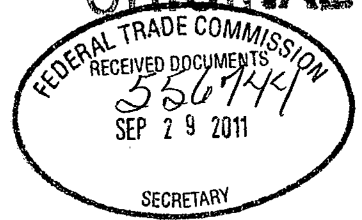
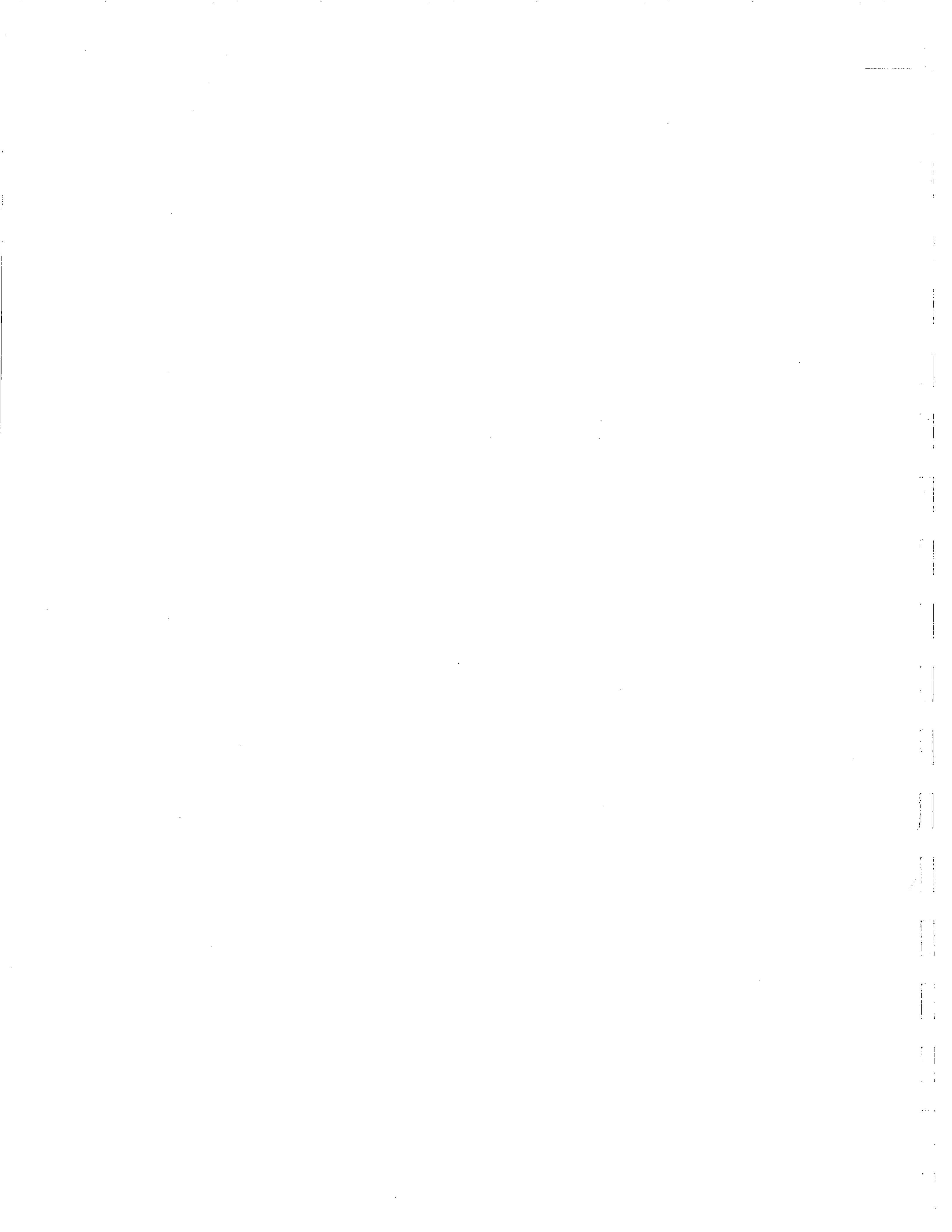


UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION

In the Matter of	)	
	)	
ProMedica Health System, Inc.	)	Docket No. 9346
a corporation	)	**PUBLIC VERSION**
	)	

RESPONDENT PROMEDICA HEALTH SYSTEM, INC.'S REPLIES TO COMPLAINT COUNSEL'S POST-TRIAL FINDINGS OF FACT AND CONCLUSIONS OF LAW



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I. EXECUTIVE SUMMARY

1. ProMedica Health System, Inc. ("ProMedica"), is a not-for-profit health system that, prior to the acquisition of St. Luke's Hospital ("St. Luke's"), operated three general acute-care hospitals in Lucas County, Ohio. ProMedica is the self-proclaimed dominant hospital system in Lucas County, as well as the highest-priced. ProMedica acquired St. Luke's, a formerly-independent not-for-profit community hospital located in Maumee, Ohio, on September 1, 2010, pursuant to a Joinder Agreement that vests ProMedica with total economic and decision-making control over St. Luke's (the "Acquisition"). (*See infra* Sections II, III).

