UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION

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

RESPONDENT PROMEDICA HEALTH SYSTEM, INC.'S
PROPOSED FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

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PROPOSED FINDINGS OF FACT

I. Background

A. Hospital Services

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

1. Inpatient Hospital Services

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

a. Primary, Secondary, Tertiary, and Quaternary Services

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

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

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

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

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

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

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

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

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

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

b. Inpatient Obstetrical Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Outpatient Hospital Services

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

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

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

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

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

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

36. {

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

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

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

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

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

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

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

3. Factors Patients Consider when Choosing a Hospital

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

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

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

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

47. Patients consider whether a hospital has a neonatal intensive care unit when choosing the hospital where they want to deliver. This choice is not dependent upon whether the

pregnancy is a high-risk pregnancy. Some mothers prefer the extra level of assurance from knowing that the hospital has facilities to care for unexpected complications. (Marlowe, Tr. 2445-2446; Read, Tr. 5284-5285).

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

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

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

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

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

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

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

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

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

B. The Toledo, Ohio Area

1. Demographics

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

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

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

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

2. Economic Conditions

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

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

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

C. The Parties

1. ProMedica Health System, Inc.

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

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

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

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

a. ProMedica's Hospitals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. ProMedica Physicians Group

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

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

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

96. ProMedica employs physicians because it considers employed physicians to be an important part of a traditional integrated delivery system and to stay competitive with the

growing national trend, which indicates that over half of the physicians in the United States are employed either by a hospital or a health system. (Oostra, Tr. 5796-5797).

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

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

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

c. Paramount Healthcare

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. ProMedica's Obligated Group

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

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

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

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

2. St. Luke's Hospital

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

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

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

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

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

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

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

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

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

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

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

129. {

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

130. {

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

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

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

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

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

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

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

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

D. Competitor Hospitals

1. Mercy Health Partners

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. University of Toledo Medical Center

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

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

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

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

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

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

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

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

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

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

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

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

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

189. {

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

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

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

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

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

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

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

3. Wood County Hospital

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

197. WCH is a not-for-profit hospital offering primary and secondary general acute care services, including general medical, inpatient and outpatient surgery, sleep lab, strokes, pneumonia, pain management, orthopedics, OB, intensive care, bariatric surgery, emergency services, and neurology. (Korducki, Tr. 475, 484, 538).

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Fulton County Health Center

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

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

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

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

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

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

5. Others

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

6. Distance Between Competing Hospitals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

236. From zip code 43402, which is located in Wood County but from which St. Luke's draws a large number of patients, driving to the furthest Lucas County hospital would take

approximately twelve additional minutes than driving to St. Luke's. (Guerin-Calvert, Tr. 7343; RX-71(A) at 000185, *in camera*).

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

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

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

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

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

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

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

E. Health Insurers

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

1. Government Health Insurers

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

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

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

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

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

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

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

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

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

254. {

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

255. {

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

2. Managed Care Organizations

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

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

a. Medical Mutual of Ohio

(i) Company Background and Products Offered

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

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

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

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

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

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

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

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

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

(ii) Network in Lucas County

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

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

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

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

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

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

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

b. Anthem Blue Cross Blue Shield

(i) Company Background and Services Offered

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) Network in Lucas County

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

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

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

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

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

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

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

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

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

(iii) National Brand Recognition

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

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

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

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

c. Paramount Healthcare

(i) Company Background and Products Offered

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

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

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

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

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

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

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

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

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

(ii) Network in Lucas County

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. FrontPath

(i) Company Background and Services Offered

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

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

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

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

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

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

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

335. {

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

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

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

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

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

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

(ii) Network in Lucas County

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

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

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

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

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

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

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

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

e. UnitedHealthcare

(i) Company Background and Services Offered

349. {

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

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

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

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

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

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

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

(ii) Network in Lucas County

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

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

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

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

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

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

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

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

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

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

(iii) National Brand Recognition

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

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

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

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

f. Aetna

(i) Company Background and Services Offered

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) Network in Lucas County

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

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

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

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

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

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

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

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

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

(iii) National Brand Recognition

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

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

g. Humana

(i) Company Background and Services Offered

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) Network in Lucas County

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

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

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

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

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

F. Employers

1. Employers Provide Health Insurance Benefits to Employees

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

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

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

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

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

2. Fully-Insured vs. Self-Insured Employers

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Factors Employers Consider When Choosing a Health Plan

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

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

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

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

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

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

441. Hospital participation is not a primary consideration for customers when choosing their MCO because customers tend not to use hospitals very frequently. For example, typically only about 6 percent of the commercially-insured go to a hospital in any given year. (Randolph, Tr. 6982-6983).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Unions Constrain Employers' Ability To Pass through Rates

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

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

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

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

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

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

5. Employers Do Not Negotiate Directly with Hospitals

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

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

6. Employers May Not Negotiate Directly with MCOs

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

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

G. Physicians

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

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

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

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

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

H. Competitive Landscape

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

1. Provider/MCO Contracting

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

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

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

471. { } (Wachsman, Tr. 4943, *in camera*).

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) ProMedica

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

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

485. {

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

486. {

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

487. {

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

488. {

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

489. {

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

490. {

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

491. {

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

492. {

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

493. {

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

494. {

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

495. {

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

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

(ii) Mercy

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

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

(iii) UTMC

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

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

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

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

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

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

d. Common MCO-Provider Contracting Terminology and Provisions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

f. Reimbursement Methodologies

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

(i) Per Diems

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

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

(ii) DRG Case Rates

571. Contracts also may use DRG case rates, which is an all inclusive rate that the hospital is paid for that patient admission, regardless of the number of days the patient stays in the

hospital or the amount of resources the hospital uses for the patient's care. (Radzialowski, Tr. 673; Randolph, Tr. 6955).

572. {

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

573. {

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

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

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

576. {

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

(iii) Percent-of-Charge

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

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

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

(iv) Fee-for-Service

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

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

(v) MCO and Provider Preferences

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

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

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

g. Dynamics of Negotiations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

603. {

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

604. {

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

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

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

(iv) Expired Contracts Favor MCOs

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

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

h. Paramount's Approach to Provider Contracting

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

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

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

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

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

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

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

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

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

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

(i) Paramount's Negotiations with ProMedica

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

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

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

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

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

i. ProMedica's Approach to MCO Contracting

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

640. {

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

641. {

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

642. {

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

643. {

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

644. {

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

645. {

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

646. {

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

647. {

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

648. {

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

649. {

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

650. {

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

651. {

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

652. {

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

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

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

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

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

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

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

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

2. Hospital Capacity and Utilization

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

660. {

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

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

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

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

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

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

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

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

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

669. UTMC also believes that the community of Northwestern Ohio has more inpatient acute care beds than needed. (Gold, Tr. 257; PX02206 at 001).

670. UTMC has referred to the Toledo area as "overbedded" and believes that there is a high degree of duplication of services in the community. (Gold, Tr. 340; PX02206 at 001).

671. Most days, UTMC could provide general acute care inpatient services to additional patients, if needed, by utilizing more of its staffed beds. (Gold, Tr. 283).

672. UTMC could also treat additional patients by staffing more of its registered beds that are currently unstaffed. (Gold, Tr. 256).

673. In the past, UTMC converted 15 geriatric psychiatry beds to inpatient patient care beds as needed. (Gold, Tr. 202).

3. Physician Privileges

a. Physicians in Lucas County Maintain Privileges at Multiple Hospitals

674. Most physicians have privileges at multiple hospitals in Lucas County. (Gbur, Tr. 3105; RX-35 (Hammerling, IHT at 16-18)).

675. Most obstetricians have privileges at several different hospitals. (Read, Tr. 5274).

676. Anthem acknowledges that Lucas County physicians tend to have admitting privileges in more than one hospital. (Pugliese, Tr. 1466, 1573-1574).

677. Anthem recognizes that employed physicians also maintain privileges at hospitals other than the hospital employing them. (Pugliese, Tr. 1467).

678. Anthem acknowledges that physicians employed by PPG have privileges at hospitals other than the ProMedica hospitals. (Pugliese, Tr. 1574).

b. Physicians Choose To Maintain Privileges at Multiple Hospitals for Personal and Patient-Care Related Reasons

679. Physicians obtain privileges at multiple hospitals for various reasons, including personal preference and convenience, access to adequate medical and surgical facilities to treat their patients, and for business reasons, such as the ability to cover for partners in their practice. (Andreshak, Tr. 1754-1755; Marlowe, Tr. 2428-2429).

680. Physicians also obtain privileges at multiple hospitals in order to respond to patient preferences and to serve patients whose health insurance plans or MCOs may not have certain hospitals in their networks. (Andreshak, Tr. 1754-1755, 1807; Marlowe, Tr. 2398; Read, Tr. 5268).

c. Having Privileges at Multiple Hospitals Benefits Patients

681. Admitting privileges allow a physician to admit and see patients, prescribe medications and perform procedures at the hospital. (Andreshak, Tr. 1752).

682. Having privileges at multiple hospitals allows a physician to direct a patient to an in-network hospital for treatment so the patient may minimize out-of-pocket expenses. (Andreshak, Tr. 1805-1806).

683. Having privileges at multiple hospitals also enables a physician to continue caring for patients if an insurer eliminates one of the hospitals or systems from its network The patient will not experience any disruption in care or have to seek a new physician, because their existing physician can direct the patient to another in-network hospital where he has privileges. (Marlowe, Tr. 2430; Read, Tr. 5271).

684. Anthem believes that having privileges at more than one hospital allows a physician to serve more customers in the community. (Pugliese, Tr. 1467).

685. Anthem believes that having a doctor with privileges at more than one hospital enables a patient to influence the choice of the hospital to which they are admitted for care. (Pugliese, Tr. 1467).

d. Hospital Employed Physicians May Hold Privileges at and Admit Patients to Other Hospitals

686. PPG physicians have admitting privileges at non-ProMedica hospitals because ProMedica wants to allow its physicians to honor patient preference if the patient wants to receive service at a non-ProMedica facility. (Oostra, Tr. 5798).

687. A PPG physician may admit a patient to a non-ProMedica facility if the physician thinks a particular service would be better delivered at another hospital or if the physician thinks there is a better specialist at another hospital. (Oostra, Tr. 5798).

688. PPG physicians' freedom to refer patients to other physicians or hospitals is memorialized in the "Use of Facilities" clause in every physician contract. (Oostra, Tr. 5799; RX-1908 at 000005, *in camera*).

689. St. Luke's WellCare employed physician group also imposes no restrictions of physicians regarding where they admit their patients. (Read, Tr. 5297). WellCare physicians receive no financial incentives to admit patients to particular hospitals. (Read, Tr. 5297).

690. Physicians employed by Mercy are not required to refer their patients to Mercy's hospitals; instead they may take into consideration other factors such as patient preference, insurance, and physician opinion. (Shook, Tr. 1057).

691. Mercy believes that many physicians who admit patients to Mercy's hospitals also practice at and admit patients to ProMedica's hospitals. (Shook, Tr. 1033).

692. Mercy recognizes that some members of its medical staff serve on ProMedica's medical staff, and some also serve on the medical staff at St. Luke's. (Shook, Tr. 1057-1058).

693. UTMC faculty physicians can admit and treat patients at hospitals other than UTMC and may refer their patients to other Toledo-area hospitals for services that UTMC offers. (Gold, Tr. 260-262).

e. Expert Review of Physician Referral Patterns Confirms that Lucas County Physicians Maintain Privileges at Multiple Hospitals and Refer Patients to Multiple Hospitals

694. {

}

(Guerin-Calvert, Tr. 7359-7360, *in camera*)

695. {

} (Guerin-Calvert, Tr. 7360-7361, *in camera*).

696. {

} (Guerin-Calvert, Tr. 7360-7361, *in camera*).

697. {

} (Guerin-Calvert, Tr. 7360-7361, *in camera*)

698. Of the physicians who admit to ProMedica, more of them admit to Mercy than to St. Luke's. (Town, Tr. 4337; Guerin-Calvert, Tr. 7366-7367, *in camera*).

699. {

} (Guerin-Calvert, Tr. 7362-7363, *in camera*; RX-71(A) at 000141-000144, *in camera*).

700. {

} (Guerin-Calvert, Tr. 7362-63, *in camera*; RX-71(A) at 000141-000144, *in camera*).

701. Twice as many of the physicians who have privileges at ProMedica admit to Mercy as well than to St. Luke's. (Town, Tr. 4338; Guerin-Calvert, Tr. 7366-7368, *in camera*).

702. {

} (Guerin-Calvert, Tr. 7365-7366, *in camera*; RX-71(A) at 000141-000144, *in camera*).

703. Even Prof. Town calculates that only 30 percent of the physicians in all of Lucas County admit to St. Luke's. (Town, Tr. 4095).

704. {

} (Guerin-Calvert, Tr. 7366, *in camera*; RX-71(A) at 000141-000144, *in camera*).

705. {

} (Guerin-Calvert, Tr. 7367-7368, *in camera*; RX-71(A) at 000141-000144, *in camera*).

706. {

} (Guerin-Calvert, Tr. 7369-7370, *in camera*; RX-71(A) at 000141-000144, *in camera*).

707. {

} (Guerin-Calvert, Tr. 7367-7371, *in camera*; RX-71(A) at 000142, *in camera*).

708. {

} (Guerin-Calvert, Tr. 7364-7367, *in camera*).

4. History of Closed Provider Network Contracting

709. In 2000, ProMedica was the only Lucas County hospital system not in MMO's network; Mercy was the only hospital system not in Paramount's or United's network; UTMC was the only hospital not in Cigna's network. Anthem, Aetna, FrontPath and Humana had all Toledo area hospitals in their networks. (Guerin-Calvert, Tr. 7324-7330).

710. In 2001, St. Luke's was dropped from Paramount's network and Mercy was still out of network; ProMedica remained out of network for MMO; UTMC remained out of network for Cigna and Mercy remained out of network for United. (Guerin-Calvert, Tr. 7326).

711. In 2002, the only change to the network configurations in the Toledo area was that UTMC was dropped from United's network. (Guerin-Calvert, Tr. 7326).

712. There were no changes again until 2005 when Anthem dropped Mercy and St. Luke's from its network, keeping only ProMedica and UTMC; Paramount still also had only ProMedica and UTMC; MMO was still without ProMedica in its network; Cigna was without UTMC and United was without Mercy and UTMC. (Guerin-Calvert, Tr. 7326-7327).

713. In 2006, United was the only managed care organization to change its network; it added Mercy and UTMC but dropped ProMedica. (Guerin-Calvert, Tr. 7327).

714. The next change came in 2008 when Anthem added Mercy and MMO added ProMedica; Anthem still did not have St. Luke's in its network at this time. (Guerin-Calvert, Tr. 7327; Radzialowski, Tr. 791, *in camera*; PX02212, *in camera*).

715. In 2009, Cigna added UTMC and Anthem added St. Luke's to their respective networks. (Guerin-Calvert, Tr. 7327).

716. In 2010, Paramount added St. Luke's to its network. (Guerin-Calvert, Tr. 7327).

717. Finally in 2011, United added ProMedica to its network. (Guerin-Calvert, Tr. 7328).

a. Lucas County's Closed Provider Networks Were Marketable and Met Patient Needs

718. The history of MCO networks in Toledo shows that major networks such as MMO and Anthem, using various narrow network configurations, and 50-55 percent of the Toledo area's bed capacity in-network competed successfully with open networks like Aetna. (Guerin-Calvert, Tr. 7328-7330).

(i) MMO Was Able Successfully To Market a Network that Did Not Include ProMedica

719. During the time that ProMedica was not in MMO's network, MMO's membership remained fairly stable. (Pirc, Tr. 2275).

720. MMO was able to compete with other MCOs and have a successful PPO product in the period prior to January 1, 2008 when ProMedica's hospitals were not in its network. (Pirc, Tr. 2204-2205, 2275-2276).

721. After ProMedica entered MMO's network, MMO's membership remained stable. (Pirc, Tr. 2276).

722. The reconfigurations of the networks that resulted in ProMedica participating with MMO and Mercy participating with Anthem did not cause a discernable change in MMO's market share relative to Anthem. (Pirc, Tr. 2276).

(ii) When ProMedica Was Not in MMO's network, Those Members with MMO as Their Health Insurance Provider Were Well-Served

723. When ProMedica was not in MMO's network, the Wood County Schools Health Consortium did not switch to a plan that had ProMedica as an in-network provider. (Caumartin, Tr. 1881-1882)

724. Members were well-served by MMO's network, despite ProMedica not being an in-network provider for a period of time. (Caumartin, Tr. 1878).

(iii) Anthem Successfully Marketed a Network that Did Not Include Mercy or St. Luke's

725. From 2005 until January 1, 2008, Anthem had only ProMedica and UTMC in its provider network. (Pugliese, Tr. 1539).

726. During the period when Anthem had only ProMedica and UTMC in its network, it still competed with other health insurance providers in Lucas County. (Pugliese, Tr. 1539-1540).

727. During this same period when Anthem had only ProMedica and UTMC in its network, the other MCOs operating in Lucas County, except for Paramount, had the Mercy hospitals in their networks. (Pugliese, Tr. 1540).

728. During the period between 2005 and 2008 when Anthem had only a limited number of hospital providers in its network, which did not include St. Luke's, Anthem's membership remained steady, indicating that Anthem was not at a competitive disadvantage. (Pugliese, Tr. 1540; Guerin-Calvert, Tr. 7941).

729. After Anthem opened its network to include Mercy and St. Luke's hospitals, its insureds continued to want to go to ProMedica's hospitals. (Pugliese, Tr. 1544-1545).

b. The Move to Open Networks Led to Reduced Volume Discounting

730. { } (Radzialowski, Tr. 791, *in camera*; PX02212, *in camera*).

731. { } (Radzialowski, Tr. 791-792, *in camera*; PX02212, *in camera*).

732. {

} (Radzialowski, Tr. 791, *in camera*; PX02212, *in camera*).

(i) MMO Paid Mercy Significant Sums To Add PHS to Its Network

733. When MMO and Mercy had an exclusive network, MMO was contractually obligated to pay Mercy additional reimbursement for the right to negotiate with ProMedica to become an in-network provider for MMO. (Shook, Tr. 1062; RX-265 at 000002, *in camera*; RX-267 at 000002, *in camera*).

734. Later, when ProMedica actually joined MMO's network, MMO paid additional reimbursement to Mercy. (Shook, Tr. 1063; Pirc, Tr. 2328, *in camera*; RX-290 at 000006, *in camera*; RX-266 at 000002, *in camera*).

735. {

} (Pirc, Tr. 2328-2329, *in camera*; RX-265 at 000002, *in camera*).

736. {

} (Pirc, Tr. 2329-2330, *in camera*).

737. Mercy and MMO negotiated the additional reimbursement because the value of MMO's narrow network to Mercy decreased when MMO broadened its network by adding ProMedica because the volume of MMO members going to Mercy was expected to decrease. (Town, Tr. 4127-4128).

738. Additionally, Mercy and MMO had a provision in their contract by which Mercy was obligated to give MMO the lowest reimbursement rates as compared to Mercy's contracts with other commercial health plans. (Shook, Tr. 1074; Pirc, Tr. 2330-2331, *in camera*; RX-265 at 000002, *in camera*).

(ii) Anthem "Paid" ProMedica To Add Mercy to Its Network

739. {

} (Pugliese, Tr. 1593, *in camera*).

740. {

} (RX 208 (Wachsman, Dep. at 41, *in camera*)).

741. {

} (Pugliese, Tr. 1593-1594, *in camera*; Guerin-Calvert, Tr. 7815, *in camera*).

742. {
} (Pugliese, Tr. 1598, *in camera*).

743. {
} (Pugliese, Tr. 1599, *in camera*; Guerin-Calvert, Tr. 7816, *in camera*).

744. Prior to Mercy's return to Anthem's network in 2008, Anthem paid Mercy over $37 million in out-of-network payments as a non-participating provider. (Pugliese, Tr. 1598, *in camera*; PX02443 at 002).

745. {
} (Pugliese, Tr. 1599, *in camera*).

746. {
} (Pugliese, Tr. 1600, *in camera*).

747. {. } (Pugliese, Tr. 1600-1601, *in camera*; PX02443 at 002; RX-1792 at 000005, *in camera*; RX-1796 at 000005, *in camera*).

748. Anthem's five-year contract with Mercy achieved "aggressive network rates" that resulted in savings to Anthem of 32 percent and over $12 million in the first year alone. (Pugliese, Tr. 1600, *in camera*; PX02443 at 002).

749. {
}
(Pugliese, Tr. 1601, *in camera*; RX-1792 at 000003, *in camera*).

750. Anthem's agreement with Mercy triggered a renegotiation of Anthem's contract with ProMedica due to the exclusivity provisions in the existing Anthem-ProMedica contract. (Pugliese, Tr. 1601, *in camera*; PX02443 at 002).

751. Following the entry of Mercy into Anthem's network, Anthem and ProMedica reached agreement on a new four-year contract. (Pugliese, Tr. 1602, *in camera*; PX02443 at 002; PX00091 at 005, *in camera*; PX00093 at 005, *in camera*; PX00095 at 005, *in camera*).

752. Anthem's new contract with ProMedica increased ProMedica's rates to adjust for the end of exclusivity and the entry of Mercy's hospitals to the Anthem provider network. (Pugliese, Tr. 1502, *in camera*; PX02443 at 002).

753. {

}
(Wachsman, Tr. 4976-4977, *in camera*; RX-208 (Wachsman, Dep. at 41-42, *in camera*)).

754. Anthem's new contract with ProMedica also included an MFN clause to ensure Anthem remained competitive with any MCO who may contract with ProMedica. (Pugliese, Tr. 1602, *in camera*; PX02443 at 002; PX00091 at 005, *in camera*; PX00093 at 005, *in camera*; PX00095 at 004, *in camera*).

755. {

} (Pugliese, Tr. 1602, *in camera*).

756. The new contracts with Mercy and ProMedica allowed Anthem to reduce its overall costs and save over $5 million in Toledo alone, including $2 million on its fully-insured plans. (Pugliese, Tr. 1603, *in camera*; PX02443 at 002).

757. {

} (Pugliese, Tr. 1603-1604, *in camera*).

758. {

} (Pugliese, Tr. 1604, *in camera*).

(iii) Anthem Paid Significantly Less To Add St. Luke's to Its Network than It Paid To Add Mercy

759. In July 2004, Anthem provided St. Luke's with notice that it was terminating its contract, effective on February 1, 2005. (RX-11 (Oppenlander, Dep. at 57)).

760. {

} (Pugliese, Tr. 1586-1587, *in camera*).

761. {

} (Pugliese, Tr. 1587, *in camera*).

762. {

} (Pugliese, Tr. 1591, *in camera*; PX02215 at 004-005, *in camera*).

763. { } (Pugliese, Tr. 1592, *in camera*; PX02215 at 006, *in camera*).

764. { } (Pugliese, Tr. 1593, *in camera*).

765. After Anthem terminated its contract with St. Luke's in 2005, St. Luke's waived out-of-network fees for Anthem's insureds who continued receiving care at St. Luke's, which succeeded in limiting St. Luke's patient decline to 2.5 percent of St. Luke's overall volume. (PX01519 at 003, *in camera*; RX-11 (Oppenlander, Dep. at 96-98)).

766. Despite threatening to take legal action against St. Luke's practice of waiving out-of-network fees for Anthem's members after Anthem had terminated its contract with St. Luke's, it never initiated a breach of contract suit against St. Luke's; St. Luke's continued the practice of waiving out-of-network fees for Anthem's insureds while it remained out of Anthem's network until July 2009. (RX-11 (Oppenlander, Dep. at 98-100)).

767. { } (Pugliese, Tr. 1478-1479, 1482-1483, *in camera*).

768. { } (Pugliese, Tr. 1483, *in camera*).

769. { } (Wachsman, Tr. 5004-5005, 5240-5241, *in camera*; PX00333 at 002, *in camera*).

770. { } (Wachsman, Tr. 5005, 5240-5241, *in camera*; PX00333 at 002, *in camera*).

771. { } (Pugliese, Tr. 1498, *in camera*).

772. { } (Pugliese, Tr. 1605, *in camera*).

773. { } (Pugliese, Tr. 1498-1499, *in camera*).

774. Once Anthem broadened its network to include St. Luke's, that contract no longer provided a benefit to ProMedica, because of the possibility that some of Anthem's members would choose St. Luke's instead of ProMedica for treatment. (Town, Tr. 4124)

775. Therefore, it was in ProMedica's interest, given the potential decline in volume and corresponding decline in the value of Anthem's network, to negotiate the removal of the discount to Anthem for a narrower network once Anthem added St. Luke's as an in-network hospital. (Town, Tr. 4125)

776. {

}

(Wachsman, Tr. 4977, *in camera*; Pugliese, Tr. 1605-1606, *in camera*).

777. {

} (Pugliese, Tr. 1608-1609, *in camera*).

778. {

} (Pugliese, Tr. 1610, *in camera*).

c. Paramount Has Always and Continues To Operate a Closed Provider Network, and Yet Is Successful in the Market

779. Paramount is the only health insurance plan in Lucas County that does not have an open or broad hospital provider network. (Pirc, Tr. 2204).

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

781. Paramount has been one of the largest health plans in Lucas County for a long time. (Pirc, Tr. 2178).

782. Paramount's network did not broaden to include Mercy even when MMO expanded to include ProMedica and Anthem expanded to include Mercy. (Town, Tr. 4328; Guerin-Calvert, Tr. 7327).

783. Prof. Town agrees that Paramount was successful in marketing a narrower network against the broader networks of MMO and Anthem. (Town, Tr. 4328-4329; Guerin-Calvert, Tr. 7332).

784. St. Luke's was included in the Paramount network until January 1, 2001. (PX01022 at 002; Rupley, Tr. 1938; Randolph, Tr. 6997).

785. St. Luke's and Paramount negotiated about a potential new contract in 2000, but did not come to an agreement. (Rupley, Tr. 1938-1940; Randolph, Tr. 6997-6999).

786. ProMedica owns property in Arrowhead, a business development park in South Toledo, near St. Luke's. (Randolph, Tr. 7000).

787. In 2000, then St. Luke's CEO Jack Bartell was concerned that ProMedica might build a hospital close to St. Luke's and then transfer its Paramount patients away from St. Luke's when the new hospital opened. (Rupley, Tr. 1938-1939).

788. ProMedica had built Bay Park close to St. Charles. As soon as Bay Park opened, Paramount cancelled its contract with St. Charles. St. Luke's did not want to suffer the same fate if ProMedica built a hospital near St. Luke's. (PX01022 at 002; Rupley, Tr. 1938-1939).

789. In 2000, St. Luke's was concerned that Paramount was "using St. Luke's as an engine of growth" in the Southwest Toledo area. (PX01022 at 002).

790. In addition, in 2000, St. Luke's did not agree with a proposed Paramount contract term that required St. Luke's to offer Paramount as a health insurance plan for its own employees if Paramount became more than 20 percent of St. Luke's MCO mix. (PX01022 at 002; Rupley, Tr. 1939).

791. A few years before the end of the St. Luke's-Paramount contract in 2001, Paramount purchased a small health plan called Medical Value Plan. (Randolph, Tr. 6998).

792. Paramount discovered through that merger that St. Luke's had been offering a greater level of discount to Medical Value Plan than it had to Paramount, despite Paramount being much larger. (Randolph, Tr. 6997-6999).

793. During contract renewal negotiations with St. Luke's in 2000, Paramount wanted the Medical Value Plan pricing to apply to the Paramount business. (Randolph, Tr. 6998).

794. St. Luke's asked for the old Paramount pricing to apply to the Medical Value Plan business. (Randolph, Tr. 6998).

795. St. Luke's then deemed that the reimbursement rates that Paramount offered St. Luke's at that time to be too low. (Rupley, Tr. 1939-1940).

796. St. Luke's and Paramount mutually parted ways in 2001 subsequent to these negotiations, after which St. Luke's was no longer in the Paramount network. (PX01022 at 002; Rupley, Tr. 1938-1940).

797. The loss of St. Luke's as a hospital provider in Paramount's network in 2001 had a minimal effect on Paramount's membership. (Randolph, Tr. 7003).

798. In 2008, St. Luke's new CEO, Mr. Dan Wakeman, contacted Paramount after he joined St. Luke's to discuss the Paramount-St. Luke's relationship. (Randolph, Tr. 7016).

799. St. Luke's submitted proposals to Paramount regarding rejoining the network, but they were not acceptable to Paramount. (Randolph, Tr. 7017).

d. MCOs with All Hospitals in Their Networks Did Not Gain Any Significant Advantage over MCOs with More Limited Networks

800. Between 2006 and 2008, Aetna had all hospitals in its hospital provider network while MMO and Anthem offered more limited networks. (Radzialowski, Tr. 741).

801. Aetna's broad network configuration at this time was a factor playing to its advantage compared to Anthem and MMO. (Radzialowski, Tr. 741-742).

802. In spite of this apparent competitive advantage, Aetna did not grow its business significantly during the period when it was the only open network in Lucas County. (Radzialowski, Tr. 742).

803. Aetna's commercial membership in Lucas County has not changed dramatically since 2004. (Radzialowski, Tr. 742).

804. After the other MCOs shifted to broad and open networks, Aetna was still able to compete successfully with those MCOs in Lucas County. (Radzialowski, Tr. 742-743).

805. Humana also maintained a broad network while MMO and Anthem were offering limited networks. (McGinty, Tr. 1198-1199).

806. Humana's commercial membership in Lucas County has declined over the years. (McGinty, Tr. 1168).

807. FrontPath has always maintained a broad network in Lucas County. (Sandusky, Tr. 1287-1288).

808. FrontPath experienced no gain or loss in membership during the period when other payors maintained limited networks. (Sandusky, Tr. 1299; PX01352 at 008).

5. Industry Trends

809. A trend among physicians is seeking employment from hospitals in lieu of opening their own practices, because they are interested in practicing medicine and not in running their own businesses. (Korducki, Tr. 459, 497; Oostra, Tr. 5796; Pugliese, Tr. 1573).

810. Physicians increasingly seek to be employed by hospital systems because of the many challenges to running a successful independent practice. These challenges include the difficulty of negotiating with powerful MCOs like Anthem and MMO. (Pugliese, Tr. 1573).

811. Many younger medical school graduates are opting for employment because of the lifestyle it allows them to lead and the ability it gives them to practice medicine in an environment that may not require a productivity level as high as is required in private practice. (Oostra, Tr. 5797).

812. Even if a hospital does not recruit or employ a particular physician, it may provide an "income guarantee" to the physician or the physician's group to cover costs and expenses of starting a new practice. (Andreshak, Tr. 1801-1802).

813. Every year more and more hospital price information is available to commercially insured patients. (RX-18 (Marcus, Dep. at 136-137)).

814. {

} (Wachsman, Tr. 5167, *in camera*).

815. The standard of care has changed from semi-private to private rooms because (1) inpatients tend to be sicker today than in the past because outpatient care has improved; (2) there is more technology and equipment in hospital rooms than in the past and private rooms provide the space for that equipment; (3) private rooms improve infection control; and (4) private rooms ensure greater patient privacy as mandated by HIPAA regulations. (Nolan, Tr. 6277-6278, *in camera*; Johnston, Tr. 5376; Guerin-Calvert, Tr. 7288-7289; Black, Tr. 5585).

816. Private rooms are more efficient operationally and also help improve patient satisfaction. (Johnston, Tr. 5375-5376; Black, Tr. 5585).

817. Because patients of different sexes cannot share a room, the use of semi-private forces St. Luke's to move patients around from room to room in order to maximize the use of its rooms. (Johnston, Tr. 5376).

818. Many patients also dislike being in semi-private rooms. (Johnston, Tr. 5376).

I. The ProMedica/St. Luke's Joinder

1. St. Luke's Considered Several Potential Partners before Seeking an Affiliation with ProMedica

a. Criteria St. Luke's Used To Evaluate Potential Partners

819. {

} (PX01030 at 002, *in camera*).

820. {

} (PX01030 at 007, *in camera*; Wakeman, Tr. 2959-2960, *in camera*; Black, Tr. 5634-5635, *in camera*).

821. {

} (Wakeman, Tr. 2961, *in camera*; Black, Tr. 5636, *in camera*).

822. {

} (Wakeman, Tr. 2888-2889, *in camera*).

823. {

} (Wakeman, Tr. 2961, *in camera*; Black, Tr. 5642, *in camera*).

824. {

}

(Wakeman, Tr. 3001-3002, *in camera*).

825. {

} (Wakeman, Tr. 2941-2942, *in camera*).

826. {

} (PX01283 at 002, *in camera*; Wakeman, Tr. 2950-2951, *in camera*).

b. Potential Non-Lucas County, Ohio Affiliation Partners

(i) The Cleveland Clinic

827. In late 2008, St. Luke's discussions with The Cleveland Clinic about a potential affiliation. (Wakeman, Tr. 2541-2542; PX01911 (Wakeman, IHT at 194-195)).

828. The Cleveland Clinic requested a fee in excess of $300,000 to evaluate a potential partnership with St. Luke's, which St. Luke's did not think was acceptable. (PX01911 (Wakeman, IHT at 194); Black, Tr. 5604).

829. The Cleveland Clinic informed St. Luke's that they were not interested in an affiliation, because they did not want to threaten their referrals from other Toledo Hospitals. (PX01911 (Wakeman, IHT at 194)).

(ii) University of Michigan Health System

830. In late 2008 or early 2009, St. Luke's had discussions with the University of Michigan Health System ("UMHS") about a potential affiliation. (Wakeman, Tr. 2542-2544; PX01911 (Wakeman, IHT at 195-196); Black, Tr. 5603).

831. During its discussions with UMHS, St. Luke's outlined its major capital needs, to which UMHS responded that it was not interested in making the significant influx of capital that St. Luke's required. (PX01911 (Wakeman, IHT at 195-196)).

832. UMHS also informed St. Luke's that they were not interested in an affiliation because UMHS did not want to jeopardize their referrals from the two large systems in Toledo. (PX01911 (Wakeman, IHT at 195)).

(iii) McLaren Health Care Corporation

833. In late 2008, St. Luke's had discussions with McLaren Health Care Corporation ("McLaren") about a potential affiliation. (PX01911 (Wakeman, IHT at 196)).

834. McLaren informed St. Luke's that it was not interested in an affiliation because it did not fit with McLaren's strategic plan. (PX01911 (Wakeman, IHT at 197)).

835. St. Luke's did not reinitiate discussions with any of the potential joinder partners from outside of Toledo, The Cleveland Clinic, UMHS, or McLaren, after those discussions initially ended because St. Luke's Board was more interested in joining with an organization that would have more local governance ties. (Wakeman, Tr. 2547-2548).

(iv) White House Group

836. The "White House Group" was a group of community hospitals located close to St. Luke's, including WCH, FCHC, Henry County Hospital, Blanchard Valley Hospital, and St. Luke's, that met on a regular basis, about once a month. (Wakeman, Tr. 2548- 2549).

837. In mid- to late 2008, St. Luke's and the other White House Group members began discussions about a potential affiliation among the White House Group members. (Wakeman, Tr. 2548-2549).

838. Affiliation discussions at the White House Group included a presentation by an attorney about developments in federal healthcare reform including potential Accountable Care Organizations. (Wakeman, Tr. 2549-2550).

839. St. Luke's believed that getting this diverse group of hospitals to agree on governance and risk sharing provisions would be very complex and challenging. (Wakeman, Tr. 2551).

840. In 2009, St. Luke's decided not to pursue an affiliation among the White House Group members because "the time frame of putting something together...would far exceed our ability to survive long-term given our losses." (Wakeman, Tr. 2551).

c. UTMC

841. UTMC began exploring an affiliation with St. Luke's in late 2008. (Gold, Tr. 225).

842. UTMC and St. Luke's signed a non-exclusive Memorandum of Understanding in April 2009. (PX02203 at 001; Wakeman, Tr. 2857; Gold, Tr. 239).

843. The Memorandum of Understanding between St. Luke's and UTMC was not a binding agreement to affiliate, had a term of 180 days, and could be terminated by either party with 30 days notice. (PX02203 at 001, 004; Wakeman, Tr. 2857).

844. St. Luke's CEO, Mr. Wakeman, described the Memorandum of Understanding between UTMC and St. Luke's in internal communications as "just an agreement to talk and explore." (PX01460; Wakeman, Tr. 2858).

845. Affiliation discussions between UTMC and St. Luke's stretched approximately eight months in 2009. (Gold, Tr. 364).

846. UTMC felt that an affiliation with St. Luke's would have to result in one surviving entity with the term "University," central in the surviving brand and that a teaching hospital ethos had to prevail. (Gold, Tr. 326; RX-944 at 000002).

847. During the eight months that UTMC was exploring an affiliation with St. Luke's, there was no discussion regarding the feasibility of such an affiliation. (Gold, Tr. 291).

848. During the eight months that UTMC was exploring an affiliation with St. Luke's, UTMC did not conduct a formal analysis of St. Luke's quality. (Gold, Tr. 226, 287).

849. During the eight months that UTMC was exploring an affiliation with St. Luke's, UTMC did not conduct formal due diligence of St. Luke's. (Gold, Tr. 248, 291). Their information exchange was limited to publicly accessible information. (Wakeman, Tr. 2866-2867).

