02102 (Wakeman Decl.) ¶ 20; PX02119 (Wagner Decl.) ¶¶ 10-24; RX-0115 (Black Decl.) ¶ 9, 14. In 2009, St. Luke's engaged Navigant to study its commercial reimbursement rates. Navigant found that "as a system, { }." RX-0240 (St. Luke's Hospital, Managed Care Opportunity Analysis, November 25, 2009). More importantly, however, {

}. *See* RX-0849-000013 (2007 Cost and Revenue Per Case market data shows that St. Luke's is losing more than $450 per case, while the vast majority of hospitals in Toledo are making money). Typically, a hospital's Medicare and Medicaid reimbursements are below a hospital's costs, but the hospital makes up these losses with commercial reimbursement rates that

sufficiently exceed the costs of providing care to those patients. RX-0056 (Den Uyl Report) ¶ 23. However, { }. St. Luke's overall reimbursement for the services it provided from 2007 through August 31, 2010 was { }, as shown in the table below. *Id.* ¶ 29 and Table 6. A fundamental reason for this was that its two largest commercial payors, { }, reimbursed St. Luke's just barely above or even below the cost of providing care to its patients. *Id.*

Cost Coverage Ratios	**2007**	**2008**	**2009**	**8/31/10**
Medicare and Medicaid (~51% of Revenue)	0.79	0.78	0.76	0.89
{ }	0.99	1.01	1.01	0.99
All Payors	0.91	0.90	0.86	0.94

St. Luke's tried in 2009 and 2010 to renegotiate its rates with { } to move them closer to the point where the { }. RX-0194 (Wakeman Decl.) ¶ 20; RX-0056 (Den Uyl Report) ¶ 25; PX02119 (Wagner Decl.) ¶¶ 10-24; RX-0115 (Black Decl.) ¶ 9, 14; RX-0094 ({ } Tr.) 32-34; RX-0023 ({ } Tr.) 58-63; RX-0334; RX-0335; RX-0336. These negotiations failed to yield higher rates from either { }. *See* PX02102 (Wakeman Decl.) ¶ 20; PX02119 (Wagner Decl.) ¶¶ 10-24; RX-0115 (Black Decl.) ¶ 9, 14; RX-0094 ({ } Tr.) at 33-34; RX-0023 ({ } Tr.) at 62-63.

3. Dan Wakeman's Three Year Plan Did Not Remedy St. Luke's Financial Difficulties

St. Luke's faced these severe financial problems despite sincere attempts by St. Luke's CEO Dan Wakeman to remedy the situation in the years prior to the joinder. Shortly after his arrival in February of 2008, Wakeman instituted a three year plan to attempt to turn around St. Luke's failing finances. *See* RX-0194 (Wakeman Decl.) ¶ 17; PX01026. This plan did not

succeed, and St. Luke's financial bleeding continued throughout 2008, 2009, and the eight months in 2010 prior to the joinder. *See* PX02102 (Wakeman Decl.) ¶ 17; RX-0056 (Den Uyl Report) ¶ 64.

Moreover, even those elements of Wakeman's plan that were achieved did not lead to sustained financial recovery. For example, a part of St. Luke's three year plan was to hire more physicians to increase patient revenue. While St. Luke's did add physician practices and revenue did increase, those acquisitions caused St. Luke's costs to increase even more than its revenues did. The losses at WellCare, St. Luke's physician group, increased significantly as more physician groups were acquired. RX-0673 (WellCare Summary, 4/7/11; RX-0056 (Den Uyl Report) ¶ 55.

($ millions)	**2007**	**2008**	**2009**	**8/31/10**
Operating Loss (WellCare)	($0.081)	{ }	{ }	{ }

Similarly, as part of the three year plan, in July 2009 St. Luke's became an in-network provider for health plans marketed by { }, one of the largest commercial insurers in Toledo. PX01021; RX-0094 ({ } Tr.) 22:11- 22:18; RX-0056 (Den Uyl Report) ¶ 56. However, while St. Luke's volume of { } patients increased, its reimbursement as a percentage of its treatment costs decreased, because { } in-network rates were lower. RX-0056 (Den Uyl Report) ¶ 57 and Table 13. As a result, St. Luke's sustained a financial loss, on average, for each { } inpatient it treated after joining the { } network, and even the small profit it made on the average { } outpatient case declined. *Id.*

{ }: Per Case	2007	2008	2009	8/31/10
Inpatient Profit (Loss)	$597	($1,096)	($1,253)	($865)
Outpatient Profit (Loss)	$341	$374	$201	$73
Total Profit (Loss)	$358	$270	$130	$22

In sum, while some of St. Luke's turnaround efforts led to higher revenues and increased patient volumes, they also generated larger corresponding costs, thereby failing to rectify St. Luke's pre-joinder financial situation.

Another element of Wakeman's turnaround strategy involved shifting patients from an inpatient to an outpatient setting, because St. Luke's outpatient reimbursement rates were more favorable. RX-0051 (Wakeman Tr.) 10:1-17. Indeed for some payors, St. Luke's receives substantially more revenue from outpatient services than it does from inpatient services. *See* PX02210-002 (showing that of the {

} was for outpatient services). Of course, according to the FTC and Complaint Counsel, outpatient services are not part of the "market."

4. Moody's and AMBAC's Independent Assessments of St. Luke's Confirmed St. Luke's Financial Difficulty

Despite Dan Wakeman's 3-year plan goal to "Maintain St. Luke's 'A' Rating With Moody's," the rating agency downgraded St. Luke's bonds twice in the three years leading up to the joinder. In connection with its second downgrade in 2010, Moody's noted that "[t]he outlook remains negative," citing large and continuing expected operating losses, unfavorable commercial contracts and a "very competitive market with the presence of a number of hospitals that are part of two larger and financially stronger systems . . . ." RX-0225-00001 and 00003.

AMBAC, St. Luke's bond insurer, made a similar negative assessment of St. Luke's financial condition and outlook in 2010 after independently evaluating St. Luke's financials and

the market dynamics. *See, e.g.*, RX-0010 (Gordon Tr.) 58:23-61:19. Bruce Gordon, a Vice President at AMBAC and a 21-year veteran of hospital analyses, (RX-0010 (Gordon Tr.) 53:18-56:5), determined that St. Luke's financial condition was concerning. *See* RX-0010 (Gordon Tr.) 77:5-10; 95:14-98:25. AMBAC declared St. Luke's in default of its bond covenants (RX-0906) and considered requiring St. Luke's to fully pay back or defease its bonds, having AMBAC obtain a mortgage on the hospital as collateral for the bonds, or having St. Luke's establish a cash collateral account designated for the bonds. RX-0010 (Gordon Tr.) 68:2-68:11. AMBAC only agreed to waive this default and its possible remedies on the condition that St. Luke's bonds would become part of ProMedica which had a much higher credit rating. RX-0907. AMBAC was concerned that without the joinder "we might be back in the same difficult situation . . . and St. Luke's financial performance could have deteriorated even further." RX-0010 (Gordon Tr.) 77:5-10.

5. St. Luke's Board and Management Concluded That St. Luke's Could Not Survive As A Stand-Alone Community Hospital

As a result of St. Luke's financial challenges, St. Luke's management and Board ultimately and reluctantly concluded St. Luke's could not survive as a stand alone hospital. St. Luke's considered drastic cuts in services and staff, including dropping obstetrics and cardiac services altogether. St. Luke's also evaluated hospitals in and outside the area as potential merger partners. After a thorough consideration of its options, St. Luke's Board and management concluded that a joinder with ProMedica would be best for ensuring that St. Luke's would be a viable hospital that could serve the community for the long term.