Response to Finding No. 1:

The proposed finding violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record. To the extent Complaint Counsel reference other portions of their findings, Respondent will address those findings there.

2. In July 2010, the Federal Trade Commission ("FTC" or "Complaint Counsel") and the State of Ohio opened investigations into the Acquisition. The FTC and ProMedica subsequently entered into a voluntary Hold Separate Agreement ("HSA") that, to date, has restricted ProMedica from making certain significant changes to St. Luke's. In January 2011, the FTC and the State of Ohio filed an action in federal district court, seeking a temporary restraining order and preliminary injunction under Sections 13(b) and 16 of the Clayton Act, pending resolution of the administrative trial on the merits of the FTC's Section 7 claim. After several briefings, submission of hundreds of exhibits, and a one and a half-day preliminary injunction hearing, the federal district court judge granted the FTC's motion and issued a preliminary injunction extending the HSA. (*See infra* Section IV).

Response to Finding No. 2:

The proposed finding violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record. Furthermore, Respondent disputes this proposed finding because "what [federal district court Judge Katz] did or didn't do is not relevant [to this proceeding]." (ALJ D. Michael Chappell, Tr. 4437-4438). To the extent Complaint Counsel reference other portions of their findings, Respondent will address those findings there.

3. For purposes of analyzing the competitive effects of the Acquisition, the two relevant markets at issue are general acute-care inpatient hospital services ("GAC") and inpatient obstetrical services ("OB") sold to commercial health plans. It is appropriate and necessary to consider OB services as a distinct relevant market because these services are

offered by a different (more limited) set of providers in Lucas County and, thus, the competitive conditions differ. For both relevant services, the relevant geographic market is no broader than Lucas County, Ohio. (*See infra* Sections VI, VII, VIII).

Response to Finding No. 3:

The proposed finding is not a fact, but an improper legal argument. The proposed finding also violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record. To the extent Complaint Counsel reference other portions of their findings, Respondent will address those findings there.

4. The Acquisition increases market shares and market concentration substantially in both relevant markets, which already were highly concentrated before the Acquisition. Such high levels of market concentration create a strong presumption – in both markets – that the Acquisition is anticompetitive and unlawful. ProMedica's post-Acquisition market share is 58.3% for GAC services and 80.5% for OB services. In the GAC market, concentration under the Herfindahl-Hirschman Index ("HHI") rises by 1,078 points to 4,391; in the obstetrics market – a duopoly after the Acquisition – concentration rises by 1,323 points to 6,854. (*See infra* Section IX). These levels far exceed the levels required to create a presumption of illegality, and also exceed, by a wide margin, levels that have been found by numerous courts to be sufficiently high to warrant condemning proposed mergers.

Response to Finding No. 4:

The proposed finding is not a fact, but an improper legal argument. The proposed finding also violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record. To the extent Complaint Counsel reference other portions of their findings, Respondent will address those findings there.

5. Additional evidence presented by Complaint Counsel confirms and strengthens the presumption of competitive harm created by the market-concentration figures. This evidence includes hundreds of ordinary-course documents from ProMedica, St. Luke's, third-party hospitals and health plans; the analysis of three expert witnesses; fact-witness testimony from sixteen investigational hearings and thirty depositions; and live testimony of 29 fact witnesses and five expert witnesses. For example, an October 2009 presentation to the St. Luke's Board of Directors stated that a "St. Luke's affiliation with ProMedica has the greatest potential for higher hospital rates. A ProMedica-SLH partnership would have a lot of negotiating clout." Formal due-diligence team notes, distributed among St. Luke's executives and assessing potential affiliation scenarios, pointed out that an affiliation with ProMedica "could still stick it to employers, that is, to

continue forcing high rates on employers and insurance companies." (*See infra* Sections X-XIII).

Response to Finding No. 5:

The proposed finding is not a fact, but an improper legal argument. The proposed finding also violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record. To the extent Complaint Counsel reference other portions of their findings, Respondent will address those findings there.

6. The evidence demonstrates that, prior to the Acquisition, ProMedica and St. Luke's were close, vigorous competitors. The Acquisition eliminated this competition and the benefits – in price, quality, and service – that flowed from that competition to Lucas County residents. After the Acquisition, ProMedica becomes a "must-have" health system that will exercise its market power to obtain higher rates from health plans. These higher rates are imposed on local employers, but ultimately are borne by the residents of Lucas County, who will face higher deductibles, co-pays, or other out-of-pocket costs for healthcare services. (*See infra* Sections X-XIII).

Response to Finding No. 6:

The proposed finding is not a fact, but an improper legal argument. The proposed finding also violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record. To the extent Complaint Counsel reference other portions of their findings, Respondent will address those findings there.

7. The evidence is clear that entry or expansion will not be timely, likely, or sufficient to counter the anticompetitive effects resulting from the Acquisition. (*See infra* Section XIV).

Response to Finding No. 7:

The proposed finding is not a fact, but an improper legal argument. The proposed finding also violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record. To the extent Complaint Counsel reference other portions of their findings, Respondent will address those findings there.