850. St. Luke's affiliation discussions with UTMC did not proceed to the due diligence stage where any potential efficiencies could have been identified or quantified in any detail. (RX-1860 at 000008; Gold, Tr. 322-323).

851. During the eight months that UTMC was exploring an affiliation with St. Luke's, UTMC did not receive any of the information it requested from St. Luke's in its draft due diligence request. (Gold, Tr. 312).

852. During the eight months that UTMC was exploring an affiliation with St. Luke's, UTMC neither learned about St. Luke's capital needs, nor evaluated St. Luke's financial health. (Gold, Tr. 318).

853. UTMC also did not offer to make a capital contribution to St. Luke's in the context of the affiliation discussions. (Gold, Tr. 320).

854. During the time that UTMC was exploring an affiliation with St. Luke's, UTMC was aware that St. Luke's was also discussing possible affiliations with other hospitals. (Gold, Tr. 293).

855. During the time that UTMC was exploring an affiliation with St. Luke's, UTMC identified several challenges to a potential affiliation, including: combining a small community hospital with a large, academic medical center; merging two different cultures; and dealing with the union status at UTMC and the non-union status at St. Luke's. (Gold, Tr. 294).

856. During the time that UTMC was exploring an affiliation with St. Luke's, the parties never finalized a business plan. (Gold, Tr. 316-317).

857. During the time that UTMC was exploring an affiliation with St. Luke's, the parties never converted the Memorandum of Understanding to a merger agreement. (Gold, Tr. 317).

858. St. Luke's management believed that a weakness of UTMC was that its board was responsible for the entire University and would give relatively little attention to the potential combined St. Luke's-UTMC hospital. (PX01352 at 020; Wakeman, Tr. 2807-2808).

859. In 2009 partnering discussions with St. Luke's, UTMC proposed an eight person board for the combined organization where the President of the University would have final say over all decisions if there was a tie vote. This proposed governance model was not acceptable to St. Luke's CEO or its board. (Wakeman, Tr. 2852-2853).

860. During its discussions with UTMC, St. Luke's was concerned that UTMC faced possible cuts in their state funding and reduced enrollment due to the economic downturn. (Wakeman, Tr. 2853-2854, 2867-2868).

861. St. Luke's management and board also had concerns about UTMC's unionized workforce and hierarchical structure in contrast to St. Luke's non-union, flat structure. (Wakeman, Tr. 2868).

862. {

} (PX01030 at 008, *in camera*).

863. In the summer of 2009, partnering talks between St. Luke's and UTMC were not making progress as the senior management and boards of directors of each of the organizations could not come to agreement on the structure of the potential partnership. UTMC's proposed structures were not acceptable to St. Luke's board leadership group. (Wakeman, Tr. 2866-2867).

864. St. Luke's and UTMC did not engage a third party consultant to evaluate the potential partnership (as St. Luke's would do when exploring a potential affiliation with Mercy). (Wakeman, Tr. 2866).

865. During partnering discussions with UTMC, St. Luke's board believed that the complexity of a relationship of St. Luke's, a private non-profit, with UTMC, a state entity, would be "onerous" and would have "a lot of challenges." (Wakeman, Tr. 2867-2868).

866. During partnering discussions with UTMC, St. Luke's perceived that UTMC was struggling with some core quality measures. (Wakeman, Tr. 2869).

867. St. Luke's board was concerned that UTMC's quality of care was not as good as St. Luke's and that was a negative consideration for an affiliation between UTMC and St. Luke's. (RX-16 (Bazeley, Dep. at 67-68)).

868. {

} (PX01030 at 018, *in camera*).

869. { } (PX01018 at 013, *in camera*).

870. { } (PX01018 at 013, *in camera*).

871. St. Luke's board was also concerned that UTMC's status as a state institution and the fact that it received state subsidies meant that it was not as financially savvy as a truly independent institution, like St. Luke's. (RX-16 (Bazeley, Dep. at 68-69)).

872. St. Luke's management believed that UTMC had {
} (PX01018 at 016, *in camera*).

873. By October 2009, St. Luke's and UTMC had not resolved many of the fundamental questions needed to procced with full due diligence, including what the functional structure of the partnership would be, what the "service line focus" would be, and how incentives would be set up to meet certain quality goals. (PX01407; Wakeman, Tr. 2956-2958, *in camera*).

874. {

} (PX01583 at 001, *in camera*; Wakeman, Tr. 2977-2978, in *camera*).

875. In late November 2009, St. Luke's Board of Directors determined that joining with UTMC was not in the best interest of the hospital or the community and terminated affiliation discussions with UTMC because: (1) UTMC's proposed board structure was not acceptable to St. Luke's because the UT leadership wanted to maintain full veto power over the combined board and any decision made by that board; (2) UTMC was "a totally unionized organization" and St. Luke's board was very concerned about the UTMC's union culture moving into St. Luke's non-union culture; and (3) the general hierarchy and culture at UTMC was not deemed to be compatible with St. Luke's culture. (Wakeman, Tr. 2556-2557; Black, Tr. 5648, *in camera*; RX-1860 at 000008-000009).

876. {

} (Wakeman, Tr. 3003, *in camera*; PX01457, *in camera*).

d. Mercy

877. St. Luke's originally approached Mercy in 2008 with a the idea of a joint venture involving heart and maternal/child services. These were two areas where St. Luke's was losing money and there appeared to be overcapacity in the community. (Wakeman, Tr. 2823-2825; Black, Tr. 5589; Shook, Tr. 988-989, *in camera*).

878. {

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(Shook, Tr. 1103-1104, *in camera*).

879. St. Luke's and Mercy hired Health Care Futures, an outside consultant, to assist them in evaluating information about the potential joint ventures in heart and vascular and maternal/child services. (Wakeman, Tr. 2825; Shook, Tr. 990, *in camera*).

880. {

} (Shook, Tr. 1097, *in camera*).

881. {

.} (Shook, Tr. 1097-1098, *in camera*).

882. { } (Shook, Tr. 1107, *in camera*).

883. {

} (PX02307 at 002, *in camera*).

884. {

} (Wakeman, Tr. 2882-2883, 2887, *in camera*; Shook, Tr. 1099, *in camera*; PX02307 at 002, *in camera*; PX01232 at 002-003, *in camera*).

885. {

} (Shook, Tr. 1100, *in camera*; PX02307 at 002, *in camera*).

886. {

}

(Shook, Tr. 1103, *in camera*; PX02307 at 002, *in camera*).

887. {

} (Shook, Tr. 991, 994, *in camera*).

888. {

} (Shook, Tr. 994, *in camera*).

889. {

}

(Shook, Tr. 1105, *in camera*; PX02307 at 009, *in camera*).

890. {

} (Shook, Tr. 1105-1106, *in camera*; PX02307 at 009, *in camera*).

891. {

} (Shook, Tr.1106, *in camera*).

892. {

} (Shook, Tr. 1106-1107 *in camera*).

893. {

} (Shook, Tr. 1107, *in camera*).

894. {

} (Shook, Tr. 1108-1109, *in camera*).

895. {

} (Shook, Tr. 1009, 1111, 1118, *in camera*).

896. { } (Shook, Tr. 1009, *in camera*).

897. { } (PX01583 at 001-002, *in camera*).

898. { } (PX01583 at 002, *in camera*; Wakeman, Tr. 2560-2561, 2980-2982, *in camera*; Black, Tr. 5647, *in camera*; Shook, Tr. 1000-1001, *in camera*; RX-16 (Bazeley, Dep. at 91-94)).

899. { } (PX01583 at 002, *in camera*; Wakeman, Tr. 2980-2982, *in camera*). "It appeared to our board that much of the key decision-making ... was coming from Catholic Health Partners in Cincinnati and not locally." (Wakeman, Tr. 2560-2561).

900. { } (Wakeman, Tr. 2888-2889, 2894, *in camera*; PX01018 at 015, *in camera*).

901. { } (PX01232 at 002, *in camera*).

902. { } (Wakeman, Tr. 3003, *in camera*).

2. ProMedica

a. Information Technology and Service Line Joint Ventures Discussions Lead to Joinder Negotiations

903. {

} (PX1232 at 003, *in camera*; Wakeman, Tr. 2892, *in camera*).

904. ProMedica and St. Luke's first discussed a possible heart and vascular service line joint venture. (Hanley, Tr. 4528).

905. At the same time that ProMedica and St. Luke's discussed a possible heart and vascular service line joint venture, they also discussed a potential information technology joint venture. (Oostra, Tr. 5840).

906. The joint venture discussions did not materialize, in part, due to the complexity of that type of integration, and because resolution of the major issues confronting St. Luke's would require a more extensive relationship, like a joinder. (Hanley, Tr. 4531; Oostra, Tr. 5841).

907. Next, the parties began discussing a full joinder in fall of 2009. (Hanley, Tr. 4531).

908. A joinder is a member substitution structure in which ProMedica functions as the parent entity and holds reserve powers over the "joined" party, which retains its own board and independent governance. (Hanley, Tr. 4531-4532).

909. ProMedica's board and finance committee discussed the potential joinder with St. Luke's at its regular meetings from late 2009 through 2010. (Oostra, Tr. 5843-5845; RX-507 at 000004; RX-508 at 000003; RX-509 at 000002; RX-510 at 000001; RX-511 at 000002; RX-512 at 000001).

910. ProMedica's board members had a detailed discussion about the wisdom of bringing St. Luke's into ProMedica Health System, given St. Luke's financial condition. (Oostra, Tr. 5850).

911. {

} (PX01232 at 002, *in camera*; Wakeman, Tr. 2894-2897, *in camera*).

912. {

} (PX01390 at 003, *in camera*; Wakeman, Tr. 2901, *in camera*).

913. {

} (Wakeman, Tr. 2902, *in camera*).

914. {

}

(Wakeman, Tr. 2902, *in camera*).

915. {

} (PX01018 at 014, *in camera*).

916. {

} (Wakeman, Tr. 2914, *in camera*).

917. {

} (PX01018 at 014, *in camera*; Wakeman, Tr. 2916, *in camera*).

918. {

} (PX01018 at 014, *in camera*; Wakeman, Tr. 2916-2917, *in camera*).

919. {

} (PX01283 at 002, *in camera*; Wakeman, Tr. 2950-2951, *in camera*).

920. {

} (Wakeman, Tr. 3000-3001, *in camera*).

921. {

} (Wakeman, Tr. 3002, *in camera*).

b. Memorandum of Understanding

922. ProMedica and St. Luke's signed a Memorandum of Understanding ("MOU") on January 15, 2010 to "provide a framework for their discussions" for a proposed transaction in which OhioCare and its subsidiaries including St. Luke's "would become an integral part of ProMedica." (Hanley, Tr. 4545; RX-1912 at 000001, *in camera*; Oostra, Tr. 5849).

923. {

}

(Wakeman, Tr. 3010-3011, *in camera*).

924. {

} (Wakeman, Tr. 3010-3011, *in camera*).

925. In the context of negotiating and drafting the MOU, ProMedica perceived that there were three conceptual topics of particular importance to St. Luke's: (1) St. Luke's maintaining its identity, (2) St. Luke's keeping its board in place, and (3) St. Luke's receiving a capital contribution from ProMedica. (Hanley, Tr. 4547-4548).

926. ProMedica understood that St. Luke's had significant capital needs for IT, EMR, outpatient surgery, private rooms, and investing in its OB program. (Hanley, Tr. 4548; Oostra, Tr. 5854-5855).

927. ProMedica believed that St. Luke's was not capable of making investments into its facility on its own. (Hanley, Tr. 4549).

928. During the MOU and joinder discussions with St. Luke's, ProMedica agreed to contribute $5 million to St. Luke's Foundation at closing and $30 million over three years to St. Luke's to be dedicated to capital projects. (Hanley, Tr. 4555; Oostra, Tr. 5852).

929. ProMedica has made a capital contribution in all of its joinders; therefore ProMedica arrived at the $35 million sum by evaluating the size and timing of its other joinders to assign a capital contribution to St. Luke's that would be in line with its contributions to other hospitals. (Oostra, Tr. 5852-5853).

930. The MOU provided that following the joinder with ProMedica, St. Luke's board and the St. Luke's Foundation board would remain intact and composed of representatives of the community. (Hanley, Tr. 4556; RX-1912 at 000003, *in camera*).

931. The MOU provided that St. Luke's would be governed by its own board, subject to ProMedica's reserve powers. (Hanley, Tr. 4557; RX-1912 at 000003, *in camera*).

932. The MOU provided that St. Luke's would maintain its name and brand. (Hanley, Tr. 4558; RX-1912 at 000004, *in camera*).

933. The MOU provided that upon closing the joinder, St. Luke's would become a participating provider in Paramount's network with rates comparable to other ProMedica hospitals. (Hanley, Tr. 4558; RX-1912 at 000005, *in camera*).

934. The MOU provided that ProMedica would keep St. Luke's open as an acute care hospital and maintain certain service lines for an agreed upon period of time. (Hanley, Tr. 4559; RX-1912 at 000005, *in camera*).

935. The Executive Committee of ProMedica's Board of Trustees unanimously approved the MOU following a discussion regarding the entities' commonality of missions, visions, and values. (Hanley, Tr. 4561-4562).

936. ProMedica estimated that the financial impact of bringing St. Luke's into its system would be an additional $50 million over and above the $35 million it pledged to St. Luke's in capital contributions. (Hanley, Tr. 4561).

c. Rationale

(i) St. Luke's Rationale for the Joinder

937. {

} (Wakeman, Tr. 2996–2997, *in camera*).

938. {

}

(PX01457 at 004, *in camera*).

939. {

} (PX01457 at 004, *in camera*; Black, Tr. 5646, *in camera*).

940. ProMedica and St. Luke's never discussed what MCO reimbursement rates would be at St. Luke's after the Joinder. (RX-43 (Wagner, IHT at 125)).

(ii) ProMedica's Rationale for the Joinder

941. When ProMedica considers entering into an affiliation with another entity, it looks at the likely effect of that affiliation on the system as a whole, on ProMedica's financial capacity in terms of cash on hand and its balance sheet, and on the greater community. (Hanley, Tr. 4518-4519).

942. {

} (Oostra, Tr. 5876-5877, *in camera*).

943. {

} (Oostra, Tr. 5878-5879, *in camera*).

944. ProMedica sought a joinder with St. Luke's because it believed that the clinical integration would result in an increase in quality, service, and access, and create a more economical model. (Hanley, Tr. 4536).

945. ProMedica also believed that a joinder was needed to gain sufficient volumes in certain programs to ensure better quality and outcomes. (Hanley, Tr. 4536).

946. ProMedica felt St. Luke's was an attractive partner because of its location and the commonality of services offered by both entities. (Hanley, Tr. 4537).

947. {

} (Oostra, Tr. 5881, *in camera*).

948. Similarly, during the course of the joinder discussions with St. Luke's, ProMedica did not discuss the potential for increasing MCO rates at St. Luke's, TTH, Flower, or Bay Park. (Hanley, Tr. 4544-4545).

949. {

} (Oostra, Tr. 5881, *in camera*).

950. {

} (Oostra, Tr. 5881, *in camera*).

d. Due Diligence

951. During its initial joinder discussions with St. Luke's, ProMedica reviewed St. Luke's public financial data in the form of audited reports and agency ratings. (Hanley, Tr. 4534).

952. ProMedica learned that St. Luke's financial strength had deteriorated during the last few years, it had a negative financial trend, it had an underfunded pension liability, and it had operational losses. (Hanley, Tr. 4535).

953. ProMedica also learned that the volume of patients St. Luke's treated had been increasing, but St. Luke's still had operational losses reflecting that the growth in volume was unprofitable. (Hanley, Tr. 4536).

954. ProMedica believed, therefore, that St. Luke's increase in patient volume was not profitable because that increase was not reflected in St. Luke's operating margin or cash flow percentage. (Hanley, Tr. 4611).

955. Following approval of the MOU, ProMedica began a due diligence review of St. Luke's. (Hanley, Tr. 4563).

956. ProMedica hired Deloitte & Touche to review St. Luke's financial position, actuaries to understand St. Luke's pension status, and bond counsel to understand St. Luke's debt issues. (Hanley, Tr. 4565).

957. Due diligence took place from January of 2010 until the joinder was consummated on September 1, 2010. (Hanley, Tr. 4563-4564).

958. Through Deloitte and due diligence, ProMedica learned that St. Luke's financial trend was negative over many years. (Hanley, Tr. 4566).

959. During due diligence of St. Luke's, ProMedica prepared a summary report containing St. Luke's financial data in the form of statistics, summaries, and ratios from 1999 to August 31, 2010. (Hanley, Tr. 4570-4571; RX-191 at 000007).

960. Statistics reflecting patient volume informed ProMedica that St. Luke's generally saw an increase in volume between 1999 and August, 2010. (Hanley, Tr. 4574; RX-191 at 000007).

961. Financial summary data informed ProMedica that St. Luke's operating income declined from 2000 to August 2010. (Hanley, Tr. 4576; RX-191 at 000007).

962. Specifically, ProMedica learned that St. Luke's had operating losses in seven years between 2000 and August 2010. (Hanley, Tr. 4576; Johnston, Tr. 5316; RX-191 at 000007).

963. ProMedica learned that on August 31, 2010, St. Luke's had an operating income loss of $2.7 million for the year. (Hanley, Tr. 4576; RX-191 at 000007).

964. ProMedica learned that St. Luke's excess revenue over expenses declined from 2000 to 2010, and St. Luke's had negative excess revenues over expenses in the amount of $3 million on August 31, 2010. (Hanley, Tr. 4577; RX-191 at 000007).

965. ProMedica learned that St. Luke's unrestricted net assets had declined by over $100 million, from $178 million in 2000 to $74 million in August of 2010. (Hanley, Tr. 4579; RX-191 at 000007).

966. ProMedica learned that St. Luke's operating margin through August of 2010 was negative 2.6 percent. (Hanley, Tr. 4580; RX-191 at 000007).

967. By contrast, ProMedica aims for an operating margin of about positive 3 to 4 percent. (Hanley, Tr. 4582).

968. ProMedica learned that St. Luke's operating cash flow margin percentage had declined since 2000 and was 3.8 percent through August of 2010. (Hanley, Tr. 4582; RX-191 at 000007).

969. By contrast, ProMedica aims for an operating cash flow margin percentage of 9.5 to 10 percent. (Hanley, Tr. 4582).

970. ProMedica learned that St. Luke's excess margin percentage had declined from 2000 and was negative 0.2 percent through August of 2010. (Hanley, Tr. 4583; RX-191 at 000007).

971. ProMedica learned that St. Luke's days cash on hand had declined from 358.5 in 2000 to 104 as of August of 2010. (Hanley, Tr. 4584).

972. ProMedica learned that St. Luke's net property and equipment assets decreased from $81 million in 2000 to $50 million in 2010, reflecting that St. Luke's was depreciating assets

faster than they were adding new assets to the hospital. (Hanley, Tr. 4588-4589; RX-191 at 000008).

973. During the time that ProMedica was conducting due diligence on St. Luke's, it learned that Moody's downgraded St. Luke's bond rating from a Baa1 to a Baa2 with a negative outlook. (Hanley, Tr. 4590, 4593; PX00053 at 001).

974. ProMedica believed that the downgrade would have a negative impact on St. Luke's ability to access capital. (Hanley, Tr. 4595).

975. Moody's downgraded St. Luke's following several years of operating losses and indicated that its outlook would remain negative, reflecting "continued operating losses expected through fiscal year 2010, and ongoing challenges to negotiate favorable commercial contracts as competitive pressures continue." (Hanley, Tr. 4596; PX00053 at 003).

976. During due diligence, ProMedica learned that St. Luke's rates with commercial health plans were, on average, 125 percent of Medicare, which is less than ProMedica targets for its own contracts. (Hanley, Tr. 4598).

977. During due diligence, ProMedica learned that St. Luke's was not in compliance with its bond covenants that were insured by AMBAC. (Hanley, Tr. 4600).

978. {
} (Hanley, Tr. 4600; RX-906 at 000001-000002).

979. AMBAC required St. Luke's to retain an independent consultant, but St. Luke's did not do so and, subsequently, AMBAC notified St. Luke's that it was in default on March, 11 2010. (Hanley, Tr. 4602).

980. St. Luke's bonds with AMBAC were not callable or refundable, and they had a million dollar negative arbitrage if paid off early. (Hanley, Tr. 4603, 4605).

981. During due diligence, ProMedica learned that St. Luke's pension was underfunded by about $34 million. (Hanley, Tr. 4606-4607).

982. During due diligence, ProMedica learned that St. Luke's average age of plant was 13.6 years at the end of 2009, as compared to industry norms of about 10 or 11 years. (Hanley, Tr. 4608).

983. ProMedica also learned during due diligence that St. Luke's parent, OhioCare, was losing money. (Hanley, Tr. 4615).

984. {
} (Hanley, Tr. 4623, 4655, *in camera*).

985. {
} (Hanley, Tr. 4654-4655, *in camera*).

986. { } (Hanley, Tr. 4655, *in camera*).

987. { } (Hanley, Tr. 4655-4656, *in camera*).

988. { } (Hanley, Tr. 4658-4659, *in camera*).

989. { } (Hanley, Tr. 4656, 4663, *in camera*).

990. { } (Hanley, Tr. 4666-4667, *in camera*).

e. Terms of the Joinder Agreement

991. ProMedica and St. Luke's signed the Joinder Agreement on May 25, 2010. (PX00058 at 001; Hanley, Tr. 4628, *in camera*).

992. { } (Black, Tr. 5660, *in camera*; RX-1235 at 004, *in camera*).

993. The Joinder Agreement commits ProMedica to "maintain [St. Luke's] using its current name and identity and at its current location for a minimum of ten (10) years . . . as a fully operational acute care hospital providing for the following services: emergency room, ambulatory surgery, inpatient surgery, obstetrics, inpatient nursing and a CLIA certified laboratory." (PX00058 at 023, 045-046; Hanley, Tr. 4631-4632, *in camera*; Oostra, Tr. 5856).

994. { } (Hanley, Tr. 4630, *in camera*; Oostra, Tr. 5857; PX00058 at 007, 009).

995. Specifically, the Joinder Agreement maintains St. Luke's independent board and gives it the authority to challenge ProMedica for any breaches of the Joinder Agreement, including its commitment to maintain services at St. Luke's. (PX00058 at 007, 051; PX00141 at 002) ("PHS and OHS acknowledge that SLH, acting by the affirmative vote of at least ten (10) of the SLH Hospital Appointees serving on the SLH board, will have the right to seek specific performance or injunctive or other equitable relief to enforce the terms and conditions of Articles 6, 7, and 13 of this Agreement after the Closing Date.").

996. In the Joinder Agreement, ProMedica agreed to provide St. Luke's with $35 million in capital to fund capital projects that St. Luke's had deferred because it lacked the funds needed to pay for them. (Hanley, Tr. 4628, *in camera*; PX00058 at 021, 056; Johnston, Tr. 5351-5352, 5372).

997. {

} (Hanley, Tr. 4628, *in camera*; PX00058 at 056).

998. The Joinder Agreement maintains St. Luke's existing medical staff bylaws, rules, and regulations. (PX00058 at 046).

999. In a draft of the Joinder Agreement, ProMedica had included an "out clause," giving St. Luke's board the authority to step away from the affiliation within a certain time frame, but it was removed from the Joinder Agreement at the St. Luke's board's request because they wanted to join and stay in the system. (Black, Tr. 5658-5659, *in camera*; Oostra, Tr. 5859-5860)

1000. The Joinder Agreement provided that St. Luke's would become a participating provider in Paramount upon closing. (Hanley, Tr. 4631, *in camera*; PX00058 at 022- 023).

II. THE RELEVANT MARKET AND MARKET CONCENTRATION

A. The Relevant Product Market Is General Acute Care Inpatient Services Available to Commercially Insured Patients

1001. The relevant product market is general acute care inpatient services available to commercially insured patients. (Guerin-Calvert, Tr. 7155, 7200-7201).

1002. Demand side substitution must be analyzed to define the relevant product market for hospitals. (Guerin-Calvert, Tr. 7186).

1003. Specifically in the Toledo healthcare marketplace, one must look at what MCOs demand in their negotiations with hospitals, what the ultimate consumers (patients) are demanding and what physician are demanding. (Guerin-Calvert, Tr. 7186).

1004. A cluster market approach is appropriate for defining the relevant product market in this situation. (Guerin-Calvert, Tr. 7189; Town, Tr. 3665).

1005. A cluster market is a method of grouping a set of services that are complements to each other in that the services included involve demands for the same kinds of services and facilities. (Guerin-Calvert, Tr. 7187).

1006. A cluster market provides the ability to assess all services at once in the context of one market. (Guerin-Calvert, Tr. 7188).

1007. The demand that is analyzed using a cluster market is the demand for a set of services and skills. (Guerin-Calvert, Tr. 7190).

1008. Relevant product market definition entails evaluation of the products and services that are provided, and are interchangeable. (Guerin-Calvert, Tr. 7193).

1009. When defining the relevant product market for hospital services, all services available to any patient seeking medical care must be considered because product market definition consists of determining what services are demanded in the marketplace and are available from potential suppliers. (Guerin-Calvert, Tr. 7200-7201).

1. MCOs Contract for All General Acute Care Inpatient Services Together

1010. MCOs demand, and contract for, a broad array of inpatient services together, such as medical/surgical care. (Guerin-Calvert, Tr. 7190; Town, Tr. 3686-3687).

1011. There is no difference in services that a hospital provides to commercially insured patients and government-insured patients. The MCO may be different, but the services are not. (Guerin-Calvert, Tr. 7202-7203).

1012. When MCOs contract with hospitals, they do not distinguish between services available to commercially insured patients and government insured patients; they look at all services available at that hospital to any patient. (Guerin-Calvert, Tr. 7202).

1013. On the other hand, outpatient and quaternary services are excluded from this relevant product market because they are often excluded or contracted for separately. (Guerin-Calvert, Tr. 7191-7192).

1014. In addition, services such as rehabilitation, skilled care, psychiatric care, and detoxification are excluded from general acute care inpatient services because these services are separately contracted and negotiated for and are sometimes provided as outpatient services. (Guerin-Calvert, Tr. 7195; Town, Tr. 3687).

1015. Other courts have also excluded outpatient, rehabilitation and psychiatric care from the relevant product market for hospital services. (Guerin-Calvert, Tr. 79).

1016. Ms. Guerin-Calvert and Prof. Town both agree that MDC codes 2, 19, 20, and 17 should be excluded from the relevant product market as these are codes for behavioral health services and have traditionally been excluded. (Guerin-Calvert, Tr. 7197; Town, Tr. 4211, 4221).

2. Hospitals Provide All General Acute Care Services in the Same Facilities And Use Similar Resources

1017. Services in the cluster market of all general acute care inpatient services use the same assets, the same operating rooms, the same beds, the same wards, the same nursing staff, and all require an overnight stay. (Guerin-Calvert, Tr. 7188, 7191).

1018. Hospitals do not discriminate between commercial and non-commercial patients when offering services to patients. (Guerin-Calvert, Tr. 7202-7203).

1019. Hospitals treat patients based on their condition, not whether they are commercially or government-insured. (Town, Tr. 3981-3982).

3. No Independent Market Exists for Inpatient Obstetrical Services

1020. Negotiations between hospital providers and MCOs cover the full range of inpatient services that the MCO's members may need, including inpatient OB services. (Pugliese, Tr. 1550; McGinty, Tr. 1240; Town, Tr. 4049-4050; Guerin-Calvert, Tr. 7229-7230; Randolph, Tr. 6960).

1021. There is no evidence that hospitals can or do price-discriminate for inpatient OB services. (Guerin-Calvert, Tr. 7230).

1022. For example, for high-risk inpatient OB services, prices are competitive for those services, even though only two hospitals offer those services, TTH and St. Vincent. (Guerin-Calvert, Tr. 7231).

1023. Thus, the joinder does not change the number of competitors offering more complex, high-risk OB services. (Town, Tr. 3968).

1024. When MCOs had only one provider of high-risk OB services in their networks, no evidence shows that the hospitals could price-discriminate, charge higher prices or that prices were any different than what cost, quality and competition would have dictated. (Guerin-Calvert, Tr. 7231).

1025. Inpatient OB services are provided in conjunction with other services, and the terms and conditions on which they are being negotiated are very similar. (Guerin-Calvert, Tr. 7230).

1026. {

} (Pugliese, Tr. 1622, *in camera*; RX-1886, *in camera*; RX-1882, *in camera*; RX-1890, *in camera*; RX-1045, *in camera*; PX02385, *in camera*; PX02533, *in camera*; RX-305; RX-306, *in camera*; RX-329, *in camera*).

1027. In prior hospital merger cases, inpatient OB services have been included in the general acute care inpatient services market. (Guerin-Calvert, Tr. 7229-7230).

B. The Relevant Geographic Market Is No Narrower than the Area Served by Hospitals Located in Lucas County, Ohio

1028. Lucas County constitutes a relevant geographic market for the purposes of analyzing the likely effects of the joinder in the general acute care services market. (RX-1860 at 000007).

1029. The relevant geographic market is properly defined on the basis of the hospitals' locations because that is where the services are provided and hospitals cannot price discriminate based on the location of their patients or MCOs, or self-insured employers. (Town, Tr. 4068; Guerin-Calvert, Tr. 7236-7237).

1030. Both Complaint Counsel's and Respondent's economic experts agree that the relevant geographic market is no narrower than hospitals in Lucas County. (Guerin-Calvert, Tr. 7155; Town, Tr. 3688-3689, 4068-4069).

1. MCOs Must Contract with at least One Hospital Located within Lucas County To Serve Their Members in the Toledo, Ohio Area

1031. No MCOs have marketed a health plan to Lucas County customers without including at least one Lucas County hospital. (Randolph, Tr. 7064-7065).

1032. ProMedica's Lucas County hospitals offer general acute care inpatient services. (JX-2 at 1).

1033. St. Luke's offers general acute care inpatient services. (JX-2 at 1).

1034. Mercy's Lucas County hospitals offer general acute care inpatient services. (JX-2 at 1).

1035. UTMC offers general acute care inpatient services. (JX-2 at 1).

2. Complaint Counsel Overstates St. Luke's Competitive Significance by Focusing on only a Subset of St. Luke's Service Area

1036. A market share and concentration analysis based solely on St. Luke's core service area is irrelevant. (Guerin-Calvert, Tr. 7248).

1037. First, St. Luke's "core service area" represents only approximately 60 percent of its discharges. (Guerin-Calvert, Tr. 7247-7248).

1038. Second, there is no evidence that hospitals can price discriminate against the residents of St. Luke's core service area and charge them a higher or lower price. (Guerin-Calvert, Tr. 7248-7249).

1039. Neither St. Luke's nor ProMedica's hospitals have a separate chargemaster that applies to Maumee residents. (Town, Tr. 4067).

1040. St. Luke's does not charge MMO a different rate for MMO's insureds that live in St. Luke's eight core zip codes than it charges to MMO insureds that live outside those eight core zip codes. (Town, Tr. 4068).

1041. Third, residents of St. Luke's core service area, like other Lucas County residents, use all eight hospitals in Lucas County, which renders market share analysis for St. Luke's core service area meaningless as an indicator of market power. (Guerin-Calvert, Tr. 7248-7249).

1042. Fourth, St. Luke's draws patients from many of the same areas as all other hospitals in Lucas County. (Guerin-Calvert, Tr. 7243-7244).

1043. St. Lucas draws approximately half of its patients from Lucas County and the remainder come from outside of Lucas County (Wood, Henry, and Fulton Counties). (Johnston, Tr. 5382).

1044. Similarly, TTH draws patients from Monroe, Fulton, Wood, Henry, Sandusky and Seneca Counties, as well as Lucas County. (Guerin-Calvert, Tr. 7240).

1045. Bay Park also draws from Wood and Sandusky Counties as well as Lucas County. (Guerin-Calvert, Tr. 7240-7241).

1046. Like St. Luke's, Flower draws from Monroe, Fulton, Wood, Sandusky and Seneca Counties as well as Lucas County. (Guerin-Calvert, Tr. 7241).

1047. UTMC and St. Vincent draw from all the same counties as St. Luke's. (Guerin-Calvert, Tr. 7241-7242).

1048. St. Charles draws from Wood and Sandusky Counties as well as Lucas County. (Guerin-Calvert, Tr. 7242).

1049. St. Anne draws from Henry, Wood, Monroe and Sandusky Counties as well as Lucas County, like St. Luke's. (Guerin-Calvert, Tr. 7242).

C. Market Concentration

1050. Market concentration analysis based on the number and relative size of competitors is only the starting point of a merger analysis. (Guerin-Calvert, Tr. 7719).

1051. Nevertheless, St. Luke's share of registered beds (less non-acute care) in 2009 was 9.4 percent. (PX02123 at 025).

1052. The ProMedica legacy hospitals had a 34.3 percent share of registered beds in 2009; in comparison Mercy had a 32.5 percent share and UTMC had 9.6 percent, giving St. Luke's the lowest share based on registered beds of the hospitals in Lucas County. (PX02123 at 025).

1053. St. Luke's share of staffed beds (less non-acute care beds) in 2009 was 8.4 percent. (PX02123 at 025). The ProMedica legacy hospitals had 39.4 percent while Mercy had 31.7 percent and UTMC had 8.9 percent, again giving St. Luke's the lowest shares based on staffed beds in 2009. (PX02123 at 025).

1054. {

} (RX-71(A) at 000036-000037. 000162. *in camera*). {

} (RX-71(A) at 000162, *in camera*). {

} (RX-71(A) at 000036-000037, 000163, *in camera*). { } (RX-71(A) at 000163, *in camera*). {

} (RX-71(A) at 000036-000037, 000162-000163, *in camera*).

1055. {

} (RX-71(A) at 000036-000037, 000162, *in camera*).

1056. {

} (RX-71(A) at 000162, *in camera*). {
} (RX-71(A) at 000162, *in camera*). {

} (RX-71(A) at 000163, *in camera*). {
} (RX-71(A) at 000163, *in camera*).

1057. {

}
(RX-71(A) at 000162, *in camera*). { }
(RX-71(A) at 000162, *in camera*). {

} (RX-71(A) at 000163, *in camera*). { }. RX-71(A) at 000163, *in camera*).

1058. {

}
(RX-71(A) at 000162, *in camera*). { }
(RX-71(A) at 000162, *in camera*).

1059. For the ProMedica/St. Luke's joinder, market share computation does not provide a comprehensive view of competitive effects, because it is a "four-to-three" transaction, which means that it would not fall into the *Horizontal Merger Guidelines'* market concentration safe harbor regardless of how shares are calculated. Therefore, it is important to analyze the competitive effects of the joinder. (Guerin-Calvert, Tr. 7256).

III. THE JOINDER WILL NOT RESULT IN ANTICOMPETITIVE EFFECTS

1060. The joinder is unlikely substantially to lessen competition for general acute care services in the Toledo area. (Guerin-Calvert, Tr. 7156; RX-71(A) at 000005, *in camera*).

1061. Post-joinder, the key questions are whether sufficient alternatives, in terms of capacity, services and locations, exist to keep prices competitive, taking into consideration the steps that MCOs can take and taking into account the incentives and abilities of market participants to reposition. (Guerin-Calvert, Tr. 7265).

A. MCOs and Hospitals Bargain over a Complex Set of Price and Non-Price Terms

1062. MCOs negotiate directly with hospitals for the services that those hospitals will provide to both their fully-insured and self-insured members. (Pugliese, Tr. 1546; McGinty, Tr. 1239).

1063. Hospital-MCO negotiations are complex negotiations during which each side tries to obtain the best possible rates it can. (Radzialowski, Tr. 750; McGinty, Tr. 1240; Pugliese, Tr. 1553; Pirc, Tr. 2211-2212).

1064. Negotiations between hospitals and MCOs typically last six to nine months or even a year or more for especially complex negotiations. (Radzialowski, Tr. 658; Pugliese, Tr. 1458; Sandusky, Tr. 1317-1318).

1065. Contract negotiations between MCOs and hospitals can be triggered by the expiration of the current contract or various other factors, including: changes or growth in volumes, changes in service levels, changes in industry standard conventions, shifts in reimbursement patterns, or changes in market dynamics. (Sandusky, Tr. 1317).

1066. An MCO and a provider may choose to renegotiate a contract prior to the termination date of the contract; that may be initiated by either the MCO or the hospital. (Radzialowski, Tr. 749-750; Pugliese, Tr. 1548; Pirc, Tr. 2283-2284).

1067. MCOs typically negotiate three to five year contracts with "evergreen" provisions that allow them to continue in effect. (Radzialowski, Tr. 658; McGinty, Tr. 1239; Pugliese, Tr. 1547; Pirc, Tr. 2207; Sheridan, Tr. 6626).

1068. {

} (Pugliese, Tr. 1471, *in camera*).

1069. MCOs may seek to negotiate a shorter contract term if they are unable to obtain satisfactory rates. (Pugliese, Tr. 1553; Pirc, Tr. 2288-2290).