In late 2008, St. Luke's contacted { } to gauge its interest in a potential affiliation. Those discussions ended after St. Luke's declined to pay the $300,000 that { } requested to conduct initial due diligence. In addition, {

} told St. Luke's it was not likely to expand into Northwest Ohio at that time, in part because it did not want to jeopardize the referrals it received from both ProMedica and Mercy for quaternary services. RX-0194 (Wakeman Decl.) ¶ 29.

Around the same time, St. Luke's contacted {

} about a potential affiliation. { } was not interested in expansion in the Toledo area through an affiliation with St. Luke's, both because it did not want to disrupt its referral patterns for oncology and quaternary patients from ProMedica and Mercy and because St. Luke's required a significant infusion of capital. *Id.* ¶ 30.

St. Luke's also contacted { }, a large multi-hospital system headquartered in { }, to discuss a possible affiliation. { } stated it had no interest in affiliating with St. Luke's because its location did not fit within { } strategic plan. *Id.* ¶ 31.

In 2009, St. Luke's explored a potential affiliation with UTMC. {

} RX-0194 (Wakeman Decl.) ¶ 32.

In 2008 and 2009, St. Luke's also engaged in discussions with Mercy about a potential affiliation. *Id.* ¶ 33. {

} RX-0475; RX-0114-000003.

St. Luke's management and board also had concerns about a potential affiliation with Mercy, including: a loss of independence and local governance for St. Luke's because Mercy's parent, Catholic Health Partners, is located in Cincinnati (*see* RX-0194 (Wakeman Decl.) ¶ 33; PX01030-10); and opposition to a merger with Mercy by St. Luke's medical staff. *See* RX-0194 (Wakeman Decl.) ¶ 33.

D. The Joinder

ProMedica and St. Luke's entered into a Joinder Agreement ("Joinder") on May 25, 2010, and St. Luke's became part of the ProMedica system on September 1, 2010. ProMedica and St. Luke's entered into the Joinder Agreement because they saw benefits from the combination to their patients, employees and the community their hospitals serve. To address its deteriorating financial condition and position itself for a changing healthcare environment, St. Luke's needed a significant infusion of capital and access to the economies of scale and resources that only a larger system could provide. RX-0197 (Black Decl.) ¶¶ 10, 15. ProMedica desired to expand its presence in the southwest portion of the Toledo MSA. RX-0038 (Oostra Tr.) 82:10-20.

Under the terms of the Joinder, ProMedica agreed to contribute $5 million to the St. Luke's Foundation and to invest $30 million in St. Luke's over the next three years, thus stabilizing St. Luke's deteriorating financial position. RX-0473 (Joinder Agreement) § 6.1(a), (b). Notably, ProMedica added St. Luke's to its "obligated group," extending the benefit of its strong credit rating to St. Luke's. ProMedica also assumed responsibility for St. Luke's $45 million unfunded pension obligation. In addition, St. Luke's became a participating hospital in Paramount's network, gaining access to new commercially insured patients at better reimbursement rates than it was receiving at Anthem and MMO.

The Joinder Agreement requires ProMedica to maintain St. Luke's as a fully operational acute care hospital using its current name and identity at its current location for a minimum of ten years. RX-0473 (Joinder Agreement) § 7.1. {

}. RX-0701 (Navigant Study January 2011). ProMedica is considering { } to

more efficiently and effectively provide services to the community. *Id.* These {

} are a documented benefit of multi-hospital systems. *See* RX-0071-9 (Guerin-Calvert Report) ¶ 9, n.6.

ARGUMENT

I. COMPLAINT COUNSEL CANNOT MEET ITS HEAVY BURDEN OF PROVING THAT THE JOINDER VIOLATES SECTION 7

Complaint counsel must prove its Section 7 claim by a preponderance of the evidence. "Analysis of the likely competitive effects of a merger requires determinations of (1) the 'line of commerce' or product market in which to assess the transaction; (2) the 'section of the country' or geographic market in which to assess the transaction; and (3) the transaction's probable effect on competition in the product and geographic markets." *FTC v. Staples, Inc.*, 970 F. Supp. 1066, 1072 (D.D.C. 1997). Complaint Counsel retains the ultimate burden of persuasion at all times, (*United States v. Baker Hughes, Inc.*, 908 F.2d 981, 982 (D.C. Cir. 1990)), and on every element of the claim. *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 116 (D.D.C. 2004).

The issue presented in this case — as in all Section 7 cases — is whether the transaction has the "potential for creating, enhancing, or facilitating the exercise of market power — the ability of one or more firms to raise prices above competitive levels for a significant period of time." *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. at 136 (quoting *United States v. Archer-Daniels-Midland Co.*, 866 F.2d 242, 246 (8th Cir. 1988)). To establish anticompetitive effects, Complaint Counsel must show more than some impact on competition. It has "the burden of showing that the acquisition is reasonably likely to have 'demonstrable and substantial anticompetitive effects.'" *New York v. Kraft Gen. Foods, Inc.*, 926 F. Supp. 321, 358 (S.D.N.Y. 1995) (quoting *United States v. Atl. Richfield Co.*, 297 F. Supp. 1061, 1066 (S.D.N.Y. 1969), *aff'd*, 401 U.S. 986 (1971)). The evidence presented at trial will demonstrate that Complaint Counsel cannot prove a Section 7 violation.

A. The Relevant Product Market Is The Provision of *All* General Acute Care Inpatient Hospital Services

A relevant product market consists of "products that have reasonable interchangeability for the purposes for which they are produced – price, use and qualities considered." *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 404 (1956). Products are reasonably interchangeable if consumers treat them as "acceptable substitutes." *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 46 (D.D.C. 1998) ("[T]he relevant market consists of all of the products that the Defendants' customers view as substitutes to those supplied by the Defendants.").

In hospital merger cases, as in some other industries, the relevant "product" might consist of a "cluster" or "collection" of products, even if the individual products within the "cluster" are not substitutes between themselves. *See, e.g.*, *FTC v. Staples*, 970 F. Supp. at 1074 (product market consisting of "consumable office supplies" purchased from an office superstore); *JBL Enters., Inc. v. Jhirmack Enters., Inc.*, 698 F.2d 1011, 1016 (9th Cir. 1983) (product market consisted of lines of beauty supplies to beauty salons and professional outlets). *See also* IIB Phillip Areeda & Herbert Hovenkamp, *Antitrust Law* ¶ 565 (3d ed. 1977). As the *Staples* court found, even though the individual pens, paper and disks that made up the basket of "consumable office supplies" were not substitutes for each other, customer purchasing patterns confirmed a particular consumer demand for this set of goods as sold by office superstores. 970 F. Supp. at 1078.

Similarly, in this, as in most hospital merger cases, the "consumers" the FTC is concerned about are managed care organizations – that is, large, nationally recognized insurance companies – who purchase hospital services to re-sell as part of the health plans or networks they offer to employers and others. These payors purchase an entire bundle of inpatient hospital services (primary, secondary and tertiary), as well as outpatient and other services, from hospital

providers, and they purchase the services in a single negotiated transaction.[4] Thus, the FTC and most courts have concluded that the proper product market for the analysis of a hospital merger is the "cluster" market of *all* inpatient hospital services. *See In re Evanston Nw. Healthcare Corp.,* Dkt. No. 9315, Opinion of the Commission at 56 (FTC Aug. 6, 2007); *Freeman Hosp.*, 69 F.3d at 268; *Univ. Health, Inc.*, 938 F.2d at 1211-12 ; *Rockford Mem'l Corp.*, 898 F.2d at 1278; *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 138-40; *Butterworth Health Corp.*, 946 F. Supp. at 1290-91.