8. The Acquisition does not produce cognizable, merger-specific efficiencies that outweigh the competitive harm resulting from the transaction. The paltry efficiencies claims that Respondent has put forth are not credible, not substantiated, and appear designed for litigation. (*See infra* Section XV).

Response to Finding No. 8:

The proposed finding is not a fact, but an improper legal argument. The proposed finding also violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record. To the extent Complaint Counsel reference other portions of their findings, Respondent will address those findings there.

9. Respondent admits that St. Luke's is not a "failing firm." Not only was St. Luke's not in grave danger of imminent failure, it was in fact, successfully rebounding under the leadership of a relatively new CEO at the time of Acquisition. Absent the Acquisition, St. Luke's would have remained a viable, independent competitor for the foreseeable future. (*See infra* Section XVI).

Response to Finding No. 9:

The proposed finding is not a fact, but an improper legal argument. The proposed finding also violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record. To the extent Complaint Counsel reference other portions of their findings, Respondent will address those findings there.

10. The Acquisition has eliminated vital competition between ProMedica and St. Luke's, and will result in higher prices, thus harming the residents of Lucas County. A remedy is justified and needed to prevent the Acquisition's substantial lessening of competition. Only a full and complete divestiture of St. Luke's, the traditional and proper remedy, will restore competition in Lucas County. (*See infra* Section XVIII).

Response to Finding No. 10:

The proposed finding is not a fact, but an improper legal argument. The proposed finding also violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record. To the extent Complaint Counsel reference other portions of their findings, Respondent will address those findings there.

II. THE PARTIES TO THE ACQUISITION

A. ProMedica Health System, Inc.

11. ProMedica Health System, Inc. ("ProMedica") is a not-for-profit healthcare system incorporated under and by virtue of the laws of Ohio. ProMedica is headquartered at 1801 Richard Road, Toledo, Ohio, 43607. ProMedica's healthcare system serves northwestern and west-central Ohio and southeastern Michigan. (Answer at ¶ 7).

Response to Finding No. 11:

Respondent has no specific response.

12. Excluding St. Luke's, ProMedica operates three general acute-care hospitals in Lucas County, Ohio: The Toledo Hospital ("TTH"); Flower Hospital ("Flower"); and Bay Park Community Hospital ("Bay Park"). (Answer at ¶ 8). ProMedica's Lucas County hospitals offer general acute care inpatient services. (Joint Stipulations of Law and Fact, JX00002A ¶ 4). ProMedica also operates Toledo Children's Hospital, which is located on the same campus as TTH. (Answer at ¶ 8; Oostra, Tr. 5773; Shook, Tr. 1030; RX-194 at 32 (Wakeman, Decl.), *in camera*).

Response to Finding No. 12:

Respondent has no specific response.

13. TTH has about 550 staffed beds and offers all basic general acute-care services, as well as more specialized, higher-acuity tertiary services. (Oostra, Tr. 5773-5774; PX01904 at 017, 027 (Steele, IHT at 58-59, 99), *in camera*; PX02389 at 015 (Navigant Proposal Presentation), *in camera*). TTH also houses a Level I Trauma Center. (Oostra, Tr. 5774; PX01904 at 014 (Steele, IHT at 49), *in camera*). Flower and Bay Park are community hospitals and do not offer tertiary-level services. (PX01902 at 008 (Sheridan, IHT at 23-24), *in camera*). Flower has about 250 staffed beds and Bay Park has about 80 staffed beds. (Oostra, Tr. 5777-5778; PX02389 at 015 (Navigant Proposal Presentation), *in camera*); PX01904 at 017 (Steele, IHT at 59), *in camera*). All three hospitals offer inpatient obstetrics services. (Oostra, Tr. 5774, 5777-5778; PX01906 at 047 (Oostra, IHT at 184), *in camera*).

Response to Finding No. 13:

The proposed finding is an incomplete statement of the record. TTH is also only one of two Lucas County hospitals to offer Level III inpatient OB services. (RPF 74).

14. ProMedica also owns Paramount Health Care ("Paramount"), a for-profit corporation that is one of the largest commercial health plans in Lucas County. (Answer at ¶ 8; Wachsman, Tr. 4855; Hanley, Tr. 4784-4785, *in camera*; PX00270 at 024 (S&P Credit Presentation)). Some of the business decisions made on behalf of Paramount or

ProMedica hospitals may have an impact on the other, and if a business decision was to have such an impact, an evaluation of that impact may be performed. (Joint Stipulations of Law and Fact, JX00002A ¶ 14).

Response to Finding No. 14:

Respondent has no specific response.

15. ProMedica is by far the largest employer of physicians in Lucas County. (Joint Stipulations of Law and Fact, JX00002A ¶ 26; Answer at ¶ 8). ProMedica employs over 300 physicians. (Oostra, Tr. 5795).

Response to Finding No. 15:

The proposed finding misstates the record. "ProMedica is the largest employer of physicians in Lucas County," not "by far" the largest. (JX00002A ¶ 26).