1. Negotiations Cover Both Reimbursement Rates and Non-Compensation Terms

1070. Contract negotiations between hospitals and MCOs include negotiations over price and other terms. (Radzialowski, Tr. 660; McGinty, Tr. 1240; Sandusky, Tr. 1318-1319; Pirc, Tr. 2205; RX-18 (Marcus, Dep. at 79-80)).

a. Rates for the Hospitals' Full Range of Inpatient and Outpatient Services Are Negotiated Together

1071. Contract negotiations include both inpatient and outpatient services as part of an all-inclusive package. (Shook, Tr. 1074; Sandusky, Tr. 1326; Pugliese, Tr. 1547; McGinty, Tr. 1240; Pirc, Tr. 2205-2206; Radzialowski, Tr. 802, *in camera*; Sheridan, Tr. 6626-6627; Korducki, Tr. 533).

1072. Included among the inpatient services for which hospitals and MCOs may negotiate reimbursement rates are intensive care services, intermediate care services, medical-surgical care, skilled care, acute rehabilitation services, sub acute care, various levels of nursery services, and various types of maternity care. (Radzialowski, Tr. 750-752).

1073. Inpatient rates are not more important than any other factor when negotiating contracts. (Town, Tr. 3953-3954)

1074. Outpatient rate negotiations may cover up to nine different levels of ambulatory surgery and five different levels of emergency care. (Radzialowski, Tr. 756-757).

1075. Outpatient negotiations also cover services like observation services, chemotherapy drugs, sleep studies, radiology and lab services. (Radzialowski, Tr. 757).

1076. Each outpatient service commonly has its own rate that will vary from provider to provider. (Radzialowski, Tr. 756-757).

1077. Negotiations between hospitals and MCOs may address separate carve-out rates for many different services, including emergency room services, MRI services, laboratory services, physical therapy services, mammograms, and/or CAT scans. (Beck, Tr. 430; Radzialowski, Tr. 753; Pugliese, Tr. 1549-1550; Pirc, Tr. 2287).

1078. Negotiations over rates may include negotiation of reimbursement methodologies, including fixed pricing methodologies, like DRGs or per diems, or percentage-of-charge methodologies. (Pirc, Tr. 2205).

1079. Hospitals and MCOs also may negotiate over whether the hospital will participate in all of the MCO's products or just some of them. (Radzialowski, Tr. 763-764).

1080. MCOs and hospitals also may negotiate different inpatient and outpatient rates for different types of insurance products. For example, Aetna negotiated different rates with ProMedica for its HMO and PPO products. (Radzialowski, Tr. 753, 758).

1081. Rate negotiations include various trade-offs, whereby a party seeking a higher rate in one service area (e.g. outpatient services) agrees to accept lower rates elsewhere (e.g.

inpatient services) in exchange. (Pugliese Tr. 1550; Pugliese, Tr. 1625-1628, *in camera*; Pirc, Tr. 2287-2288; Radzialowski, Tr. 758; Sheridan, Tr. 6627-6628).

1082. MCOs approach contract negotiations with a view toward the overall cost for inpatient, outpatient and all other services for their entire insured patient base at a particular hospital or hospital system. (Radzialowski, Tr. 759-760; Sheridan, Tr. 6627-6628; Pirc, 2287-2288).

1083. {

} (Radzialowski, Tr. 798-799, *in camera*; RX-132, *in camera*).

b. Other Terms that May Impact Compensation Are Also Negotiated Together With Rates

1084. Non-compensation terms are as important as the compensation terms. (RX-18 (Marcus, Dep. at 79-80)).

1085. The non-compensation terms in a hospital's contract with an MCO often translate into compensation or the lack thereof. (RX-18 (Marcus, Dep. at 79-80)).

1086. In addition to rates, the negotiations between hospitals and MCOs cover many other contractual terms including, for example, claims adjudication procedures, payment outliers, payment escalators, hold-harmless provisions, chargemaster limits, reimbursement methods, renewal or renegotiation provisions, grievance procedures, medical necessity provisions, coordination of benefits provisions, pay-for-performance provisions, pre-certification requirements, nondiscrimination provisions, "never event" provisions, contract length provisions, termination provisions, and other specific provisions that may be important to the hospital or MCO. (Shook, Tr. 949-950, 1074; Pugliese, Tr. 1550-1553; McGinty, Tr. 1241, 1258; Pirc, Tr. 2206-2207, 2288-2290; Radzialowski, Tr. 760-763; Radzialowski, Tr. 804, 806, *in camera*; Sheridan, Tr. 6627; Randolph, Tr. 6951).

1087. MCOs and providers also may negotiate for the right to act as the third-party administrator of the provider's health plan for its own employees. For example, Anthem raised the issue of administering St. Luke's employee health benefit plan in 2010 in the context of a possible renegotiation of St. Luke's rates. (Pugliese, Tr. 1551-1552).

1088. Anthem's contract negotiations with providers also include discussions relating to the provider's participation in Blue Cross and Blue Shield's BlueCard program. (Pugliese, Tr. 1551).

1089. Trade-offs also occur with respect to these non-compensation terms. If a hospital seeks changes to any of these terms, MCOs may seek reconsideration of other terms, including price-related terms. (Radzialowski, Tr. 764).

c. Other Factors Also Influence Negotiations

1090. Disputes and other issues between a hospital and an MCO that are outside the scope of their contract may impact negotiations about a contract between them. RX-18 (Marcus, Dep. at 79-80)).

1091. {

} (Sandusky, Tr. 1354-1360, *in camera*; RX-1700 at 000007, *in camera*).

1092. {

} (Sandusky, Tr. 1354-1360, *in camera*; RX-1700 at 000007, *in camera*).

1093. {

} (Sandusky, Tr. 1358-1359, *in camera*).

2. Negotiations with Hospital *Systems* Add Additional Complexity to Negotiations

1094. Negotiations with hospitals that are part of integrated hospital systems involve not only inpatient and outpatient services, but also employed physician groups and the whole continuum of care, including skilled nursing facilities, home health services and even hospice services. (McGinty, Tr. 1178)

1095. In negotiating with hospital systems, MCOs may seek a decrease in rates at one hospital if the system seeks as increase at another hospital. (Radzialowski, Tr. 770-771; Pirc, Tr. 2290).

1096. {

} (Radzialowski, Tr. 806-807, *in camera*).

3. Prof. Town's Analysis Fails To Capture the Complexity of MCO Contracting

1097. Prof. Town's bargaining framework does not reflect the overall reality and the richness of how bargaining takes place in Lucas County. It fails to account for key elements that take place in setting prices. (Guerin-Calvert, Tr. 7448-7450).

1098. Prof. Town posits two stages of bargaining – first, the bargaining between hospitals and MCOs for inclusion in a network; second, how hospitals in-network then compete for patients. (Guerin-Calvert, Tr. 7448).

1099. Prof. Town's model implies that what MCOs bring versus what hospitals bring to the bargaining table are the two elements that largely determine the price of reimbursement, which is inaccurate. (Guerin-Calvert, Tr. 7449-7451).

1100. For example, Prof. Town's bargaining framework does not reflect the bargaining between MMO and Mercy that resulted in a lower price level for MMO payments to Mercy when MMO did not include ProMedica in its network. (Guerin-Calvert, Tr. 7451).

1101. Prof. Town's model also does not reflect trade-offs such as higher outpatient rates in exchange for lower inpatient rates. (Guerin-Calvert, Tr. 7454).

1102. Examples of terms over which MCOs and hospitals negotiate include: exclusivity, inpatient and outpatient rates, term of the contract, and MFN clauses. (Guerin-Calvert, Tr. 7455-7457).

1103. The size and exclusivity of the network affects the bargaining process between providers and MCOs, because if an MCO can configure a narrow network it can result in lower rates being paid to the provider; open networks tend to have to pay higher rates. (Guerin-Calvert, Tr. 7458).

1104. The history a provider and MCO have of negotiating with each other will also affect bargaining dynamics, because MCOs and providers with a longer history will have more information about each other to use during negotiations. Prof. Town's bargaining model ignores this factor. (Guerin-Calvert, Tr. 7462-7463).

B. Mercy and ProMedica Were and Remain Each Other's Closest Competitors

1. Mercy and ProMedica Consider Each Other To Be Their Closest Competitor

1105. The three large and vigorous hospital competitors in Lucas County are ProMedica, Mercy, and UTMC. (Guerin-Calvert, Tr. 7747).

1106. { } (Shook, Tr. 1091-1092, *in camera*).

1107. { } (Shook, Tr. 1091, *in camera*; PX02534 at 003, 006, 013, 020, 023, *in camera*; RX-250 at 000005, 000013, 000018, *in camera*).

1108. Likewise, ProMedica considers Mercy to be its most significant competitor in the Toledo area. (Oostra, Tr. 5803-5804; Wachsman, Tr. 4866; Randolph, Tr. 6934-6935).

1109. ProMedica considers Mercy to be its most significant competitor because of Mercy's size and backing by CHP, its access to capital, ability to make investments in communities, re-entry into the physician employment business, and because it is a multi-hospital system that virtually mirrors ProMedica. (Oostra, Tr. 5804-5805).

1110. {
} (RX-46 (Pirc, IHT at 23-24), *in camera*).

1111. The history of MCO networks also shows that ProMedica and Mercy are next best substitutes in terms of their array of services, and the areas they serve, because MCOs successfully established competing networks with only one of the two in the network. (Guerin-Calvert, Tr. 7329).

1112. {
} (PX01902 (Sheridan, IHT at 48-49, *in camera*)).

1113. United considers either ProMedica or Mercy to be the largest hospital or hospital system in Lucas County. (Sheridan, Tr. 6616).

1114. United considers the ProMedica and Mercy hospitals to be extremely similar in terms of their location and the types of services and acuity of care they offer. (Sheridan, Tr. 6616-6618).

1115. United considers UTMC to be the next biggest hospital or hospital system after ProMedica and Mercy. (Sheridan, Tr. 6618).

1116. Prof. Town agrees that "Mercy is ProMedica's closest substitute." (Town, Tr. 4058).

1117. Draw area analysis shows that ProMedica hospitals draw from almost exactly the same zip codes as their Mercy counter-parts. (Guerin-Calvert, Tr. 7315-7319; RX-71(A) at 000195-000199, *in camera*).

1118. On the other hand, St. Luke's has significantly less overlap with ProMedica hospitals' draw areas. (Guerin-Calvert, Tr. 7315-19).

1119. {
} (RX-0027 (Sheridan, Dep. at 15), *in camera*; PX02067 at 3, *in camera*).

1120. Patients cannot get all of the services they may need from only St. Luke's. (Buehrer, Tr. 3092).

1121. The average case weight severity at ProMedica across all DRGs would be higher than at St. Luke's because ProMedica offers services with higher acuity than St. Luke's offers. (Town, Tr. 4356).

1122. Prof. Town agrees that "St. Luke doesn't offer the same breadth of services that Mercy does...." (Town, Tr. 4059).

1123. {

} (Town, Tr. 3785-3786, *in camera*).

1124. ProMedica and St. Luke's are not reasonably interchangeable and ProMedica could not be substituted with St. Luke's in a MCO's network. (Town, Tr. 4057, 4081).

2. A Diversion Analysis Confirms that Mercy and ProMedica Are Closest Substitutes

1125. {

} (Guerin-Calvert, Tr. 7373, *in camera*).

1126. {

}

(Guerin-Calvert, Tr. 7375, *in camera*).

1127. {

} (Guerin-Calvert, Tr. 7376, *in camera*).

1128. {

} (Guerin-Calvert, Tr. 7377, *in camera*).

1129. {

}

(Guerin-Calvert, Tr. 7377, *in camera*).

1130. { } (Guerin-Calvert, Tr. 7380, *in camera*; PX01850 at 018, *in camera*).

1131. {

} (Guerin-Calvert, Tr. 7380-7381, *in camera*; PX01850 at 018, *in camera*).

1132. {
} (Guerin-Calvert, Tr. 7383, *in camera*; RX-71(A) at 000191-000193, *in camera*).

1133. {
} (Guerin-Calvert, Tr. 7384, *in camera*; RX-71(A) at 000191-000193, *in camera*).

1134. The 2010 rate of diversion in the MMO network shows that diversion from ProMedica to Mercy is twice the diversion from ProMedica to St. Luke's. (Town, Tr. 4338; PX01850 at 018, *in camera*).

1135. {
} (RX-71(A) at 000029, *in camera*).

1136. Even after ProMedica had been in the MMO network for three full years (2008-2010), there is more diversion from St. Luke's to Mercy than from St. Luke's to ProMedica. (Town, Tr. 4338-4339).

1137. Prof. Town agrees that at least with respect to MMO members, Mercy and St. Luke's are closer substitutes than ProMedica and St. Luke's. (Town, Tr. 4340).

1138. {
} (Guerin-Calvert, Tr. 7378, *in camera*).

1139. {
} (Guerin-Calvert, Tr. 7379, *in camera*).

C. St. Luke's Is Vulnerable To Losing Patients to UTMC

1140. UTMC is the closest hospital to St. Luke's and is approximately five to seven miles away. (Shook, Tr. 928; Radzialowski, Tr. 738-739).

1141. When St. Luke's stopped participating in the Paramount and Anthem networks, UTMC was the biggest beneficiary in terms of increased market share. (PX01111 at 001; PX01352, at 020; Wakeman, Tr. 2789-2790, 2807-2808, 2831, 3046).

1142. From 2000 to 2007, St. Luke's in-patient admissions, not including obstetrics, decreased by 11.3 percent. At the same time, UTMC's admissions increased by 56 percent, significantly more than any other hospital in the Toledo area; no other hospital had an increase of more than 13.7 percent during that time period. (RX-2162 at 000001).

1143. In October 2008, St. Luke's assessed "the shift of patients away from St. Luke's to other providers due to [its] exclusion from Paramount and Anthem BCBS networks" and concluded that for non-obstetrical discharges the main beneficiary was UTMC. (RX-2162 at 000001).

1144. Most new St. Luke's Paramount inpatient activity after the joinder was coming from UTMC. (Wakeman, Tr. 3025, *in camera*, 3045-3046, 3049-3050).

1145. After St. Luke's joined Paramount, UTMC's admissions went down while TTH increased its admissions and admissions at Flower and Bay Park remained stable. (Wakeman, Tr. 3049-3051).

D. Complaint Counsel Overstate St. Luke's Competitive Significance

1146. Hospital competitors acknowledge that the majority of patients residing in the southwest area of Toledo seek treatment from hospitals other than St. Luke's, that are farther from their homes than St. Luke's. (Shook, Tr. 1039-1040).

1147. St. Luke's serves approximately ten commercially insured patients per day, across all MCOs. (Guerin-Calvert, Tr. 7544).

1148. St. Luke's is not a "must have" hospital. (Town, Tr. 4093).

1149. MCOs acknowledge that there are no acute care inpatient services that St. Luke's provides that patients cannot otherwise obtain from any other hospitals in Lucas County. (Pugliese, Tr. 1540-1541; Pirc, Tr. 2202; Radzialowski, Tr. 737; McGinty, Tr. 1237; Sandusky, Tr. 1402; Sheridan, Tr. 6619).

1150. Mercy recognized that St. Luke's does not offer any services that are not also offered by Mercy's Lucas County hospitals. (Shook, Tr. 1065).

1151. {
} (PX02288 at 002-003, *in camera;* Shook, Tr. 1113, *in camera*).

1152. {
} (PX02288 at 003, *in camera*; Shook, Tr. 1112, *in camera*).

1153. All else equal, the more valuable a product or service is, the more willing someone is to pay for that product or service. (Town, Tr. 4098-4099).

1154. However, MCOs in Lucas County have paid lower rates to St. Luke's than they have paid to other hospitals located in Lucas County, indicating that St. Luke's is less valuable than other hospitals in Lucas County. (Town, Tr. 4099-4100).

1155. In addition, some MCOs that have not had St. Luke's in their network were able to serve their members and remain competitive in Lucas County. (Guerin-Calvert, Tr. 7779, 7783; Pugliese, Tr. 1586-1587, *in camera*). {
} (RX-27 (Sheridan, Dep. at 16), *in camera*).

E. Competing Hospitals Have the Incentive and Ability To Respond Competitively

1156. Ohio does not have certificate of need ("CON") requirements for building a new hospital; Ohio only has certificate of need requirements for skilled nursing beds. (RX-11 (Oppenlander, Dep. at 37)).

1157. Around 2004 or 2005, Mercy considered building a new inpatient hospital southwest of Toledo, in Monclova, Ohio. (Shook, Tr. 963-964).

1158. {

} (RX-272 at 000006, *in camera*). Mercy purchased land on which to build the new hospital for $2.6 million. (Shook, Tr. 966).

1159. The new inpatient hospital would have included a 34-bed general medical-surgical hospital with emergency rooms, surgical suites, diagnostic capabilities, and a medical offices building. (Shook, Tr. 965; RX-783 at 000001).

1160. Mercy had architectural line drawings completed for the potential facility and also sought zoning approval for the project. (Shook, Tr. 1067; RX-783 at 000001).

1161. Mercy planned a joint venture with physicians to build a 35-37 bed specialty hospital at 20A and Strayer Road about a mile and a half from St. Luke's. (Wakeman, Tr. 2770).

1162. Mercy received zoning approval for the project. (Shook, Tr. 1067).

1163. Mercy later abandoned its plans to construct a new inpatient hospital in Monclova for two reasons: healthcare reform precluded physicians from having an ownership interest in the hospital, as Mercy had desired; and Mercy concluded that additional inpatient beds were not needed. (Shook, Tr. 966-968).

1164. {

} (PX02288 at 003, *in camera*; Shook, Tr. 1112, *in camera*).

1165. Mercy examined trends that revealed that inpatient admissions had decreased as more services shifted to an outpatient setting instead of inpatient, and inpatient lengths of stay were becoming much shorter than in the past. (Shook, Tr. 967).

1166. {

} (PX01940 (Shook, Dep. at 13, *in camera*)).

1167. {

} (PX01940 (Shook, Dep. at 14, *in camera*)).

1168. Mercy believes that it can continue to compete in the Toledo market following the joinder. (Shook, Tr. 1120, *in camera*; RX-695 at 000001).

1169. {

} (PX01940 (Shook, Dep. at 45, *in camera*)).

1170. {

}

(PX01940 (Shook, Dep. at 15-17, *in camera*)).

1171. {

} (PX01940 (Shook, Dep. at 17, *in camera*)).

1172. {

} (PX01030 at 021, *in camera*; Wakeman, Tr. 2962, *in camera*).

1173. {

} (PX01018 at 014, *in camera*).

1174. Likewise, ProMedica understood, through a Mercy publication issued in May 2010, that Mercy intended to move forward with its plans to expand in the southwest area of Toledo in response to ProMedica's joinder with St. Luke's. (Oostra, Tr. 5807-5808; RX-475 at 000001).

1175. {

}

(Shook, Tr. 971, 982, *in camera*; Guerin-Calvert, Tr. 7386-7388, *in camera*; PX02288 at 004-005, *in camera*).

1176. {

} (Shook, Tr. 985, *in camera*).

1177. {

} (Shook, Tr. 973, *in camera*; PX02288 at 001, *in camera*; Guerin-Calvert Tr. 7388-7389, *in camera*).

1178. {

} (Shook, Tr. 982, 1115, *in camera*; RX-296 at 000001, *in camera*). {

} (Shook, Tr. 984-985, 1115, *in camera*).

1179. {
} (Shook, Tr. 983, *in camera*; RX-295, *in camera*). {
} (Shook, Tr. 1018-1019, *in camera*).

1180. {
}
(Wakeman, Tr. 2667-2668, *in camera*).

1181. {
} (Wakeman, Tr. 2667-2668, *in camera*). {
} (Wakeman, Tr. 2667-2668, *in camera*).

1182. {
} (RX-286 at 000015, *in camera*).

1183. Separate from its Southwest Strategy, Mercy routinely recruits physicians for employment or to join the active staff at Mercy's hospitals. (Shook, Tr. 907-909).

1184. In doing so, Mercy creates annual physician recruiting goals. (Shook, Tr. 909). Mercy exceeded its physician recruiting goals in 2007, 2008, 2009, and 2010. (Shook, Tr. 1055-1056; RX-281 at 000007, *in camera*; RX-293 at 000002, *in camera*).

1185. In fact, Mercy exceeded its 2009 physician recruiting goal of 20 physicians and its 2010 goal of another 20 physicians. (Shook, Tr. 909-910).

1186. Mercy recruits physicians with the hope that the physicians will refer patients to Mercy's hospitals for inpatient services. (Shook, Tr. 1056).

1187. {
} (Guerin-Calvert, Tr. 7390-7391, *in camera*).

1188. {
} (Guerin-Calvert, Tr. 7391-7392, *in camera*).

1189. Mercy's ability to implement its Southwest Strategy, convert semi-private rooms to private rooms, recruit physicians and use its excess capacity is a means of entry or

expansion into the southwest Toledo area and provides a competitive constraint against ProMedica. (Guerin-Calvert, Tr. 7541-7543).

1190. UTMC also recently completed a number of renovations, expanded its facilities and engaged in outreach activity, which is also a means of entry or expansion and offers a competitive constraint against ProMedica. (Guerin-Calvert, Tr. 7543).

1191. UTMC has outreach clinics located in and around Lucas County. (Gold, Tr. 262-263).

1192. One of these clinics is located in Lucas County and offers primary care services as well as some specialty services, such as pulmonary medicine. (Gold, Tr. 263).

1193. Another one of these clinics is located just outside of Lucas County, in Perrysburg, and is a specialty clinic offering cardiac and vascular services. (Gold, Tr. 263).

1194. UTMC chose to develop an outreach clinic in Perrysburg because UTMC considers that area to be part of its referral base. (Gold, Tr. 263-264).

1195. UTMC is also examining sites for two more outreach clinics in and around Lucas County. (Gold, Tr. 264).

1196. UTMC hopes that patients that visit its outreach clinics will seek inpatient services from UTMC in the future. (Gold, Tr. 265).

1197. UTMC's board recently approved an expenditure of $25 million for private room conversion, implementation of electronic medical records, improving outpatient care, and constructing a cancer center. (Gold, Tr. 334).

1198. The private room conversion project involves extensive renovations to convert all two-patient rooms to single patient, private rooms and will cost between $5 and $7 million. (Gold, Tr. 224, 285).

1199. UTMC is performing the private room conversion because it believes that the standard of care is shifting from semi-private rooms to private rooms. (Gold, Tr. 285).

1200. Recently, UTMC completed renovations on a portion of its third floor and opened a new 22-bed intensive care unit at a cost of approximately $7 million. (Gold, Tr. 266).

1201. The new ICU unit features advanced beds, sound therapy, automated hand-washing, and 42-inch patient monitors. (Gold, Tr. 332).

1202. In the past few years, UTMC also completed inpatient and outpatient facility modernization that included renovated spaces for heart and vascular services, and renovated space for outpatient orthopedics; which cost about $5.8 million. (Gold, Tr. 333-334).

1203. In 2010, UTMC completed an emergency department renovation to buffer overflow volume from the emergency room. (Gold, Tr. 333).

1. Physician Privileges at Multiple, Competing Hospitals and Participation in Multiple Plans Facilitate Patient Switching

1204. Physicians in Lucas County generally have privileges at more than one hospital. (RX-26 (Riordan, Dep. at 98-99); Gbur, Tr. 3105; RX-35 (Hammerling, IHT at 16-17, 18, *in camera*)).

1205. Even physicians employed by hospital systems may hold privileges at competing hospitals. For example, PPG does not limit where its physicians may admit patients. (RX-26, (Riordan, Dep. at 94, 99); RX-1858 at 000010-000011, *in camera*; Oostra, Tr. 5799; RX-1908 at 000005, *in camera*).

1206. Physicians in Lucas County believe that they can refer patients away from ProMedica and St. Luke's if rates increase following the joinder. (RX-21 (Peron, Dep. at 167-168)).

1207. { } (Guerin-Calvert, Tr. 7363-7365, *in camera*).

1208. { } (Guerin-Calvert, Tr. 7366-7367, *in camera*).

1209. { } (Guerin-Calvert, Tr. 7367-7368, *in camera*).

2. Travel Times between Competing Hospitals Are Not a Deterrent to Patients Switching Hospitals

1210. Respondent's economic expert's drive time analysis shows that hospitals in the Toledo area are all located conveniently to patients; that the overall drive time to reach hospitals in Toledo is short; and the incremental drive time between them is minimal. (Guerin-Calvert, Tr. 7344-7345; RX-71(A) at 000030-000034, 000175-000177, 000183, *in camera*).

1211. This means that location or distance is not an impediment to MCOs' ability to offer alternative networks that do not include ProMedica and St. Luke's. (Guerin-Calvert, Tr. 7344-7345, 7352; RX-71(A) at 000035, *in camera*).

1212. The drive time analysis also shows that St. Luke's location does not increase the number of patients willing to travel there, because many patients for whom St. Luke's is the closest hospital travel to other hospitals that are farther away. (Guerin-Calvert, Tr. 7351-7352; RX-71(A) at 000032-000034, 000186, *in camera*).

1213. For approximately half of those patients, a hospital was located closer to them than St. Luke's; thus, to the extent that those patients were diverted from St. Luke's, they would travel *less* far compared to going to St. Luke's. (Guerin-Calvert, Tr. 7347; RX-71(A) at 000184-000186, *in camera*).

1214. For those patients who would have to drive further, the incremental time would increase for just over half of the patients and for a very large number of those, the incremental travel time would increase only one to two minutes. (Guerin-Calvert, Tr. 7347; RX-71(A) at 000032, 000184, *in camera*).

1215. Prof. Town's drive time calculations for general acute care inpatient services show similar results; about 49 percent of patients would have a negative drive time (that is, they would save driving time) if diverted from St. Luke's, while travel times would increase from one to ten minutes for approximately 51 percent of patients. (Guerin-Calvert, Tr. 7350; PX02148 at 140-141, *in camera*).

1216. For Prof. Town's inpatient OB patients, 37 percent have a hospital located closer to them than St. Luke's, 63 percent would have to travel further, with 75 percent of those having to travel only 10 minutes or less. (Guerin-Calvert, Tr. 7351; PX02148 at 140-141, *in camera*).

1217. This analysis shows that a large number and proportion of patients are not choosing the hospital located closest to them. (Guerin-Calvert, Tr. 7352; RX-71(A) at 000032-000034, *in camera*).

1218. Moreover, for any hospital in the Toledo area, the drive time analysis shows that all patients are willing to travel to more distant hospitals than their closest available hospital for both general acute care inpatient services and inpatient OB services, indicating that location is not a material factor when patients choose a hospital. (Guerin-Calvert, Tr. 7352-7353; RX-71(A) at 000032-000034, *in camera*).

3. The Demographics and Economic Conditions of Toledo Mean that Rivals Can Reposition Themselves To Attract Patients and Physicians Away from ProMedica

1219. The declining population of the Toledo area means that there are fewer patients overall. (Guerin-Calvert, Tr. 7274-7275).

1220. The high unemployment rate in Toledo means more residents are covered by Medicaid or Medicare or are uninsured. (Guerin-Calvert, Tr. 7274-7275).

1221. The Toledo area also has an aging population, which means that Medicare, not commercial insurance, covers an increasing number of residents. (Guerin-Calvert, Tr. 7274-7275).

1222. As a result, the Toledo area has substantially declining commercially insured admissions. (Guerin-Calvert, Tr. 7274-7275). The number of commercially insured patients in the

Toledo area has declined since 2004 to 2009 from 45,000 to 35,000; TTH experienced much of this decline. (Guerin-Calvert, Tr. 7300).

1223. These factors mean that the total number of commercially insured patients available to hospitals is smaller; therefore, hospitals are going to try to attract MCOs and their commercially insured patients in order to cover their costs. (Guerin-Calvert, Tr. 7275, 7297-7298).

1224. This combination puts increasing financial pressures on hospitals because a higher percentage of the hospital's revenue comes from the government, which does not cover a hospital's total cost of providing care. (Guerin-Calvert, Tr. 7274-7275, 7302-7303).

1225. A decreasing percentage of revenues to hospitals from commercially insured patients has also put MCOs in a stronger position to reconfigure and move patients to other networks in order to get better prices. (Guerin-Calvert, Tr. 7275).

1226. It has also created a dynamic of hospitals repositioning to realign services to attract more patients and physicians. (Guerin-Calvert, Tr. 7274-7275).

1227. This means that if ProMedica attempted to raise its prices, rival hospitals can and already have begun to reposition to attract patients, hire more physicians, and put new or expanded facilities to use. (Guerin-Calvert, Tr. 7275).

1228. Healthcare reform also will impact the competitive conditions in the Toledo area, because the rate of reimbursement from Medicare and Medicaid will decrease, the rate of reimbursement for commercial insurance will also decrease, and there will be fewer inpatients and more outpatients, all of which put increased financial pressures on the hospitals. (Guerin-Calvert, Tr. 7307-7310).

4. Excess Bed Capacity Creates Heightened Competitive Pressures and Allows Rivals To Reposition in Response to a Price Increase

1229. New entry is not necessary to provide substantial additional capacity in the Toledo area; it can come from more efficient and lower cost realignment and utilization of existing capacity. (Guerin-Calvert, Tr. 7291).

1230. There were approximately 2,200 staffed beds in 2009 in Lucas County. (Guerin-Calvert, Tr. 7276).

1231. All hospitals in Lucas County, except Bay Park, have many more registered beds than staffed beds. (Guerin-Calvert, Tr. 7276, 7283-7284; RX-71(A) at 000208, *in camera*).

1232. MCO configurations in the past have excluded about 40 percent to 50 percent of the bed capacity in the market at any point in time. (Guerin-Calvert, Tr. 7278).

1233. Based upon the number of beds per thousand, a standard metric used in healthcare, Toledo, as compared to other similar metropolitan areas in the U.S., has substantially more beds per thousand residents. (Guerin-Calvert, Tr. 7278-7279).

1234. For example, Toledo has 3.63 beds per thousand residents, while Grand Rapids, Michigan, an area similar to Toledo, has just over 2 beds per thousand residents, and Detroit has approximately 2.5 beds per thousand residents. (Guerin-Calvert, Tr. 7280-7283; RX 71(A) at 000150, *in camera*).

1235. This shows that there is excess capacity that exceeds the current level of demand. (Guerin-Calvert, Tr. 7283-7284).

1236. Another metric that shows the excess capacity for Toledo area hospitals is the occupancy rate, which divides the average daily census of a hospital by the number of staffed beds or registered beds. (Guerin-Calvert, Tr. 7284-7285).

1237. { } (Guerin-Calvert, Tr. 7284-7286; RX-71(A) at 000208, *in camera*).

1238. { } (Guerin-Calvert, Tr. 7284-7286; RX-71(A) at 000208, *in camera*).

1239. { } (Guerin-Calvert, Tr. 7284-7286; RX-71(A) at 000208, *in camera*).

1240. { } (Guerin-Calvert, Tr. 7284-7286; RX-71(A) at 000208, *in camera*).

1241. { } (Guerin-Calvert, Tr. 7284-7286; RX-71(A) at 000208, *in camera*).

1242. { } That ranks as the seventh lowest occupancy rates of the eight Toledo hospitals. (Guerin-Calvert, Tr. 7284-7286; RX-71(A) at 000208, *in camera*).

1243. { } (Guerin-Calvert, Tr. 7284-7286; RX-71(A) at 000208, *in camera*).

1244. { } (Guerin-Calvert, Tr. 7284-7286; RX-71(A) at 000208, *in camera*).

1245. That registered beds far outnumber staffed beds indicates that hospitals have adjusted to the decline in population and, in turn, the decline in demand for inpatient hospital services, by reducing their staffing levels. (Guerin-Calvert, Tr. 7276-7278).

1246. Similarly, it shows that hospitals could adjust their staffing and use of currently unused beds to accommodate an increase in demand and counter an attempted price increase by ProMedica, because they have the capacity to do so. (Guerin-Calvert, Tr. 7277, 7279, 7283-7284).

1247. The low occupancy rates also show that hospitals have the capability to respond and reposition to serve patients and attract additional volume in response to an attempted price increase by ProMedica. (Guerin-Calvert, Tr. 7286-7287).

1248. The excess capacity at ProMedica will motivate it to attract and serve additional patients. (Guerin-Calvert, Tr. 7289).

F. The Joinder Will Not Enable ProMedica To Raise Rates above Competitive Levels

1. The History of Closed Network Contracting Demonstrates MCOs Can Offer a Viable Network without ProMedica and St. Luke's

1249. A Mercy-UTMC only network has not been offered in the past; however, there is no evidence that shows how consumers would choose between a lower priced Mercy-UTMC network and a higher priced ProMedica-St. Luke's network. (Town, Tr. 4259-4260).

1250. { } (Town, Tr. 4311; Radzialowski, Tr. 715, *in camera*).

1251. { } (Shook, Tr. 1132, *in camera*).

1252. The option of having an open network has always been available to MCOs in the Toledo area, but members found narrow networks attractive and sufficient to serve their needs. (Guerin-Calvert, Tr. 7329-7331).

1253. A narrower network can be more valuable to a participating hospital than a broader network, because the hospital in the narrower network would get more patients from that MCO. (Town, Tr. 4108).

1254. As a result, a hospital and an MCO may agree to lower reimbursement rates for a narrower network than for a broader network. (Town, Tr. 4109; Radzialowski, Tr. 657-658).

1255. Conversely, if an MCO goes from a narrow network to a broad network, the network becomes less valuable to the in-network hospitals, making those in-network hospitals less willing to agree to a lower price or discount. (Town, Tr. 4111-4112).

1256. For example, during the period of time when Aetna offered a broader network than MMO, Anthem and Paramount, it was not able to gain patients from those three MCOs, which may be attributable to the higher prices patients would have had to pay for a broader network as compared to the narrow networks offered by MMO, Anthem and Paramount. (Town, Tr. 4327-4328).

1257. {

} (Radzialowski, Tr. 819-821, *in camera*; PX02504 at 001-002, *in camera*).

1258. In addition, an MCO does not need each individual hospital in its network to provide a full spectrum of services, so long as its network consists of enough hospitals to provide all the services its members may. (Guerin-Calvert, Tr. 7778; Radzialowski, Tr. 656-657).

1259. {

} (Guerin-Calvert, Tr. 7355, *in camera*).

1260. {

} (Guerin-Calvert, Tr. 7356, *in camera*).

a. MCOs Have Not Studied Whether and to What Extent Patients Are Willing To Travel for General Acute Care Inpatient Services and Inpatient Obstetrical Services

1261. Anthem has not performed any analysis in Lucas County regarding how far Anthem's insureds will travel for general acute care services. (Pugliese, Tr. 1563).

1262. Anthem has not studied where its insureds in Lucas County obtain general acute care services relative to where those persons actually live. (Pugliese, Tr. 1563).

1263. In determining whether a hospital is a viable alternative in its network, MMO considers a hospital located 35 minutes away too far. A hospital located within 10 minutes driving distance is considered a viable alternative. A hospital located 20 minutes away could be acceptable if another hospital were not located within 10 minutes. (Pirc, Tr. 2267-2268).

1264. MMO has not, however, actually performed any market study regarding how far its members will travel for general acute care services. (Pirc, Tr. 2297-2298).

1265. MMO has not performed any study of where expectant mothers went to deliver their babies in Lucas County. (Pirc, Tr. 2298).

1266. {
} (Pirc, Tr. 2303, *in camera*).

1267. United does not know whether there is an outer limit for how far patients in Lucas County would be willing to travel for general acute care inpatient services. (Sheridan, Tr. 6681).

1268. {
} RX-27 (Sheridan, Dep. at 20, *in camera*)).

1269. Aetna has not performed any studies within the last five years of Lucas County members' willingness to travel to different hospitals in Lucas County. (Radzialowski, Tr. 774).

1270. Aetna has not performed any studies within the last five years of Lucas County members' patient preferences. (Radzialowski, Tr. 774).

1271. Aetna has not studied travel patterns for tertiary services. (Radzialowski, Tr. 637-638).

2. MCOs and Employers Can Incentivize Patients To Use Certain Providers and Not Others

1272. MCOs may use multiple tools to steer insureds to utilize certain healthcare providers, including affirmative financial or other incentives. MCOs may also provide information to members to assist their healthcare decision-making, such as posting relative cost information on their websites. (Radzialowski, Tr. 723-724; Pugliese, Tr. 1463-1464; Town, Tr. 4342-4343).

1273. Steerage can produce lower costs for health plans and lower out-of-pocket costs for plan members. (Pugliese, Tr. 1464).

1274. { }
(Pirc, Tr. 2307, *in camera*).

1275. { }
(Randolph, Tr. 7039, *in camera*).

1276. {

} (Guerin-Calvert, Tr. 7411-7413, *in camera*).

1277. There is no prohibition on MCOs providing hospital cost information to physicians. (Town, Tr. 4343). {

} (Guerin-Calvert, Tr. 7358, *in camera*).

1278. {

}

(Guerin-Calvert, Tr. 7413, *in camera*).

a. The Lucas County Government Steers Its Employees toward Particular Hospital Networks

1279. {

} (Shook, Tr. 1093-1094, 1096, *in camera*).

1280. {

} (Randolph, Tr. 7039-7040, *in camera*; RX-261 at 000004, *in camera*).

1281. {

} (Shook, Tr. 1092, *in camera*).

1282. {

} (Shook, Tr. 1095, *in camera*).