The FTC alleges this product market in its Complaint. Compl. ¶ 12. But, Complaint Counsel's economic expert actually *excludes* significant segments of this "cluster" market from his market definition and subsequent share computation, and then conducts a "competitive effects" analysis using yet another combination of relevant "products." For example, Professor Town eliminates from his market definition and calculation of general acute care market "shares" any inpatient service (identified as "diagnostic related groups," or "DRGs") performed by all of the other market participants if St. Luke's did not perform three or more of those services on commercially insured patients. RX-1265 (Town Report) ¶ 40 n.53 ("The relevant product market is the set of overlapping DRGs in which there are at least three privately insured discharges for St. Luke's.").[5] Complaint Counsel have no principled basis for this random and

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[4] Complaint Counsel does not consider outpatient services to be within the same market as inpatient services on the grounds that *most* inpatient services can only be provided in a hospital setting. Compl. ¶ 13. While this may have been true in the past, the evidence will show that it is changing and that for some inpatient services – particularly of the type provided at St. Luke's – outpatient procedures are now and in the future will increasingly become competitive for those services. RX-0004 ({ } Tr.) 33:12-35:8. Thus, although it *may* be appropriate to exclude outpatient services from the product market in this case, when analyzing the probable future competitive effects of this transaction, it is important to take note of the fact, recognized by hospital competitors in Toledo, that as a stand-alone community hospital, St. Luke's will increasingly be constrained by competition from outpatient services in the future. RX-0254-000002-3.

[5] Professor Town also excludes from his market definition and share calculations hospital services in which the case mix index (a measure of severity) is above 3.0 and services in which the case mix index is above 2.0 and more than

(continued...)

artificial gerrymandering of the product market.[6] Professor Town has defined the market by looking only at supply side characteristics – that is, those services St. Luke's supplies to the market. But this is contrary to the U.S. Department of Justice & Federal Trade Commission Horizontal Merger Guidelines (2010) ("Merger Guidelines") which provide that market definition "focuses solely on demand substition factors. No basis exists in any FTC or federal court hospital merger case law to support Professor Town's or Complaint Counsel's tortured market definition, which certainly does not represent what payors and providers negotiate over.[7]

Complaint Counsel will cite to no evidence – because there is none – demonstrating that any payor has ever attempted to negotiate with any Lucas County hospital provider for "all inpatient hospital services representing those DRGs performed three or more times by St. Luke's

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15 percent of patients sought hospital services outside the relevant geographic area. He excludes these services even though the services may have been provided by ProMedica and St. Luke's and even though the services unquestionably are provided by hospitals in Lucas County. The effect of these exclusions is to inflate artificially St. Luke's competitive significance. RX-0071-18 (Guerin-Calvert Report) ¶ 25.

[6] Professor Town claims that he excludes DRGs not performed by St. Luke's or performed only a few times by St. Luke's on the theory that it is only the services actually performed that represent "lost" competition as a result of the transaction. RX-1264 (Town Report) ¶ 40, n.57. This analysis ignores the reality that providers and payors negotiate for *all* inpatient hospital services, whether or not they are performed three or more times at St. Luke's. This is true even for St. Luke's contracts with payors. Thus, St. Luke's contracts provide for payment for *any* inpatient general acute care service, based on a DRG rate (or whatever other rate is specified by the contract). Whether St. Luke's had or had not billed for a particular DRG three or more times in the period prior to the contract is irrelevant to the inpatient rate negotiated and irrelevant to whether and what St. Luke's would be paid for the service if it were performed over the course of the contract. More significantly, excluding these DRGs from his market share calculations is completely inconsistent with Professor Town's later decision to *include* all DRGs in his "competitive effects" analysis on the theory that because payors and providers negotiate for *all* DRGs, a competitive effect could result across all DRGs.

[7] The evidence is overwhelming and undisputed that payors and hospitals negotiate for an entire package of hospital services, including inpatient and outpatient services and "outlier" rates, laboratory, and rehabilitation services among other things. RX-0029 ({ } Tr.) 14:20-15:25; RX-0012 ({ } Tr.) 36:22-39:1; RX-0013 ({ } Tr.) 75:15-21, 76:13-78:4; RX-0027 ({ } Tr.) 31:11-32:15, 32:24-33:4. The evidence is similarly overwhelming and undisputed that payors and hospitals bargain between and among these services to achieve a single overall contract price. RX-0023 ({ } Tr.) 26:18-25; RX-27 ({ } Tr.) 31:23-32: 3; RX-0013 ({ } Tr.) 76:13-17. Thus, in response to an "increase" in the price sought for inpatient services, a payor might request a corresponding reduction in the price of laboratory services, so as to achieve an overall contract "price" that the payor considers competitive. RX-0071 (Guerin-Calvert Report) ¶ 66. Complaint Counsel's single-minded focus on inpatient rates presents a distorted view of the true competitive dynamic between payors and providers and creates the mistaken impression that inpatient rates are the only, or the only significant, factor in the "price" of the ultimate contract. *Id.* This is false, as the evidence will show.

Hospital," or any similar variation of that definition. There simply is no product sold in the market which matches that definition. Rather, payors and providers negotiate over a complex and complete array of services offered by hospitals, and the ultimate "price" they agree to in the resulting contract reflects a sophisticated calculation by the payor and provider of the net benefit to be derived from a contract encompassing all of those services. Any attempt to measure "shares," looking only at the inpatient DRGs performed three or more times by St. Luke's Hospital, is wrong as a matter of fact and law.

Similarly, the FTC's and Complaint Counsel's claim that obstetrics services constitute a separate "market" also fails.[8] First, there is no legal basis for concluding that inpatient obstetrics services constitute a separate "market." No previous hospital merger case has ever done so. Complaint Counsel's assertion that obstetrics services constitute a separate "market" because no other inpatient hospital services can substitute for them is equally applicable to inpatient cardiac surgery, inpatient knee surgery and inpatient gastro-intestinal services, but Complaint Counsel does not allege those services constitute separate "markets." To do so would totally defeat the purpose of alleging that *all* general acute care inpatient services constitute a "cluster" market. *See California v. Sutter Health Sys.*, 130 F. Supp. 2d at 1119 ("While the treatments offered to patients within this cluster of services are not substitutes for one another (for example, one cannot substitute a tonsillectomy for heart bypass surgery), the services and resources that

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[8] As with their "general acute care" market, Complaint Counsel and their expert define the "obstetrics" market differently than the Complaint does. The Complaint alleges that there is a market for "inpatient obstetrical services." (Compl. ¶ 14). Professor Town claims the relevant market is "inpatient obstetrics services offered at St. Luke's." RX-1265 (Town's Expert Report) ¶ 41. The difference matters because ProMedica and Mercy provide a wide range of inpatient obstetrics services that St. Luke's does not now and has *never* provided. To exclude those services from the relevant market and treat them as if they do not exist is to ignore significant and important competition in the overall market for inpatient general acute care hospital services. *See* RX-0071-08 (Guerin-Calvert Report) ¶ 25.

hospitals provide tend to be similar across a wide range of primary, secondary, and tertiary inpatient services. Accordingly, courts have consistently recognized the cluster of services comprising acute inpatient services as the appropriate product market in hospital merger cases.").

Second, the fact that some payor-provider contracts contain a separate "rate" for OB services does not, as Complaint Counsel allege, demonstrate that the services are separately negotiated. Rather, the evidence will show that payors and hospitals do *not* separately contract for OB services. ProMedica has no contracts with any health plan in Lucas County in which it has sought to negotiate separately for OB services. RX-0029 (Wachsman Tr.) at 42:14-18.