16. ProMedica is the dominant hospital system in Lucas County, a fact its executives have highlighted in internal analyses and external presentations. (PX00270 at 025 (S&P Credit Presentation) ("ProMedica Health System has market dominance in the Toledo MSA"); PX00221 at 002 (ProMedica 2009 Presentation) ("it is critical that ProMedica evolves to maintain its competitive dominance in the Region"); PX00319 (TTH SWOT Analysis) ("Dominant market share position")).

Response to Finding No. 16:

The proposed finding of fact mischaracterizes the record. ProMedica's Chief Financial Officer, Ms. Hanley, testified that ProMedica used the term "dominance" in its presentation to Standard & Poor's in order to put its "best foot forward" to the credit rating agency. (Hanley, Tr. 4758, *in camera*). Furthermore, the data that ProMedica relied on to make that claim came from 2004 through 2006. (Hanley, Tr. 4758, 4811, *in camera*). Since 2006, ProMedica's market share has declined. (Hanley, Tr. 4811, *in camera*). ProMedica's CEO, Mr. Oostra, further testified that the statement does not reflect ProMedica's view today. (Oostra, Tr. 5966).

17. Both before and after the Acquisition, ProMedica's market share is higher than its competitors in Lucas County, whether calculated by registered beds, beds-in-use, or occupancy. (Joint Stipulations of Law and Fact, JX00002A ¶ 17). ProMedica accounted for almost 50 percent of patient days for general acute-care services in Lucas County from July 2009 through March 2010, before the acquisition of St. Luke's. (PX02148 at 143 (Ex. 6) (Town Expert Report), *in camera*); PX02150 at 001 (market share chart)).

ProMedica accounted for 71.2 percent of patient days for obstetrics services during the same period. (PX02148 at 143 (Ex. 6) (Town Expert Report), *in camera*; PX02150 at 002 (market share chart)).

Response to Finding No. 17:

Professor Town's market shares for inpatient general acute care services are flawed not only because he uses less than one year's worth of data, (PX02148 at 143, *in camera*) ("Based on hospital discharges with commercial insurance from July 2009 through March 2010"), but also because he limits his "market" to only those general acute care inpatient services (identified as "diagnostic related groups" or "DRGs") that both ProMedica and St. Luke's provided to at least three commercially-insured patients (RPF 1491), thereby eliminating from his "market" (and his share calculations) many services that ProMedica, Mercy, and UTMC offer and provide. (RPF 1489-1493, 1504, 1510, *in camera*). Professor Town also excluded overlapping St. Luke's and ProMedica DRGs for which St. Luke's and ProMedica compete with hospitals outside of Lucas County (RPF 1494-1495), and DRGs with a case weight index, which reflects complexity of care, greater than two. (RPF 1496). Professor Town included, however, some DRGs with case weights higher than four, which captures some services that could be classified as tertiary or quaternary medical services. (RPF 1500).

Moreover, Professor Town's market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

18. Prior to the Acquisition, ProMedica considered St. Luke's a competitor for general acute care services and obstetric services. (Joint Stipulations of Law and Fact, JX00002A ¶ 20); Response to RFA at ¶ 41; Oostra, Tr. 5801, 6038-6039, 6040).

Response to Finding No. 18:

Respondent has no specific response.

19. ProMedica receives the highest commercial reimbursement rates in Lucas County. (Radzialowski, Tr. 684, *in camera*; Pugliese, Tr. 1484-1485, 1513, 1656-1657, *in camera*; Pirc, Tr. 2238, *in camera*; PX02296 at 001 (Anthem notes), *in camera*; PX02125 at 027 (Ex. 4) (Town, Decl.), *in camera* (calculating that ProMedica's rates are { } percent higher than St. Luke's' rates, as a volume-weighted average)). Health plans have told ProMedica executives that its rates are among the highest in the state of Ohio. (PX00153 at 001 (ProMedica Jan. 2009 e-mail) ("we hear from payors we are among the most expensive in ohio [sic]"); Oostra, Tr. 5996).

Response to Finding No. 19:

The proposed finding is an incomplete statement of the record and mischaracterizes the record. {

} (Radzialowski, Tr. 684, *in camera*; RPF 1527, *in camera*). {

} (Pugliese, Tr. 1513, *in camera*). Some of the variation in rates can also be explained by MCO testimony. {

} (Pirc, Tr. 2316-2315, *in camera*). {

} (Pirc, Tr. 2316, *in camera*). {

} (Pirc, Tr. 2316, *in camera*).

20. In 2009, ProMedica's total net revenues exceeded $1.6 billion. (Answer at ¶ 8; Oostra, Tr. 6123; PX00015 at 006 (ProMedica and Subsidiaries Consolidated Financial Statements 2009: "Total revenues, gains, and other support" line)). ProMedica also had a reserve fund with more than $1 billion, as of December 31, 2009. (PX00009 at 048-049

(ProMedica Credit Presentation); PX00015 at 004 (ProMedica and Subsidiaries Consolidated Financial Statements 2009: sum of "Cash and cash equivalents," "Marketable securities," and "Internally designated for capital acquisition" lines); Hanley, Tr. 4804-4805, *in camera* (over $1 billion in reserve fund for last several years); Johnston, Tr. 5495, *in camera* (about $1 billion at time of Acquisition)). At the end of 2009, ProMedica's total assets exceeded $2.4 billion. (PX00009 at 062 (ProMedica Credit Presentation); Oostra, Tr. 6122-6123).