1283. {

} (Shook, Tr. 1093-1094, *in camera*).

1284. {

} (PX00524 at 001, *in camera*).

1285. In 2011, the Lucas County Government contributed a greater percentage to its employees' healthcare costs if they chose to enroll with PHC instead of their two other options, Paramount or FrontPath. (Guerin-Calvert, Tr. 7294-7295; Shook, Tr. 1096, *in camera*; Guerin-Calvert, Tr. 7395-7396 *in camera*).

1286. {

} (Randolph, Tr. 7043, *in camera*; PX00524 at 001, *in camera*).

1287. {

} (Oostra, Tr. 5940, *in camera*).

1288. {

}

(Randolph, Tr. 7043, 7050, *in camera*).

1289. {

}

(Shook, Tr. 1092-1093, *in camera*).

1290. {

} (Oostra, Tr. 5942, *in camera*).

1291. The Lucas County model of offering different tiers of health plans is a new technique employers are using to offer multiple health plans and control their costs. (Guerin-Calvert, Tr. 7902).

1292. {

} (Randolph, Tr. 7050, *in camera*).

1293. {

} (Guerin-Calvert, Tr. 7397-7398, *in camera*).

b. The Catholic Diocese of Toledo Steers Its Employees Exclusively to the Mercy Hospitals

1294. The Catholic Diocese of Toledo has used United as its health insurance provider for its approximately 1500 insureds. (Sheridan, Tr. 6628).

1295. Because the Diocese prefers its employees use the Catholic hospitals in Lucas County, , the Mercy system hospitals are the only participating hospitals in United's network for the Diocese. (Sheridan, Tr. 6628-6629).

1296. For this narrow network product, United and Mercy negotiated lower rates for Diocese members. (Sheridan, Tr. 6629; Sheridan, Tr. 6631 *in camera*).

c. Mercy Steers Its Employees toward Mercy Hospitals

1297. Mercy is one of the ten largest employers in Lucas County. (Shook, Tr. 1067-1068).

1298. Mercy offers health insurance benefits to its employees and provides health insurance to approximately 8,000 insureds. (Shook, Tr. 1068, 1072).

1299. Mercy is self-insured and contracts with MMO to manage its health insurance plan. (Shook, Tr. 1068).

1300. Mercy's health plan puts its provider hospitals into three tiers in order to steer, or incentivize, its employees to seek services from Mercy's hospitals instead of other Lucas County hospitals. (Shook, Tr. 1068; Marlowe, Tr. 2427-2428; Read, Tr. 5287-5288; Guerin-Calvert, Tr. 7294-7295; Town, Tr. 4383, *in camera*; Guerin-Calvert, Tr. 7395 *in camera*).

1301. Tier one is the preferred tier and includes Mercy's facilities. (Shook, Tr. 1072).

1302. Mercy believes that commercial health plans can protect themselves from increased hospital rates by steering their enrollees to lower cost hospitals. (Shook, Tr. 1070).

d. UTMC Steers to Its Own Physicians

1303. UTMC offers its employees health insurance benefits. (Gold, Tr. 259). UTMC employees can choose from three health insurance plans: FrontPath, MMO, and Paramount. (Gold, Tr. 259).

1304. The plans contain incentives for insured members to seek services from UTMC's faculty physicians. (Gold, Tr. 259).

1305. UTMC has a faculty practice group, known as the University of Toledo Physicians, which employs approximately 175-full time physicians. (Gold, Tr. 204).

e. Aetna's Steering Program

1306. {

} (Town, Tr. 4383, *in camera*).

1307. Aetna offers "soft" steerage programs to employers that provide information to patients and providers to try to change where care is provided. (Radzialowski, Tr. 723-724).

1308. Aetna is also piloting a "hard" steerage program that offers financial incentives to patients to obtain care from specific, lower-cost providers. (Radzialowski, Tr. 724).

1309. Aetna launched the pilot steerage program on January 1, 2011 with a select population of Aetna employees to encourage patients to use services at lower-cost hospitals. (Radzialowski, Tr. 775; Guerin-Calvert, Tr. 7396, *in camera*). Aetna typically tests new insurance products with its own employees before launching them in the market. (Radzialowski, Tr. 724).

1310. The program is in effect in Lucas County and throughout Ohio. (Radzialowski, Tr. 775-776). None of Aetna's existing contracts in Northern Ohio have any language restricting its ability to implement a steerage program. (Radzialowski, Tr. 726-727).

1311. As part of the program, Aetna categorizes hospitals into various tiers. (Radzialowski, Tr. 775). The placement of a hospital in a particular tier is determined, in part, by the cost of care at that hospital. (Radzialowski, Tr. 775).

1312. All Lucas County hospital providers are represented in Aetna's lower-cost hospital tier, which includes St. Luke's, UTMC, Bay Park, St. Charles, and St. Anne. (Radzialowski, Tr. 776).

1313. Aetna has not yet compiled enough data to determine whether the program will be successful. (Radzialowski, Tr. 725-726). At the end of the year, Aetna will evaluate the effectiveness of the program and determine whether to expand it to include other members and markets. (Radzialowski, Tr. 776-777).

f. Other Employers

1314. Some FrontPath sponsors that are also healthcare providers have designed three-tiered networks that encourage employees to use the sponsor's services before using other in-network providers. (Sandusky, Tr. 1328).

1315. FrontPath would negotiate for tiered networks with providers if its sponsors requested it. (Sandusky, Tr. 1328-1329).

3. MCOs Can Use Excess Bed Capacity to Their Advantage

1316. The excess capacity of available beds in Lucas County means that MCOs do not have to have every hospital in their networks because there are enough beds for their members with just a few hospitals. (Guerin-Calvert, Tr. 7291-7294).

1317. For example, MMO grew into one of the largest MCOs in the Toledo area without ProMedica in its network; the hospitals that were in MMO's network were able to serve its member volume. (Guerin-Calvert, Tr. 7291-7292).

1318. Similarly, Anthem's members were all able to be served with only ProMedica and UTMC in its network for several years and, during that time, Anthem became one of the top four MCOs in the Toledo area. (Guerin-Calvert, Tr. 7292).

1319. Moreover, MCOs can take advantage of the excess bed capacity in the hands of non-ProMedica hospitals to discipline ProMedica's pricing and seek opportunities to get more attractive pricing from Mercy or UTMC by making those hospitals the principal providers in a network, because sufficient beds will exist to serve the MCO's members. (Guerin-Calvert, Tr. 7292-7294).

4. ProMedica's Pre- and Post-Joinder Negotiations with MCOs Resulted in Competitive Contracts

1320. "Bargaining leverage" is the advantage, or perception of advantage, of a particular entity at the bargaining table to try to make use of certain attributes in the negotiation. (Guerin-Calvert, Tr. 7440).

1321. Bargaining leverage is not an economic term and does not necessarily equate with or cause an anticompetitive effect. (Guerin-Calvert, Tr. 7440).

1322. A hospital's bargaining leverage is a function of the available substitutes in the area. If other hospitals in the area are close substitutes for a given hospital, the marketability of a MCO's product would be impacted little by failing to reach an agreement with the hospital. (Town, Tr. 3644-3645).

1323. "Bargaining power" is not the same as bargaining leverage. (Guerin-Calvert, Tr. 7441).

1324. While bargaining power is used in economic literature, it refers to the concept of the share of the available profits or the available rents that a party gets, but it does not equate with or cause anticompetitive effect. (Guerin-Calvert, Tr. 7441-7442).

1325. "Market power" means that an entity has some ability to price above its marginal cost because of some differentiation it has compared to its competitors. (Guerin-Calvert, Tr. 7442).

1326. That a competitor has market power does not necessarily mean an anticompetitive market exists, because most firms face a less than perfectly elastic demand; they can differentiate themselves in some respect. (Guerin-Calvert, Tr. 7442).

1327. Bargaining leverage and market power are related to the extent that a firm is able to differentiate itself. (Guerin-Calvert, Tr. 7443).

1328. Bargaining power is distinguished from market power in that the outcomes of bargains can vary based on the skill and capability of the parties and the value of their offerings. (Guerin-Calvert, Tr. 7443-7444).

1329. A party's negotiating skills will affect its bargaining leverage. (Guerin-Calvert, Tr. 7445).

1330. All hospitals and MCOs in Lucas County each have bargaining leverage, bargaining power and market power. (Guerin-Calvert, Tr. 7445-7446).

1331. Complaint Counsel's economic expert would not characterize the bargaining leverage in Lucas County pre-joinder as anticompetitive. (Town, Tr. 4142-4143).

1332. Higher reimbursement rates, in and of themselves, are not anticompetitive. (Town, Tr. 4200-4201).

1333. {

} (Guerin-Calvert, Tr. 7436-7439, *in camera*).

a. Pre-Joinder

(i) MMO

1334. {

} (Pirc, Tr. 2286, *in camera*).

1335. {

} (Wachsman, Tr. 4996, *in camera*).

(ii) FrontPath

1336. { } (Sandusky, Tr. 1362, *in camera*).

1337. {

} (Sandusky, Tr. 1362-1363, *in camera*).

1338. {

} (Sandusky, Tr. 1367-1368, *in camera*).

1339. {

} (Sandusky, Tr. 1368, *in camera*)

1340. {

} (Sandusky, Tr. 1368-1369, *in camera*).

1341. {

} (Sandusky, Tr. 1369, *in camera*).

(iii) Anthem

1342. Anthem's pre-joinder negotiations with ProMedica resulted in a contract that was mutually agreeable and executed by both parties. (Pugliese, Tr. 1554).

1343. { } (Pugliese, Tr. 1475, *in camera*).

(iv) Aetna

1344. { } (Radzialowski, Tr. 788, *in camera*; RX-129 at 000002, *in camera*).

1345. { } (Radzialowski, Tr. 788, *in camera*; RX-129 at 000001-000002, *in camera*).

1346. { } (Radzialowski, Tr. 788, *in camera*; RX-129 at 000001, *in camera*).

1347. { } (Radzialowski, Tr. 789-790, *in camera*; RX-128 at 000001, *in camera*).

1348. { } (Radzialowski, Tr. 809, *in camera*).

1349. { } (Radzialowski, Tr. 820, *in camera*).

1350. { } (Radzialowski, Tr. 790, *in camera*).

b. Post-Joinder

1351. { } (Oostra, Tr. 5942-5943, *in camera*). { } (Wachsman, Tr. 5080, *in camera*).

(i) Anthem

(a) Negotiations Relating to ProMedica Legacy Hospitals

1352. { } (Pugliese, Tr. 1475, *in camera*).

1353. {

} (Pugliese, Tr. 1649, *in camera*).

1354. {

}

(Pugliese, Tr. 1475, 1649-1650, *in camera*).

1355. {

} (Pugliese, Tr. 1650, *in camera*).

1356. {

} (Pugliese, Tr. 1650, *in camera*).

(b) Negotiations Relating to St. Luke's

1357. There have been no negotiations between ProMedica and Anthem since the joinder of ProMedica and St. Luke's relating to Anthem's contracts with St. Luke's. (Pugliese, Tr. 1583).

1358. Since the joinder of ProMedica and St. Luke's, ProMedica has not sought to modify any of St. Luke's rates to be comparable to the rates that ProMedica is presently getting from Anthem for any of its hospitals. (Pugliese, Tr. 1583-1584).

1359. ProMedica has not sought to terminate St. Luke's contract with Anthem since the joinder. (Pugliese, Tr. 1584).

1360. Terminating St. Luke's contract with Anthem would be detrimental to ProMedica because ProMedica would lose access to Anthem's fully-insured and self-insured patient base. (Pugliese, Tr. 1584).

(ii) MMO

(a) Negotiations Relating to ProMedica Legacy Hospitals

1361. { }
(Pirc, Tr. 2372-2373, *in camera*).

(b) Negotiations Relating to St. Luke's

1362. On August 27, 2010, St. Luke's CEO Mr. Wakeman sent a letter to MMO giving St. Luke's "formal notice of [its] intent to discontinue [its] arrangement of providing services at current rates to MMOH beneficiaries as of December 31, 2010." (PX00485 at 001).

1363. {

} (Wakeman, Tr. 3017-3018, *in camera*).

1364. St. Luke's sent this termination letter to MMO because St. Luke's wanted to renegotiate rates with MMO at the end of the contract; St. Luke's believed that it was being underpaid and not receiving market rates. (RX-43 (Wagner, IHT at 83)).

1365. {
} (Wakeman, Tr. 3018, *in camera*).

1366. {
} (Pirc, Tr. 2249-2250, *in camera*).

1367. {
} (Pirc, Tr. 2254, *in camera*).

1368. {
} (Pirc, Tr. 2357, *in camera*; PX02350 at 001, *in camera*).

1369. {
} (Pirc, Tr. 2357, *in camera*; PX02350 at 001, *in camera*; Wachsman, Tr. 5065, *in camera*; RX-741 at 000002, *in camera*).

1370. {
} (Pirc, Tr. 2358, *in camera*; PX02350 at 001, *in camera*).

1371. { } (Pirc, Tr. 2358, *in camera*).

1372. {
} (Pirc, Tr. 2360-2361, *in camera*; RX-737 at 000005, *in camera*; Guerin-Calvert, Tr. 7429, *in camera*).

1373. {
} (Pirc, Tr. 2361, *in camera*; RX-737 at 000005, *in camera*).

1374. {
} (Pirc, Tr. 2362, *in camera*; RX-737 at 000004, *in camera*).

1375. {

} (Pirc, Tr. 2363, *in camera*; Guerin-Calvert, Tr. 7429-7430, *in camera*; RX-737 at 000004, *in camera*).

1376. {

} (Pirc, Tr. 2364, 2367-2369, *in camera*; RX-736 at 000001, *in camera*).

1377. {

} (Pirc, Tr. 2369-2370, *in camera*).

1378. {

} (Pirc, Tr. 2370, *in camera*).

1379. {

} (Pirc, Tr. 2370, *in camera*).

1380. {

} (Pirc, Tr. 2251, *in camera*).

1381. {

} (PX02385 at 032-033, *in camera*; Wachsman, Tr. 5064, *in camera*).

1382. {

} (Pirc, Tr. 2271, *in camera*; PX02385 at 032-033, *in camera*).

1383. {

} (Pirc, Tr. 2371-2372, *in camera*).

1384. {

} (Guerin-Calvert, Tr. 7429-7430, *in camera*).

1385. { } (Guerin-Calvert, Tr. 7429-7430, *in camera*; Wachsman, Tr. 5066, *in camera*).

1386. { } (Guerin-Calvert, Tr. 7430-7431, *in camera*).

1387. MMO and ProMedica negotiated a contract for St. Luke's effective January 19, 2011, that reflects equilibrium prices, because both parties felt that they were better off with the contract than they were without it. (Town, Tr. 3847, 4418-4419, *in camera*).

1388. { } (Pirc, Tr. 2367-2369, *in camera*; Wachsman, Tr. 5074, 5076-5077, *in camera*; PX00487 at 003, *in camera*; PX00488 at 001, *in camera*).

(iii) United

(a) Negotiations Relating to ProMedica Legacy Hospitals

1389. { } (Sheridan, Tr. 6652, *in camera*).

1390. { } (Wachsman, Tr. 5068, *in camera*).

1391. { } (RX-27 (Sheridan, Dep. at 50), *in camera*).

1392. United successfully negotiated a lower final base rate than the rate initially proposed by ProMedica at the start of negotiations. (RX-27 (Sheridan, Dep. at 50)).

1393. { } (Sheridan, Tr. 6653, 6661, *in camera*).

1394. { } (Sheridan, Tr. 6661, 6666-6667, *in camera*).

1395. { } (Sheridan, Tr. 6663-6664, *in camera*).

1396. {

} (Sheridan, Tr. 6668, *in camera*).

(b) Negotiations Relating to St. Luke's

1397. {

} (Guerin-Calvert, Tr. 7432-7433, *in camera*).

1398. {

} (Wachsman, Tr. 5068-5069, *in camera*; PX02118 at 422, *in camera*).

1399. {

} (Guerin-Calvert, Tr. 7432-7433, *in camera*).

1400. {

} (Wachsman, Tr. 5074, 5227-5228, *in camera*; RX-759).

1401. {

} (Guerin-Calvert, Tr. 7433, *in camera*).

1402. {

} (RX-27 (Sheridan, Dep. at 124-25, *in camera*)).

(iv) Aetna

(a) Negotiations Relating to ProMedica's Legacy Hospitals

1403. {

} (Radzialowski, Tr. 714, *in camera*).

(b) Negotiations Relating to St. Luke's

1404. {

} (Radzialowski, Tr. 836, *in camera*).

1405. {

} (Radzialowski, Tr. 827-832, *in camera*; Wachsman, Tr. 5069, *in camera*).

1406. {
} (Radzialowski, Tr. 828-829, *in camera*; PX02295 at 003, *in camera*).

1407. {
} (Radzialowski, Tr. 829, *in camera*; PX02295 at 002, *in camera*).

1408. {
} (Radzialowski, Tr. 829-830, *in camera*; PX02295 at 002, *in camera*).

1409. {
} (Radzialowski, Tr. 830-831, *in camera*; Wachsman, Tr. 5070-5071, *in camera*).

1410. {
} (Radzialowski, Tr. 831, *in camera*; PX02295 at 001, *in camera*).

1411. {
} (Radzialowski, Tr. 831, *in camera*).

1412. {
} (Radzialowski, Tr. 831, *in camera*; PX00491 at 001, *in camera*).

1413. {
} (Radzialowski, Tr. 831-832, *in camera*).

1414. {
} (Radzialowski, Tr. 832, *in camera*).

1415. {
} (Radzialowski, Tr. 836, *in camera*; PX02519 at 002).

1416. {
} (Radzialowski, Tr. 836-837, *in camera*).

1417. {
} (Radzialowski, Tr. 837, *in camera*; PX02519 at 002).

1418. {

} (Radzialowski, Tr. 837-838, *in camera*).

1419. {

} (Radzialowski, Tr. 838, *in camera*).

1420. {

}

(Radzialowski, Tr. 846, *in camera*).

(v) Humana

(a) Negotiations Relating to ProMedica's Legacy Hospitals

1421. Humana also has not engaged in negotiations with ProMedica about ProMedica's participation in Humana's health plans since the joinder with St. Luke was consummated. (McGinty, Tr. 1224).

(b) Negotiations Relating to St. Luke's

1422. Humana has not had any discussions with ProMedica about its contract with St. Luke's since the consummation of the joinder. (McGinty, Tr. 1209).

G. ProMedica's Ownership of Paramount Does Not Enhance Its Ability To Raise Rates above Competitive Levels

1. Members of Broad Access Plans that Might Terminate with ProMedica Are Most Likely To Switch to Other Broad Access Plans

1423. Anthem has not attempted to quantify how many insureds it might lose if ProMedica was not a part of its provider network. (Pugliese, Tr. 1578).

1424. Anthem believes that if it were unable to reach agreement with ProMedica to have the ProMedica hospitals participate in its network, it would lose members to plans that offer a broad open-access network, like MMO or United. (Pugliese, Tr. 1575).

1425. ProMedica experiences no net benefit when Anthem members switch to competing health plans other than Paramount. (Pugliese, Tr. 1576).

1426. The bulk of Aetna's business is with large, national customers. These large, national customers are less tolerant of smaller networks and would not switch to Paramount's smaller network if ProMedica terminated participation with Aetna. (Radzialowski, Tr. 772-773).

1427. {

} (RX-27 (Sheridan Dep. at 76, *in camera*)).

2. Members that Remain with Broad Access Plans that Terminate with ProMedica Are Less Likely To Use ProMedica Hospitals

1428. In the event that Anthem and ProMedica were unable to reach agreement for ProMedica's hospitals to participate in Anthem's network, fewer Anthem insureds are likely to use ProMedica hospitals than they would have been if ProMedica were an in-network provider. (Pugliese, Tr. 1577).

3. Plans that Terminate ProMedica May Obtain Lower Rates from Other Hospitals

1429. In the event that Anthem and ProMedica were unable to reach agreement for ProMedica's hospitals to participate in Anthem's network, Anthem could be able to obtain lower rates from other hospital providers like Mercy because Anthem would be able to assure those hospitals a greater volume of patients than it could if ProMedica were part of its network. (Pugliese, Tr. 1577).

1430. Obtaining lower rates by pushing a greater volume of patients to a narrower network of hospitals could enable an MCO to reduce premiums for fully insured employers and to lower costs for self-insured employers. (Pugliese, Tr. 1577).

H. The Joinder Will Not Adversely Impact St. Luke's Quality

1. "Quality" Metrics Vary

1431. Quality of care can be defined by various measures, including mortality rates, patient satisfaction scores, and other common measures of hospitals and hospital systems across the country. (RX-18 (Marcus, Dep. at 46)).

1432. There are varying degrees of reliability for quality metrics. (RX-1652).

1433. National and regulatory groups that produce quality scores based on evidence, clinical guidelines, and outcome indicators are considered the most reliable. This group includes sources such as CMS and the Joint Commission on Accreditation of Hospitals Organization ("JCAHO"), ACC, STS, and Acute Physiology And Chronic Health Evaluations ("APACHE"). (RX-1652; PX01930 (Reiter, Dep. at 184)).

1434. ProMedica believes that the CMS core measures are important quality indicators. (PX01930 (Reiter, Dep. at 184)).

1435. Less reliable quality sources include non-profit organizations such as LeapFrog and the Institute for Healthcare Improvement. (RX-1652).

1436. The least reliable group of sources include for-profit organizations that base their scores on coding-based indicators and studies with poor validity. This group includes sources such as HealthGrades and Thomson Reuters. (RX-1652).

1437. MMO believes that the healthcare industry does not presently know how to measure quality. (Pirc, Tr. 2214).

1438. {

} (Pirc, Tr. 2310, *in camera*).

1439. Anthem has since 1992 had its own internal quality assessment program to measure hospital quality, and uses it to gauge quality in its hospital network and to determine quality-based components of reimbursement for some provider contracts. (Pugliese, Tr. 1425).

1440. Anthem does not rely upon external quality ratings to determine hospital quality. (Pugliese, Tr. 1425).

1441. Aetna relies upon the Joint Commission's quality accreditation program to assess hospital quality. (Radzialowski, Tr. 632).

1442. Humana's claims data alone offers an insufficient sample size to offer a valid assessment of hospital quality. (McGinty, Tr. 1166-1167).

1443. Humana relies primarily on third party organizations for assessments of hospital quality. (McGinty, Tr. 1165-1166).

1444. LeapFrog's 2008 Highest Value Hospital report was not based upon a review of all services offered by participating hospitals. It only covered four service areas, including some cardiac services and pneumonia care. (Pugliese, Tr. 1569-1570; PX02449 at 002).

1445. It is typical for hospitals to be high quality in one dimension, but low quality in other dimensions; it is challenging to come up with one measure of quality for a given hospital. (Town, Tr. 4192-4193).

2. Hospitals, MCOs, and Patients View All Hospitals in Toledo As Quality Hospitals and Do Not Perceive Quality To Be Superior at St. Luke's

1446. Data, documents and testimony reveal that all of the hospitals in Lucas County are quality hospitals. (Guerin-Calvert, Tr. 7553-7554).

1447. Lucas County residents perceive the quality of care at Lucas County hospitals to be on par with one another. (Shook, Tr. 945-946).

1448. Physicians in Lucas County also perceive quality to be comparable among TTH, St. Vincent, and St. Luke's. (Gbur, Tr. 3117; Marlowe, Tr. 2417-2419; Andreshak, Tr. 1819-1820; Read, Tr. 5272; RX-21 (Peron, Dep. at 187)).

1449. ProMedica believes that all of its hospitals, including St. Luke's following the joinder, have comparable quality. (Hanley, Tr. 4723).

1450. Mercy believes that the quality of its physicians is comparable to physicians that practice primarily at ProMedica's hospitals. (Shook, Tr. 1032-1033).

1451. MMO considers that all hospitals in Lucas County do well in terms of quality. (Pirc, Tr. 2296).

1452. Aetna believes all hospitals in Lucas County are high-quality hospitals. (Radzialowski, Tr. 640).

1453. FrontPath considers all hospitals in Lucas County to be quality hospitals. (Sandusky, Tr. 1402).

1454. {

} (RX-250 at 000013, *in camera*).

1455. {

} (RX-250 at 000047, *in camera*).

3. MCOs Were Unwilling To Increase St. Luke's Rates in Recognition of Its Allegedly Superior Quality

1456. The rates Anthem pays to St. Luke's are lower than the rates it pays to other Lucas County hospitals. (Pugliese, Tr. 1564).

1457. The rates that MCOs pay to St. Luke's are not tied to St. Luke's quality measures. (Pugliese, Tr. 1564; McGinty, Tr. 1248-1249).

1458. "Pay for performance" rewards healthcare providers like hospitals for their performance on quality and other metrics. (Pugliese, Tr. 1564).

1459. Anthem offers "pay for performance" to some hospitals, but it does not offer it to St. Luke's. (Pugliese, Tr. 1564).

1460. St. Luke's did not qualify for any quality incentive from Anthem in 2010. (Pugliese, Tr. 1567-1568).

4. More Recent Quality Data Shows ProMedica's Hospitals Performing Higher than St. Luke's

1461. In the beginning of 2009, other hospitals in Toledo were quickly catching up to St. Luke's quality and service levels. (Wakeman, Tr. 2494).

1462. { } (Wakeman, Tr. 3020-3023, *in camera*; PX00559, *in camera*).

1463. { } (Wakeman, Tr. 3021-3023, *in camera*; PX00559 at 003, *in camera.*)

1464. { } (PX0559 at 001, *in camera*; Wakeman, Tr. 3022, *in camera*).

1465. American College of Cardiology data through third quarter of 2010 ranked TTH higher than St. Luke's for cardiology services. (RX-1653 at 000002, 000005).

1466. Quality data collected for CMS reporting requirements from the fourth quarter of 2010 ranked Bay Park, Flower, and TTH higher than St. Luke's. (RX-1655).

1467. In fact, as of March 2011, St. Luke's was the lowest performing hospital of ProMedica's Toledo-area hospitals according to CMS scores. (RX-25 (Reiter, Dep. at 169-170)).

1468. TTH also outperformed St. Luke's with regard to heart services on two outcome-validated measures, issued by the Society of Thoracic Surgeons ("STS") and the American College of Cardiology Foundation ("ACC"). (RX-25 (Reiter, Dep. at 158-159)).

1469. TTH has a three-star rating for its open-heart program, according to STS which is in the top 12 percent, nationally. St. Luke's has a two-star rating from STS, which is about the 65th percentile. RX-25 (Reiter, Dep. at 135)).

1470. TTH's STS ranking for cardiac surgery places it at the same level as The Cleveland Clinic, in the top tier in the nation. (RX-26 (Riordan, Dep. at 84)).

1471. TTH ranks in the third quartile for the ACC scores that reflect a national cardiac data registry, while St. Luke's is in the bottom quartile. (RX-25 (Reiter, Dep. at 135-136)).

1472. ProMedica ranks in the top decile for critical care under the APACHE measurements, which assess critical care outcomes. (RX-25 (Reiter, Dep. at 136)).

1473. { } (PX01221 at 068, *in camera*).

1474. {

} (Nolan, Tr. 6399, *in camera*).

1475. {

} (Nolan, Tr. 6401, *in camera*).

1476. {

}

(Nolan, Tr. 6400, *in camera*; PX01221 at 074, *in camera*).

1477. {

} (Nolan, Tr. 6400, *in camera*).

I. Prof. Town's Analysis Is Fatally Flawed and Does Not Reflect Competitive Realities

1478. Generally, merger simulation models have not been shown, based on real-world follow-up studies to yield reliable or accurate and precise predictions for a given merger case. (Guerin-Calvert, Tr. 7511-7512).

1. Location Is Not as Important as Prof. Town Suggests

1479. Town testified that a hospital's location is important because patients are unwilling to travel an additional six minutes to get to a hospital. (Town, Tr. 3936-3937).

1480. However, the vast majority, approximately 60 percent, of the patients who reside in St. Luke's service area travel to hospitals other than St. Luke's to receive general acute care inpatient services. (Town, Tr. 3938). These patients considered other hospitals as more attractive alternatives than St. Luke's for general acute care inpatient services. (Town, Tr. 3944).

1481. Similarly, with respect to OB services, 82.4 percent of the expectant mothers who resided in St. Luke's core service area went to hospitals other than St. Luke's, even though those hospitals were further away than St. Luke's. (Town, Tr. 3944-3945).

1482. A patient origin analysis reveals that patients are already willing to travel across county lines, across areas and from across the metro area to receive services in Toledo. (Guerin-Calvert, Tr. 7244-7245; RX-71(A) at 000186, *in camera*).

1483. In addition, patient origin and drive time analyses show that patients do not necessarily go to the next closest hospital. (Guerin-Calvert, Tr. 7244-45; RX-71(A) at 000034, *in camera*).

1484. Patients usually rank availability of a service, access to a particular physician, and alignment of a patient's insurance company ahead of the geographic location of the hospital. (Wakeman, Tr. 2510).

1485. Distance is not as big a deterrent for patient travel in Lucas County as much as the out-of-pocket costs required by insurers. (Read, Tr. 5286-5287).

2. The "Relevant Product Market" on which Prof. Town Performs His Competitive Effects Analysis is Different from the Market for General Acute Care Inpatient Services as Defined by the Complaint and Ignores Relevant Patient Data

1486. The Complaint defines the relevant product market as general acute care inpatient services sold to commercial health plans, which encompasses a broad cluster of basic medical and surgical diagnostic and treatment services that include an overnight hospital stay, such as emergency services, internal medicine, and minor surgeries. (Town, Tr. 3977-3978; Compl. ¶ 12).

1487. The Complaint excludes outpatient services and more sophisticated and specialized tertiary and quaternary services such as major surgeries and organ transplants. (Town, Tr. 3978; Compl. ¶ 13).

1488. Prof. Town's product market definition is inconsistent with the FTC's definition in the complaint. (Town, Tr. 3977-3986). For example, Prof. Town's market definition includes some primary, some secondary and some tertiary services, but excludes others. (Guerin-Calvert, Tr. 7212).

1489. Prof. Town's relevant product market excludes services that were included in contracts between MCOs and St. Luke's and ProMedica, as well as contracts negotiated with Mercy and UTMC. (Guerin-Calvert, Tr. 7210).

1490. Prof. Town also arbitrarily excludes a large number of services from his general acute care inpatient services product market that were provided across all Lucas County hospitals that were not excluded from MCO contracts and that were available to commercially-insured patients. (Guerin-Calvert, Tr. 7225).

1491. Prof. Town also excludes any overlapping DRGs between St. Luke's and ProMedica in which there are less than three commercially insured discharges for St. Luke's and ProMedica. (Town, Tr. 3983-3984).

1492. In contrast, the FTC's complaint does not limit the relevant product market to only those services that both St. Luke's and ProMedica provide. (Town, Tr. 3986).

1493. By excluding services that had less than three commercially insured discharges, Prof. Town is ignoring available services that were provided to up to one hundred government-insured patients, that are also available to commercially insured patients. (Guerin-Calvert, Tr. 7218).

1494. In addition, Prof. Town excludes DRGs that overlap between St. Luke's and ProMedica, but that fall into a different geographic market, meaning that those DRGs that experience outflow from Lucas County are not included in Prof. Town's relevant product market or competitive effects analysis. (Town, Tr. 3986-3988)

1495. Prof. Town excludes these DRGs, despite that fact that both St. Luke's and ProMedica may provide these services, simply because St. Luke's and ProMedica compete with hospitals outside of Lucas County for these services. (Town, Tr. 3988).

1496. Prof. Town also excludes DRGs with a case weight index greater than two with outmigration, where the percentage of patients residing in Lucas County going outside of that area to seek care exceeds 15 percent and there are more than 20 discharges. No other litigated hospital merger case has used that criterion. (Town, Tr. 3991-3992).

1497. Prof. Town also excludes DRGs with a case weight index greater than three with outmigration, where the percentage of patients residing in Lucas County going outside of that area to seek care exceeds 15 percent. (Town, Tr. 3992-3993). No other litigated hospital merger case has used that criterion either. (Town, Tr. 3994-3995).

1498. Prof. Town used DRG weights to distinguish tertiary and quaternary services from those services that otherwise should be included in the relevant product market. (Town, Tr. 3995-3996).

1499. However, the Complaint does not exclude DRGs with a case weight index greater than two, outmigration of greater than 15 percent, with more than 20 discharges. And, no other prior litigated hospital merger has used such criteria to define the relevant product market. (Town, Tr. 3991-3992).

1500. Moreover, Prof. Town includes in his relevant market DRGs with case weights higher than four, which captures some services that could be classified as tertiary or quaternary medical services and which the Complaint excludes from its relevant product market definition. (Town, Tr. 4014-4015).

1501. Similarly, for his separate inpatient OB services product market, Prof. Town excludes OB services that are not offered by both St. Luke's and ProMedica, where the case weight was greater than two, outmigration was greater than 15 percent, and more than 20 discharges occurred, even though the Complaint contains none of these exclusions. (Town, Tr. 4003-4006).

1502. The Complaint alleges that all inpatient OB services comprise a separate relevant product market. (Guerin-Calvert, Tr. 7228-7230).

1503. On the other hand, Prof. Town includes in his definition of general acute care relevant market normal newborns, but includes the mothers who delivered the normal newborns in his market for inpatient OB services. (Town, Tr. 4007-4008).

1504. Prof. Town excludes DRGs for which Mercy, ProMedica and UTMC have considerable discharges, which understates their competitive influences and overstates St. Luke's influence. (Guerin-Calvert, Tr. 7218-7220).

1505. Prof. Town's exclusions and filtering captures only about 30 percent of the total commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (Town, Tr. 4032-4034).

1506. In fact, Prof. Town ignores data from almost two-thirds of the patients that are treated at St. Luke's and ProMedica. (Town, Tr. 4357).

1507. By focusing on only commercially insured patients, Prof. Town ignores information on 201,000 discharges and services obtained by patients. (Guerin-Calvert, Tr. 7214).

1508. The contracts that MCOs negotiate with ProMedica and St. Luke's incorporate reimbursement rates for the DRGs that Prof. Town excluded from his relevant product market analysis. (Town, Tr. 4044).

1509. Prof. Town's method of defining a relevant product market is based solely on numerical filters; he does not evaluate how the services he excludes from his relevant product markets relate to the prices reflected in contracts negotiated between MCOs and providers. (Guerin-Calvert, Tr. 7227-7228).

1510. This prevents Prof. Town from correctly evaluating the true competitive dynamics of the Toledo area hospital market. (Guerin-Calvert, Tr. 7227-7228). {

} (RX-71(A) at 000015-000018, *in camera*).

1511. Prof. Town's relevant product market definitions are inconsistent with each other -- he defines a separate inpatient OB services market based on the premise that two Lucas County hospitals do not provide inpatient OB services; however, he includes some DRGs in his general acute care inpatient product market regardless of the number of Lucas County hospitals that offer the services. (Guerin-Calvert, Tr. 7235).

1512. For purposes of defining a relevant product market, the number of other competitors providing the service is irrelevant, because at this stage one must determine substitute services demanded by consumers, not the number of suppliers. (Guerin-Calvert, Tr. 7221).

1513. There is no evidence that hospitals can price discriminate for certain services based on the number of suppliers of that service in the area. (Guerin-Calvert, Tr. 7236).

1514. Prof. Town's methodology for defining a relevant product market does not comport with the *Horizontal Merger Guidelines*. (Guerin-Calvert, Tr. 7236).

3. Professor Town's Case-Mix Adjusted Prices Are "Constructed" Prices That Do Not Reflect Actual Real-World Rates

1515. Prof. Town's case-mix-adjusted price estimations do not indicate the reason for the difference in prices across hospitals in Lucas County, and Prof. Town agrees that the presence of price differences alone are not sufficient to determine the exercise of market power. (Town, Tr. 4151-4152, 4155; PX02148 at 145, *in camera*).

1516. Prof. Town's methodology for his constructed prices controlled for basic patient characteristics – age, gender, DRG, and length of stay – and the hospital's "fixed effect." (Guerin-Calvert, Tr. 7467-7468).

1517. Prof. Town's hospital "fixed effect" variable estimates the average change in the price holding constant age, gender, DRG and length of stay. In other words, the "fixed effect" variable attributes any other change in price to the hospital's characteristics. (Guerin-Calvert, Tr. 7467-7468).

1518. Prof. Town's "fixed effect" variable does not explain why there is a difference in price between hospitals, nor does it take into account the complexity of the negotiating process. (Town, Tr. 4155; Guerin-Calvert, Tr. 7469-7471).

1519. Prof. Town's case-mix-adjusted price estimations also do not control for the differences in the cost of care across the hospitals, even though hospitals do not necessarily incur the same costs to deliver general acute care inpatient services. (Town, Tr. 4103, 4165-4166, 4168; Guerin-Calvert, Tr. 7467).

1520. Prof. Town has no specific variable in his regression analysis that measures the differences in the cost of care across the hospitals; even though cost of care may potentially account for differences in prices. (Town, Tr. 4165-4166).

1521. These case-mix-adjusted prices also do not take into consideration the complexity of the bargaining process. (Guerin-Calvert, Tr. 7471).