Third, the fact that UTMC or Mercy's St. Anne Hospital, does not currently provide obstetrics services does not justify treating them as a separate product "market." Product markets are defined by demand side factors – to whom customers can and do turn to purchase the product – not the supply side factors that Complaint Counsel and Professor Town propound. Moreover, Complaint Counsel's focus on the number of competitors offering OB services is a red herring. There are now and always have been in Lucas County only two providers of moderate- to high-risk OB services – Mercy and ProMedica. Complaint Counsel does not allege – because no facts would support such an allegation – that ProMedica and Mercy have been able to extract supracompetitive rates for the OB services that they alone provide. Indeed, for significant periods in the recent past, major insurers in the market have contracted with only *one* provider of most moderate- to high-risk OB services. This was the case when MMO contracted solely with Mercy and St. Luke's (which does not provide moderate- to high-risk OB services), while Anthem and Paramount contracted only with ProMedica and UTMC (which provides no OB services at all). Complaint Counsel does not allege, nor could it, that Mercy and ProMedica were able to extract "monopoly" profits when they were the sole provider of services in this

"market," for the simple and obvious reason that OB services do not constitute a separate "market," because no one contracts separately for them.[9]

Finally, the evidence will show that no payor would or could respond to the attempt by ProMedica or Mercy to extract supracompetitive prices for OB services by threatening to contract solely with St. Luke's for those services. St. Luke's was not prior to the joinder exercising any sort of competitive constraint on the "price" of OB services and its absence as an independent provider of those services will have no competitive effect that is any different than the effect in the overall general acute care services market.

Even if some principled basis existed on which to single out inpatient obstetrics services, there is no basis for finding a Section 7 violation in that "market" because Complaint Counsel's economic expert conducted no competitive effects analysis of the separate "OB services" market. Rather, significant portions of his competitive price effects analysis treats obstetrics and general acute care services as if they were a single market. Town (5/10/11 Tr.) 169:10-16, 171:8-24. In short, Complaint Counsel's theory that there is a separate "market" for inpatient OB services is wrong as a matter of fact and law. It is nothing more than a naked attempt to manipulate market shares to arbitrarily inflate the competitive significance of St. Luke's beyond any measure reflecting actual market dynamics. It should be rejected.

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[9] Professor Town implicitly acknowledges that there is no separate "price" for the "product" consisting of "inpatient obstetrics services" or "inpatient obstetrics services provided by St. Luke's," because in his competitive effects analysis he does not separately calculate a "willingness to pay" (which he uses to calculate the expected price effect from the joinder), in those separate "markets." *See* Town (5/10/11) Tr. 169:10-16; 171:8-24. Rather, in calculating the alleged price effect of the joinder, Professor Town uses *all* DRGs, not just those offered three or more times at St. Luke's, or limited to the alleged product market, either as defined in his report, or as defined in the Complaint. *Id.*

B. The Relevant Geographic Market Is Lucas County And All Providers In Lucas County Are Equally Viable Substitutes

Complaint Counsel has the burden to prove a proper geographic market. *United States v. Conn. Nat'l Bank*, 418 U.S. 656, 669 (1974). A proper geographic market is "that geographic area 'to which consumers can practically turn for alternative sources of the product and in which the antitrust defendants face competition.'" *Freeman Hosp.*, 69 F.3d at 268. The geographic market must reflect commercial realities, and must involve a dynamic as opposed to static analysis of "where consumers could practicably go, not only where they actually go." *Freeman Hosp.*, 69 F.3d at 268. *See also FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1052 (8th Cir. 1999) (A "properly defined geographic market includes potential suppliers who can readily offer consumers a suitable alternative to the defendant's services.").

Complaint Counsel allege that Lucas County is the relevant geographic market, but their economic expert proceeds to calculate market shares and analyze competitive effects in a much smaller area, consisting of the eight zip codes closest to St. Luke's. It is inappropriate to measure St. Luke's "market share" or purport to analyze any alleged competitive effects of the transaction in any area narrower than the entire alleged geographic market. Moreover, Complaint Counsel's static focus on where Lucas County patients currently go for inpatient hospital services unnecessarily limits consideration of the alternatives that are practicably available to payors in the event of an attempt by ProMedica to raise St. Luke's rates to supracompetitive levels. *See, e.g., FTC v. Tenet Health Care*, 186 F.3d at 1052 (to prove a relevant geographic market, the FTC must present evidence of "where consumers could practicably go, not on where they actually go."). Wood County Hospital, for example, is only 15 miles away from St. Luke's, and it has recently expanded it's capabilities for treating OB patients. RX-0093 (Guerin-Calvert Decl.) ¶ 15.

Here, Complaint Counsel have undertaken no analysis of where payors could turn in the event of a supracompetitive price increase. Instead, they have elicited anecdotal testimony from payors and employers to the effect that it will be difficult to market plans that exclude a combined ProMedica and St. Luke's. *See, e.g.*, PX02062 (Weinrich Decl.) ¶ 6; PX02070 (Neal Decl.) ¶ 8; RX-0004 ({ } Tr.) 49:22-50:8, 63:11-19; RX-0046 ({ } Tr.) 64:15- 65:5. But courts routinely reject this type of anecdotal customer "evidence." *See Tenet*, 186 F.3d at 1054 (where the court found that testimony of third party payors that they would be forced to accept price increases from the merged entity because patients insist on going to hospital closest to home was "suspect."). The *Tenet* court also noted that "large, sophisticated third-party buyers can and do resist price increases" and observed that the testimony of market participants spoke only to current customer perceptions and habits, but did not address what customers would do in the event of a price increase. *Id. See also FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 145-46 (D.D.C. 2004) (court noted that many cases and antitrust authorities "do not accord great weight to the subjective views of customers in the market," and stated that the concern expressed by the customers at issue "is little more than a truism of economics: a decrease in the number of suppliers *may* lead to a decrease in the level of competition in the market.") (emphasis added).

Complaint Counsel's myopic focus on the eight zip codes closest to St. Luke's is inappropriate. Payors contract for inpatient hospital services in all of Lucas County. Moreover, the evidence will show that even for those patients closest to St. Luke's, more travel to hospitals in other parts of the county (to Mercy's three hospitals, UTMC or ProMedica) than seek treatment at St. Luke's. RX-0071-32-34. Shares based on this limited area are irrelevant and uninformative on the question of where payors (the "consumers" at issue here) could turn for supply in the event of a supracompetitive price increase.

C. Complaint Counsel Cannot Prove The Joinder Increases ProMedica's "Market Power" Such That It Can Raise Prices To Supracompetitive Levels

Even if Complaint Counsel had established a relevant product and geographic market, it still cannot prove the joinder violates Section 7 because it cannot show that, as a result of the joinder with St. Luke's, there is a "reasonable probability" of a substantial lessening of competition in the future. *See Long Island Jewish Med. Ctr.*, 983 F. Supp. at 135 ("To meet the requirements of Section 7, the Government must show a reasonable probability that the proposed merger would substantially lessen competition in the future."). "[Section] 7 . . . forbids mergers that are likely to 'hurt consumers, as by making it easier for the firms in the market to . . . force price above or farther above the competitive level.'" *Rockford Mem'l Corp.*, 898 F.2d at 1282-83 (7th Cir. 1990) (quoting *Hosp. Corp. of Am. v. FTC*, 807 F.2d 1381, 1386 (7th Cir. 1986)). Generally, anticompetitive effects are measured in two ways. "First, with reasonable probability, will the merged entity have enough market power to enable it to profitably increase prices above competitive levels for a substantial period of time? Second, will the merged entity with its increased market share and leverage, reduce the quality of care, treatment and medical services rendered?" *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 142.

Where, as in hospital merger cases, the products at issue are highly differentiated, a lessening of competition may occur through "unilateral effects." *See United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1113 (N.D. Cal. 2004). *See also* Merger Guidelines § 6.0. In differentiated markets, the merged firm may be able to raise prices unilaterally if customers accounting for a "significant fraction" of the merged firms' sales view the merging parties as their first and second choices for the product, and if, in response to a price increase, rival sellers likely would not "replace any localized competition lost through the merger by repositioning their product lines." *Oracle Corp.*, 331 F. Supp. 2d at 1123. That is not the case here.