Response to Finding No. 20:

Respondent has no specific response.

21. Approximately 34 percent of TTH's 2009 patient days was derived from commercially-insured patients. (PX02148 at 171 (Ex. 16) (Town Expert Report), *in camera* (commercial share, third quarter 2009 to first quarter 2010 data)). For Flower and Bay Park, the percentage of patient days that came from commercially-insured patients was 28.4 and 22.5 percent, respectively. (PX02148 at 171 (Ex. 16) (Town Expert Report), *in camera* (commercial share, third quarter 2009 to first quarter 2010 data)).

Response to Finding No. 21:

The proposed finding is an incomplete statement of the record. Approximately 66-71 percent of ProMedica's hospitals' 2009 patient days were derived from non-commercially insured patients, such as Medicare and Medicaid which alone comprise over 41 percent of ProMedica's payor mix. (RPF 469). ProMedica, like all healthcare providers, cannot negotiate Medicare and Medicaid reimbursement rates; they are established by CMS, and the provider community simply agrees to accept that level of reimbursement. (RPF 249). Medicare and Medicaid reimbursements do not cover the costs of providing the hospital services to those patients. (RPF 250). For example, {

} (RPF 470, 472, *in camera*).

22. ProMedica's hospitals in Lucas County have had lower quality measures and outcomes than St. Luke's. (PX01172 at 001 (Aug. 2009 St. Luke's email), *in camera*; PX01030 at 018-019 (St. Luke's Board Affiliation Analysis Update Oct. 2009), *in camera*; PX01016 at 006 (St. Luke's Board Meeting Affiliation Update Dec. 2009), *in camera*; Nolan, Tr. 6339-6343, *in camera*; PX01221 at 068 (Sept. 2010 Navigant report), *in camera*). In fact, St. Luke's Board of Directors and executives worried that an affiliation with

ProMedica might lower St. Luke's quality. (Rupley, Tr. 2011, *in camera* ("[W]e wanted to make sure that [St. Luke's] quality ratings didn't go down as a result of joining the ProMedica system.") (discussing PX01560 at 003 (Notes from Due Diligence Meetings: Aug. 2009), *in camera*; PX01130 at 002 (Notes from Due Diligence Meetings, Aug. 2009), *in camera* ("Some of ProMedica's quality outcomes/measures are not very good. Would not want them to bring poor quality to St. Luke's."); PX01016 at 023 (St. Luke's Board Meeting Affiliation Update Dec. 2009), *in camera*; PX01911 at 061 (Wakeman, IHT at 237), *in camera* (acknowledging concern that affiliating with a lower quality institution might have an adverse impact on St. Luke's)). Mr. Wakeman informed St. Luke's Board of Directors that ProMedica "[a]cknowledges they need to improve" quality measures. (PX01030 at 018 (St. Luke's Board Affiliation Analysis Update Oct. 2009), *in camera*; *see also* PX01920 at 025 (Wakeman, Dep. at 92-93), *in camera*).

Response to Finding No. 22:

The proposed finding is inaccurate and misleading. Data, documents and testimony reveal that all of the hospitals in Lucas County are quality hospitals. (RPF 1446). For example, Lucas County residents, as well as physicians, perceive quality to be comparable among TTH, St. Vincent, and St. Luke's. (RPF 1447-1448).

Nevertheless, quality of care can be defined by many different measures and metrics, each of varying reliability. (RPF 1431-1444). {

} (RPF 1454, *in camera*).

{

} (RPF 1455, *in camera*).

{

} (RPF 1462, *in camera*). {

} (RPF 1463, *in camera*). {

}

(RPF 1464, *in camera*). Mr. James Black, the Chairman of the Board of St. Luke's Hospital, testified that since the joinder with ProMedica, St. Luke's has been able to "recover [its] sagging quality numbers." (Black, Tr. 5666).

B. St. Luke's Hospital

23. St. Luke's Hospital ("St. Luke's"), located at 5901 Monclova Road, Maumee, Ohio, 43537, is a formerly independent, non-profit general acute-care community hospital. (Answer at ¶ 9).

Response to Finding No. 23:

Respondent has no specific response.

24. St. Luke's offers general acute care inpatient services. (Joint Stipulations of Law and Fact, JX00002A ¶ 5).

Response to Finding No. 24:

Respondent has no specific response.

25. St. Luke's has 178 staffed beds and provides a full array of general acute-care hospital services and some tertiary cardiac services through its Heart Center, which opened in 2001. (Wakeman, Tr. 2638, *in camera* (about 175-185 staffed beds), 2753-2754; PX01322 (St. Luke's Aug. 2010 e-mail), *in camera*; PX01909 at 029 (Dewey, IHT at 109), *in camera*; PX01022 at 005 (St. Luke's Revenue and Expense Milestone Descriptions)). St. Luke's currently performs few, if any, tertiary services and no quaternary services. (Joint Stipulations of Law and Fact, JX00002A ¶ 6).