1522. Prof. Town agrees that prices for a hospital may differ across MCOs for a number of reasons such as cost or quality. (Town, Tr. 4191).

1523. Prof. Town's case-mix-adjusted prices assume that reimbursement rates are in equilibrium, which is not necessarily true, especially because St. Luke's sought to renegotiate its contract with Anthem in 2009 soon after it was negotiated. (Guerin-Calvert, Tr. 7471-7473).

1524. A correlation may exist between market shares and prices for competitively benign reasons such as quality and costs; Prof. Town's calculations do not acknowledge this. (Guerin-Calvert, Tr. 7252-7256).

1525. Prof. Town's purported relationship between price and market shares uses ProMedica's share across all of its commercial MCOs and hospitals, which means he is aggregating

contracts with different reimbursement rates, different time periods and other terms that differ. (Guerin-Calvert, Tr. 7252-7256).

1526. Moreover, general acute care inpatient services are differentiated products, which means that factors such as cost, quality, underestimating the increase in inflation or cost escalation, and the time period for which a contract is negotiated can cause differences in price. (Town, Tr. 4157-4161; Guerin-Calvert, Tr. 7266, 7474).

1527. {

} Radzialowski, Tr. 684, *in camera*; RX-129 at 000001, *in camera*, PX02148 at 145, *in camera*). However, Prof. Town's case-mix-adjusted price calculations result in Mercy's prices being higher. (Town, Tr. 4181-4182).

1528. {

}. (Radzialowski Tr. 684, *in camera*; PX02148 at 145, *in camera*)

{

} (Town Tr. 4183, 4185-4186).

1529. Prof. Town's case-mix-adjusted prices are derived from a methodology that predicts prices under the hypothetical scenario of each hospital in Lucas County treating exactly the same patient population; that is, it computed prices for patients at hospitals where the patients were not actually treated. (Town, Tr. 4168-4170, 4187-4188).

1530. Prof. Town's case-mix-adjusted prices predict that if ProMedica raised MMO's rates with St. Luke's to the level of Bay Park, that would represent about a 120 percent to 134 percent increase. (Town, Tr. 4189-4191). {

} (Pirc, Tr. 2356-2372, *in camera*; PX02148 at 145, *in camera*).

1531. Furthermore, if Prof. Town's estimated price increases are analyzed at a disaggregated level, by hospitals and MCO, it shows that ProMedica's prices are not higher than all other hospitals in Lucas County. (Guerin-Calvert, Tr. 7480).

1532. Prof. Town's case weight adjusted price for St. Vincent is higher than for any other hospital for Aetna and ProMedica's system price is lower than Mercy's system price for Aetna. (Town, Tr. 4177).

1533. Similarly, for Anthem, each of the Mercy hospitals' case weight adjusted prices is higher than TTH, about the same as Bay Park, but lower than Flower; St. Luke's has the lowest adjusted price. For Anthem, the estimated system price for Mercy is higher than the system price for ProMedica. (Town, Tr. 4177-4178; Guerin-Calvert, Tr. 7483).

1534. For Blue Cross Blue Shield of Michigan ("BCBS of Michigan"), St. Vincent's price is higher than that of TTH's. (Town, Tr. 4178).

1535. For FrontPath, St. Anne's price is higher than TTH's, St. Vincent's, UTMC's, and Flower's. (Town, Tr. 4180).

a. Overview of Prof. Town's Merger Simulation Model

1536. Prof. Town's econometric, or merger simulation model, tries to predict what the change in price would be to MCOs from the joinder, taking into consideration the change in the network configuration. (Guerin-Calvert, Tr. 7485).

1537. Step one of Prof. Town's merger simulation model identifies the price differences among hospitals, but does not explain the differences in price. (Town, Tr. 4203-4205).

1538. For step one, Prof. Town starts with MCO data for discharges at greater Toledo area hospitals from January 1, 2004 through December 31, 2009, which includes inpatient discharges from Aetna, Anthem, BCBS of Michigan, MMO, FrontPath, Paramount, Cigna and United. (Guerin-Calvert, Tr. 7488; Town, Tr. 4208-4209).

1539. In step one, Prof. Town's predicted price for each hospital is calculated under the hypothetical that each hospital treats exactly the same patient population. (Guerin-Calvert, Tr. 7488).

1540. Prof. Town then excludes all discharges from hospitals outside of Lucas County, except WCH and FCHC. (Town, Tr. 4210).

1541. Prof. Town then excludes data for managed care organization/hospital-year combinations for which there were fewer than 30 discharges. (Town, Tr. 4210).

1542. Prof. Town also excludes all discharges for which the patient was older than 64 years of age even though those patients may have commercial insurance as their primary insurance. (Town, Tr. 4210-4211).

1543. Prof. Town excludes discharges coded MDC 0, 19, 20 and -1. (Town, Tr. 4211-4212).

1544. Prof. Town excludes discharges in which the amount paid to the hospital by the MCO was less than $100. (Town, Tr. 4212).

1545. Prof. Town excludes 2004 discharges reimbursed by Aetna and CIGNA. (Town, Tr. 4212).

1546. Prof. Town uses the remaining data to run a regression that shows only the difference in prices between hospitals, but not any hospital-specific factors that account for any of these differences in the hospital prices. (Town, Tr. 4212-4215).

1547. Step two measures bargaining power as "willingness-to-pay" at a system level. (Town, Tr. 4206).

1548. In other words, step two predicts the value that consumers (MCOs) place on the individual hospital or system in a MCO's network by analyzing patient discharge data. (Guerin-Calvert, Tr. 7485-7486, 7489-7490).

1549. The willingness-to-pay measure is not expressed in dollars or prices; it is expressed in utils. (Guerin-Calvert, Tr. 7490; Town, Tr. 3800, *in camera*). If the util is higher, then what is being measured is more valuable than if the util is lower. (Guerin-Calvert, Tr. 7490; Town, Tr. 3800, *in camera*).

1550. To calculate an MCO's "willingness-to-pay", Prof. Town includes OB patients in the data, but excludes newborns. Prof. Town also does not estimate a separate willingness-to-pay for inpatient OB services, even though in his report he states that "competitive conditions for OB services are substantially different from those in the broad market of general acute care services." (Town Tr. 4248, 4291-4292; PX02148 at 023-024, *in camera*).

1551. Prof. Town admits that his willingness-to-pay regression model is not a tool to forecast prices. (Town, Tr. 3883).

1552. Prof. Town's willingness-to-pay analysis estimates the probability, based on patient data in a number of counties, that a given hospital is going to be chosen across a range of services, but it does not take into account relative prices. (Guerin-Calvert, Tr. 7169-7170).

1553. Prof. Town admits that there are several factors that may affect the bargaining relationship, such as the leverage of the MCOs, costs, number of interns per bed, and the fact that prices change over time. (Town, Tr. 3884-3886).

1554. Prof. Town includes all but four DRGs, even ones he previously excluded from his case-mix-adjusted price estimate, to calculate his willingness-to-pay. (Town, Tr. 4247-4248).

1555. Step three then estimates the relationship between willingness-to-pay and price. (Town, Tr. 4206).

1556. Prof. Town uses his predicted prices and his willingness-to-pay utils in step three, and also controls for other factors including a MCO's size, year fixed effects, MCO fixed effects, interns per bed and average cost in the regression. (Guerin-Calvert, Tr. 7492-7493).

1557. In other words, in step three, Prof. Town tries to explain his case mix adjusted price based on the willingness-to-pay utils and the additional factors added at this step. (Guerin-Calvert, Tr. 7493).

1558. Prof. Town uses the coefficient on the system willingness-to-pay that results from this regression to measure the effect of bargaining power on price. (Guerin-Calvert, Tr. 7494-7495).

1559. Steps four and five attempt to estimate the magnitude of the likely price effects from the joinder. (Town, Tr. 4206).

1560. Prof. Town estimates in his system willingness-to-pay regression, the first of two regressions, the overall system increase to be 16.2 percent. (Guerin-Calvert, Tr. 7495-7496).

1561. Prof. Town then tries to estimate an overall measure of harm of this 16.2 percent by using his diversion ratios to allocate proportions of harm between ProMedica and St. Luke's. (Guerin-Calvert, Tr. 7496-7497).

1562. He then takes that allocated harm attributed to St. Luke's and compares it to St. Luke's existing pre-joinder rates and calculates the percentage change, arriving at 38.38 percent change in rates for St. Luke's and a 10.75 percent increase for ProMedica's rates. (Guerin-Calvert, Tr. 7497).

1563. Finally, Prof. Town takes the residual, or the unexplained portion, from his regression and adds that amount to the 38.38 percent for St. Luke's to arrive at his predicted rise in rates at St. Luke's of 56 percent. (Guerin-Calvert, Tr. 7497-7498).

b. Critiques of Prof. Town's Merger Simulation Model

1564. Prof. Town defines a general acute care inpatient services market for the purpose of his report that is narrower than the market for which he provides results from his merger simulation model. (Town, Tr. 4291)

1565. Prof. Town also includes data from hospitals located in counties other than Lucas County, including The Cleveland Clinic, the University of Michigan Health System and St. Joseph Mercy in his merger simulation model, even though hospitals outside Lucas County are not in the relevant geographic market. (Town, Tr. 4221-4222; PX02148 at 173, *in camera*).

1566. Prof. Town's merger simulation model does not allow one to independently or directly observe an individual's second choice of hospitals if his or her first choice becomes unavailable or more expensive. (Town, Tr. 4240-4242).

1567. Prof. Town, however, admits that "the realized choice is almost, by definition, going to be different than the probability choice." (Town, Tr. 4243).

1568. Prof. Town acknowledges that there is a need to appropriately control for the intrinsic value associated with each hospital, i.e., the extent to which patients like a hospital due to quality, reputation, location and services, which is reflected in patient preference for a hospital. (Town, Tr. 4280-4283; PX01850 at 062, *in camera*).

1569. Prof. Town's system willingness-to-pay captures the effect of the intrinsic value of member hospitals and the effect of system membership (i.e., the diversion or substitution between member hospitals). (Town, Tr. 4280-4281).

1570. Prof. Town agrees that the joinder does not affect a person's intrinsic value of a given hospital. (Town, Tr. 4281-4282).

1571. To predict the acquisition-related price changes, one must isolate the substitution or diversion effect on price from the effect of the intrinsic value on price by holding the characteristics of individual hospitals fixed. (Town, Tr. 4282).

1572. Prof. Town's model assumes there is no difference in price or cost to the consumer of MCOs offering different networks. (Town, Tr. 4324-4325).

1573. The results from Prof. Town's merger simulation model are subject to misinterpretation because the system willingness-to-pay variable captures all the things that go to the intrinsic value of the hospital, including those qualities that are competitively benign. (Guerin-Calvert, Tr. 7502).

1574. Prof. Town does not control for case mix index, assets per bed, percent Medicare reimbursements, percent Medicaid reimbursement and hospital-level willingness-to-pay, all of which can affect the intrinsic value associated with a hospital. (Town, Tr. 4283-4284; Guerin-Calvert, Tr. 7499-7550).

1575. When included in his model, the variables that Prof. Town does not include can explain the reason for the price differences. (Guerin-Calvert, Tr. 7501).

1576. The case mix index variable accounts for the distribution of the patient population at a hospital. In addition, hospitals with a greater case mix index have different staffing, different attributes and possible different reputations, all of which could affect prices. (Guerin-Calvert, Tr. 7513-7514).

1577. The assets per bed variable is a measure of equipment and facilities at a hospital that could explain prices. (Guerin-Calvert, Tr. 7514-7515).

1578. The percent of Medicaid and Medicare discharges variables explains that the larger the proportion of Medicaid and Medicare patients a hospital has, the more it may have shortfalls it needs to cover with its MCO contracts, which may also explain prices. (Guerin-Calvert, Tr. 7515-7516).

1579. The hospital average willingness-to-pay per person variable accounts for differences in specific hospitals, rather than aggregating the willingness-to-pay at a system level. (Guerin-Calvert, Tr. 7516-7517).

1580. Adding all these variables into Prof. Town's model results in a 7.3 percent calculated price change but the coefficient on the system willingness-to-pay that generated the 7.3 percent is not statistically significant, which means that there is no confidence that the relationship between system willingness-to-pay and price is different from zero. (Guerin-Calvert, Tr. 7525-7526; RX-71(A) at 000081, *in camera*).

1581. These variables that Prof. Town does not include are variables identified in economic literature and are ones that other economists, including some employed by the FTC, have included in past hospital merger analyses and regressions. (Guerin-Calvert, Tr. 7505-7506, 7510; RX-71(A) at 000077-000079, *in camera*).

1582. On the other hand, the variables Prof. Town uses in his choice model have not appeared in any peer-reviewed academic literature. (Town, Tr. 4247).

1583. Prof. Town's willingness-to-pay model has not been accepted in any other hospital merger cases. (Town, Tr. 3969).

1584. In addition, the multinomial logit functional form that Prof. Town uses has been criticized in economic literature for generating restrictive substitution patterns. (Town, Tr. 4236).

1585. There are no peer-reviewed studies that Prof. Town, or Ms. Guerin-Calvert, are aware of that validate the accuracy of the price predictions Prof. Town's merger simulation model generates. (Town, Tr. 4288-4289; Guerin-Calvert, Tr. 7511-7512).

1586. Prof. Town has not confirmed with MCOs or hospitals in Toledo that his model accurately captures the bargaining process between the MCOs and hospitals. (Town, Tr. 4297).

1587. Further, Prof. Town's model does not predict a price effect specific to St. Luke's; rather it allocates a price effect to St. Luke's based on the price effect predicted for a ProMedica Health System that contains St. Luke's. (Town, Tr. 4297-4298).

1588. {

} (Guerin-Calvert, Tr. 7375, *in camera*).

1589. Prof. Town also did not validate his allocation of price effect between St. Luke's and ProMedica. (Town, Tr. 4307).

1590. Prof. Town performs this allocation by using diversion ratios that are calculated using data which includes DRGs outside his defined relevant product market. (Town, Tr. 4299-4300).

1591. However, the diversion rates Prof. Town uses were not calculated based upon a price increase at St. Luke's or at ProMedica. (Town Tr. 4301-4302).

1592. Prof. Town's methodology for estimating the change in price at ProMedica and St. Luke's post-joinder does not take into consideration any response by rivals. (Town, Tr. 4309).

1593. Prof. Town agrees that hospitals generally negotiate prices over a broad range of services, and, therefore, he uses a broader set of DRGs to calculate his willingness-to-pay model than he uses in his definition of relevant product market. (Town, Tr. 4295-4296).

1594. Prof. Town's model shows that UTMC has the lowest willingness-to-pay per person, but UTMC is the most unique hospital in Lucas County and has few proximate hospitals, thus, it should have a high willingness-to-pay per person. (Town, Tr. 3874-3879).

1595. Prof. Town's merger simulation model also cannot predict *when* ProMedica will be able to raise St. Luke's rates, only that it would occur over time. (Town, Tr. 4256).

1596. In general, merger simulation models have been shown to yield imprecise predictions than what is shown to actually occur in a merger case when studied after the fact. (Guerin-Calvert, Tr. 7511-7512). {

} (Guerin-Calvert, Tr. 7437, *in camera*)

4. Prof. Town's Conclusion that Competing Hospitals Cannot Constrain ProMedica Is Not Based on Actual Post-Joinder Data

1597. Prof. Town's willingness-to-pay model does not test whether patients or MCOs would prefer a Mercy-UTMC network offered at a lower price than a ProMedica-St. Luke's network because the price to employers and consumers of the network does not factor into the calculation of willingness-to-pay. (Town, Tr. 4258).

1598. Prof. Town has not done any analysis to determine at what price a UTMC-Mercy network would be marketable for MCOs. (Town, Tr. 4323-4324).

1599. Prof. Town bases his opinion that the presence of Mercy and UTMC will not prevent ProMedica from raising prices on the differences in market share between Mercy and ProMedica, the differences in share between a network that includes ProMedica and St. Luke's compared to one that includes just Mercy and UTMC, and the difference in his estimated post-acquisition willingness-to-pay for a network with ProMedica and St. Luke's as opposed to a network comprised only of Mercy and UTMC. (Town, Tr. 4253-4254).

1600. The differences in shares that Prof. Town uses are for the period July 2009 through March 2010, less than one year. (Town, Tr. 4254).

1601. For the post-joinder share configurations, Prof. Town rearranged the shares that existed prior to the joinder; he did not measure how the shares for ProMedica and St. Luke's have changed since the joinder was consummated on September 1, 2010. (Town, Tr. 4254).

1602. There is no actual share data showing the results of a ProMedica-St. Luke's network competing against a Mercy-UTMC network. (Town, Tr. 4254-4255).

1603. Moreover, one cannot calculate a difference in price from a change in market shares alone. (Guerin-Calvert, Tr. 7476-7480).

1604. There is not enough data available to be able to explain the price levels, such as how an MFN clause affected the price levels, how the point at which the contract was negotiated affected prices, whether a contract was likely to be re-negotiated or adjusted, how the prices take into account trade-offs between inpatient and outpatient prices, and the general strategy of each party. (Guerin-Calvert, Tr. 7477-7479).

1605. Prof. Town has not attempted to quantify his predicted higher out-of-pocket expenses, reduced coverage, or lower wages that will be passed on to employees as a result of the joinder. (Town, Tr. 4346-4347).

5. Prof. Town Can Cite No Post-Joinder Evidence of Reduced Non-Price Competition

1606. Prof. Town cannot cite any evidence that post-joinder there had been a reduction in non-price competition. (Town, Tr. 4330-4331).

1607. Nor has Prof. Town attempted to quantify his statement that quality-promoting, non-price competition will be eliminated as a result of the joinder. (Town, Tr. 4332-4333).

1608. Prof. Town has not examined any evidence of adverse patient outcomes specifically resulting from the joinder, nor has he examined how future patient outcomes will change as a result of the joinder. (Town, Tr. 4348).

1609. There is no evidence of longer patient wait times or a reduction in patient care as a result of the joinder. (Town, Tr. 4348-4349).

6. Prof. Town Has Not Analyzed the Effects of the Joinder on the Inpatient Obstetrical Services Market Defined by the Complaint

1610. Prof. Town's merger simulation model combines his inpatient OB services and general acute care inpatient services into one price effect. (Town, Tr. 4290-4291).

1611. Prof. Town provides no evidence, prediction or expectation of the predicted price in his inpatient OB services market. (Guerin-Calvert, Tr. 7163-7165).

IV. Absent the Joinder, St. Luke's Financial Condition Would Have Diminished Its Competitive Significance

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

1. Operational Losses and Deteriorating Financial Performance

1612. St. Luke's suffered from poor operating financial performance throughout the 2000s, breaking even and making money in only two years. (RX-33 (Deacon, IHT at 76)).

1613. The most important time period in analyzing St. Luke's financial viability is from 2008 when Mr. Wakeman arrived, through 2010 when the joinder occurred. (Dagen, Tr. 3337-3338).

1614. Respondent's financial expert, Mr. Den Uyl, focused his analysis on the time period starting with Mr. Wakeman's arrival, through 2010 when the joinder occurred. He also included 2007, just before Mr. Wakeman's arrival, to help him assess what, if any, impact Mr. Wakeman had and to account for any distortions that might be caused by the financial crisis in 2008. (Den Uyl, Tr. 6416-6417).

1615. To determine whether St. Luke's could be a viable competitor as an independent community hospital, one has to remove any of the effects that the joinder might have had on St. Luke's financial performance. It would be inappropriate to incorporate any post-joinder effects. (Dagen, Tr. 3353-3354).

1616. OhioCare, St. Luke's parent, experienced significant financial losses from 2007 through the joinder in 2010. OhioCare's operating loss was $8.2 million in 2007, $12.7 million in 2008, $20.3 million in 2009, and $7.7 million in the first eight months of 2010. This amounted to operating margins of -6.2 percent in 2007, -9.1 percent in 2008, -13 percent in 2009, and -6.9 percent for the first eight months of 2010. (Den Uyl, Tr. 6418-6419; RX-56 at 000006, *in camera*).

1617. St. Luke's itself also experienced high financial losses. St. Luke's loss was $7.6 million in 2007, $8.8 million in 2008, $15.1 million in 2009, and $2.7 million for the first eight months of 2010. This amounted to operating margins of -5.9 percent in 2007, -6.5 percent in 2008, -10.3 percent in 2009, and -2.6 percent in the first eight months of 2010. (Den Uyl, Tr. 6418-6419; RX-56 at 000006, *in camera*; Dagen, Tr. 3304-3305).

1618. St. Luke's operating performance was significantly below that of other Ohio hospitals. St. Luke's had negative operating margins in the years leading up to the joinder, while other Ohio hospitals were profitable. The average operating margin for Ohio hospitals was 4.0 percent in 2007, 1.5 percent in 2008, and 5 percent in 2009. (Den Uyl, Tr. 6420-6421; RX-56 at 000006, *in camera*).

1619. St. Luke's operating performance was significantly below that of similarly sized (100-249 beds) non-profit urban hospitals. St. Luke's had negative operating margins in the years leading up to the joinder, while those other hospitals were profitable. The average operating margin for similarly sized non-profit urban hospitals was 3.2 percent in 2007, 1.8 percent in 2008, and 3 percent in 2009. (Den Uyl, Tr. 6420-6421; RX-56 at 000006, *in camera*).

1620. St. Luke's operating performance was significantly below that of hospitals with comparable Moody's bond ratings as St. Luke's. St. Luke's had negative operating margins in the years leading up to the joinder while those other hospitals were profitable. The average operating margin for Moody's A-2 rated hospitals was 2.6 percent in 2007 when St. Luke's bond rating was A-2; the average operating margin for Moody's Baa1

rated hospitals was 0.3 percent in 2008 and 1.6 percent in 2009 when St. Luke's bond rating was Baa1. (Den Uyl, Tr. 6420-6422; RX-56 at 000006, *in camera*).

1621. EBITDA is earnings before interest, taxes, depreciation, and amortization. EBITDA is calculated by adding interest, depreciation, taxes, and amortization expenses to the operating income. (Den Uyl, Tr. 6424-6425; RX-56 at 000006, *in camera*).

1622. EBITDA does not reflect the true cash flow of a hospital because it does not consider capital expenditures. At certain times, it also does not reflect pension expenses or gains and losses from investments. These items need to be examined as well to get a full picture of the true cash flow of a hospital. (Den Uyl, Tr. 6427-6428).

1623. Improving EBITDA does not necessarily indicate financial strength. (Dagen, Tr. 3188).

1624. EBITDA is not a number that can be obtained off of the financial statements; it needs to be calculated. (Den Uyl, Tr. 6427; Dagen Tr. 3313).

1625. OhioCare's EBITDA and EBITDA margin were negative from 2008 through the joinder. (Dagen, Tr. 3313-3314). {

} (RX-56 at 000007, *in camera*).

1626. {

} (Den Uyl, Tr. 6591-6592, *in camera*).

1627. {

} (RX-56 at 000007, *in camera*).

1628. {

} (RX-56 at 000007, *in camera*).

1629. It is important to consider capital expenditures as part of the measurement of a hospital's true cash flow, because hospitals are very capital intensive. They need to spend much capital, "just to stay even." (Den Uyl, Tr. 6431-6432).

1630. St. Luke's could not have operated the hospital as a stand-alone hospital and met all the capital needs that it faced without access to some type of financing. (Johnston, Tr. 5459-5461).

1631. Operating cash flow and capital expenditures are reported on OhioCare's financial statements on the consolidated statement of cash flows. Operating cash flow and capital

expenditures are typically reported on a company's financial statements. (PX01006 at 007; Den Uyl, Tr. 6428-6429).

1632. St. Luke's and ProMedica's executives considered operating cash flow in conjunction with capital expenditures in assessing the financial condition of their respective hospitals. (Den Uyl, Tr. 6432-6433; Wakeman, Tr. 3013-3014, *in camera*).

1633. {

}

(RX-56 at 000008, *in camera*).

1634. The cash flow losses that OhioCare, St. Luke's parent, was running from 2007 through the joinder were not sustainable, because St. Luke's could not draw down on its reserves indefinitely. St. Luke's was facing significant capital expenditures, and St. Luke's had to fund its underfunded pension plan. Moreover, St. Luke's struggling financial situation would make it more difficult for St. Luke's to borrow money. (Den Uyl, Tr. 6434-6435; RX-56 at 000015, *in camera*).

1635. Reserve funds exist for emergency cash needs that may arise outside of normal operations. (Johnston Tr. 5521-5522).

1636. St. Luke's does not have a high level of reserves in comparison to other hospitals. (Johnston, Tr. 5522).

1637. Because St. Luke's has a very low debt level, its cash-to-debt ratio is not the only measure that should be examined to assess the adequacy of its reserve funds. (Johnston, Tr. 5525-5526).

1638. The metric that St. Luke's and bond rating agencies use to evaluate the state of its reserve fund is days cash on hand. (Johnston, Tr. 5527).

1639. St. Luke's strives to have its days cash on hand at a level comparable to Aa-rated hospital organizations. (Johnston, Tr. 5527).

1640. The amount of days cash on hand held by Aa-rated institutions is about double what St. Luke's currently holds. (Johnston, Tr. 5527).

1641. {

} (RX-56 at 000016, *in camera*).

1642. {

} (Den Uyl, Tr. 6460, *in camera*).

1643. {

}

(Den Uyl, Tr. 6461, *in camera*).

1644. In 2010, St. Luke's "didn't really have the wherewithal to borrow money." St. Luke's "was not seeking to borrow money because it was running losses. And to borrow money would put more leverage on the hospital" and "put them in a more difficult situation." From a financial standpoint "it wouldn't have been prudent" for St. Luke's to borrow money. (Den Uyl, Tr. 6547).

2. Pension Funding Challenges

1645. St. Luke's has two pension plans, a defined benefit pension plan and a 403(b) defined contribution pension plan. (Johnston, Tr. 5331).

1646. A defined benefit pension plan promises employees certain benefits payable over a period of years upon retirement. That promise is backed by the assets in the pension plan account. The employer must contribute enough money to the plan to have sufficient assets to live up to the pension plan's obligations. (Arjani, Tr. 6729).

1647. {

} (Johnston, Tr. 5397, *in camera*).

1648. Employers who offer a defined benefit pension plan face various risks, including the risk that plan assets may shrink through investment losses and that benefit obligations may increase due to higher salaries, longer life expectancies, or extended employee tenures. (Arjani, Tr. 6730).

1649. The state of St. Luke's pension funding in early 2009 was "shocking." Where St. Luke's pension fund had been about 108 percent funded at the end of 2007 it was about 63 percent funded at the end of 2008 and there was an approximately $50 million shortfall in the funding requirement which had to be booked as a current liability for 2008. (Wakeman, Tr. 2838-2839).

1650. {

} (Den Uyl, Tr. 6451-6452, *in camera*).

a. St. Luke's Defined Benefit Pension Plan Was Under-Funded According to Both Primary Measures of a Pension Plan's Financial Status

1651. There are two primary ways that the health of a defined benefit pension plan is evaluated. On the one hand, plans are examined according to generally accepted accounting

principles; they are also examined under rules established by ERISA, as modified by the Pension Protection Act. (Johnston, Tr. 5331-5332; Arjani, Tr. 6731-6732).

1652. {

} (Arjani, Tr. 6768, *in camera*).

1653. At the close of the joinder, St. Luke's defined benefit pension plan was under-funded from both an accounting and funding perspective. (Johnston, Tr. 5336).

b. St. Luke's Pension Plan Was Significantly Under-Funded according to Accounting Calculations Used for Determining the Plan's Liability on St. Luke's Financial Statements

1654. The "accounting calculation" determines the liability that must be entered on an organization's annual financial statements. {

} (Johnston, Tr. 5331; Johnston, Tr. 5389, *in camera*).

1655. The accounting liability is essentially the difference between the market value of the plan's assets and its projected benefit obligation. The liability is calculated by outside actuaries and audited by external auditors. (Johnston, Tr. 5331-5332; Arjani, Tr. 6731; Arjani, Tr. 6742, *in camera*).

1656. The accounting liability is an important measure of a defined benefit pension plan's health that is reviewed by an organization's board members and rating agencies. (Johnston, Tr. 5331).

1657. {

} (Johnston, Tr. 5391, *in camera*; PX01006 at 002).

1658. {

} (Johnston, Tr. 5391, *in camera*; Arjani, Tr. 6743, *in camera*; RX-214 at 000001, *in camera*).

1659. {

} (Johnston, Tr. 5395-5396, *in camera*; Arjani, Tr. 6743-6745, *in camera*; RX-214 at 000001, *in camera*).

c. St. Luke's Pension Plan Was Also Significantly Under-Funded according to Funding Calculations Used for Compliance with Federal Statutes

(i) ERISA, as Modified by the Pension Protection Act, Defines the Rules To Assess Pension Plan Funding Requirements

1660. A separate funding calculation analysis conducted under the ERISA rules determines the funding level of a defined benefit pension plan by comparing the "funding target" of the plan to the actuarial value of the assets of the plan. (Johnston, Tr. 5332; Arjani, Tr. 6731).

1661. The "funding target" is an assessment for ERISA purposes of the benefit obligations of the pension plan. It is calculated by examining the census of plan participants, which provides data on how long employees have been with the employer and the level of their accrued pension benefits, as well as the level of accrued benefits for retirees and terminated vested employees who are entitled to future benefits. (Arjani, Tr. 6779).

1662. {

} (Arjani, Tr. 6757-6758, *in camera*).

(ii) Under Federal Law, Employers Must Bring Their Defined Benefit Pension Plans to 100 Percent Funding

1663. Each year, actuaries are required to certify the funding level of St. Luke's defined benefit pension plan. (Johnston, Tr. 5333, 5337-5338).

1664. Under ERISA, as modified by the PPA, if St. Luke's defined benefit pension plan is less than 100 percent funded, it is required to amortize the amount of the under-funding and make payments over seven years to bring the plan to 100 percent funding. (Arjani, Tr. 6736-6737; Den Uyl, Tr. 6446-6447, *in camera*).

1665. Even if St. Luke's is able to make current payments to its defined benefit pension plan beneficiaries, it must still restore the plan to full funding. (Johnston, Tr. 5343).

1666. Actuaries calculate the amount of contributions required for St. Luke's defined benefit pension plan; the required annual contributions are made on a quarterly basis. Depending on the actuarial valuation of the plan, additional contributions beyond the planned quarterly payments may be required to satisfy the annual contribution requirement. (Arjani, Tr. 6737-6738).

1667. {

} (Arjani, Tr. 6759-6760, *in camera*).

1668. {

} (Arjani, Tr. 6759-6760, *in camera*).

(iii) Employers May Need To Accelerate Funding To Prevent Pension Plans from Being Under 80 Percent Funded

1669. {

} (Arjani, Tr. 6758-6759, *in camera*; RX-56 at 000011, *in camera*.)

1670. If a plan falls below 80 percent funding, an employer may be required to accelerate contributions into the plan in order to get the plan above the 80 percent level. (Johnston, Tr. 5336-5337).

1671. Accelerating payments means that payments made during the current plan year are re-allocated to the prior plan year for purposes of measuring the funding level of the plan as of January 1st of the current year. (Arjani, Tr. 6739).

1672. {

} (Johnston, Tr. 5397, 5400, *in camera*).

1673. If St. Luke's plan risks being certified below 80 percent funded, its actuaries will notify St. Luke's and recommend corrective actions that can be taken. (Johnston, Tr. 5339).

1674. Prior to January 1, 2011, St. Luke's obtained actuarial services for its defined benefits pension plan from Towers Watson; after that date, Findley Davies replaced Towers Watson. (Johnston, Tr. 5342; Arjani, Tr. 6723-6724).

d. St. Luke's Had To Accelerate Contributions to Its Pension Plan in 2010 To Attain the 80 Percent Funding Level as of January 1, 2010

1675. In order to be certified as 80 percent funded as of January 1, 2010, St. Luke's had to accelerate contributions from 2010 into 2009 and also had to apply or "forfeit" a credit balance. (Arjani, Tr. 6739-6740; PX01397).

1676. St. Luke's applied approximately $800,000 from its 2010 plan year contributions back to the 2009 plan year. (Arjani, Tr. 6739; PX01397; Johnston, Tr. 5401, *in camera*; PX01392 at 005, *in camera*).

1677. At the same time, St. Luke's also forfeited its prior credit balance of approximately $1.4 million dollars. (Arjani, Tr. 6739-6740; PX01397; PX01392 at 005, *in camera*;).

1678. As a result of forfeiting the credit balance and reallocating 2010 plan year contributions to the 2009 plan year, St Luke's was able to get its defined benefit pension plan to 80 percent funding. (Arjani, Tr. 6739; PX01392 at 006, *in camera*).

1679. {

} (Johnston, Tr. 5402, *in camera*; PX01392, *in camera*).

e. St. Luke's Also Had To Accelerate Contributions in 2011 To Achieve 80 Percent Funding as of January 1, 2011

1680. {

} (Johnston, Tr. 5403-5404, *in camera*; PX00474 at 004, *in camera*).

1681. {

} (Johnston, Tr. 5407, *in camera*; Arjani, Tr. 6748-6749, *in camera*; PX00474 at 004, *in camera*).

1682. {

} (Johnston, Tr. 5406, *in camera*; Arjani, Tr. 6749, *in camera*; PX00474 at 001, *in camera*).

1683. St. Luke's made the required $5 million contribution to its defined benefit pension plan prior to March 31, 2011. (Arjani, Tr. 6740-6741).

1684. {

} (Johnston, Tr. 5408, *in camera*).

1685. {

} (Arjani, Tr. 6751-6752, 6765, *in camera*).

3. Deferred Capital Needs

1686. Due to St. Luke's poor operating performance, the hospital had deferred basic capital investments for two years prior to the joinder. (Johnston, Tr. 5351).

1687. The type of basic capital expenditures that St. Luke's had been deferring included routine and ongoing upgrades of facilities and replacement of equipment, and not strategic or

one-time expenditures like major new construction or the IT investments required for "meaningful use" compliance. (Johnston, Tr. 5351-5353).

1688. Some examples of the type of routine capital expenditures that St. Luke's was forced to defer include the replacement of air handlers, patient beds, surgical tables, and a sleep lab system. (Johnston, Tr. 5354).

1689. St. Luke's deferred the purchase of two types of hospital beds: regular hospital beds and birthing beds. (Johnston, Tr. 5355).

1690. The beds were beyond their useful life. Many were no longer supported by their manufacturers and were experiencing mechanical problems. (Johnston, Tr. 5355). The estimated cost of replacing the regular hospital beds was $150,000. (Johnston, Tr. 5356).

1691. The purchase of new hospital beds had been deferred for several years. No specific date for replacement had been determined. (Johnston, Tr. 5356).

1692. A birthing bed is a bed used in St. Luke's labor, delivery, recovery and postpartum area. It has many features a regular hospital bed does not have. (Johnston, Tr. 5356). A birthing bed cannot be replaced by a regular hospital bed. (Johnston, Tr. 5357).

1693. St. Luke's needed to replace all 11 beds in its maternity unit, but had deferred doing so for several years. (Johnston, Tr. 5356-5357). The estimated cost of replacing all 11 birthing beds was $110,000. (Johnston, Tr. 5357).

1694. St. Luke's had also deferred the purchase of a replacement radiographic surgical table used in urological surgeries that needed to be replaced, because it was beyond its useful life and its imaging quality had started to deteriorate. (Johnston, Tr. 5358). The estimated cost of replacing the radiographic surgical table was $450,000. (Johnston, Tr. 5358).

1695. St. Luke's had also needed to replace its sleep lab system, because the existing system had been going down and interrupting patient care. A sleep lab is a department where patients come to be tested for sleep apnea. (Johnston, Tr. 5359).

1696. The sleep lab system is software that tracks brain activity while the patient is sleeping. (Johnston, Tr. 5359). St. Luke's existing sleep lab software is old and no longer supported by the manufacturer. (Johnston, Tr. 5359). The estimated cost of replacing the sleep lab system is $125,000 to $150,000. (Johnston, Tr. 5359-5360).

1697. St. Luke's also had to replace two of the 31 air handlers that it has on its campus. (Johnston, Tr. 5360). An air handler system provides air temperature control for the hospital. (Johnston, Tr. 5360).

1698. The two air handlers that require replacement are beyond their useful life and service the cafeteria, pulmonary life systems, and patient rooms in the intermediate care and intensive care units; an outage of these air handlers would mean that temperature control

for these areas could not be maintained. (Johnston, Tr. 5360-5361). The estimated cost of replacing the air handlers is $250,000. (Johnston, Tr. 5361).

1699. St. Luke's has also deferred replacement of its nurse call system. (Johnston, Tr. 5363). The nurse call system is the system patients use to contact a nurse when they need help in their rooms. (Johnston, Tr. 5362).

1700. A nurse call system is a critical, core system for the hospital. A failing nurse call system poses a risk for patient care. (Johnston, Tr. 5363).

1701. St. Luke's nurse call system is beyond its useful life, and keeps going down. (Johnston, Tr. 5362). The estimated cost of replacing St. Luke's nurse call system was approximately $700,000. (Johnston, Tr. 5363).