1. Pre-Joinder, St. Luke's Was Not ProMedica's Closest Substitute and Therefore Elimination Of St. Luke's Does Not Give ProMedica The Ability To Exercise Unilateral Effects

Complaint Counsel cannot establish unilateral anticompetitive effects flowing from the joinder. First, no payor (the customers at issue here) will testify that it considers St. Luke's to be the "next best substitute" for ProMedica in designing a health network to market in Toledo. Rather, payors acknowledge that Mercy and ProMedica are each other's primary competitor. RX-0004 ({ } IH Tr.) 29:18-23; RX-0046 ({ } Tr.) 23:15-24:6. St. Luke's is a small, stand-alone community hospital, offering a limited array of the least complex inpatient hospital services. RX-0027 ({ } Tr.) 13:7-22; RX-205 ({ } Tr.) 10:8-18. Because of their broad service offerings and their geographic reach throughout the Toledo metropolitan area, payors believe that they must have *either* Mercy or ProMedica in their health plan. RX-0027 ({ } Tr.) 15:3-7; RX-0204 ({ } Tr.) 11:18-12:3; PX02067 ({ } Decl.) at ¶ 9. Payors do not place St. Luke's in that category. RX-0204 ({ } Tr.) 11:13-17; RX-0205 ({ } Tr.) 10:19-11:10; RX-0023 ({ } Tr.) 16:10-14. Stated another way, prior to the joinder, faced with an anticompetitive price increase, no payor would have dropped ProMedica from its network in exchange for St. Luke's. Similarly, no payor would have dropped Mercy in exchange for St. Luke's. But payors can and have marketed networks with only one of the two main systems. RX-0204 ({ } Tr.) 29:7-11; RX-0046 ({ } Tr.) 39:21-40:10, 40:22-41:5.

a. Complaint Counsel's theory of competitive harm inappropriately elevates the competitive significance of St. Luke's

Complaint Counsel focus inordinate attention to the claimed market "shares" of ProMedica and St. Luke's to support their claim that the joinder is "presumptively" likely to have anticompetitive effects. But their reliance is misplaced. First, their economic expert has

"gerrymandered" the market to artificially inflate St. Luke's "share" of the alleged product markets.[10] By claiming that the "markets" consist only of those services currently offered at St. Luke's, and excluding the significant competition that occurs between Mercy, ProMedica and UTMC for services that St. Luke's does not provide, Professor Town's calculations magnify St. Luke's "importance" beyond anything reflected in the real world negotiations among payors and providers in Toledo. RX-0071 (Guerin-Calvert Report) ¶¶ 21-25. Moreover, it is universally recognized that market "shares" are only the beginning of the analysis of the likely competitive effects of a transaction – not the end in itself. *FTC v. CCC Holdings Inc.*, 605 F. Supp. 2d 26, 46 (D.D.C. 2009); *see also Baker Hughes, Inc.*, 908 F.2d 981, 983, 992 (D.C. Cir. 1990) (noting, "The Herfindahl-Hirschman Index cannot guarantee litigation victories."). Where, as here, market "shares" are not an accurate predictor of future competitive effects, they are no substitute for a rigorous analysis of actual market dynamics. *See* 908 F.2d at 983-5.

Second, Professor Town's analysis of the market, which measures the market solely by the services offered at St. Luke's, fails to account for much of the actual competition between ProMedica, Mercy and UTMC. Complaint Counsel claim that measuring the market by the services offered only at St. Luke's "captures" approximately 91 percent of the inpatient hospital services "that St. Luke's and ProMedica offered." RX-1264 (Town Report) ¶ 42. But this is true *only* for the inpatient services offered at St. Luke's. The evidence will show that Professor Town's market share measures actually account for only about 61 percent of the general acute

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[10] For example, Professor Town claims that St. Luke's has a 9.3 percent "share" of the OB services market. PX02148 (Town Report) at Exhibit 6. But he arrives at this figure by counting only those DRGs performed at St. Luke's, ignoring that no payors actually contract for those limited services. Moreover, he measures shares based on "patient days," rather than revenues, another possible measure of market share, which would tend to decrease the significance of the relatively low-level, low-cost, low-risk services performed at St. Luke's. When billed charges for *all* OB services for all discharges from all Lucas County residents are measured, St. Luke's market share is just 3 percent. RX0071(Guerin-Calvert Report) ¶¶ 59-60.

care inpatient services offered at ProMedica. And the remaining services, which Professor Town ignores, represent significant volumes of general acute care inpatient services that payors actually negotiate with ProMedica (and Mercy and UTMC) to provide. To ignore and pretend that these services have no impact on the market is to distort the reality of the competitive dynamics. RX-71 (Guerin-Calvert Report) at ¶¶ 21-22.

b. Complaint Counsel's theory of competitive harm ignores Mercy's and UTMC's substantial excess capacity, which gives them the potential and actual ability to re-position in response to any attempt by ProMedica to exercise market power

Complaint Counsel's theory, and Professor Town's analysis, inappropriately discount the competitive constraint that Mercy and UTMC actually imposed on ProMedica. That competitive constraint, which existed prior to the joinder and will continue after, will prevent ProMedica from charging prices above a competitive level after the joinder. Both Mercy and UTMC have substantial excess capacity, which gives them the incentive and ability to reposition in response to any attempt by ProMedica to exercise market power.

The evidence will establish that other competitors *are* repositioning their product offerings in response to the joinder between ProMedica and St. Luke's. PX01940 ({ } Tr.) 15:11-17:14; RX-1661. { } in particular has a well-thought out and presumably economically rational plan to compete even more vigorously for patients in the area immediately around St. Luke's. RX-0254; PX01940 ({ } Tr. 44:10-45:1). { } does not believe that it needs to build a new hospital facility to implement its plan to compete for patients in that area. PX01940 ({ } Tr. 45:2-17). Rather, it can and is pursuing a plan to hire primary care physicians with the belief that those physicians will refer patients to { } hospitals. RX-0254. Complaint Counsel discount the competitive *threat* that these efforts pose to ProMedica Complaint Counsel's Pre-Trial Brief, pp. 41-44, but there is no reason to doubt that { } is

acting in its rational economic self interest when it asserts that it intends to increase its market presence and position in the southwest Toledo area. Moreover, it is undisputed that ProMedica believes { } will pursue a vigorous plan to compete with it in southwest Toledo, PX01947 (Oostra Tr.) 60:6-14, and ProMedica's *belief* that { } is likely to expand its presence in the southwest market is independently significant because "the threat of entry can stimulate competition in a concentrated market, regardless of whether entry ever occurs." *Baker Hughes*, 908 F.2d at 988.

Furthermore, the evidence will show that it would take relatively little actual diversion of patients from St. Luke's to defeat completely any attempt by ProMedica to extract anticompetitive price increases from commercial insurers. St. Luke's only admits approximately ten commercially insured patients per day. Mercy's announced plan to increase its market share in the area immediately around St. Luke's, even if partially successful, would be economically devastating to St. Luke's. Because Mercy has substantial excess capacity, it has the incentive and the ability to accomplish this diversion, and its threat will constrain ProMedica's prices. RX-0071 (Guerin-Calvert Report) at ¶¶ 121-123.

2. Complaint Counsel Cannot Show That ProMedica's Allegedly "High" Prices Reflect The Exercise of Market Power

Complaint Counsel assert that ProMedica will be able to raise prices as a result of the joinder because ProMedica already has "market power" and that market power is reflected in its high prices. But in a market of highly differentiated products, such as the market for inpatient hospital services, it is inappropriate to infer market power from "high prices" or "high profits." *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1410-12 (7th Cir. 1995). Rather there are a large number of competitively benign reasons ProMedica's prices might be "higher" than others in the market. RX-0071 (Guerin-Calvert Report) ¶¶ 146-154.