Response to Finding No. 25:

The proposed finding is an incomplete statement of the record. 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. (RPF 121). St. Luke's does not offer more complex obstetrical services. (RPF 122).

Furthermore, the proposed finding is misleading to the extent it implies that St. Luke's currently performs fewer services than it did prior to the joinder. Such an implication is clearly

contradicted by the record. Indeed, {

} (RPF 2230, *in camera*).

26. St. Luke's was broadly recognized as a low-cost, high-quality hospital before it was acquired by ProMedica. (Answer at ¶ 9; Wakeman, Tr. 2494-2496; Sandusky, Tr. 1310-1311; PX00390 at 001 (ProMedica May 2010 news release); PX01072 at 001 (Key Messages from St. Luke's Nov. 2009); PX01914 at 016 (Pirc, IHT at 55-56), *in camera*).

Response to Finding No. 26:

The proposed finding misstates the record. Respondent's Answer admitted that St. Luke's was recognized as a high-quality low-cost hospital, not "broadly recognized." (Answer at ¶ 9).

27. St. Luke's is located in a desirable and strategically important southwestern suburb in Lucas County. (Wakeman, Tr. 2477; 2478-2481; PX01911 at 015 (Wakeman, IHT at 53), *in camera* ("terrific location"); PX01906 at 031 (Oostra, IHT at 117-118), *in camera* ("very appealing location"); PX00009 at 029 (ProMedica Credit Presentation) ("desirable section of the Toledo metro area where PHS lacks a physical presence"); PX01917 at 017 (Radzialowski, Dep. at 62) ("huge population that resides in Southwest Toledo relies on [St. Luke's] as their primary source of secondary care, hospital care"), PX01917 at 020 (Radzialowski, Dep. at 76), *in camera*). St. Luke's is easily accessible from major highways, and its location provides it with access to a growing population of employed and commercially-insured patients. (Wakeman, Tr. 2479-2481; PX01911 at 015 (Wakeman, IHT at 53-55), *in camera*; Oostra, Tr. 6036-6038; Nolan, Tr. 6287, *in camera* (St. Luke's is "in a highly visible area, right off the highway, good highway access, and it's an area with good demographics, reasonable population growth and good average household incomes."); PX01132 at 002-004 (St. Luke's evaluation), *in camera*; PX01215 at 003 (Navigant Presentation: ProMedica Health System Market and Facility Assessment Summary), *in camera* ("good access and visibility from the Interstate"); JX00003-004 (photo of freeway next to St. Luke's)).

Response to Finding No. 27:

The proposed finding is misleading. To begin, Lucas County, not the "southwestern portion of Lucas County," is the geographic market Complaint Counsel alleges in their Complaint. (Compl. at ¶ 16). In addition, the record shows that a hospital's location is not an

important factor because patient origin and drive time analyses show that patients do not necessarily go to the next closest hospital. (RPF 1483). For example, the vast majority of patients that reside in St. Luke's service area travel to hospitals other than St. Luke's to receive general acute care inpatient services. (RPF 1480). Physicians note that some of their patients drive past St. Luke's to seek services from hospitals located further away from their homes. (RPF 218). A drive time analysis shows that hospitals in Toledo 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 in minimal. (RPF 1210). 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 obstetric services, indicating that location is not a material factor when patients choose a hospital. (RPF 1218).

28. Prior to the Acquisition, St. Luke's considered ProMedica, Mercy, and UTMC to be competitors. (Joint Stipulations of Law and Fact, JX00002A ¶ 19; Response to RFA at ¶ 40; Wakeman, Tr. 2758).

Response to Finding No. 28:

Respondent has no specific response.

29. St. Luke's was not an in-network provider with Paramount from 2001 through August 31, 2010. (Joint Stipulations of Law and Fact, JX00002A ¶ 46).

Response to Finding No. 29:

Respondent has no specific response.

30. St. Luke's total revenues were approximately $156 million in 2009. (PX01006 at 005 (OhioCare and Subsidiaries 2009 Consolidated Financial Report)).

Response to Finding No. 30:

The proposed finding is misleading. In 2009, St. Luke's had $156 million in "total unrestricted revenue, gains, and other support." (PX01006 at 005). Its total expenses in 2009

were $176 million, resulting in an operating loss of approximately $20 million. (PX01006 at 005).

31. As of August 31, 2010, St. Luke's held a total of at least $65 million in cash and investment balances. (Joint Stipulations of Law and Fact, JX00002A ¶ 34). As of December 31, 2010, St. Luke's held a total of at least $70 million in cash and investment balances. (Joint Stipulations of Law and Fact, JX00002A ¶ 35).

Response to Finding No. 31:

Respondent has no specific response.

32. As of August 31, 2010, St. Luke's had enough cash and investments on its financial statement to pay off all of its outstanding debt. (Joint Stipulations of Law and Fact, JX00002A ¶ 24).

Response to Finding No. 32:

Respondent has no specific response.