1702. St. Luke's also deferred the purchase of a backup transformer for the electrical substation that services all of the outpatient centers on the hospital campus, including laboratory and radiology sites and ambulatory physician practices. (Johnston, Tr. 5354-5355). Without the backup transformer, St. Luke's will lose power for the outpatient centers when the primary transformer is shut down for required testing. (Johnston, Tr. 5354-5355).

1703. {

} (RX-22 (Perron, Dep. at 50-51, *in camera*)).

1704. {

} (RX-22 (Perron, Dep. at 52, *in camera*)). {

} (RX-22 (Perron, Dep. at 52, *in camera*)). {

} (RX-22 (Perron, Dep. at 52, *in camera*)).

1705. St. Luke's also deferred many other basic projects beyond these limited examples. (Johnston, Tr. 5361-5362).

1706. Prior to its capital spending freeze, St. Luke's normal annual capital spend was approximately $11-$12 million. (Johnston, Tr. 5352).

1707. {

} (Johnston, Tr. 5411-5412, *in camera*).

1708. {

} (Johnston, Tr. 5412, *in camera*).

4. Federal Healthcare Reform Requirements

1709. The HITECH Act, passed in 2009, provides hospitals with increased Medicare reimbursement if they implement and upgrade their electronic medical record ("EMR") systems, document a portion of patient care, to meet statutory "meaningful use" requirements by certain deadlines. (Johnston, Tr. 5344; Wakeman, Tr. 2849-2850; RX-22 (Perron, Dep. at 45-46)).

1710. The "meaningful use" requirements mean that the different technological systems related to a patient's care need to be connected and able to share information back and forth. (Johnston, Tr. 5343).

1711. An EMR exists in each patient care setting: hospitals, physician offices, etc. (Johnston, Tr. 5344, 5520-5521).

1712. "Meaningful use" not only requires that healthcare providers employ EMR systems, but also that the EMRs have the ability to connect with one another to create an overall EHR, or electronic health record, for each patient. (Johnston, Tr. 5343-5344, 5520-5521).

1713. St. Luke's has numerous IT systems that are implicated by the "meaningful use" requirements, including, for example, its patient registration, patient billing, nursing documentation, radiology, laboratory, surgery, pharmacy, cardiac cath lab, and pulmonary medicine systems. (Johnston, Tr. 5345-5346).

1714. In addition to these systems, St. Luke's also requires network and infrastructure systems. (Johnston, Tr. 5346). New laptop and desktop work stations are also needed to work with the new systems. (Johnston, Tr. 5346).

1715. St. Luke's cannot simply update its current systems. Many are no longer supported by the manufacturers and creating new interfaces between the old systems is costly and inefficient. (Johnston, Tr. 5346; RX-22 (Perron, Dep. at 39-40)).

1716. Hospitals that meet "meaningful use" requirements by 2013 will receive additional Medicare reimbursements for being compliant. (Johnston, Tr. 5344-5345). But, hospitals that fail to do so by 2015 will face penalties in the form of reduced Medicare reimbursements. (Johnston, Tr. 5344-5345; RX-22 (Perron, Dep. at 81)).

1717. In addition to "meaningful use," St. Luke's information technology systems required significant investments to meet health information exchanges, HIPAA 5010, ICD-10, patient centered medical home, and accountable care requirements. (RX-22 (Perron, Dep. at 43)).

1718. {

} (RX-22 (Perron, Dep. at 37, *in camera*)).

1719. Prior to the joinder, St. Luke's had begun planning for compliance with "meaningful use" requirements. (Johnston, Tr. 5347).

1720. St. Luke's had selected AllScripts as the vendor for the physician practice EMR that its employed physicians would use. (Johnston, Tr. 5347).

1721. St. Luke's had also selected Eclipsys as the vendor for its hospital-based EMR system. (Johnston, Tr. 5347).

1722. St. Luke's selected Eclipsys as its clinical software vendor, but the St. Luke's internal multi-disciplinary team that made the selection felt that either Eclipsys or McKesson would have been satisfactory. (PX-1933 (Oppenlander, Dep. at 210)).

1723. Eclipsys's proposal to St. Luke's was slightly more costly than McKesson's. (RX-22 (Perron, Dep. at 90).

1724. Eclipsys's proposal to St. Luke's contained a total estimated cost of $20,776,511 over seven years. (PX01495; PX01496 at 003; Den Uyl, Tr. 6453, *in camera*).

1725. Eclipsys' hospital EMR system would cover most, but not all of the hospital systems that St. Luke's required. (Johnston, Tr. 5347, 5349).

1726. St. Luke's estimated that to support the implementation of EMR it would have to upgrade its information technology infrastructure, networking, storage, and servers, for an additional cost of 25 percent of the cost of the EMR system itself. (RX-22 (Perron, Dep. at 71-72)).

1727. At the time of the joinder, St. Luke's did not have sufficient IT staff to comply with the "meaningful use" requirements. (Johnston, Tr. 5346-5347). {

} (Den Uyl, Tr. 6454–6455, *in camera*; RX-56 at 000014, *in camera*).

1728. Eclipsys' proposal to St. Luke's for a hospital-based EMR system, did not account for the operational expenses associated with implementing and maintaining that system, such as additional clinical and non-clinical staff. (PX01496; RX-22 (Perron, Dep. at 101-106); Johnston, Tr. 5348-5349).

1729. {

} (Den Uyl, Tr. 6454–6455, *in camera*; RX-56 at 000014, *in camera*).

1730. Although some government subsidies exist that could help reduce the cost of meaningful use compliance, St. Luke's would first have to pay out the full cost of purchasing and implementing the system before the required deadline in order to qualify for any available subsidies. (Johnston, Tr. 5349).

1731. {

} (Den Uyl, Tr. 6455-6456, *in camera*; PX01496 at 003).

1732. {

} (RX-22 (Perron, Dep. at 111, *in camera*)).

1733. St. Luke's had budgeted $6 million for 2010 to begin implementation of the EMR system, but given the capital freeze, never allocated funds to purchase a new system. (Wakeman, Tr. 2851-2852; PX01928 (Perron, Dep. at 23, *in camera*)).

1734. Patient centered medical home regulations promulgated in July 2010 mean that St. Luke's would also have to ensure that its ambulatory and hospital-based EMR systems can communicate with each other, requiring the purchase of additional middleware products from a vendor. (RX-22 (Perron, Dep. at 120-124)).

1735. ICD-10 is comprised of diagnosis codes required to transmit claims to Medicare for reimbursement, and ICD-10 represents a 900 percent increase in the number of codes over the prior version, ICD-9. (RX-22 (Perron, Dep. at 124-125)).

1736. ICD-10 imposes additional information technology needs on St. Luke's. (RX-22 (Perron, Dep. at 124-125)).

1737. Like all hospitals, St. Luke's is obliged to comply with these statutory requirements, but would have been unable to do so in any financially prudent manner. (Johnston, Tr. 5351; Johnston, Tr. 5482-5483, *in camera*).

5. St. Luke's Poor Financial Condition Forced It To Divert ER Patients

1738. Between 2003 and 2008, St. Luke's patient volumes dropped significantly. (Johnston, Tr. 5363-5364). As a consequence of this drop in patient volume, St. Luke's converted patient care areas into support areas, like offices and conference rooms. (Johnston, Tr. 5364).

1739. As a further result of the decline in patient volume, St. Luke's also reduced its staffing levels by not replacing employees who left the hospital. (Johnston, Tr. 5365).

1740. When patient volumes increased again, St. Luke's lacked adequate space to care for patients. (Johnston, Tr. 5364).

1741. St. Luke's lacked the capital to convert these spaces back to patient care rooms as patient volumes increased. (Johnston, Tr. 5365-5366).

1742. St. Luke's reduced number of available beds led it to divert patients from its emergency room on a regular basis. (Johnston, Tr. 5364-5365).

1743. Under EMTALA laws, if a hospital does not have a bed in which it can place a patient, it cannot accept the patient into the facility. (Johnston, Tr. 5366).

1744. A hospital may have to divert ER patients because it does not have either *adequate* patient rooms or *appropriate* patient rooms. (Johnston, Tr. 5369).

1745. When a hospital has a lack of *appropriate* patient rooms, this means the hospital lacks the *type* of beds that may be needed to serve ER patients or it lacks the staff needed to serve those types of patients. (Johnston, Tr. 5369-5370).

1746. For example, if St. Luke's only had a bed available in a semi-private room and that room already had one male patient, St. Luke's would have to divert patients because it may get female patients presenting at the ER. (Johnston, Tr. 5369).

1747. When St. Luke's could not accept patients, it contacted the county EMS system to alert them that they did not have capacity for new ER patients and ambulances were then diverted from St. Luke's to the next nearest hospital. (Johnston, Tr. 5366).

1748. Emergency room diversions pose a risk to patients having true emergencies like heart attacks since traveling to a more distant hospital can have an effect on patient outcomes. (Johnston, Tr. 5366-5367).

1749. Emergency room diversions may result in a patient being diverted to a hospital where his physician does not have privileges. (Johnston, Tr. 5367).

1750. According to Lucas County EMS reports, St. Luke's had one of the highest emergency room diversion rates in Lucas County between January 1 and November 20, 2010. (Johnston, Tr. 5368-5369; PX02109 at 009-017).

1751. At the time of the joinder, the majority of St. Luke's capacity was in semi-private rooms. (Johnston, Tr. 5370).

1752. At the time of the joinder, St. Luke's was attempting to address patient volume increases by doubling up some private rooms to create semi-private rooms. (Johnston, Tr. 5371).

1753. The lack of private rooms impacted St. Luke's ER diversion rate. (Johnston, Tr. 5370).

1754. ER patients presenting with contagious infections or other conditions requiring isolation must be placed in private rooms. (Johnston, Tr. 5370; Guerin-Calvert, Tr. 7288).

1755. Gender issues also prevent patients of the opposite gender from being placed in the same semi-private room, and this can impact the hospital's ER diversion rate. (Johnston, Tr. 5370).

1756. Due to its financial condition, St. Luke's had very limited capacity to increase its overall bed capacity prior to the joinder. (Johnston, Tr. 5370-5371; Guerin-Calvert, Tr. 7288-7289).

1757. This inability to convert to private rooms puts St. Luke's at a competitive disadvantage in attractiveness to patients. (Guerin-Calvert, Tr. 7288-7289).

B. St. Luke's Contracts with MCOs Yielded Below-Cost Reimbursement Rates

1. St. Luke's Payor Mix

1758. Medicare payments make up approximately 50 percent of St. Luke's revenues. Medicare is by far St. Luke's largest payor. (Wakeman, Tr. 2751; Den Uyl, Tr. 6440, *in camera*).

1759. Medicaid payments make up close to 10 percent of St. Luke's revenues. (Wakeman, Tr. 2751).

1760. MCOs represent approximately 40 percent of St. Luke's revenues. (Wakeman, Tr. 2751).

1761. {

} (RX-56 at 000010, *in camera*).

1762. Outpatient reimbursement rates provide a greater return to a hospital than inpatient reimbursement rates. (Dagen, Tr. 3183).

2. St. Luke's Reimbursements Were Not Covering Its Costs

1763. {

} (Hanley, Tr. 4806, *in camera*).

1764. {

} (Dagen, Tr. 3395, *in camera*).

1765. St. Luke's internal financial systems provide reports that allow it to track its revenue per discharge on a case-mix adjusted basis as well as its cost per discharge on a case-mix adjusted basis. (Johnston, Tr. 5318-5819).

1766. The difference between revenue per case-mix adjusted discharge and cost per case-mix adjusted discharge is earnings per case-mix adjusted discharge. (Johnston, Tr. 5319).

1767. Earnings per case-mix adjusted discharge is also referred to as "earnings per adjusted discharge" or by the acronym "EPAD." (Johnston, Tr. 5319).

1768. The earnings data reviewed by St. Luke's was adjusted to account for the relative portions of revenue derived from inpatient and outpatient services. (Johnston, Tr. 5320).

1769. The earnings data reviewed by St. Luke's was also adjusted for the case-mix to account for the different acuity of patients being treated; this adjustment permits proper comparisons of hospitals providing different levels of service. (Johnston, Tr. 5320-5321).

1770. St. Luke's reviewed its revenue per adjusted discharge and expense per adjusted discharge data against industry benchmarks. (Johnston, Tr. 5319-5320).

1771. At the time of the joinder, St. Luke's earnings per adjusted discharge figures showed that, on average, St. Luke's was losing money on every commercially insured patient it treated. (Johnston, Tr. 5318-5322).

1772. A negative earnings per adjusted discharge number meant that in the aggregate St. Luke's was not making money on patient care. (Johnston, Tr. 5322).

1773. {

} (Den Uyl, Tr. 6438, *in camera*).

1774. {

} (Den Uyl, Tr. 6438).

1775. {

} (Den Uyl, Tr. 6440, *in camera*).

1776. {

} (Den Uyl, Tr. 6440, *in camera*).

1777. {

} (Den Uyl, Tr. 6441-6442, *in camera*; RX-56 at 000010, *in camera*).

1778. {

} (Den Uyl, Tr. 6474-6475, *in camera*; RX-56 at 000024, *in camera*).

1779. {

} (Den Uyl, Tr. 6474-6475, *in camera*; RX-56 at 000024, *in camera*).

1780. {

} (Den Uyl, Tr. 6474-6475, *in camera*; RX-56 at 000024, *in camera*).

1781. {

} (Den Uyl, Tr. 6474-6475, *in camera*; RX-56 at 000024, *in camera*).

1782. { } (Den Uyl, Tr. 6475-6475, *in camera*).

1783. {

} (RX-34 (Dewey, IHT at 244, *in camera*)).

1784. {

} (PX01018 at 003, *in camera*; Wakeman Tr. 2907-2908, *in camera*).

1785. {

} (PX01018 at 002, *in camera*; Wakeman, Tr. 2904-2906, *in camera*).

1786. {

} (PX01018 at 002, *in camera*; Wakeman, Tr. 2904-2906, *in camera*).

1787. St. Luke's believed that its of lack of reimbursement, including from MCOs, was a leading cause of its poor operating financial performance. (RX-33 (Deacon, IHT at 76-77)).

1788. {

}

(Wakeman, Tr. 2942-2944, *in camera*; PX01283 at 002, *in camera*).

1789. {

} (Wakeman, Tr. 2986-2987, *in camera*; PX01029, *in camera*).

1790. {

}

(PX01029 at 007, *in camera*; Wakeman, Tr. 2988-2989, *in camera*; RX-37 (Machin, IHT at 53)).

1791. {

} (Wakeman, Tr. 2998-2999, *in camera*).

3. St. Luke's Largest MCOs Reimbursed It Below Its Costs

1792. {

} (RX-56 at 000010, *in camera*).

1793. Prior to the joinder, St. Luke's received commercial reimbursement rates from MMO and Anthem that it understood was less than what other similar institutions were receiving for similar services rendered. (RX-16 (Bazeley, Dep. at 96-97)).

a. MMO

1794. {

} (Wakeman, Tr. 2933, *in camera*; RX-56 at 000010, *in camera*).

1795. { } (Wakeman, Tr. 2936, *in camera*).

1796. {

} (RX-56 at 000010, *in camera*; Dagen Tr. 3394-3395, *in camera*).

1797. {

} (Den Uyl, Tr. 6474, *in camera*; RX-56 at 000023, *in camera*).

1798. {

} (Den Uyl, Tr. 6474, *in camera*; RX-56 at 000023, *in camera*).

1799. {

} (Den Uyl, Tr. 6474, *in camera*; RX-56 at 000023, *in camera*).

1800. {

} (Pirc, Tr. 2339-2340, *in camera*; Wakeman, Tr. 2933-2934, *in camera*).

1801. { } (Guerin-Calvert, Tr. 7414-7415, *in camera*).

1802. { } (Guerin-Calvert, Tr. 7415-7416, *in camera*).

1803. { } (Pirc, Tr. 2339, 2353, *in camera*).

1804. { } (Pirc, Tr. 2340-2341, 2343-2344, *in camera*; PX02280 at 007, 013-015; PX02275, *in camera*).

1805. { } (RX-11 (Oppenlander, Dep. at 185, *in camera*)).

1806. { } (Pirc, Tr. 2346-2347, *in camera*).

1807. { } (PX02280 at 014; Guerin-Calvert, Tr. 7417-7418, *in camera*; Pirc, Tr. 2346, *in camera*).

1808. { } (PX02275; Guerin-Calvert, Tr. 7418-7419, *in camera*; Pirc, Tr. 2349-2350, *in camera*).

1809. { } (Pirc, Tr. 2349-2350, *in camera*; Guerin-Calvert, Tr. 7421-7422, *in camera*).

1810. { } (Wakeman, Tr. 2934-2935, *in camera*).

1811. { } (Wakeman, Tr. 2932-2935, *in camera*).

1812. {

} (Guerin-Calvert, Tr. 7420-7421, *in camera*; PX02275, *in camera*).

1813. { } (Pirc, Tr. 2350-2351, *in camera*; PX02275, *in camera*).

1814. {

} (Guerin-Calvert, Tr. 7424, *in camera*; Pirc, Tr. 2350-2351, *in camera*).

1815. {

} (Pirc, Tr. 2351-2352, *in camera*).

1816. {

} (Guerin-Calvert, Tr. 7422-7423, *in camera*; Pirc, Tr. 2355-2356, *in camera*).

1817. {

} (Pirc, Tr. 2354-2355, *in camera*; PX02284 at 001, *in camera*).

1818. {

} (Pirc, Tr. 2355-2356, *in camera*).

1819. {

} (Wakeman, Tr. 2975-2976, *in camera*; PX01583 at 001, *in camera*; PX01016 at 012-013, *in camera*; RX-37 (Machin, IHT at 127, *in camera*)).

1820. Equilibrium occurs within a bargaining framework when both parties to the negotiation conclude that they are better off with the deal than without the deal. (Town, Tr. 3847).

1821. {

} (Guerin-Calvert, Tr. 7423-7424, *in camera*).

1822. {

} (Guerin-Calvert, Tr. 7425-7426, *in camera*).

b. Anthem

(i) St. Luke's Negotiated To Re-Enter Anthem's Network in 2008

1823. Anthem had terminated its contract with St. Luke's in 2005. (PX01022 at 010).

1824. St. Luke's identified its lack of access to Anthem as a key challenge in 2008. (PX01352 at 022; Wakeman, Tr. 2809).

1825. St. Luke's engaged in negotiations to get back into the Anthem network in 2008. (Wakeman, Tr. 2810-2811; Pugliese, Tr. 1610-1612, *in camera*).

1826. Anthem would not allow St. Luke's back into its network until July 2009 and would not allow St. Luke's in the network unless St. Luke's agreed to a MFN clause in the contract before the State of Ohio passed a law making such MFN clauses illegal. (Pugliese, Tr. 1612-1615, *in camera*; Wakeman, Tr. 2810-2811; RX-1802 at 000002).

1827. {

} (Pugliese, Tr. 1613-1615, *in camera*; PX02237 at 003, 010, *in camera*).

1828. Mr. Wakeman, St. Luke's CEO, felt "miserable" at the time he signed the agreement with Anthem in 2008, but believed he needed to capitulate to Anthem's terms to serve the large portion of the community insured by Anthem. (Wakeman, Tr. 2810-2811).

1829. {

} (Pugliese Tr. 1614-1617, *in camera*).

1830. {

} (Pugliese, Tr. 1616, *in camera*).

1831. {

} (Pugliese, Tr. 1617, *in camera*; RX-968 at 000001-000002, *in camera*).

1832. {

} (Pugliese, Tr. 1617-1618, *in camera*).

1833. {
} (Pugliese, Tr. 1618, *in camera*). {
}
(Pugliese, Tr. 1618, *in camera*).

1834. {
} (Pugliese, Tr. 1618, *in camera*).

1835. {
} (Pugliese, Tr. 1619-1620, *in camera*; PX02276 at 002, *in camera*).

1836. {
} (Pugliese, Tr. 1620-1621, *in camera*; PX02408 at 001, *in camera*). {
}
(Pugliese, Tr. 1624, *in camera;* PX02408 at 001, *in camera*).

1837. {
} (Pugliese, Tr. 1624-1625, *in camera*; PX02408 at 001, *in camera*).

1838. {
}
(Pugliese, Tr. 1624-1625, *in camera*).

(ii) St. Luke's Determined Its Anthem Rates Did Not Cover Its Costs and Sought To Renegotiate

1839. {
} (Pugliese, Tr. 1629, *in camera*; PX02382 at 003, *in camera*).

1840. {
} (Pugliese, Tr. 1631, 1639, *in camera*; PX02382 at 003, *in camera*; RX-965 at 000003, *in camera*).

1841. {

} (RX-848 at 000001; PX02382 at 001, *in camera*; PX02276 at 002, *in camera*; Pugliese, Tr. 1614-1615, 1619-1620, *in camera*).

1842. {
} (Pugliese, Tr. 1634-38, *in camera*; PX02382 at 003, *in camera*).

1843. { } (Pugliese, Tr. 1632-1633, *in camera*; PX02382 at 003, *in camera*; RX-965 at 000003, *in camera*).

1844. { } (Pugliese, Tr. 1633, *in camera*; PX02382 at 003, *in camera*).

1845. { } (Pugliese, Tr. 1633, *in camera*).

1846. { } (Pugliese, Tr. 1633, *in camera*).

1847. { } (Pugliese, Tr. 1512, 1640, *in camera*; PX02382 at 001, *in camera*).

1848. { } (Pugliese, Tr. 1639-1640, *in camera*; RX-965 at 000003, *in camera*).

1849. { } (Pugliese, Tr. 1640, *in camera*, RX-965 at 000003, *in camera*).

1850. { } (Pugliese, Tr. 1640, *in camera*; RX-965 at 000003, *in camera*). { } (Pugliese, Tr. 1640, *in camera*; RX-965 at 000003, *in camera*).

1851. { } (Pugliese, Tr. 1640-1641, *in camera*; RX-965 at 000003, *in camera*).

1852. { } (Pugliese, Tr. 1641, *in camera*; RX-965 at 000003, *in camera*).

1853. { } (Pugliese, Tr. 1641, *in camera*; RX-965 at 000003, *in camera*).

1854. { } (Pugliese, Tr. 1642, *in camera*; RX-965 at 000002, *in camera*).

1855. {
} (Pugliese, Tr. 1642, *in camera*; RX-965 at 000002, *in camera*).

1856. {
} (Pugliese, Tr. 1643, *in camera;* RX-965 at 000002, *in camera*).

1857. {
} (Pugliese Tr. 1509-1510, 1642-43, *in camera*; PX02382 at 001-002 *in camera*; RX-965 at 000002, *in camera*).

1858. {
} (Pugliese, Tr. 1510, *in camera*; PX02382 at 002, *in camera*).

1859. {
} (Pugliese, Tr. 1511, *in camera*); PX02382 at 001, *in camera*).

1860. {
} (Pugliese, Tr. 1643-1644, *in camera*).

c. Aetna

1861. {
} (RX-155 at 000001, *in camera*).

1862. {
} (Radzialowski, Tr. 834-835, *in camera*).

d. United

1863. { } (Sheridan, Tr. 6638, *in camera*).

1864. {
} (Sheridan, Tr. 6638-6639, *in camera*).

1865. {
} (Sheridan, Tr. 6643-6645, *in camera*; RX-1070 at 000044, *in camera*).

1866. {
} (Sheridan, Tr. 6643, *in camera*; RX-1070 at 000043, *in camera*).

1867. {

} (Sheridan, Tr. 6643, *in camera*).

1868. {

} (Sheridan, Tr. 6646-6648, *in camera*; RX-920, *in camera*).

1869. {

} (Sheridan, Tr. 6648-6651, *in camera*; RX-920, *in camera*).

1870. {

} (Sheridan, Tr. 6707-6708, *in camera*; RX-920, *in camera*).

1871. {

} (Sheridan, Tr. 6708, *in camera*; RX-920, *in camera*).

e. FrontPath Was an Exception

1872. { } (Sandusky, Tr. 1386-1387, *in camera*; Guerin-Calvert, Tr. 7433-7434, *in camera*).

1873. {

} (Sandusky, Tr. 1386-1388, *in camera*).

1874. {

} (Sandusky, Tr. 1387-1388, *in camera*; RX-782 at 000001, *in camera*).

1875. {

} (Sandusky, Tr. 1388, *in camera*).

1876. {

} (Guerin-Calvert, Tr. 7433-7434, *in camera*).

C. St. Luke's Financial Condition Prior to the Joinder Was Not Improving

1. St. Luke's Financial Condition When CEO Dan Wakeman Arrived

1901. St. Luke's physician practices incurred significant financial losses during the years leading up to the joinder: in 2008 St. Luke's employed physicians had an operating loss of about $2.5 million; in 2009 the loss increased to $4.5 million. By the time of the joinder, the total losses from St. Luke's physician practices from 2008-August 31, 2010 totaled about $11 million. (Den Uyl, Tr. 6480; RX-56 at 000022, *in camera*).

1902. Because 21 of the 23 physicians employed by St. Luke's as part of its physician strategy were employed during 2008 and 2009 any revenue growth that St. Luke's achieved as a result of increased admissions from the newly employed physicians would be more significant in 2008 and 2009 than in 2010. (Den Uyl, Tr. 6479).

1903. Employing physicians had both one time and recurring costs, including initial capitalization, insurance coverage, physician salaries, practice operational expenditures and capital expenditures, like the AllScripts EMR system. (Wakeman, Tr. 2803-2804, 2819-2820).

1904. Another goal of the three-year plan was to convert all of St. Luke's patient rooms from double-bed to single-bed rooms to improve St. Luke's infection control, patient safety, and patient satisfaction. In addition, it was important for St. Luke's to make this conversion to stay competitive locally and keep up with national standards. (PX01010 at 003; Wakeman, Tr. 2815; Black, Tr. 5584-5585).

1905. Another goal of the three-year plan was to achieve breakeven margins by the end of 2007 and then 2-4 percent margins for subsequent years. (PX01010 at 003; Wakeman, Tr. 2815-2816).

1906. Another goal of the three-year plan was to maintain St. Luke's "A" rating with Moody's in order to borrow money at low costs for capital expenditures. (PX01026 at 003; Wakeman, Tr. 2816).

1907. Another goal of the three-year plan was to gain access to additional managed care plans, in particular Anthem and Paramount. (PX01010 at 001).

1908. St. Luke's realized that to accomplish its three-year plan it would also need to make significant investments in its IT capabilities to keep up with the rest of the marketplace. (Wakeman, Tr. 2816-2817).

1909. St. Luke's board monitored and questioned the costs of implementing St. Luke's three-year plan, including its physician strategy. (Wakeman, Tr. 2820-2822; PX01284). For example, one member of St. Luke's board expressed concern that St. Luke's was "burning through cash" as a result of its three-year plan. (PX01284; Wakeman, Tr. 2821-2822).

1910. As part of the three year plan St. Luke's engaged in discussions with other providers in the Toledo area to develop win-win relationships. St. Luke's engaged in discussions with UTMC, Mercy, and ProMedica. (PX01010 at 001; Wakeman, Tr. 2822-2824; Black, Tr. 5587-5588).

3. Other Efforts To Improve St. Luke's

a. Capital Freeze

1911. In 2009, St. Luke's instituted a capital freeze, limiting capital expenditures to those that were necessary for safety and patient care. (Wakeman, Tr. 2842; RX-1226 at 000004; Black, Tr. 5610).

1912. Previously, in the Fall of 2008, St. Luke's stopped capital expenditures so St. Luke's could make its $900,000 HCAP funding payments, which are funds paid into a pool by all hospitals to compensate certain hospitals based on the amount of care for the poor, such as Medicaid, or underinsured or noninsured individuals that they treat. (RX-844; Wakeman, Tr. 2828).

1913. During the capital freeze, St. Luke's Vice Presidents did not propose capital requests to Mr. Wakeman "unless they were absolutely necessary replacements or a part of the strategic plan and had to be justified." (Wakeman, Tr. 2575-2576).

1914. In October 2009, Mr. Wakeman expressed concern that St. Luke's was still spending too much on capital given its financial difficulties. CFO Dave Oppenlander assured him that recent capital purchases reflected bare bones essentials, only those necessary for serving patients. (PX01361; Wakeman, Tr. 2937-2939, *in camera*).

1915. St. Luke's tried not to engage in cost cutting initiatives that would affect patient outcomes, core measures, or patient satisfaction. (Wakeman, Tr. 2614-2615).

1916. {

(Den Uyl, Tr. 6469-6470, *in camera*).

} (Den Uyl, Tr. 6470-6471, *in camera*).

1917. {

} (Den Uyl, Tr. 6470-6471, *in camera*).

1918. {

} (RX-56 at 000018, *in camera*).

b. Wage and Benefit Reductions and Hiring Freeze

1919. Employee compensation is the largest expense item for hospitals and represents about 40 percent of St. Luke's total operating expenses. (Johnston, Tr. 5326).

1920. In late 2008, St. Luke's began cutting back hours of its employees in an attempt to reduce operational expenses. (Black, Tr. 5598-5599).

1921. St. Luke's also froze employee compensation in 2008, including step increases and merit pay increases, for all employees; at the time of the joinder, employees had not received pay increases for two years. (Johnston, Tr. 5317; Wakeman, Tr. 2841-2842; Black, Tr. 5608; RX-1226 at 000002-000003).

1922. As an additional cost-cutting measure, St. Luke's had reduced the amount of earned time off that employees accrued and increased employees' premium contributions for their healthcare benefit. (Johnston, Tr. 5317; Black, Tr. 5609; RX-1226 at 000002-000003).

1923. In 2009, all of St. Luke's executives took a 10 percent pay cut. (Johnston, Tr. 5317).

1924. St. Luke's has access to published survey data on healthcare compensation at both the state and national levels. (Johnston, Tr. 5327).

1925. Key clinical positions at St. Vincent and UTMC are unionized and compensation data for these positions is publicly available as a result. (Johnston, Tr. 5327).

1926. During the period while St. Luke's salaries were frozen, other Lucas County hospitals were giving salary increases. (Johnston, Tr. 5327-5328).

1927. There is a shortage in Lucas County of many key clinical positions, such as lab technicians, RNs, and pharmacists. (Johnston, Tr. 5328).

1928. The fact that St. Luke's salaries were frozen while other Lucas County hospitals were giving pay increases created a situation where employees had the incentive and ability to leave St. Luke's to work for other Lucas County hospitals. (Johnston, Tr. 5328-5329).

1929. Freezing salaries was a short-term strategy that could not continue, especially when no other Lucas County hospitals were freezing salaries at the same time. (Johnston, Tr. 5329).

1930. When St. Luke's lifted its salary freeze, St. Luke's would face operating expenses that would increase at a greater percentage than previously, placing greater financial pressure on the organization. (Johnston, Tr. 5330).

1931. St. Luke's also had a strategy of avoiding layoffs, but in the years immediately prior to the joinder it did not hire replacements as workers retired or left the organization. (Johnston, Tr. 5441-5442).

1932. In February 2009, St. Luke's instituted a hiring freeze, going into a "highly oversighted mode" for hiring, restricting it to essential positions that affected patient care. (Wakeman, Tr. 2574, 2842; PX01597 at 001). St. Luke's hiring freeze continues to the present and was not part of St. Luke's three-year plan. (Wakeman, Tr. 2843-2844).

1933. During the hiring freeze, volume increased at St. Luke's so it generally did not make sense to conduct layoffs. Instead, St. Luke's cut pay, cut benefits, and froze pay. (Wakeman, Tr. 2573).

1934. {

} (Den Uyl, Tr. 6468, *in camera*).

1935. {

} (Den Uyl, Tr. 6468-6469, *in camera*).

c. Freezing Defined Benefit Pension Plan

1936. On December 31, 2009, St. Luke's froze its employee defined benefit plan and shifted employees to a contribution plan. (Johnston, Tr. 5331; Arjani, Tr. 6730). This change resulted in cost savings for St. Luke's. (Wakeman, Tr. 2871).

1937. Freezing a pension plan means that no new participants will be added to the plan; benefits only accrue to those people who are vested as of the date of the freezing of the plan. The pension benefit is also based on compensation as of that date; future compensation is not counted in calculating the plan's pension obligation or funding target. (Johnston, Tr. 5339; Arjani, Tr. 6730-6731).

1938. After St. Luke's defined benefit pension plan was frozen, St. Luke's still had an obligation to make up the difference between the funding target, the present value of the plan's obligations, and the plan's assets. (Arjani, Tr. 6731).

d. Shifting Patients to the SurgiCare Joint Venture

1939. In response to its financial challenges, St. Luke's encouraged surgeons, where possible to perform surgeries at SurgiCare, the joint venture outpatient center in which St. Luke's had a 50 percent interest. (Wakeman, Tr. 2876).

1940. Because St. Luke's was a 50 percent owner of SurgiCare, St. Luke's would only receive half the margin on each case at SurgiCare. Nonetheless, because SurgiCare's MCO rates were higher than those of St. Luke's and its costs were lower as well, it was profitable for St. Luke's to shift patients to SurgiCare. Mr. Wakeman explained that "half of something positive is better than 100 percent of a total loss." (Wakeman, Tr. 2876).

4. St. Luke's Financial Problems Continued Despite the Three-Year Plan

1941. Despite increasing utilization of the hospital after Mr. Wakeman's arrival, St. Luke's did not see an improvement in its bottom line. (RX-34 (Dewey, IHT at 183-185)). St. Luke's net patient service revenue had increased since 2007, but those revenues were still less than St. Luke's operating expenses. (PX1016 at 002, *in camera*; RX-11 (Oppenlander, Dep. at 176-177)).

1942. St. Luke's did not achieve the financial goals of the three-year plan or any of the objective metrics that were outlined in those financial goals. (PX01010 at 003-004; Rupley, Tr. 1973; Wakeman, Tr. 3018-3019, *in camera*).

1943. St. Luke's did not accomplish the three-year plan goal of having "a break even margin by the end of 2009." (PX01010 at 003-004; Wakeman, Tr. 3018-3019, *in camera*).

1944. St. Luke's did not even achieve a break even margin by the end of 2010. (PX01010 at 003-004; Wakeman, Tr. 3018-3019, *in camera*).

1945. St. Luke's did not accomplish the three-year plan goal to "Maintain St. Luke's "A" rating with Moody's." (PX01010 at 003-004; Wakeman, Tr. 3018-3019, *in camera*).

1946. St. Luke's did not accomplish the three-year plan goal to maintain a "Debt Service Coverage Ratio of 2.0." (PX01010 at 003-004; Wakeman, Tr. 3018-3019, *in camera*).

1947. St. Luke's did not accomplish the three-year plan goal to "Achieve an average age of plant consistent with Moody's "A" rated hospitals." (PX01010 at 003-004; Wakeman, Tr. 3018-3019, *in camera*).

1948. St. Luke's did not accomplish the three-year plan goal of "[w]ithin three years, systematically convert all St. Luke's double-bed patient rooms to single-bed patient rooms." (PX01010 at 002; Wakeman, Tr. 3018-3019, *in camera*).

1949. St. Luke's did not accomplish the three-year plan goal to "Establish two signature clinical service plans within 3 years: obstetrics and surgery." (PX01010 at 001; Wakeman, Tr. 3018-3019, *in camera*).

1950. St. Luke's negative operating margin in the years prior to the joinder led to a very tight cash-on-hand situation, which caused it to withhold normally scheduled payments to vendors. (Johnston, Tr. 5316). St. Luke's average invoice statements require payments in 30 days; however, St. Luke's average term of payment was 53 days. (Wakeman, Tr. 2571).

1951. An accounts payable system typically includes payment parameters that seek to maximize cash flow, but after normal payment parameters were applied, St. Luke's could not fund all of its vendor checks due to its limited cash. (Johnston, Tr. 5322-5324).

1952. As a result, St. Luke's would review the amount of outgoing checks each week and compare this against its target level of cash-on-hand after payroll. If the amount scheduled to go out each week would place St. Luke's cash-on-hand below the target

level, then St. Luke's manually withheld these checks and did not mail them to vendors. (Johnston, Tr. 5324).

1953. At the time of the joinder, St. Luke's target for cash-on-hand after payroll was $1.6 million dollars. (Johnston, Tr. 5323). By comparison, St. Luke's gross annual revenues were approximately $400 million. (Johnston, Tr. 5323).

1954. Holding checks back manually is considered a poor internal control practice because it creates the risk of error or impropriety. (Johnston, Tr. 5324-5325). Holding back checks also leads to vendor frustration. (Johnston, Tr. 5325).

1955. {

} (Wakeman, Tr. 2920-2921, *in camera*).

1956. In the three year period prior to the joinder, St. Luke's only experienced three or four months of positive operating performance from patient care. (Wakeman, Tr. 2604).

1957. In August 2010, the last month before the joinder, St. Luke's "was able to squeeze out a $7,000 margin on $36 million revenue" running almost at full capacity. Mr. Wakeman believed this was "not impressive." (Wakeman, Tr. 2605; PX00170 at 001).

1958. The $7,000 operating margin on $36.7 million in gross revenue that St. Luke's attained in August 2010 incorporated two large, unusual additions to St. Luke's operating income that month: (1) a catch up payment for the University of Toledo faculty involved with the Family Medicine Residency; and (2) a tax credit from the State of Ohio as St. Luke's taxes had been over projected. (PX00170 at 001).