A key assumption of Complaint Counsel's theory that the joinder will give ProMedica the power to raise prices above competitive levels is the claim of their economist that ProMedica's "case mix adjusted prices" are as much as 74 percent higher than St. Luke's "case mix adjusted prices," and that all differences in "case mix adjusted" prices across hospitals (other than patient characteristics such as age, gender and ailment) are attributable to "bargaining power." RX-1264 (Town Report) at ¶ 68.[11] Differences in price in differentiated markets are neither surprising, nor can they be attributed to "market power." As the FTC's own economists have noted:

> In a market with differentiated products, different price levels are neither necessary, nor sufficient, to demonstrate the exercise of market power. Established models of monopolistic competition allow that differentiated products may sell at different prices at the same point in time, even in the long run, when economic profits are zero. Hospitals offer differentiated products, differentiated by type, location and other dimensions.[12]

The evidence will show that ProMedica's negotiations with payors, both pre- and post-joinder, resulted in competitively priced contracts. Professor Town's "constructed" prices, which purport to show that ProMedica's prices are dramatically above all other market participants' prices, does not withstand close examination. In fact, market participants – the payors who negotiate contracts with hospital providers in Toledo – will describe a much more

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[11] Professor Town's "case mix adjusted prices" are not prices at all. They are a theoretical construct, he created to attempt to compare prices and price levels across hospitals. *See* RX-0050 (Town Tr.) 211:3-212:19; RX 0071-69 (Guerin-Calvert Report) at n.133. There are numerous problems with Professor Town's "prices," not least of which is that they do not reflect any actual *price* paid by any payor to any provider in Toledo. But that is just one of the many reasons why his comparison of these "prices" across hospitals and his attempt to draw conclusions regarding the likely competitive effects of the merger from this comparison, are seriously flawed. *See* RX0071-66-68.

[12] *See* Deborah Haas-Wilson & Christopher Garmon, *Hospital Mergers and Competitive Effects: Two Retrospective Analyses*, 18 Int'l J. of the Econ. of Bus. 17, 22 (2011). *See also* Timothy J. Muris (Former Chairman, Federal Trade Commission), Symposium: *Improving the Economic Foundations of Competition Policy*, 12 Geo. Mason L. Rev. 1, 28 (2003) ("Most real world markets, even those for relatively 'homogenous' products, and a market structure consistent with significant market power exhibit significant price variation. These price differences do not prove that the firms have market power.").

competitive market, resulting in contract price levels between Mercy and ProMedica that are comparable. RX-0004 ({ } IH Tr.) 59:6-20; RX-0205 ({ } IH Tr.) 36:1-8.

3. Complaint Counsel's Attempt To Show A "Price Effect" Resulting From The Joinder Is Based On A Flawed Economic Model

The ultimate question presented by this case is whether the joinder gives ProMedica the ability to raise prices above a "competitive level." Complaint Counsel assert that St. Luke's pre-joinder prices were "competitive," and thus *any* post-joinder price increase *must* reflect the exercise of market power by ProMedica. In fact, Complaint Counsel claim that price increases are a "strategically-planned" goal of the joinder, and assert that "a top strategic goal for Respondent in 2011 was to obtain a substantial rate hike for St. Luke's." CC Pre-Trial Br. at 31. Complaint Counsel's citation to PX01113 as support for this claim exemplifies their propensity to mischaracterize and misrepresent the evidence adduced during discovery in this case. PX01113 is a document that was prepared *by St. Luke's, prior* to the joinder. It says absolutely *nothing* about ProMedica's "top strategic goals" for 2011, nor does it even identify a "substantial" rate hike as a top strategic "goal" of St. Luke's. Under the heading "SLH Top Strategic Issues, (Finance)" the document lists the need to re-negotiate the { } contract effective January 1, 2011. That is consistent with the undisputed fact that the { } contract was set to expire at the end of 2010. Rather than crowing about any "goal" to "obtain a *substantial* rate hike," the document lays out the rather modest hope that St. Luke's might get its reimbursement levels with its largest commercial payor to a level that would exceed *Medicare* reimbursement. *See* PX01113. Since it is undisputed that Medicare reimbursement does not come close to covering a hospital's *costs* of providing service, this goal is hardly evidence that St. Luke's, let alone ProMedica, had any hope of exercising "market power" in upcoming rate negotiations with { }.

In fact, the evidence at trial will demonstrate that ProMedica did not enter into the transaction with any expectation about increasing St. Luke's commercial payor rates. There are no internally-prepared ProMedica documents, presented to ProMedica's board or reviewed by its management, that assess the benefits of the St. Luke's transaction based on the assumption that ProMedica will achieve rate increases in St. Luke's commercial contracts.[13] ProMedica made no assumptions whatsoever regarding St. Luke's contract rates in its decision to pursue the joinder. RX-0192 (Oostra Decl.) ¶ 21.

The evidence is uncontroverted that St. Luke's pre-joinder prices were not sustainable and would have increased irrespective of the joinder. St. Luke's had determined, independently and prior to ever negotiating with ProMedica, that its commercial reimbursement rates were too low. It commissioned a study by an independent third-party consultant that confirmed St. Luke's was being paid substantially below market rates and, more significantly, it determined based on an internal analysis that it was being paid below its costs of providing service. The evidence will show that prior to its joinder with ProMedica, St. Luke's itself had negotiated a new contract with one payor ({ }) whose contract had come up for renewal. The rate negotiated by St. Luke's was substantially above its then-existing rates with its two largest payors ({ }). Furthermore, the evidence will show that St. Luke's attempted to negotiate a mid-contract increase in the reimbursement rates that it would receive from its largest payor – { } – prior to concluding negotiations with ProMedica. St. Luke's was unable to finalize

[13] The only ProMedica-prepared document Complaint Counsel has ever identified (PX00226) to support their claim that it was ProMedica's "plan" to increase St. Luke's rates provides no such support. First, no ProMedica witness has ever been asked about the document. There is no indication that the document has ever been distributed outside of ProMedica, there is no testimony in the record to establish that the document in fact refers to any "leverage" achieved as a result of a joinder, and no indication whatsoever that the document has anything at all to do with the St. Luke's joinder. The document is evidence of nothing.

that agreement, not because the parties were unable to agree on the price for the re-negotiated contract, but because { } insisted on enforcement of a "most favored nations" clause in its contract that required St. Luke's to negotiate a similarly increased contract rate with { } competitor, { }. When { } refused to enter into a new contract with St. Luke's, { } also refused. Complaint Counsel ignore this entire history, and merely assert that St. Luke's pre-joinder contract rates were "competitive" and thus any post-joinder rate negotiated by ProMedica is either (1) a "supracompetitive" rate reflecting the exercise of ProMedica's "market power," or (2) if competitive, it was "manipulated" by the knowledge that the FTC had brought this action.

This is blind adherence to a theory with no relationship to the facts. The evidence in this case will demonstrate that St. Luke's pre-joinder contracts were not sustainable. St. Luke's was not willing to extend those contracts into the future, as its pre-joinder termination of the { } contract demonstrates. RX-0685. Complaint Counsel's "assumption" that St. Luke's pre-joinder rates were "competitive" is not, in this case, supported by the facts. St. Luke's { } contract negotiation and the price agreement it reached with { } (but which did not result in a contract, not because of "price" disagreement, but because { } demanded St. Luke's obtain a similar increase from its competitor), are powerful evidence of the "but for" prices that would prevail in the market, in the absence of the joinder. The actual contract rates which ProMedica has negotiated on St. Luke's behalf post-joinder are competitive with those benchmarks, and do not demonstrate the exercise of market power.[14]

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[14] Complaint Counsel's claim that these contract negotiations were "manipulated" is not credible. { } testified that it wanted to reach an agreement with ProMedica to keep St. Luke's "in network." { } was aware it could have insisted on keeping St. Luke's old rates in place under the Hold Separate Agreement, and it nevertheless agreed (continued...)