33. In 2009, St. Luke's admitted 10,969 inpatients, performed 22,811 outpatient surgeries, had 40,781 emergency-department visits, and had 26,610 patient days. (PX01149 at 009 (St. Luke's Presentation May 2010), *in camera*; PX02148 at 171 (Ex. 16) (Town Expert Report), *in camera* (total patient days, third quarter 2009 to first quarter 2010 data)). As a result of St. Luke's growth prior to the Acquisition, St. Luke's was the third-largest hospital in Lucas County based on commercial discharges. (Wakeman, Tr. 2600; PX02148 at 171 (Ex. 16) (Town Expert Report), *in camera*).

Response to Finding No. 33:

The proposed finding is misleading, because the data cited represent both commercially insured and non-commercially insured patients. (PX01149 at 009, *in camera*). The product market that Complain Counsel alleges in their Complaint is limited to general acute-care inpatient hospital services sold to commercial health plans. (Compl. at ¶ 12). Only about 31 percent of St. Luke's patient days in 2009 were from commercially-insured patients. (CCPF 35).

34. In Lucas County, St. Luke's had a market share based on patient days of 11.5 percent for GAC services and 9.3 percent for OB services from July 2009 through March 2010. (PX02148 at 143 (Ex. 6) (Town Expert Report), *in camera*; PX02150 (market share charts)).

Response to Finding No. 34:

The proposed finding is misleading. Many DRGs and service lines cost more than others, require longer stays, and, hence, generate higher revenues. (RX-71(A) at 000036), *in camera*). Market shares based on patient days would not reflect these differences. (RX-71(A) at 000036), *in camera*). Because St. Luke's has primarily low risk and low acuity patients, use of patient day market shares would artificially inflate St. Luke's shares. (RX-71(A) at 000036), *in camera*). Using revenue-based (or billed charges) shares, St. Luke's has approximately a { } percent market share of an all general acute care market (including OB). (RX-71(A) at 000036), *in camera*). In a separate OB market, St. Luke's has a } percent market share, based on billed charges. (RX-71(A) at 000036-000037, *in camera*).

35. In 2009, St. Luke's generated approximately 31 percent of its patient days from commercially-insured patients, a higher percentage than all but one of ProMedica's Lucas County hospitals. (PX02148 at 171 (Ex. 16) (Town Expert Report), *in camera*).

Response to Finding No. 35:

The proposed finding is an incomplete statement of the record. By Complaint Counsel's own calculation, therefore, 69 percent of St. Luke's patient days were from non-commercially insured patients, including Medicare and Medicaid patients, which reimburse St. Luke's below the cost of care. (RPF 250).

36. Commercial payors represent about 39-40 percent of St. Luke's net patient revenue. (Wakeman, Tr. 2751).

Response to Finding No. 36:

The proposed finding is an incomplete statement of the record. The majority of St. Luke's net patient revenue (approximately 60 percent) comes from non-commercial payors, including Medicare and Medicaid, which reimburse St. Luke's below cost. (RPF 250, 1480).

III. THE ACQUISITION

37. On May 25, 2010, ProMedica entered into a Joinder Agreement with OhioCare Health System, Inc. ("OHS"), St. Luke's, and St. Luke's Foundation, Inc. ("SLF") to acquire St.

Luke's, SLF, and other affiliates. (PX00058 (Joinder Agreement); Oostra, Tr. 6115; PX00390 at 001 (ProMedica News Release)).

Response to Finding No. 37:

Respondent has no specific response.

38. Prior to the Acquisition, OHS was the parent company of St. Luke's, SLF, and other affiliates (collectively, "OHS Affiliates"). (PX00058 at 006 (Joinder Agreement Recitals)).

Response to Finding No. 38:

Respondent has no specific response.

39. Upon consummation of the Acquisition on August 31, 2010 (effective as of Sept. 1, 2010), ProMedica became the sole corporate member or shareholder of St. Luke's and its affiliated entities. (Answer at ¶ 2, 11; PX00058 at 009 (Joinder Agreement § 3.1)).

Response to Finding No. 39:

Respondent has no specific response.

40. The Joinder Agreement ("Agreement") vests ProMedica with economic and decision-making control over St. Luke's and the other OHS Affiliates. Among other things, and subject only to certain limited qualifications, ProMedica has the right to: (a) appoint ProMedica nominees to the boards of directors of St. Luke's and the other OHS Affiliates; (b) approve St. Luke's-nominated appointments to the boards of St. Luke's and the other OHS Affiliates; (c) remove members from the boards of St. Luke's and the other OHS Affiliates; (d) adopt and approve strategic plans and annual operating and capital budgets for St. Luke's and other OHS Affiliates; (e) authorize and approve non-budgeted operating expenses and capital expenditures above certain amounts; (f) authorize and approve the incurrence or assumption of debt above certain amounts; (g) authorize and approve contracts for expenditures above certain amounts; (h) authorize and approve any merger, consolidation, sale, or lease of St. Luke's and the other OHS Affiliates; and (i) appoint and remove the President, Secretary, and Treasurer of St. Luke's and the other OHS Affiliates. (PX00058 at 016-018 (Joinder Agreement § 4.1)).