1959. Mr. Wakeman was not confident that the small positive operating margin in the month of August in 2010 reflected the operating margin for the remainder of the year: "There were many months that we had high capacity and lost money from operations due to the payor mix inside the organization and the services provided." (Wakeman, Tr. 2618-2619).

1960. At the time of the joinder, St. Luke's was still not in a position to fund the capital needs of the organization through operations. (Wakeman, Tr. 2619).

1961. Prior to the joinder, Mr. Wakeman doubted that a stand-alone St. Luke's could be a significant competitor after 2011: "With healthcare reform and the stimulus bill going through that mandated meaningful use, the capital improvements that we needed to put into the organization because of our average age of plant, that now exceeded 16 years, and the private rooms we had to put in. All of those capital demands would have put us so far behind the eight-ball, we would have had a very difficult time competing in the long term after 2011 as an independent." (Wakeman, Tr. 2619-2620).

D. St. Luke's Board and Management Concluded that St. Luke's Could Not Survive as a Full Service, Stand-Alone Community Hospital

1962. The fact that St. Luke's was not making money, because of increasing expenses, despite staying busy, was a factor for members of St. Luke's board that precipitated the need to look for an affiliation partner. (RX-16 (Bazeley, Dep. at 50-51)).

1963. {

} (PX01018 at 008, *in camera*).

1964. {

} (Wakeman, Tr. 2909-2911, *in camera*; PX01018 at 008, *in camera*).

1965. {

} (Wakeman, Tr. 2909-2910, *in camera*).

1966. To survive independently, St. Luke's board determined that it would have to make significant changes to its employee base and services to resize the hospital commensurate with demands it was facing. (RX-34 (Dewey, IHT at 183-186)).

1967. At about the same time, the initial indications of what healthcare reform legislation was going to require were coming to light, and St. Luke's concluded that meeting those requirements, such as a substantial capital investment IT, would require an organization beyond St. Luke's. (RX-34 (Dewey, IHT at 184-185)).

1968. St. Luke's board also recognized that St. Luke's physical plant was aging and needed a number of improvements; and to maintain this asset that was serving the community, the St. Luke's board stated that St. Luke's management should try to find an affiliation partner. (RX-34 (Dewey, IHT at 184-185)).

1969. {

} (PX01018 at 008, *in camera*; Wakeman, Tr. 2910-2911, *in camera*).

1970. {

} (PX01283 at 002, *in camera*; Wakeman, Tr. 2949-2950, *in camera*).

1971. {

} (PX01283 at 002; Wakeman, Tr. 2951, *in camera*).

1972. {

} (Wakeman, Tr. 2965-2966, *in camera*).

1973. St. Luke's CEO, Mr. Wakeman, did not agree with the St. Luke's board approach on November 4, 2009, as he believed it was not sufficiently focused to resolve St. Luke's serious financial problems. He believed that the November 4 board meeting "was an example of how large boards have an arduous time making difficult decisions. They are struggling with losses of $2 million per month and holding onto independence." (RX-880 at 000001; Wakeman, Tr. 2967, *in camera*).

1974. After the November 4, 2009 board meeting, Mr. Wakeman believed that St. Luke's large financial losses and need for significant investments in, for example, an underpaid workforce, aging plant and equipment, and a new IT system, would eventually persuade the board to choose a joinder partner or make more aggressive service cuts. (RX-880 at 000001; Wakeman, Tr. 2967-2970, *in camera*).

1975. {

}. (PX01583 at 001-002 *in camera*; Wakeman, Tr. 2977-2984, *in camera*).

1976. {

} (PX01029 at 001, *in camera*).

1977. {

(Wakeman, Tr. 2984-2985, *in camera*).

1978. {

} (PX01016 at 001, *in camera*).

1979. {

} (PX01016 at 014, *in camera*; Wakeman, Tr. 2992, *in camera*).

1980. {. } (Wakeman, Tr. 2999-3000, *in camera*).

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

1. Moody's Downgraded St. Luke's in November 2008 and in February 2010

1981. Moody's, the credit rating agency, downgraded St. Luke's Series 2004 revenue bonds by two grades in November 2008, from "A2" to "Baa1." (PX00379 at 001).

1982. Moody's description of the challenges faced by St. Luke's in Moody's November 2008 downgrade report accurately reflected challenges faced by St. Luke's at that time. These challenges include: "significant operating loss of $7.9 million (-6.1 percent operating margin) in fiscal year 2007 and operating losses continued through ten months FY 2008, with an operating loss of $7.2 million (-6.3 percent operating margin.) Losses driven by inpatient surgical and cardiac volume declines, due in part to physician losses in fiscal year 2007; ongoing physician competition in cardiac services, and a weaker economy." (Wakeman, Tr. 2834; PX00379 at 001-002).

1983. Moody's further downgraded St. Luke's on February 3, 2010 from Baa2 to Baa1. (PX00053 at 001).

1984. {' } (Wakeman, Tr. 3007, *in camera*).

1985. Moody's February 3, 2010 downgrade concluded that St. Luke's "outlook remains negative." (PX00053 at 001).

1986. Moody's February 3, 2010 downgrade of St. Luke's highlighted that a challenge for St. Luke's was the "[t]hird consecutive year of large operating losses and an operating cash flow deficit posted for the first time through 11 months of FY 2009 (-9.8 percent operating margin and -2.0 percent operating cash flow.)" (PX00053 at 001).

1987. Moody's February 3, 2010 downgrade of St. Luke's highlighted that a challenge for St. Luke's was "[c]urrently unfavorable commercial contracts and ongoing challenges with negotiating higher commercial reimbursement rates with SLH's two largest commercial payors, MMO and Anthem Blue Cross Blue Shield (who account for approximately 22 percent of SLH's gross revenues)." (PX00053 at 001).

1988. Moody's February 3, 2010 downgrade of St. Luke's highlighted that another challenge for St. Luke's was the "[v]ery competitive market with the presence of a number of hospitals that are part of two larger and financially stronger systems, ProMedica Health System (Aa3-rated) and Mercy Health Partners (owned by A1-rated Catholic Health Partners)." (PX00053 at 001).

1989. Moody's February 3, 2010 downgrade of St. Luke's highlighted that a further challenge for St. Luke's was the "[w]eak demographics in the primary service area that includes Toledo, OH is characterized by declining volume trends, high unemployment levels, and low median income levels." (PX00053 at 002).

1990. Moody's February 3, 2010 downgrade of St. Luke's highlighted that a challenge for St. Luke's was the "[t]ransition in senior leadership with the recent resignation in December 2009 of the Chief Financial Officer (CFO) of six years." (PX00053 at 002).

1991. Moody's February 3, 2010 downgrade concluded that St. Luke's "negative outlook." This means that there was a greater likelihood there would be a further downgrade than an upgrade in the future. (PX00053 at 001; Den Uyl, Tr. 6463, *in camera*).

1992. At the time of the latest Moody's downgrade, St. Luke's level of bonds outstanding was fairly low. (Dagen, Tr. 3312).

1993. {

} (Den Uyl, Tr. 6463-6464, *in camera*; RX-56 at 000019, *in camera*).

2. St. Luke's Bond Default Was Only Resolved When ProMedica Agreed To Take Over St. Luke's Bond Obligations

a. AMBAC's Review of St. Luke's Bonds

1994. {
} (Gordon, Tr. 6784, 6789, *in camera*).

1995. AMBAC completed a credit analysis of St. Luke's bonds in late 2008 and early 2009 and downgraded St. Luke's credit from an A- to a BBB+ rating. (Gordon, Tr. 6791, *in camera*, 6792; 6799-6800; RX-177).

1996. As part of this credit analysis of St. Luke's, AMBAC evaluated the Moody's and S&P's ratings for St. Luke's bonds and three years of financial metrics including admissions, net patient service revenue, operating margin, EBITDA margin, and debt coverage. (Gordon, Tr. 6792-6796, *in camera*; RX-177).

1997. In its analysis, AMBAC highlighted that St. Luke's operating margin was negative {
} (Gordon, Tr. 6796, *in camera*; RX-177).

1998. AMBAC also noted that St. Luke's admissions were declining which {
} (Gordon, Tr. 6795, *in camera*; RX-177).

1999. Mr. Gordon recommended that St. Luke's rating be put on a downward trend, because {
} (Gordon, Tr. 6798, *in camera*; RX-177).

2000. Mr. Gordon recommend the downward trend despite the fact that St. Luke's EBITDA margin and days cash on hand were{ }
(Gordon, Tr. 6797-6799, *in camera*; RX-177).

2001. In his review of the rating analysis, Mr. Gordon's supervisor downgraded St. Luke's to BBB+ and agreed with Mr. Gordon's downward trend recommendation. (Gordon, Tr. 6799-6800, *in camera*; RX-177).

2002. {
} (Gordon, Tr. 6800-6801, *in camera*).

2003. {
} (Gordon, Tr. 6804, *in camera*).

2004. {
} (Gordon, Tr. 6805, *in camera*).

b. St. Luke's Default

2005. {
} (Gordon, Tr. 6820, *in camera*).

2006. {
}

(Gordon, Tr. 6808, *in camera*).

2007. {
} (Gordon, Tr. 6808-6809, *in camera*).

2008. St. Luke's bond covenants required that it maintain a debt service coverage ratio of 1.3 as of the end of any fiscal year. (RX-906 at 000001; PX01542 at 001).

2009. St. Luke's informed AMBAC that for 2009 St. Luke's debt service coverage ratio would be *negative* 2.9. (PX02355 at 001; RX-182; Gordon, Tr. 6806-6809, *in camera*; RX-10 (Gordon, Dep. at 97)).

2010. In December 2009, St. Luke's informed AMBAC that St. Luke's had also violated the debt service coverage ratio covenant for 2008. St. Luke's had failed to report that previously because it had calculated the 2008 ratio incorrectly. (PX02355 at 001; RX-182; Gordon Tr. 6806-6810; RX-10 (Gordon, Dep. at 97)).

2011. St. Luke's informed AMBAC that its 2008 debt service coverage ratio was 0.5. (RX-10 (Gordon, Dep. at 97)).

2012. St. Luke's operational shortfalls, not unrealized gains and losses, caused St. Luke's to violate its debt service coverage ratio bond covenant. (RX-11 (Oppenlander, Dep. at 168-169)).

2013. On December 23, 2009, St. Luke's filed a "Material Event Notice" formally notifying AMBAC, the bond insurer; the Huntington Bank, the trustee; and the City of Maumee, the issuing authority, that St. Luke's had violated its debt service coverage ratio covenants for 2008 and 2009. (RX-183 at 000004; Gordon, Tr. 6815-6816, *in camera*).

2014. {
} (Gordon, Tr. 6811, *in camera*).

2015. In December 2009, St. Luke's CFO also informed AMBAC that he would be resigning as of December 31, 2009. (PX2355 at 001-002; Gordon, Tr. 6812, *in camera*).

2016. {
} (Gordon, Tr. 6812, *in camera*).

2017. {

}

(Gordon, Tr. 6814, *in camera*).

2018. {

} (Gordon, Tr. 6815, *in camera*).

2019. In its December 23, 2009 "Material Event Notice," St. Luke's stated that its "plan to address its future covenant compliance is to attempt to negotiate new, or renegotiate existing contracts with its insurance carriers." And, St. Luke's stated that it "may explore other options, including but not limited to exploring an affiliation with another health system." These statements did not give AMBAC comfort that St. Luke's financial condition would improve. (RX-183 at 000004; Gordon, Tr. 6816-6817, *in camera*).

2020. {

} (Gordon, Tr. 6819, *in camera*).

2021. {

} (Gordon, Tr. 6820, *in camera*.)

2022. {

} (Gordon, Tr. 6821, *in camera*.)

2023. {

} (Gordon, Tr. 6859, *in camera*).

2024. {

} (Den Uyl, Tr. 6465-6466).

2025. {

} (RX-181 at 000001, *in camera*; Gordon, Tr. 6822-6824, *in camera*).

2026. {

} (RX-181 at 000001, *in camera*; Gordon, Tr. 6824-6825, *in camera*).

2027. {

} (Gordon, Tr. 6825, *in camera*).

2028. {

} (Gordon, Tr. 6825-6826, *in camera*).

2029. {

} (RX-181 at 000001, *in camera*; Gordon, Tr. 6827, *in camera*).

2030. {

} (RX-181 at 000002, *in camera*; Gordon, Tr. 6827, *in camera*).

2031. On March 11, 2010, AMBAC sent St. Luke's a formal notice of default. (RX-906 at 000001; Gordon, Tr. 6829-6830, *in camera*).

2032. {

}
(Gordon, Tr. 6830, *in camera*).

2033. {

} (Wakeman, Tr. 3009, *in camera*).

2034. {

} (Wakeman, Tr. 3009, *in camera*).

2035. { } (RX-179 at 000001, *in camera*; Gordon, Tr. 6832, *in camera*).

2036. {
}
(Gordon, Tr. 6832, *in camera*).

2037. {
} (Gordon, Tr. 6832, *in camera*).

2038. { } (RX-179 at 000003, *in camera*; Gordon, Tr. 6832-6833, *in camera*).

2039. {
} (RX-179 at 000003, *in camera*).

2040. {
} (RX-179 at 000003, *in camera*.)

2041. {
} (Gordon, Tr. 6835, *in camera;* RX-179 at 000003, *in camera*).

2042. {

} (Gordon, Tr. 6837-6838, *in camera*).

c. ProMedica Assumes Responsibility for St. Luke's Bonds To Resolve the Default

2043. On June 1, 2010, AMBAC, St. Luke's and ProMedica came to a Forbearance and Waiver Agreement to resolve St. Luke's debt covenant violation. (PX01542 at 001, Gordon, Tr. 6845-6855, *in camera*).

2044. {

} (Den Uyl, Tr. 6466, *in camera*).

2045. In the Forbearance and Waiver Agreement, AMBAC agreed to waive its remedies against St. Luke's upon a joinder between St. Luke's and ProMedica when ProMedica would become responsible for making payments on those bonds. If St. Luke's and ProMedica did not join then St. Luke's would be required to defease the complete balance of the bonds by the end of the year, December 31, 2010. The Agreement required St. Luke's to set up an irrevocable Escrow in case this defeasance would become necessary. (PX01542 at 003-004; Gordon, Tr. 6845-6855, *in camera*).

2046. The Forbearance and Waiver Agreement also required St. Luke's to immediately pay $50,000 to AMBAC to cover legal and administrative costs associated with St. Luke's default. (PX01542 at 004).

2047. And the Forbearance and Waiver Agreement required St. Luke's to maintain a cash to debt ratio of 2.5 while the joinder with ProMedica was still pending. (PX01542 at 004).

2048. {

} (RX-1001, *in camera*; Gordon, Tr. 6843-6844, *in camera*).

d. Any Changes That Occurred In St. Luke's Financials In 2010 Would Likely Not Have Changed AMBAC's Assessment of St. Luke's Credit Risk

2049. {

} (Gordon, Tr. 6871, *in camera*).

2050. {

} (Gordon, Tr. 6872-6873, *in camera*).

2051. {

} (Gordon, Tr. 6883, *in camera*).

F. Complaint Counsel's Financial Experts Mischaracterize St. Luke's Financial Condition

2052. Mr. Dagen did not compare St. Luke's operating margin to the operating margins for nonprofit urban hospitals with a bed size of 100 to 249 during the years 2007 to 2009. (Dagen, Tr. 3309).

2053. Mr. Dagen did not compare St. Luke's operating margin to the operating margins of hospitals that received comparable bond ratings from Moody's during the time period 2007 up until the time of the joinder on September 1, 2010. (Dagen, Tr. 3310).

2054. Mr. Dagen did not calculate the average age of plant for St. Luke's. (Dagen, Tr. 3321).

2055. Mr. Dagen has not done any analysis to rebut Mr. Den Uyl's conclusion that St. Luke's average age of plant was higher than that of other hospitals that received comparable Moody's bond ratings to St. Luke's. (Dagen, Tr. 3322-3323).

2056. The only thing that Mr. Dagen did to determine the effect of additional Paramount revenue on St. Luke's financials in the period after the joinder was to compare the percentage of revenue that St. Luke's obtained from Paramount before the joinder and compared it with the percentage of revenue that St. Luke's received from Paramount after the joinder. (Dagen, Tr. 3326).

2057. Mr. Dagen did not calculate how St. Luke's addition to the Paramount network affected its cost coverage ratio from 2009 to 2010, even though he may have had the data to do this analysis. (Dagen, Tr. 3331-3332).

2058. Mr. Dagen did not calculate how St. Luke's addition to the Paramount network affected its number of patient days from 2009 to 2010. (Dagen, Tr. 3331-3332).

2059. Mr. Dagen did not calculate how St. Luke's addition to the Paramount network affected its number of outpatient visits from 2009 to 2010. (Dagen, Tr. 3331-3332).

2060. Mr. Dagen does not know if any expenses were shifted from St. Luke's to ProMedica as a result of the joinder. (Dagen, Tr. 3360).

2061. Mr. Dagen's characterization of St. Luke's financial performance trends is misleading. As of the joinder date, St. Luke's had not reached profitability. In addition, Mr. Dagen ignored a number of cost items going forward. Also, even Mr. Dagen's own analysis would generate negative cash flow during the period he considered. (Den Uyl, Tr. 6484).

2062. In his conclusions regarding St. Luke's financials, Mr. Dagen relies heavily on the time period before 2007 going all the way back to 2000. (PX02147 at 005-006, 010, 012-013, 014-015, 019, 022-026; Dagen, Tr. 3156-3163).

2063. {

} (RX-56 at 000030, *in camera*).

2064. {

}

(RX-56 at 000028, *in camera*).

2065. Mr. Dagen's reliance of financial data going back more than ten years also is inconsistent with his own hearing testimony in which he admits that "the most important time period is from 2008 when Dan Wakeman arrived, through 2010 when the joinder occurred." (Dagen, Tr. 3338).

2066. Mr. Dagen's reliance on St. Luke's positive EBITDA in nine of the previous eleven fiscal years, including 2011, to support his conclusion that St. Luke's was financially healthy at the time of the joinder is misleading. (Den Uyl, Tr. 6484-6485; RX-56 at 000028, *in camera*).

2067. {

} (RX-56 at 000028, *in camera*).

2068. {

} (RX-56 at 000028-000029, *in camera*).

2069. In his conclusions regarding St. Luke's financials, Mr. Dagen repeatedly relies on OhioCare's reserve balance on December 31, 2010, four months after the joinder. (PX02147 at 005-006, 013).

2070. In his conclusions regarding St. Luke's financials, Mr. Dagen repeatedly relies on St. Luke's EBITDA as of December 31, 2010, four months after the joinder. (PX02147 at 005, 007-008, 010, 012-013; PX01852 at 002-003).

2071. In his conclusions regarding St. Luke's financials, Mr. Dagen relies on St. Luke's cost coverage ratio as of December 31, 2010, four months after the joinder. (PX01852 at 003).

2072. {

} (RX-56 at 000029, *in camera*).

2073. Mr. Dagen's reliance on financial data from after August 31, 2010 is inappropriate because after the joinder St. Luke's financially benefitted from the relationship with ProMedica. For example, St. Luke's joined the Paramount network and achieved certain cost savings as a result of the joinder including becoming part of ProMedica's insurance plan, reducing supply costs, and heart center savings. (RX-56 at 000031, *in camera*; Den Uyl, Tr. 6491-6492).

2074. For his financial analysis of St. Luke's, Mr. Dagen assumes that St. Luke's could access the entirety of its reserve funds including its restricted reserves to fund its operations despite testimony to the contrary by St. Luke's executives. (Dagen, Tr. 3339-3344).

2075. St. Luke's "would not have realized if they were on their own" the cost savings that St. Luke's received as a result of the joinder (Den Uyl, Tr. 6492-6493).

2076. { } (RX-56 at 000029, *in camera*).

2077. { } (RX-56 at 000031, *in camera*).

2078. { } (RX-56 at 000036, *in camera*).

2079. { } (RX-56 at 000036, *in camera*).

2080. { } (RX-56 at 000036, *in camera*).

2081. { } (RX-56 at 000036, *in camera*).

2082. Mr. Dagen assumed that MMO would increase St. Luke's contract rates in 2011 despite the fact that St. Luke's tried unsuccessfully to negotiate higher rates from MMO in late 2009. (Dagen, Tr. 3349).

2083. Mr. Dagen assumed that Anthem would increase St. Luke's contract rates in June 2011 despite the fact that Anthem's contract did not expire until July 2012, and St. Luke's

attempted unsuccessfully to negotiate higher rates from Anthem in late 2009. (Dagen, Tr. 3349-3353).

2084. Mr. Dagen's projections assume that operating expenses would only grow by 3 percent over the 2010 expenses for the years 2011 to 2013. This assumption is inappropriate. (Dagen, Tr. 3361; RX-56 at 000037-000038, *in camera*; Den Uyl, Tr. 6487-6491).

2085. Mr. Dagen's 3 percent operating expense growth projection relies on a St. Luke's document that assumes the joinder occurs and reflects efficiencies from the joinder. (RX-56 at 000037, *in camera*; Den Uyl, Tr. 6487–6488).

2086. {

}

(Dagen, Tr. 3363-3369, *in camera*; PX0395 at 003, *in camera*).

2087. {

} (Dagen, Tr. 3371-3373, *in camera*; PX01590 at 001-023, *in camera*).

2088. {

} (Dagen, Tr. 3373, *in camera*).

2089. The St. Luke's document on which Dagen relies for his 3 percent operating expense growth projection is for St. Luke's only, although Mr. Dagen's model is for the entire OhioCare system. (Den Uyl, Tr. 6487–6489; RX-56 at 000037, *in camera*).

2090. If Mr. Dagen had been consistent with the growth methodology he used to establish his inpatient and outpatient revenue growth rate, his assumed operating expense growth rate would have been 5 percent rather than 3 percent. (Den Uyl, Tr. 6489-6490; RX-56 at 000037, *in camera*).

2091. {

} (Dagen, Tr. 3377-3378, *in camera*).

2092. {

} (Dagen, Tr. 3378, *in camera*).

2093. {

} (RX-56 at 000037, *in camera*; Dagen, Tr. 3409-3410, *in camera*).

2094. { } (Dagen, Tr. 3409-3410, *in camera*).

2095. The Hospital and Related Services portion of the Medical Care Consumer Price Index increased at a rate of approximately 6.8 percent over the 2007 through 2010 time period, during which Mr. Dagen assumes a 3 percent expense growth rate for OhioCare. (Den Uyl, Tr. 6490-6491; RX-56 at 000037, *in camera*).

2096. { } (RX-56 at 000033-000034, 000038, *in camera*).

2097. Mr. Dagen assumed that restricted funds would be available for use for the purpose of his analysis. In reality, St. Luke's trustee restricted funds are specifically designated for debt service coverage and professional liability insurance purposes and are not available for ordinary and routine use. (Den Uyl, Tr. 6493-6494; RX-56 at 000038, *in camera*).

2098. Mr. Dagen's assumptions regarding St. Luke's EMR capital expenditures and associated subsidies are flawed, because they captured all the EMR related subsidies, but have not accounted for the necessary costs to obtain those subsidies. (Den Uyl, Tr. 6495; RX-56 at 000039-000040, *in camera*).

2099. { } (RX-56 at 000039-000040, *in camera*).

2100. { } (RX-56 at 000039-000040, *in camera*).

2101. { } (RX-56 at 000040, *in camera*).

2102. Mr. Dagen's projection assumes capital expenditures that are significantly below St. Luke's historical average capital expenditures. Mr. Dagen assumed capital expenditures of only $4.9 million, $8.2 million, and $9.1 million in 2011, 2012, and 2013 respectively. However, St. Luke's historical capital expenditures averaged $11.3 million annually. (RX-56 at 000040, *in camera*; PX02147 at 014-015).

2103. The fact that Mr. Dagen assumes capital expenditures that are significantly below St. Luke's historical average capital expenditures is particularly problematic because St. Luke's has just come off a period where it reduced its capital expenditures in both 2009 and 2010. To project a continued low amount, therefore, understates what the hospital will need. (Den Uyl, Tr. 6495-6496).

2104. {
} (RX-56 at 000040, *in camera*).

2105. Mr. Dagen's analysis is incorrect as it relates to capital expenditures that St. Luke's will need going forward. St. Luke's will have to spend money on routine capital expenditures, on the private bed conversions, and on a new EMR system. In addition, St. Luke's had deferred a number of capital expenditures. (Den Uyl, Tr. 6498-6501).

2106. Mr. Dagen assumed an 8 percent return for St. Luke's investment portfolio reserves. This assumption is quite aggressive. (PX02147 at 039; RX-56 at 000041, *in camera*).

2107. {
} (RX-56 at 000041, *in camera*).

2108. {
} (RX-56 at 000041, *in camera*).

2109. If one adjusted Mr. Dagen's model by adding in cash outlays that St. Luke's needed to make but are unaccounted for by his model, then St. Luke's unrestricted reserves would be $14.46 million at the end of 2011, $3.768 million at the end of 2012, and *negative* $4.610 million at the end of 2013. (Den Uyl, Tr. 6500-6502; RX-56 at 000042, *in camera*).

2110. If one further adjusted Mr. Dagen's model to assume a 5 percent increase in annual operating cost, rather than Mr. Dagen's 3 percent assumption, then St. Luke's unrestricted reserves would be $10.805 million at the end of 2011, *negative* $7.489 million at the end of 2012, and *negative* $27.728 million at the end of 2013. (Den Uyl, Tr. 6502-6503; RX-56 at 000042-000043, *in camera*).

2111. {
} (Dagen, Tr. 3411-3413, *in camera*).

V. The Joinder Creates Pro-Competitive Benefits and Forcing ProMedica To Divest St. Luke's Would Harm St. Luke's and the Community

A. The Joinder Has Improved St. Luke's Financial Condition

2112. St. Luke's has benefitted by becoming part of a larger system, such as utilizing corporate infrastructure overhead services. (Hanley, Tr. 4681).

2113. The infusion of capital into St. Luke's has increased the benefits to the community by allowing St. Luke's to remain as an ongoing hospital. (Guerin-Calvert, Tr. 7551-7552).

2114. It also allows St. Luke's to make improvements to the hospital that benefit patients such as converting semi-private rooms to private rooms and investment in technology. (Guerin-Calvert, Tr. 7569-7570).

1. ProMedica Has Infused St. Luke's with Needed Capital

2115. As part of the joinder, ProMedica has contributed $5 million to the St. Luke's Foundation. (Hanley, Tr. 4679; Johnston, Tr. 5375). ProMedica has also committed to contribute $30 million over three years to St. Luke's Hospital. (Johnston, Tr. 5375).

2116. { } (RX-31 (Akenberger, Dep. at 39-40, *in camera*)).

2117. ProMedica's $10 million allocation of strategic capital to St. Luke's for 2011 was based upon the obligation ProMedica made to invest $30 million dollars into St. Luke's over a three-year period. (RX-31 (Akenberger, Dep. at 41, *in camera*); Hanley, Tr. 4679; Johnston, Tr. 5375).

2118. { } (RX-31 (Akenberger, Dep. at 41, *in camera*)).

2119. { } (RX-31 (Akenberger, Dep. at 40-41, *in camera*)).

2120. ProMedica defines routine capital expenditures as capital that is currently being in service with the various facilities and will need to be replaced; examples of routine capital expenditures include replacement of medical imaging machines like CT scanners and replacement of carpeting in a facility. (RX-31 (Akenberger, Dep. at 30)).

2121. Routine capital is capital that needs to be replaced because its useful life is no longer operating at an appropriate level. (RX-31 (Akenberger, Dep. at 34)).

2122. ProMedica defines strategic capital expenditures as reflecting investments that it is making in the community to provide support for ProMedica's strategic plan to meet patient and quality needs, employee needs, and financial needs. (RX-31 (Akenberger, Dep. at 34)).

2123. Strategic capital would be something that would require new investment of capital towards a new service, expansion of a service, or new technology. (RX-31 (Akenberger, Dep. at 34)).

2124. {

} (RX-31 (Akenberger, Dep. at 68, *in camera*)).

2125. The influx of capital that ProMedica provided to St. Luke's allowed St. Luke's to start planning for and implementing strategic capital projects such as private room expansion, facility renovations, and IT upgrades relating to meaningful-use compliance. (Johnston, Tr. 5372).

2126. Prof. Town agrees that consumers may benefit from additional money ProMedica has allocated to St. Luke's. (Town, Tr. 4366-4367, 4374).

2127. ProMedica would not invest in St. Luke's without the joinder. (Town, Tr. 4374; RX-1855 at 000024, *in camera*).

2128. {

} (RX-1856 at 000027, *in camera*).

2129. {

} (RX-1855 at 000024, *in camera*).

2130. {

} (RX-1855 at 000025, *in camera*).

2. St. Luke's Became Part of ProMedica's Obligated Group

2131. Effective at closing, ProMedica brought St. Luke's into its Obligated Group. (Hanley, Tr. 4513; Johnston, Tr. 5372).

2132. Subsequently, AMBAC granted a waiver to St. Luke's, which required that ProMedica's Obligated Group replace St. Luke's on the bond note. (Hanley, Tr. 4677; RX-907).

2133. Additionally, on September 28, 2010, Moody's upgraded St. Luke's bond rating because St. Luke's joined ProMedica's Obligated Group and took on its bond rating. (Hanley, Tr. 4676; RX-350 at 000001).

3. ProMedica Absorbed St. Luke's Pension Liability

2134. Since the joinder, ProMedica has helped fund contributions to St. Luke's pension plan. (Hanley, Tr. 4678).

2135. {

} (Johnston, Tr. 5409, *in camera*).

2136. {

} (Johnston, Tr. 5409, *in camera*).

4. The Joinder Has Already Allowed St. Luke's To Reduce Some of Its Costs

2137. St. Luke's was not large enough to fund a captive insurance plan or be a part of a captive insurance plan on its own. (Wakeman, Tr. 2838).

2138. Following the joinder, St. Luke's has saved about $500,000 in malpractice insurance from becoming part of ProMedica's captive insurance company. (Hanley, Tr. 4680).

2139. Additionally, moving St. Luke's into ProMedica's captive insurance company had the effect of freeing up over $8 million in cash that remains unencumbered on St. Luke's balance sheet. (Hanley, Tr. 4680).

2140. {

} (Wakeman, Tr. 3023-3025, *in camera*).

5. The Joinder Has Given St. Luke's Increased Revenues from Paramount Members

2141. Following the joinder, St. Luke's became a participating provider in Paramount, and its volume of Paramount patients has increased significantly since then. (Hanley, Tr. 4678-4679; Johnston, Tr. 5375, 5382; Wakeman, Tr. 3023-3025, *in camera*).

2142. {

} (Wakeman, Tr. 3023-3025, *in camera*; Johnston, Tr. 5513, *in camera*).

2143. St. Luke's addition to the Paramount network was one reason St. Luke's financial performance improved after its joinder with ProMedica. (Dagen, Tr. 3329).

2144. Mr. Dagen estimates that St. Luke's addition to the Paramount network increased St. Luke's revenues in 2010 as compared to 2009 by about 23 percent. (Dagen, Tr. 3330).

2145. Mr. Dagen estimates that St. Luke's addition to the Paramount network increased St. Luke's EBITDA in 2010 as compared to 2009 by about 23 percent. (Dagen, Tr. 3330).

6. The Joinder Will Allow ProMedica and St. Luke's To Realize Additional Efficiencies

2146. { } (Hanley, Tr. 4619-4621, *in camera*; PX00421 at 010-011, *in camera*).

2147. { } (Hanley, Tr. 4625, *in camera*; Oostra Tr. 5868, *in camera*).

2148. { } (Hanley, Tr. 4648, *in camera*).

2149. { } (Hanley, Tr. 4651, *in camera*).

2150. { } (Hanley, Tr. 4650, *in camera*; PX00020 at 004, *in camera*).

2151. { } (Hanley, Tr. 4652, *in camera*).

2152. { } (Hanley, Tr. 4652-4653, *in camera*).

2153. { } (Hanley, Tr. 4728, *in camera*).

2154. Since the closing of the joinder on August 31, 2010, ProMedica and St. Luke's have established a steering committee that has charged approximately 20 integration teams to further develop the efficiencies opportunities summarized in the Compass Lexecon report and identify new opportunities not identified for the Compass Lexecon report. (RX-31 (Akenberger, Dep. at 97-98)).

B. The Joinder Enhances St. Luke's Ability To Respond to Healthcare Reform

2155. {

} (RX-1858 at 000017-000018, *in camera*).

2156. ProMedica believes that St. Luke's has allocated part of its initial capital contribution of $10 million toward investment to become compliant for "meaningful use." (Hanley, Tr. 4679). {

} (RX-31 (Akenberger, Dep. at 175, *in camera*)).

2157. St. Luke's has begun planning with ProMedica for implementation of "meaningful use" requirements. (Johnston, Tr. 5380-5381). St. Luke's is beginning implementation of clinical documentation, medical administration and bar-coding systems. (Johnston, Tr. 5381).

2158. {

} (RX-1858 at 000016, *in camera*).

2159. ProMedica has also provided approximately 55 individual employees who have assisted with the "meaningful use" conversion process. (Johnston, Tr. 5380).

2160. St. Luke's expects that, based on the progress seen so far on the "meaningful use" IT project, St. Luke's will now be able to meet deadlines required by healthcare reform legislation. (Johnston, Tr. 5381).

C. The Joinder Allows ProMedica and St. Luke's To Consolidate Clinical Services To Lower Costs, To Improve Quality, and To Optimize Facilities

2161. {

} (PX02105 at 013, *in camera*).

1. Navigant Consulting's Clinical Service Line Consolidation Recommendations

2162. { }
(Shook, Tr. 1110, *in camera*).

2163. ProMedica retained Navigant Consulting, Inc. ("Navigant") in mid-2010 to conduct a clinical integration study to determine how best to deploy services across the ProMedica system following the joinder with St. Luke's. (Nolan, Tr. 6253, 6263; Hanley, Tr. 4670, *in camera*).

2164. The project required Navigant to review the Toledo metropolitan marketplace, determine current and projected future healthcare needs in that market, and develop a set of recommendations as to the best distribution of services across ProMedica's facilities to meet community needs. (Nolan, Tr. 6254).

2165. Clinical integration describes the process when two organizations join together and combine their clinical capabilities in the optimal manner to provide high-quality and cost-effective healthcare. (Nolan, Tr. 6254-6255).

2166. {
} (Nolan, Tr. 6328, *in camera*).

2167. When making clinical integration recommendations, Navigant considers the market demographics and population projections, physical plants and facilities, anticipated healthcare-related legislation, and emerging community needs. (Nolan, Tr. 6255-6256).

2168. Navigant believes that benefits of clinical integration include operational efficiencies, economies of scale, the seamless flow of information across the system, better access and affordability for patients, staffing efficiencies, and higher quality from achieving a critical mass of volume of particular services. (Nolan, Tr. 6257-6260).

2169. Likewise, Mercy believes that the volume or frequency of procedures has an effect on quality such that the more a hospital, physician, or nurse does something, the more proficient they will become at that particular task. (Shook, Tr. 959).

2170. Navigant believes that independent community hospitals face an increasingly competitive and resource-constrained environment and struggle to gain economies of scale or efficiencies. (Nolan, Tr. 6261).

2171. Navigant also believes that independent community hospitals tend to lack capital resources to provide new medical technology. (Nolan, Tr. 6261-6262).

2172. Navigant perceives St. Luke's to be similar to other independent, community hospitals it has studied in terms of its competitive environment and financial challenges. (Nolan, Tr. 6262-6263).

2173. {
} (Hanley, Tr. 4670, *in camera*).

2174. {

} (Nolan, Tr. 6268-6270, *in camera*).

2175. { } (Nolan, Tr. 6284, *in camera*; PX00479 at 001, *in camera*).

2176. {

} (Nolan, Tr. 6286-6288, *in camera*; PX00479 at 007-008, *in camera*).

2177. {

} (Nolan, Tr. 6289, *in camera*).

2178. {

}

(Nolan, Tr. 6291-6292; PX00479 at 009, *in camera*).

2179. {

} (Nolan, Tr. 6284-6285, *in camera*; PX00479 at 006, *in camera*).

2180. {

} (PX00479 at 006, *in camera*; Hanley, Tr. 4670-4671, *in camera*).

2181. {

} (Nolan, Tr. 6301-6302, *in camera*).

2182. {

} (Nolan, Tr. 6302-6303, *in camera*; Hanley, Tr. 4672, *in camera*).

2183. { } (Nolan, Tr. 6303, *in camera*).

2184. { } (Nolan, Tr. 6295, 6304, *in camera*).

2185. { } (Nolan, Tr. 6304, *in camera*).

2186. { } (Hanley, Tr. 4672, *in camera*).

2187. { } (Nolan, Tr. 6305, *in camera*).

2188. { } (Nolan, Tr. 6296, *in camera*).

2189. { } (Nolan, Tr. 6296, *in camera*).

2190. { } (Nolan, Tr. 6305-6306, *in camera*).

2191. { } (Nolan, Tr. 6307, *in camera*).

2192. { } (PX00479 at 010, *in camera*).

2193. { } (Nolan, Tr. 6293, *in camera*; PX00479 at 010, *in camera*).

2194. { } (Nolan, Tr. 6293-6294, *in camera*; PX00479 at 010, *in camera*).