Complaint Counsel ignore all of this real world evidence regarding the actual competitive dynamics in the Toledo market – both pre- and post-joinder – in favor of an economic "model" that purports to predict ProMedica will have the ability to raise St. Luke's rates by more than 50 percent as a result of this transaction.[15] But Professor Town's economic "model" of price effects as result of the joinder is seriously flawed. *See generally* RX-0071(Guerin-Calvert Report) at 68-80. His model fails adequately to account for all of the numerous (and generally recognized) factors that impact price negotiations between hospitals and payors. When just a few of these additional factors are included in his model, the alleged "price effect" of the joinder is reduced to zero. *Id.*

II. COMPLAINT COUNSEL'S ANALYSIS OF ST. LUKE'S PRE-JOINDER FINANCIAL CONDITION IS MISLEADING AND ITS CONCLUSION THAT ST. LUKE'S WAS VIABLE AS A STAND-ALONE COMPETITOR IS WRONG

Not only is Complaint Counsel's conclusion regarding the price effects of the joinder flawed, so too is their conclusion that St. Luke's financial condition prior to the joinder was improving. According to Complaint Counsel, St. Luke's investment returns, inpatient and outpatient revenue and patient volumes, EBITDA and market share all increased prior to the joinder. However, Complaint Counsel's focus on short-term 2010 improvements in volume, market share and EBITDA does not account or explain the losses associated with these volume

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to enter into a four-year contract at rates very close to those it had previously agreed to pay St. Luke's prior to the joinder. There is no reason to believe that { } had any incentive to "manipulate" its contract with St. Luke's.

[15] RX-1264 (Town Report) ¶ 108. This estimate of the post-joinder price increase represents a decline from Professor Town's original estimate, which claimed ProMedica would have the ability to increase St. Luke's rates with commercial payors by a whopping { } percent. RX-0050 (Town Tr. 2/3/11) 206:4-12. Neither analysis holds up.

increases.[16] It is undisputed that, prior to the joinder, St. Luke's had significant financial losses and resultant negative cash flow. The steps that St. Luke's undertook to increase volume, such as hiring more physicians and contracting to be an in-network provider to { }, actually increased St. Luke's losses because the costs associated with those actions were greater than any corresponding revenue improvements.

Moreover, Complaint Counsel rely on EBITDA to try to show St. Luke's was not struggling financially (presumably because St. Luke's EBITDA looks less bad than more meaningful measures such as operating profit and cash flow.) However, EBITDA is not the best measure of financial performance because it does not account for real costs incurred by a hospital such as interest expense, taxes, depreciation, and amortization. RX-0056 ¶¶ 19-21; Den Uyl Tr. 73:6-76:6. Nor does EBITDA measure the actual cash flow or cash available at St. Luke's. *Id.* Also, Complaint Counsel, and their expert, repeatedly misstate what St. Luke's EBITDA was prior to the joinder. According to Complaint Counsel's financial expert, H. Gabriel Dagen, "St. Luke's has generated positive EBITDA in nine of its previous eleven fiscal years (including 2010)." RX-1261 (Dagen Report) ¶ 11. In fact, St. Luke's EBITDA in 2008, 2009, and the eight months in 2010 leading up to the joinder was *negative*, it only turned positive after St. Luke's had joined ProMedica.

Similarly, throughout their Pre-Trial Brief, as well as in the report of their financial expert, Complaint Counsel repeatedly, and misleadingly, describe St. Luke's financial condition based upon financial data that post-dates the consummation of the joinder, September 1, 2010, to

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[16] Complaint Counsel's Pre-Trial brief discussing St. Luke's financial problems mentions such volume metrics eleven times, while only once, in a footnote, attempting to address the losses associated with the increased volume. *See* CC's Trial Br. at 50-56.

justify the conclusion that St. Luke's finances were strong and improving prior to the joinder. For example:

- "St. Luke's has generated positive EBITDA in nine of its previous eleven fiscal years (including 2010) and has a reserve fund valued at approximately $70 million." RX-1261 (Dagen Report) ¶ 11; *See also* Table 1: St. Luke's EBITDA Since 2000.
- "By the close of 2010, St. Luke's reached a positive EBITDA." RX-1261 (Dagen Report) ¶ 16.
- "The reserve fund's value as of December 31, 2010 had increased to approximately $70 million." RX-1261 (Dagen Report) ¶ 48.
- "[Wakeman] also noted that cash from operations and commercial health plan revenue improved further in the final quarter of 2010." RX-1261 (Dagen Report) ¶ 59.
- "One ordinary course document concluded that St. Luke's census experienced its 'largest spike [of the 2010 year] . . . in the last quarter." RX-1261 (Dagen Report) ¶ 59.

This evidence is misleading as it incorporates the benefits of the joinder, but does not reflect St. Luke's financial condition as an independent hospital.

To justify their arguments, Complaint Counsel repeatedly cite to statements Dan Wakeman made to St. Luke's Board of Directors after the joinder was complete; however, they fail to provide a full explanation of the circumstances surrounding his statements. *See* CC Pre-Trial Br. at 6, 52, 53 (citing PX01072 twelve times). In his report, Wakeman noted that St. Luke's had an operating margin of $7,000 on $36.7 million in gross revenue in the last month that St. Luke's operated independently. PX01072. But Complaint Counsel ignore the *de minimus* size of St. Luke's margin (only $7,000) and short time period (one month) to which it

applies. They similarly ignore Mr. Wakeman's acknowledgement in the same report that this margin is "not impressive." *Id.* Both St. Luke's CEO's mention of such a trivial positive monthly margin, and Complaint Counsel's repeated citation to it as a sign of St. Luke's financial success, only serves only to highlight St. Luke's dire financial position at the time of the joinder.

The evidence also will show that Mr. Dagen's financial projections for St. Luke's, had it remained an independent entity, include a number of erroneous assumptions which render his analysis inaccurate and meaningless. For example, Mr. Dagen assumes that St. Luke's expenses will increase at a rate of only 3% per year, whereas St. Luke's expenses actually increased in the 2007-2010 time period by 8.4% per year, or 33% more than the Hospital and Related Services portion of the Medical Care Consumer Price Index which increased 6.3% per year over the same time period.

Similarly, on the revenue side, Mr. Dagen assumes that St. Luke's would be able to negotiate higher rates from Anthem and MMO, a feat that St. Luke's had not been able to accomplish as an independent hospital in the recent past. And, the documents that Mr. Dagen cites to support this assumption are the communications reflecting commerical payors rejection of St. Luke's attempts to secure rate increases from them. RX-1261 (Dagen Report) n.114.

Mr. Dagen also erroneously assumes that all reserve funds, *including* all trustee restricted funds are generally available to St. Luke's to fund capital projects and/or cover the hospital's operating expenses. However, St. Luke's trustee restricted funds are specifically designated for debt service coverage and professional liability insurance purposes. PX02108 (Johnston Decl.) ¶ 24.

Dagen further assumes that St. Luke's would have started to implement its EMR system in 2011. However, St. Luke's planned to start it in 2010. RX-0056 (Den Uyl Report) ¶ 93 and

Table 20. The one year delay in Mr. Dagen's analysis understates the EMR expenditures that St. Luke's would have had to make to implement this system that plays such a prominent role in healthcare reform. In addition, Mr. Dagen's analysis fails to account for the operational costs St. Luke's would incur in its EMR implementation, estimated to be { }. *Id.* At the same time, Mr. Dagen credits St. Luke's with subsidies it would have received only if it met certain EMR completion milestones, even though it is uncertain whether St. Luke's would have been able to achieve these milestones as an independent hospital given its financial difficulties. Indeed, Complaint Counsel's assumption of a later start date for the EMR project makes it less certain that St. Luke's would have qualified for the subsidies.

Mr. Dagen also assumes capital expenditures at St. Luke's of only $4.9 million, $8.2 million, and $9.1 million, in 2011, 2012, and 2013, respectively. RX-0056 (Den Uyl Report) ¶ 94. These expenditures would be far below St. Luke's historical average of { }. RX-0056 (Den Uyl Report) ¶ 94. And, Mr. Dagen fails to account for St. Luke's deferred capital items in his analysis – those projects cannot be deferred permanently and should have been considered by Complaint Counsel. RX-0056 (Den Uyl Report) ¶ 96.

Finally, Mr. Dagen assumes an 8% return for St. Luke's investment portfolio reserves. RX-1261 (Dagen Report) ¶ 70. This assumption is very aggressive, as St. Luke's earned only 0.7% on its reserve fund over the ten year period ending December 31, 2009 and lost 1.8% over the three year period ended December 31, 2009. RX-1282.

In other words, Complaint Counsel's blind ignorance to the financial difficulties that St. Luke's faced at the time of the joinder, coupled with their assertion that St. Luke's would have been a viable competitor in Lucas County if the joinder had not occurred, lacks a credible and reliable factual basis and should be rejected.

III. THE JOINDER HAS THE POTENTIAL TO IMPROVE ST. LUKE'S AND PROVIDE SIGNIFICANT COMMUNITY BENEFITS

St. Luke's joinder with ProMedica provided St. Luke's with a number of important financial benefits that St. Luke's could not have achieved on its own. First, ProMedica provided St. Luke's $5 million upon closing and has committed to invest $30 million over the next three years to fund delayed and needed capital projects, including conversion of private rooms, updates to information technology systems, and the enhancement of various inpatient and outpatient facilities. RX-0473 (Joinder Agreement) § 6.1(b), and Exhibit 6.1.

Second, upon consummating the joinder, ProMedica absorbed St. Luke's pension liability of approximately $44.8 million at August 31, 2010. At the same time, St. Luke's became part of the ProMedica obligated group (and therefore eligible for credit at better rates), and pursuant to a waiver agreement with AMBAC, St. Luke's as no longer at risk of being forced to defease those bonds in 2010.

Third, the joinder gave St. Luke's access to medical malpractice insurance from ProMedica's captive insurance policy, resulting in significant savings to St. Luke's. RX-0194 (Wakeman Decl.) ¶ 40.

Finally, the joinder allowed St. Luke's to become an in-network provider for Paramount's health insurance products. This means Paramount members can now choose St. Luke's as an in-network hospital at which to receive their care. The rates that St. Luke's receives from Paramount are comparable to the rates that Paramount pays the other ProMedica hospitals and higher than the rates St. Luke's receives from its other large payors (MMO and Anthem.) RX-0194 (Wakeman Decl.) ¶ 39.

Although Complaint Counsel discount these benefits as insignificant, St. Luke's did not have the financial wherewithal to make the capital investments and expenditures necessary to

improve its facility or even to maintain its systems. All of the financial benefits attributable to the joinder are investments St. Luke's could not have made on its own.

Moreover, ProMedica's plan to rationalize health care delivery across its system of hospitals, as Navigant has proposed, has the potential to result in delivery of health care services to Toledo area residents that is more efficient and cost effective, and that better utilizes the current over-supply of beds in the area. And ProMedica's decision to add St. Luke's to its network, and its agreement to keep the hospital as a full-service stand along community hospital, offering a full array of general acute care inpatient services is also a benefit that – especially when contrasted to St. Luke's uncertain future without the joinder – should not be overlooked.

CONCLUSION

Complaint Counsel bear the burden of proving each and every element of their Clayton Act Section 7 case. They cannot do that in this case. While the Complaint alleges the relevant product market to be "general acute-care inpatient hospital services sold to commercial health plans," Complaint Counsel and their economic expert focus their analysis of the joinder's potential competitive effects on a market different, and substantially narrower, than the one alleged in the Complaint. And the evidence will demonstrate that there is no basis in law or fact to support the existence of a separate market for "inpatient obstetrical services." Moreover, the evidence will show that whatever the competitors' properly calculated market shares might be, they are not a reliable predictor of any competitor's ability to obtain supracompetitive prices in the intensely competitive market for general acute care inpatient hospital services in Lucas County. To the contrary, Mercy, UTMC, and the large commercial insurers themselves, can and will constrain ProMedica's ability to raise either St. Luke's or its other hospitals' rates above competitive levels, just as they constrained ProMedica's ability to exercise market power prior to

its joinder with St.Luke's. Finally, the joinder will provide procompetitive benefits--both for St. Luke's and for the Lucas County community as a whole--that St. Luke's could not have achieved, given its deteriorated and declining financial situation, on its own. Simply put, the evidence will establish that the joinder will not result in a substantial lessening of competition in any relevant market and, therefore, does not violate Clayton Act Section 7.

Respectfully submitted,

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By: DAVID MARX, Jr.

Stephen Y. Wu
Amy J. Carletti
Erin C. Arnold
McDERMOTT WILL & EMERY LLP
227 West Monroe Street
Chicago, Illinois 60606
Telephone: (312) 372-2000
Facsimile: (312) 984-7700
dmarx@mwe.com
swu@mwe.com
acarletti@mwe.com
earnold@mwe.com

Amy E. Hancock
Jennifer L. Westbrook
Vincent C. van Panhuys
Carrie G. Amezcua
Christine G. Devlin
Daniel Powers
James B. Camden
McDERMOTT WILL & EMERY LLP
600 13th Street, N.W.
Washington, D.C. 20005-3096
Telephone: (202) 756-8000
Facsimile: (202) 756-8087
ahancock@mwe.com

jwestbrook@mwe.com
vvanpanhuys@mwe.com
camezcua@mwe.com
cdevlin@mwe.com
dgpowers@mwe.com
jcamden@mwe.com

Attorneys for Respondent ProMedica Health System, Inc.

CERTIFICATE OF SERVICE

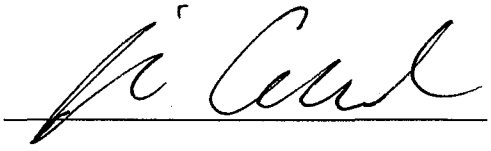
I, James B. Camden, hereby certify that I served a true and correct copy of the foregoing Respondent's Pre-Trial Brief, Public Version, upon the following individuals by hand on June 1, 2011.

Hon. D. Michael Chappell
Chief Administrative Law Judge
Federal Trade Commission
600 Pennsylvania Avenue, NW
Room H110
Washington, DC 20580

Donald S. Clark
Secretary
Federal Trade Commission
600 Pennsylvania Avenue, NW
Room 172
Washington, DC 20580

I, James B. Camden, hereby certify that I served a true and correct copy of the foregoing Respondent's Pre-Trial Brief, Public Version, upon the following individuals by electronic mail on June 1, 2011.

Matthew J. Reilly
Jeffrey H. Perry
Sara Y. Razi
Jeanne H. Liu
Alexis J. Gilman
Stephanie L. Reynolds
Janelle L. Filson
Maureen B. Howard
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580
mreilly@ftc.gov
jperry@ftc.gov
srazi@ftc.gov
jliu@ftc.gov
agilman@ftc.gov
sreynolds@ftc.gov
jfilson@ftc.gov
mhoward@ftc.gov



James B. Camden