2195. {

} (Nolan, Tr. 6295, *in camera*; PX00479 at 010, *in camera*).

2196. {

} (Nolan, Tr. 6295, *in camera*; PX00479 at 010, *in camera*).

2197. {

} (Nolan, Tr. 6297-6298, *in camera*; PX00479 at 010, *in camera*).

2198. {

} (Nolan, Tr. 6298-6299, *in camera*).

2199. {

} (RX-31 (Akenberger, Dep. at 131-132, *in camera*)).

2200. Cardiac physicians believe that a hospital needs about 180 cardiac cases a year to break even. (RX-26 (Riordan, Dep. at 59)).

2201. Prior to the joinder, St. Luke's had about 150 cardiac cases a year and had been unable to raise it above that number. (RX-26 (Riordan, Dep. at 60)).

2202. {

} (Nolan, Tr. 6299, *in camera*).

2203. {

} (Nolan, Tr. 6299-6300, *in camera*).

2204. {

} (Nolan, Tr. 6300, *in camera*).

2205. {

} (Nolan, Tr. 6300, *in camera*).

2206. {

} (RX-31 (Akenberger, Dep. at 123, *in camera*)).

2207. {

} (Nolan, Tr. 6318, *in camera*).

2208. {

} (Nolan, Tr. 6315-6316, *in camera*).

2209. {

} (Nolan, Tr. 6316-6317, *in camera*).

2210. {

} (Nolan, Tr. 6317, *in camera*).

2211. {

} (Nolan, Tr. 6319, *in camera*).

2212. {

} (Nolan, Tr. 6319-6320, *in camera*).

2213. { } (Nolan, Tr. 6320, *in camera*).

2214. {

} (Nolan, Tr. 6321-6322, *in camera*).

2215. {

} (PX01221 at 018, *in camera*).

2216. {

} (Nolan, Tr. 6322, *in camera*).

2217. {

} (Nolan, Tr. 6322, *in camera*).

2218. {

} (Nolan, Tr. 6355-6356, *in camera*).

2219. {

} (Hanley, Tr. 4814, *in camera*).

2220. {

} (Hanley, Tr. 4748, *in camera*).

2221. {

} (RX-1855 at 000028, *in camera*).

2. Consolidating Some Clinical Services with ProMedica Has Already Allowed St. Luke's To Increase Its Capacity and Its Proportion of Private Rooms

2222. {

} (Nolan, Tr. 6276-6277, *in camera*; PX01216 at 025, *in camera*).

2223. {

} (Nolan, Tr. 6282, *in camera*; PX01215 at 003, *in camera*).

2224. {

} (RX-1855 at 000025-000026, *in camera*).

2225. {

} (RX-1856 at 000026, *in camera*).

2226. {

} (PX02105 at 011, *in camera*; Hanley, Tr. 4681).

2227. {

} (RX-31 (Akenberger, Dep. at 106, *in camera*)).

2228. {

} (RX-31 (Akenberger, Dep. at 107-108, *in camera*)).

2229. {

} (RX-31 (Akenberger, Dep. at 108, *in camera*)).

2230. {

} (Wakeman, Tr. 3025-3026, *in camera*).

2231. {

} (RX-31 (Akenberger, Dep. at 111, *in camera*)).

2232. As a result of adding new beds in the previous inpatient rehabilitation unit, St. Luke's has been able to reduce its ER diversions virtually to zero. (Johnston, Tr. 5374).

2233. As a stand-alone hospital, St. Luke's is limited in its ability to turn semi-private rooms to private rooms, even though it has more beds available than it is using. (Guerin-Calvert, Tr. 7287).

2234. In addition, given its deteriorating financial condition, if St. Luke's cannot take advantage of its excess capacity and reposition itself by converting semi-private rooms to private rooms, it will fall behind its competitors. (Guerin-Calvert, Tr. 7288-7289).

2235. With the benefit of capital it received from ProMedica, St. Luke's plans to add 17 additional private rooms. (Johnston, Tr. 5372, 5376-5377).

2236. The project budget for the additional 17 private rooms is $3 million. (Johnston, Tr. 5377).

2237. The private room conversion will convert existing non-patient space within St. Luke's into new private patient rooms. (Johnston, Tr. 5377).

2238. Converting semi-private rooms to private rooms is a less expensive alternative than new construction, but would make St. Luke's bed capacity situation worse because this approach would reduce the overall bed capacity of the hospital. (Johnston, Tr. 5378-5379).

2239. Converting non-patient spaces into new private rooms is the least expensive way to add new private rooms without reducing overall bed capacity. (Johnston, Tr. 5377-5379).

2240. Prof. Town agrees that private rooms would be a benefit to St. Luke's patient base. (Town, Tr. 4365-4366).

3. The Joinder Gives St. Luke's Access to ProMedica's Quality Programs and Systems

2241. Each of ProMedica's hospitals, as well as Paramount and PPG, has its own quality council. (PX01930 (Reiter, Dep. at 19)).

2242. ProMedica also has service line and institute quality councils for the cancer institute, the orthopedic institute, the heart and vascular institute, and a fourth related to critical care services. (PX01930 (Reiter, Dep. at 22-23)).

2243. ProMedica's corporate quality department provides quality report cards to measure how each hospital and business unit is doing based on valid quality metrics. (PX01930 (Reiter, Dep. at 19-20)).

2244. ProMedica compares its performance with and sets its goals in comparison to national quality scores and best practices, as well as local and regional hospitals. (RX-25 (Reiter, Dep. at 100)). In that way, ProMedica tracks the quality performance of each of its business units. (PX01930 (Reiter, Dep. at 20)).

2245. The eICU is a computerized telemonitoring system that allows ProMedica to monitor all of its ICU beds across the system from a central control tower. (PX01930 (Reiter, Dep. at 24)).

2246. {

} (PX00605 at 004, *in camera*).

2247. ProMedica implemented eICU to achieve better critical care quality scores. (PX01930 (Reiter, Dep. at 180)).

2248. Smart pumps are computerized infusion pumps that allow for medication to be infused into the body through veins, like an IV. (RX-25 (Reiter, Dep. at 65)).

2249. Unlike normal IVs, smart pumps are computerized allowing the hospital staff to set safe limits for drug doses and alerting the staff if the dosing exceeds those limits. (RX-25 (Reiter, Dep. at 65)).

2250. ProMedica believes that smart pumps improve quality of care by reducing medication errors. (RX-25 (Reiter, Dep. at 65)).

2251. St. Luke's did not have smart pumps or the eICU before the joinder. (RX-25 (Reiter, Dep. at 66); PX01930 (Reiter, Dep. at 180-181)).

2252. In the early joinder discussions, ProMedica identified the eICU as a potential benefit that St. Luke's would realize from joining the ProMedica system. (PX01930 (Reiter, Dep. at 181)).

2253. {

} (Johnston, Tr. 5412-5413, *in camera*).

2254. Following the joinder, ProMedica began the process of bringing St. Luke's into its system-wide quality efforts. (PX01930 (Reiter, Dep. at 56)).

2255. For example, ProMedica took steps to bring St. Luke's into its patient safety council, which includes the safety officers from all of ProMedica's provider organizations. (PX01930 (Reiter, Dep. at 57)). ProMedica also involved St. Luke's in its best practice standardization initiatives. (PX01930 (Reiter, Dep. at 57)).

D. Other Joinder Benefits

2256. {

} (RX-1855 at 000024, *in camera*).

2257. {

} RX-1855 at 000029, *in camera*).

2258. Becoming part of ProMedica has improved St. Luke's employee morale as employees feel more secure being part of a financially stable organization. (Johnston, Tr. 5373).

2259. St. Luke's employees received a 1 percent pay increase on January 1, 2011. (Johnston Tr. 5373). St. Luke's employees received a second 1 percent pay increase in July 2011. (Johnston, Tr. 5373).

2260. In June 2011, all employees received a one-time financial thank-you. Full-time employees received $200; part-time employees received $100; and contingent employees received $25. (Johnston, Tr. 5373).

2261. In the past, as its patient volumes increased before the joinder, St. Luke's was forced to place many of the nursing staff on mandatory call. (Johnston, Tr. 5365).

2262. Mandatory call means a nurse was on call beyond their normal hours of work and in most cases being on call meant that the nurses were called in and required to work overtime. (Johnston, Tr. 5365).

2263. Being part of ProMedica enables St. Luke's to tap into the ProMedica staffing pool to help ramp up staffing at its facilities. (Johnston, Tr. 5373-5374). St. Luke's has been able to use ProMedica's nurse staffing pool and reduce the number of units that have mandatory call duty. (Johnston, Tr. 5387).

2264. St. Luke's has been able to utilize the services of ProMedica's physician recruiters to help with physician recruitment. (Johnston Tr. 5374).

2265. Since the joinder, ProMedica's recruiters have assisted three of St. Luke's physician groups with their recruitment efforts. (Johnston, Tr. 5386). ProMedica's recruiters have already helped recruit certified registered nurse anesthetists for St. Luke's anesthesiology group. (Johnston, Tr. 5386).

2266. Through ProMedica's partnership with the University of Toledo, all full-time employees will receive free tuition to any undergraduate or graduate program. Part-time employees will receive 50 percent tuition. (Johnston, Tr. 5374).

2267. St. Luke's has improved its cash-on-hand after payroll from $1.6 million at the time of the joinder to a current total of between $3 and $7 million. (Johnston, Tr. 5380).

2268. St. Luke's has been able to pool its investments with the ProMedica investment pool and reduce investment fees. (Johnston, Tr. 5373).

2269. {

} (Johnston, Tr. 5495-5497, *in camera*). {

} (Johnston, Tr. 5497, *in camera*).

2270. { } (Johnston, Tr. 5496-5497, *in camera*).

PROPOSED CONCLUSIONS OF LAW

I. Complaint Counsel Has the Ultimate Burden of Persuasion as to Each Element of Its Section 7 Claim

1. Complaint Counsel alleges that the joinder (the "joinder") between ProMedica Health System, Inc. ("ProMedica") and St. Luke's Hospital ("St. Luke's") violates Section 7 of the Clayton Act, as amended, 15 U.S.C. § 18. Compl. ¶¶ 39-40.

2. Clayton Act Section 7 only prohibits an entity from acquiring "the whole or any part" of a business' stock or assets if the effect of the acquisition "may be substantially to lessen competition, or tend to create a monopoly." *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1109 (N.D. Cal. 2004) (citing 15 U.S.C. § 18)).

3. An analysis of a Section 7 claim requires a determination of (1) the product market in which to assess the transaction, (2) the geographic market in which to assess the transaction, and (3) the transaction's probable effect on competition in the product and geographic markets. *FTC v. Staples, Inc.*, 970 F. Supp. 1066, 1072 (D.D.C. 1997).

4. Complaint Counsel bears the burden of proving every element of its Section 7 claim by a preponderance of the evidence. *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1109 (N.D. Cal. 2004).

5. To prevail on a Section 7 claim, Complaint Counsel must show that there is a reasonable probability that the transaction will result in a substantial lessening of competition in the future. *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 135 (E.D.N.Y. 1997). To meet this burden, Complaint Counsel cannot simply demonstrate some likely impact on competition; instead, Complaint Counsel "has the burden of showing that the acquisition is reasonably likely to have 'demonstrable and substantial anticompetitive effects.'" *New York v. Kraft Gen. Foods, Inc.*, 926 F. Supp. 321, 358 (S.D.N.Y. 1995) (quoting *United States v. Atl. Richfield Co.*, 297 F. Supp. 1061, 1066 (S.D.N.Y. 1969); *see also FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1051 (8th Cir. 1999) ("Section 7 deals in probabilities, not ephemeral possibilities.").

6. If an analysis of the parties' market shares and the market concentration creates a presumption that the joinder of ProMedica and St. Luke's will have anticompetitive effects, ProMedica may rebut that presumption by showing "that the market share statistics give an inaccurate account of the merger's probable effects on competition in the relevant market." *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1110 (N.D. Cal. 2004). Rebuttal evidence may also include factors relating to competition in the relevant market or the competitive or financial weakness of the acquired company. *United States v. Baker Hughes Inc.*, 908 F.2d 981, 983, 985 (D.C. Cir. 1990). If ProMedica successfully rebuts the presumption, then the burden shifts back to Complaint Counsel to produce "additional evidence of anticompetitive effects." *Id.* at 1110. At all times, however, the ultimate burden of persuasion remains with Complaint Counsel. *Id.* at 983.

II. Complaint Counsel Did Not Meet Its Burden of Proving Proper Relevant Markets in Which To Analyze the Effects of the Joinder

7. Complaint Counsel must prove by a preponderance of the evidence that an acquisition is reasonably likely to cause anticompetitive effects in a proven relevant market. *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1109 (N.D. Cal. 2004); *see also United States v. Penn-Olin Chem. Co.*, 378 U.S. 158, 171 (1964). Complaint Counsel "bear[] the burden of proof and persuasion in defining the relevant market." *United States v. SunGard Data Sys.*, 172 F. Supp. 2d 172, 182-83 (D.D.C. 2001); *see also FTC v. Lundbeck, Inc.*, No. 10-3458, slip op. at 4 (8th Cir. Aug. 19, 2011). If Complaint Counsel does not properly define a relevant market, their case fails. *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 140 (E.D.N.Y. 1997); *Bathke v. Casey's Gen. Stores, Inc.*, 64 F.3d 340, 345 (8th Cir. 1995) ("Antitrust claims often rise or fall on the definition of the relevant market.").

8. The Complaint alleges two relevant product markets: 1) "general acute care inpatient services sold to commercial health plans, which encompasses a broad cluster of basic medical and surgical diagnostic and treatment services that include an overnight hospital stay, such as emergency services, internal medicine, and minor surgeries," and 2) "inpatient obstetrical services," which includes "hospital services provided for labor and delivery of newborns." Compl. ¶¶ 12, 14.

9. A relevant product market consists of "products that have reasonable interchangeability for the purposes for which they are produced – price, use and qualities considered." *United States v. E.I. Du Pont de Nemours*, 351 U.S. 377, 404 (1956). Products are reasonably interchangeable if consumers treat them as "acceptable substitutes." *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 46 (D.D.C. 1998). A relevant product may consist of a cluster of products, even if the individual products within the cluster are not substitutes between themselves. *See, e.g., FTC v. Staples, Inc.*, 970 F. Supp. 1066, 1074 (D.D.C. 1997); *JBL Enters., Inc. v. Jhirmack Enters., Inc.*, 698 F.2d 1011, 1016 (9th Cir. 1983).

10. In hospital merger cases, federal courts, the FTC, and the DOJ have agreed that the proper market in which to analyze the competitive effects of a hospital merger is the market for general "acute care inpatient hospital services." The same is true in this case. *See In re Evanston Nw. Healthcare Corp.*, 2007 FTC LEXIS 210, at *149 (F.T.C. Aug. 6, 2007).

11. Consistent with past precedent, this Court concludes that general acute-care inpatient services, inclusive of inpatient obstetrical services, constitute a proper relevant market in which to analyze the competitive effects of St. Luke's joinder with ProMedica. *See e.g., In re Evanston Nw. Healthcare Corp.*, 2007 FTC LEXIS 210, at *149 (F.T.C. Aug. 6, 2007); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 139 (E.D.N.Y. 1997); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1290-91 (W.D. Mich. 1996).

12. The Complaint alleges a separate relevant market of inpatient obstetrical services. Compl. ¶¶ 12, 14. In prior hospital merger cases, courts have included inpatient obstetrical services in the general acute care inpatient services market. RPF 1024. *See California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1119 (N.D. Cal. 2001) (explaining that "[w]hile the treatments offered to patients within this cluster of services are not substitutes for one another (for example, one cannot substitute a tonsillectomy for heart bypass surgery), the services and resources that hospitals provide tend to be similar across a wide range of primary, secondary, and tertiary inpatient services. Accordingly, courts have consistently recognized the cluster of services comprising acute inpatient services as the appropriate product market in hospital merger cases.").

13. This Court concludes that Complaint Counsel's claims regarding the alleged market for inpatient obstetrical services must fail because they have not met their burden of proving that a narrower market for inpatient obstetrical services exists. *See FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 122 (D.D.C. 2004) ("The burden ... is squarely on plaintiffs to establish that [the service at issue] is a separate relevant market."); *United States v. SunGard Data Sys.*, 172 F. Supp. 2d 172, 182-83 (D.D.C. 2001); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 140 (E.D.N.Y. 1997); *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1172 (N.D. Cal. 2004).

14. Complaint Counsel also have the burden of proving the relevant geographic market by a preponderance of the evidence. *United States v. Conn. Nat'l Bank*, 418 U.S. 656, 669 (1974); *United States v. SunGard Data Sys.*, 172 F. Supp. 2d 172, 182-83 (D.D.C. 2001). To meet that burden, Complaint Counsel must present evidence on "where consumers of hospital services could practicably turn for alternative services should the merger be consummated and prices become anticompetitive." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1052-53 (8th Cir. 1999). The relevant geographic market must "correspond to the commercial realities of the industry and be economically significant." *Brown Shoe Co. v. United States*, 370 U.S. 294, 336-37 (1962). Therefore, to sustain its burden, Complaint Counsel must present evidence on "where consumers could practicably go, not on where they actually go." *Tenet*, 186 F.3d at 1052; *FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir. 1995).

15. This Court concludes that the relevant geographic market in which to analyze the effects of the St. Luke's joinder with ProMedica is Lucas County, Ohio. *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1290 ("A properly defined market includes potential suppliers who can readily offer consumers a suitable alternative to defendants' services.").

III. Complaint Counsel Did Not Meet Its Burden of Demonstrating That The Joinder of ProMedica and St. Luke's Will Enable ProMedica To Raise Rates Above Competitive Levels in Either Alleged Relevant Market

16. Clayton Act Section 7 requires Complaint Counsel to demonstrate that as a result of the joinder, there is a "reasonable probability" of a substantial lessening of competition in the future for general acute care inpatient services, or inpatient obstetrical services, in Lucas County. *See United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 135

(E.D.N.Y. 1997). Complaint Counsel must show that a predicted post-joinder price increase is not "totally speculative," and to make this showing, Complaint Counsel must demonstrate that the prices that have resulted or will result from the joinder exceed competitive levels, not just that they may be higher than they were before the joinder. *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 143 (E.D.N.Y. 1997).

A. Market Concentration Statistics Do Not Accurately Portray Competitive Dynamics

17. Calculating market shares and market concentration does not end the analysis of whether a transaction is likely to substantially lessen competition. *FTC v. CCC Holdings, Inc.*, 605 F. Supp. 2d 26, 46 (D.D.C. 2009). The Supreme Court has cautioned that "statistics concerning market share and concentration are not conclusive indicators of anticompetitive effects." *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 130 (D.D.C. 2004) (citing *United States v. General Dynamics Corp.*, 415 U.S. 486, 498 (1974). Courts recognize that "determining the existence of or threat of anticompetitive effects has not stopped at a calculation of market shares" and, therefore, "a finding of market shares and consideration of [the presumption created by market shares] should not end the court's inquiry." *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1111 (N.D. Cal. 2004); *see also United States v. Baker Hughes Inc.*, 908 F.2d 981, 992 (D.C. Cir. 1990) (noting "The Herfindahl-Hirschman Index cannot guarantee litigation victories").

18. Based on its findings, this Court concludes that the "structure, history, and probable future" of the general acute care inpatient services market show that Complaint Counsel's market shares are not indicative of likely anticompetitive effects from the joinder. *United States v. General Dynamics Corp.*, 415 U.S. 486, 498 (1974). Therefore, a presumption based on market concentration statistics that the joinder will lead to anticompetitive effects does not satisfy Complaint Counsel's burden of proof to establish a violation of Clayton Act Section 7. Relying solely on market shares to analyze competitive effects is "especially problematic" when the transaction involves differentiated products, such as inpatient general acute care services. *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1122 (N.D. Cal. 2004); *see also Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1410-12 (7th Cir. 1995) (It is "always treacherous to try to infer monopoly power from a high rate of return" in a market of differentiated products because "the difference may reflect higher quality more costly to provide"). Particularly with differentiated products, there is no automatic correlation between market share and price. *See Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1410-12 (7th Cir. 1995). Where market shares are not an accurate predictor of future competitive effects, they are no substitute for a rigorous analysis of actual market dynamics. *See United States v. Baker Hughes Inc.*, 908 F.2d 981, 983-85 (D.C. Cir. 1990).

B. Complaint Counsel Have Failed To Produce Evidence that the Joinder Resulted or Will Result in Anticompetitive Effects in their Alleged Relevant Markets

19. "Analysis of the likely competitive effects of a merger requires [a determination] of...the transaction's probable effect on competition in the relevant product and geographic markets." *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 117 (D.D.C. 2004). Complaint Counsel cannot "simply [make] conclusory allegations that...the merger will significantly limit competition without any evidence." *Advocacy Org. v. Mercy Health Servs.*, 987 F. Supp. 967, 974 (E.D. Mich. 1997). Rather, they must show "anticompetitive effects...that will result from the merger." *Advocacy Org. v. Mercy Health Servs.*, 987 F. Supp. 967, 974 (E.D. Mich. 1997).

20. An economic expert's econometric analysis must reflect competitive realities; if the expert's opinion "is not supported by sufficient facts to validate it in the eyes of the law . . . it cannot support a decision." *United States v. General Dynamics Corp.*, 415 U.S. 486, 498 (1974); *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045 n.13 (8th Cir. 1999); *see FTC v. CCC Holdings, Inc.*, 605 F. Supp. 2d 26, 70-72 (D.D.C. 2009) (dismissing an expert's model because "the data and predictions cannot reasonably be confirmed by the evidence."). Because general acute care inpatient services are differentiated products, factors such as cost, quality, underestimation of the increase in inflation or cost escalation, and the duration of a contract can cause differences in competing hospitals' prices. *See Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1412 (7th Cir. 1995) (noting that quality can affect prices). *See Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 242 (1993). Indeed, the *Brooke Group* court ruled that "when indisputable record facts contradict or otherwise render the [expert's] opinion unreasonable, it cannot support a jury's verdict." *Brooke Group*, 509 U.S. at 242.

21. Likewise, this Court concludes the Complaint Counsel's economic expert's econometric analysis "is not supported by sufficient facts to validate it in the eyes of the law," because it does not accurately reflect the actual competitive dynamics in the general acute care inpatient services market. Therefore, "it cannot support a decision." *United States v. General Dynamics Corp.*, 415 U.S. 486, 498 (1974); *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045 n.13 (8th Cir. 1999).

22. Complaint Counsel's failure to present any evidence of anticompetitive effects in its alleged inpatient obstetrical services market is fatal to their case as to that alleged relevant market. *See United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1172 (N.D. Cal. 2004); *Menasha Corp. v. News Am. Mktg. In-Store, Inc.*, 354 F.3d 661, 664-65 (7th Cir. 2004) (holding that conclusory reasoning does not replace the need for actual economic analysis).

C. The Joinder Will Neither Enhance ProMedica's Market Power Nor Enable It To Increase Rates for General Acute Care Inpatient or Inpatient Obstetrical Services above Competitive Levels

23. Complaint Counsel must show that the joinder gives ProMedica the ability to raise prices above a competitive level. *See, e.g.*, *See United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1170 (N.D. Cal. 2004). Particularly because the joinder has been consummated, this Court concludes that evidence of actual competitive effects, pre- and post-joinder, should be given substantial weight in this analysis. *See United States v. Archer-Daniels-Midland Co.*, 781 F. Supp. 1400, 1421 (S.D. Iowa 1991); *Lektro-Vend Corp. v. Vendo Co.*, 660 F.2d 255, 276 (7th Cir. 1981); *Lektro-Vend*, 660 F.2d at 276 (stating "post-acquisition evidence favorable to a defendant can be an important indicator of the probability of anticompetitive effects where the evidence is such that it could not reflect deliberate manipulation by the merged companies temporarily to avoid anti-competitive activity").

24. In differentiated markets, the merged firm may be able to raise prices unilaterally if customers accounting for a "significant fraction" of the merged firms' sales view the merging parties as their first and second choices for the product, and if, in response to a price increase, rival sellers likely would not "replace any localized competition lost through the merger by repositioning their product lines." *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1123 (N.D. Cal. 2004); *In re Evanston Nw. Healthcare Corp.*, 2007 FTC LEXIS 210, at *158-59 (F.T.C. Aug. 6, 2007).

25. Because ProMedica and St. Luke's are not close substitutes and because Mercy and UTMC are ready alternatives that can constrain ProMedica's pricing, this Court concludes that the joinder will not affect ProMedica's bargaining leverage. *See Oracle*, 331 F. Supp. 2d at 1172 (finding plaintiffs failed to prove unilateral effects as a result of the merger because they failed to prove that there were a significant number of customers who regarded the merging companies as first and second choices); *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1129-32 (N.D. Cal. 2001) (using diversion analysis to support finding that patients would turn to other hospitals in the face of a price increase).

26. Merging parties are constrained from increasing prices to supracompetitive levels if other firms can enter the relevant markets. *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 149 (E.D.N.Y. 1997). Entry can occur if new firms enter the relevant markets, or if existing firms expand their current capacity or "expand into new regions of the market." *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 55 (D.D.C. 1998). *See also United States v. Baker Hughes Inc.*, 908 F.2d 981, 989 n.8 (D.C. Cir. 1990). Indeed, in *Baker Hughes*, the court noted the presence of existing companies "poised for future expansion" in the relevant markets to support its conclusion that the merger would not likely cause anticompetitive effects. 908 F.2d at 988-89. *See also In re Evanston Nw. Healthcare Corp.*, 2007 FTC LEXIS 210, at *159 (F.T.C. Aug. 6, 2007) (quoting IV Phillip E. Areeda, Herbert Hovenkamp & John L. Solow, *Antitrust Law* ¶ 914a at 67 (2d ed. 2006) ("The degree to which a merger in a product-differentiated market might facilitate a unilateral price increase depends on . . . the relative inability of other firms to

redesign their products to make them close to the output of the merging firms.")). Even perceived entry or expansion can constrain a possible anticompetitive price increase. *See Baker Hughes*, 908 F.2d at 988.

27. Declining demand for a product or service can increase competition and constrain that product's or service's price. *United States v. Rockford Mem'l*, 717 F. Supp. 1251, 1283-84 (N.D. Ill. 1989) (noting that demand for inpatient care in northern Illinois hospitals had decreased due to "[t]he advent of outpatient services, cost containment and managed healthcare.... In turn, this has led the acute inpatient care market to become more price sensitive and competitive as hospitals attempt to attract steady sources of inpatients through lower prices.").

28. The ability of even a few patients to switch to other hospitals for care is a key factor that can constrain any potential price increase by a merging hospital. *FTC v. Tenet Health Care Corp.*, 186 F. 3d 1045, 1054 (8th Cir., 1999) (finding that a switch of a small percentage of patients could render any potential price increase unprofitable); *see also California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109 (N.D. Cal. 2001) (using actual physician overlapping privileges data to counter managed care organizations' testimony that patients would not switch hospitals in the face of a price increase).

29. The physical closeness of all the hospitals in Lucas County also affects the competitive dynamics of the market. *See FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1053 (8th Cir. 1999) (finding the fact that over 22 percent of residents in the "most important zip codes" already use hospitals outside the proposed geographic market is a "check on the exercise of market power by the hospitals within the service area"). Courts have routinely dismissed testimony that location is a deterrent to patients switching hospitals when the testimony is based on anecdotal statements from MCOs and employers. *See Tenet*, 186 F.3d at 1054 (testimony of third party MCOs that they would be forced to accept price increases from the merged entity because patients insist on going to hospital closest to home was "suspect."); *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1131 (N.D. Cal. 2001) ("Informal, off-the-cuff remarks and anecdotal evidence concerning the marketplace are no substitute for solid economic evidence.") (quoting *FTC v. Freeman Hosp.*, 911 F. Supp. 1213, 1220 (W.D. Mo. 1995). This Court concludes that the distances between the Lucas County hospitals is a "check on the exercise of market power" by ProMedica and St. Luke's. *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1053 (8th Cir. 1999)

30. In light of the fact that this Court has previously found that rivals to ProMedica and St. Luke's are "poised for future expansion," declining demand will increase competition, and the fact that only a few patients need to switch to other hospitals which are nearby to constrain a price increase, this Court concludes that the joinder is not reasonably likely to cause anticompetitive effects. *See e.g., United States v. Baker Hughes Inc.*, 908 F.2d 981, 988-89 (D.C. Cir. 1990); *United States v. Rockford Mem'l*, 717 F. Supp. 1251, 1283-84 (N.D. Ill. 1989); *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999); *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109 (N.D. Cal. 2001).

31. In this matter several managed care organizations and employers testified during trial. However, testimony from industry participants is inherently suspect, particularly when the testimony is from large, sophisticated buyers. *See FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999) (stating that MCOs' testimony that they would unhesitatingly accept a price increase was contrary to their economic interests and, therefore suspect). The *Tenet* court noted that "large, sophisticated third-party buyers can and do resist price increases." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999). Moreover, large, sophisticated buyers – who have years of experience and access to information including their own insureds' historical utilization of hospitals in the market, hospital costs and revenues, and coordination of benefits – are expected to substantiate their apprehensions that the joinder would raise prices to an anticompetitive level. *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1131 (N.D. Cal. 2004). Otherwise, the testimony of market participants speaks only to current customer perceptions and habits, but does not address what customers would do in the event of a price increase. *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999). *See also FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 145-46 (D.D.C. 2004) (noting that many cases and antitrust authorities "do not accord great weight to the subjective views of customers in the market," and stating that the concern expressed by the customers at issue "is little more than a truism of economics: a decrease in the number of suppliers *may* lead to a decrease in the level of competition in the market.") (emphasis added).

32. This Court concludes that the subjective testimony of managed care organizations and employers offers the Court no probative evidence of post-joinder anticompetitive effects, and the Court disregards it. *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 146 (D.D.C. 2004) (discrediting testimony of customers because they lack expertise to opine on what will happen in the market in the future); *see also FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999) (dismissing testimony of market participants that failed to show where consumers could practicably go for inpatient hospital services).

IV. Absent the Joinder, St. Luke's Competitive Significance Would Decrease

33. As part of the Court's examination of the likely competitive effects of the joinder, it must consider what St. Luke's competitive strength and capability would have been absent the joinder. *See, e.g. United States v. Int'l Harvester, Co.*, 564 F.2d. 769, 773-76 (7th Cir. 1997) (holding that the district court properly considered the defendant seller's financial weakness and resultant weakness as a competitor in the context of ruling that a merger did not violate Section 7 of the Clayton Act); *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 155-57 (D.D.C. 2004) (seller's "weak competitive status remains relevant to...whether substantial anticompetitive effects are likely from the transaction.").

34. The District Court's analysis in *Arch Coal* exemplifies the type of analysis this Court applied. *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004). There, the court assessed the acquired entity's poor financial condition in determining that the FTC's claims of its competitive significance were "far overstated." *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 155-57 (D.D.C. 2004). For example, the court found the acquired entity "consistently lost money" and ruled that a "company with a positive EBITDA but a

negative net income is not sustainable for the long term." *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 155 (D.D.C. 2004). Importantly, the court noted that even though the failing firm defense did not apply, the acquired entity's "weak competitive status remains relevant to an examination of whether substantial anticompetitive effects are likely from a transaction." *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004). The evidence there showed that the acquired entity was struggling financially and would be a stronger competitor as a result of the acquisition than it would have been without. *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004). The court considered all this evidence before ultimately concluding that the FTC had failed to establish that the merger at issue there would likely result in anticompetitive effects. *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004).

35. As part of the Court's overall charge to evaluate the "structure, history, and probable future" of the general acute care inpatient hospital services market, it has also examined St. Luke's future competitive state within the context of the health care industry and rapid changes occurring within it. *United States v. General Dynamics Corp.*, 415 U.S. 486, 498 (1974).

36. This Court has evaluated St. Luke's deteriorating financial condition as part of its determination of whether anticompetitive effects will likely result from the joinder. *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 155-57 (D.D.C. 2004). This Court concludes that Complaint Counsel have "far overstated" St. Luke's competitive significance and that its joinder with ProMedica is not reasonably like to result in substantial anticompetitive effects because of St. Luke's sustained weak competitive status. *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004).

V. The Joinder Has Resulted In And Will Continue To Yield Meaningful Procompetitive Benefits For The Community

37. The court in *Arch Coal* considered evidence that the seller as part of a joined entity "will be a stronger competitive force in a post-merger market than [the seller] has been or will be if no merger occurs" in holding that the merger was not anticompetitive. *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004). Similarly, in *International Harvester*, the Seventh Circuit found that the district court had properly considered the fact that the merger agreement "substantially improved [the defendant seller's] financial, operating, and competitive position" in affirming that the agreement did not violate the antirust laws. *United States v. Int'l Harvester, Co.*, 564 F.2d. 769, 777 (7th Cir. 1997).

38. Evidence of qualitative and quantitative benefits to consumers of healthcare services in Toledo is recognized as relevant to a defense to a government challenge to a merger. *See FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1053-54 (8th Cir. 1999) (noting improved quality as a benefit of the merger); *In re Evanston Nw. Healthcare Corp.*, 2007 FTC 210, at *225-28 (F.T.C. Aug. 6, 2007) (reviewing respondents' proposed efficiencies).

39. Evidence of efficiencies may be introduced to rebut a plaintiff's *prima facie* case. *FTC v. Heinz Co.*, 246 F.3d 708, 720 (D.C. Cir. 2001); *United States v. Baker Hughes Inc.*, 908

F.2d 981, 982-3 (D.C. Cir. 1990). The Eleventh Circuit has held that "a defendant may rebut the government's prima facie case with evidence showing that the intended merger would create significant efficiencies in the relevant market." *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1222-23 (11th Cir. 1991) (holding that a defendant could overcome a presumption that the proposed acquisition would lessen competition by demonstrating that the acquisition would result in significant efficiencies to benefit consumers). Courts, therefore, should consider "evidence of enhanced efficiency in the context of the competitive effects of the merger." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999). Further, in the hospital merger context, evidence may show that "a hospital that is larger and more efficient ... will provide better medical care than either of those hospitals could separately." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999). Efficiencies are particularly compelling in the health care industry where hospitals face significant challenges to meet the demands of new health care legislation, and regulatory reforms are changing the competitive landscape such that "a merger deemed anticompetitive today, could be considered procompetitive tomorrow." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054-55 (8th Cir. 1999) (citing *United States v. Mercy Health Servs.*, 107 F.3d 632, 637 (8th Cir. 1997)). For example, in *Tenet*, the Eighth Circuit criticized the district court for not "properly evaluat[ing] evolving market forces in the rapidly-changing healthcare market." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1055 (8th Cir. 1999).

40. In light of its previous findings that St. Luke's has benefitted from the joinder, this Court concludes that the joinder will mean that St. Luke's "will be a stronger competitive force" than without the joinder, making anticompetitive effects unlikely. *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004). This Court also concludes that the St. Luke's joinder with ProMedica may create significant efficiencies that will benefit the community they serve if allowed to proceed. *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1222-23 (11th Cir. 1991).

41. Accordingly, this Court concludes Complaint Counsel have not met their burden of providing a Clayton Act Section 7 violation and will issue an order dismissing the Complaint with prejudice and entering judgment in favor of Respondent.

UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION

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

RESPONDENT PROMEDICA HEALTH SYSTEM, INC.'S,
PROPOSED ORDER DISMISSING COMPLAINT

The hearing in the administrative action *In the Matter of ProMedica Health System, Inc.*, Docket 9346, having concluded, the record being closed, counsel for both parties having briefed the relevant issues, and the Court being fully advised,

THE ADMINISTRATIVE LAW JUDGE FINDS:

1. Complaint Counsel has failed to meet its burden of proof in defining a proper relevant market in which to assess the competitive effects of the joinder of ProMedica and St. Luke's;

2. Complaint Counsel has failed to meet its burden of proof in establishing that the joinder of ProMedica and St. Luke's is reasonably likely to enable ProMedica to increase reimbursement rates from managed care organizations above competitive levels for a prolonged period in either of its alleged relevant markets; and

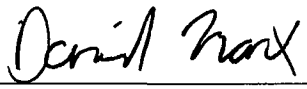
3. Complaint Counsel has failed to meet its burden of proof in establishing that the joinder of ProMedica and St. Luke's will result in a substantial lessening of competition in its alleged relevant markets in violation of Clayton Act Section 7, as amended.

THEREFORE, IT IS ORDERED that the administrative action *In the Matter of ProMedica Health System, Inc.*, Docket 9346 is hereby DISMISSED WITH PREJUDICE, AND THAT JUDGMENT IS ENTERED IN FAVOR OF THE RESPONDENT.

Dated this ___ day of _____, 20__.

_____
D. Michael Chappell
Administrative Law Judge

Dated: September 15, 2011



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I, Christine Devlin, hereby certify that I served a true and correct copy of the foregoing Respondent's Proposed Findings of Fact and Conclusions of Law, Public Version, upon the following individuals by hand on September 15, 2011.

Hon. D. Michael Chappell
Chief Administrative Law Judge
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I, Christine Devlin, hereby certify that I served a true and correct copy of the foregoing Respondent's Proposed Findings of Fact and Conclusions of Law, Public Version, upon the following individuals by electronic service:

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