Response to Finding No. 40:

The proposed finding mischaracterizes the record. The Joinder Agreement vests ProMedica with "reserve powers" regarding St. Luke's. (PX00058 at 016-018). Mr. Oostra testified that the reserve powers "really aren't used or needed" anymore with St. Luke's, but ProMedica has them in place "to make sure the whole system works together." (Oostra, Tr.

5856-5658). Indeed, ProMedica has never not approved any of the directors that St. Luke's has nominated to its board. (Oostra, Tr. 6239). Respondent also refers to its response to Complaint Counsel's proposed findings 1257 and 1258, which it incorporates here by reference.

41. ProMedica also has the exclusive right to negotiate contracts with managed care organizations on behalf of St. Luke's. (PX00058 at 025, 058 (Joinder Agreement § 9, Ex. 9); PX01905 at 042 (Wachsman, IHT at 162), *in camera*). Since the Acquisition, ProMedica has negotiated with health plans for general acute care services performed at St. Luke's. (Joint Stipulations of Law and Fact, JX00002A ¶ 16). ProMedica admits that it has negotiated and will continue to negotiate reimbursement rates with health plans for St. Luke's. (Response to RFA at ¶ 34).

Response to Finding No. 41:

The proposed finding is an incomplete statement of the record. {

} (RPF 1351, *in camera*).

{

} (RPF 1351, *in camera*).

42. ProMedica admits that the Acquisition constitutes an acquisition under Section 7 of the Clayton Act. (Answer at ¶ 10).

Response to Finding No. 42:

Respondent has no specific response.

43. ProMedica's ordinary course internal analysis concluded that the "[b]ottom line, for accounting purposes" is that ProMedica "has acquired St. Luke's." (PX00223 at 005 (ProMedica Jul. 2010 e-mail)). ProMedica's CFO confirmed in testimony that ProMedica had "complete economic control" over St. Luke's. (PX01903 at 035 (Hanley, IHT at 130), *in camera*).

Response to Finding No. 43:

Respondent has no specific response.

44. The Agreement requires ProMedica to add St. Luke's to the provider network of its health-insurance subsidiary, Paramount, at rates comparable to other general acute-care

hospitals in the ProMedica system. (PX00058 at 022-023 (Joinder Agreement § 6.2(i)); PX00140 at 002 (Second Amendment to Joinder Agreement § 1.c)). St. Luke's was not an in-network provider with Paramount from 2001 through August 31, 2010. (Joint Stipulations of Law and Fact, JX00002A ¶ 46). After the consummation of the Acquisition, Paramount added St. Luke's to its network. (Oostra, Tr. 5788; Wakeman, Tr. 2584; PX01918 at 020 (Oostra, IHT at 72), *in camera*).

Response to Finding No. 44:

Respondent has no specific response.

45. The Agreement requires ProMedica to maintain St. Luke's as an acute-care hospital providing six general categories of services in its current location for ten years, but does not require ProMedica to maintain or provide any other services at St. Luke's that are not specified in the Agreement. Thus, for example, ProMedica could cease offering – or reduce service levels – for services including oncology, cardiology, orthopedics, spinal neurosurgery, pediatrics, or diabetes care. (PX00058 at 023, 045-046 (Joinder Agreement §§ 7.1, 13.2-13.3); PX02102 at ¶ 5 (Wakeman, Decl.) (identifying St. Luke's' current services); *see also* PX01920 at 040 (Wakeman, Dep. at 152-153), *in camera*).

Response to Finding No. 45:

Respondent disputes the proposed finding because it mischaracterizes the record and is contradicted by record evidence. ProMedica has not "cease[d] offering [] services" at St. Luke's since the joinder. {

} (RPF 2225, *in camera*, 2230, *in camera*). In fact, ProMedica has *added* beds to St. Luke's. (RPF 2232).

46. By September 1, 2012, ProMedica will have the right to approve two-thirds of the members of St. Luke's Board of Directors. (Joint Stipulations of Law and Fact, JX00002A ¶ 25; Response to RFA at ¶ 50).

Response to Finding No. 46:

Respondent has no specific response.

47. ProMedica already has significant influence on St. Luke's Board of Directors after the Acquisition. ProMedica has already added ProMedica representatives to the St. Luke's Board of Directors and St. Luke's Foundation Board. (Oostra, Tr. 5856-5857).

ProMedica also has the power to approve and remove any board member at any time from the St. Luke's Hospital Board and the Foundation Board with or without cause. (Black, Tr. 5674; PX00058 at 016-017 (Joinder Agreement § 4.1)). ProMedica also has the right to appoint the president and CEO, and approve budgets and strategic plans, for St. Luke's. (Oostra, Tr. 5857-5858; Black, Tr. 5674-5675; PX00058 at 017-019 (Joinder Agreement § 4.1). The St. Luke's Board of Directors is subject to a list of reserve powers. (PX00058 at 016-018 (Joinder Agreement § 4.1). For example, St. Luke's cannot sell property or assets without ProMedica's approval. (Oostra, Tr. 5857; PX00058 at 017 (Joinder Agreement § 4.1). ProMedica can remove all of the profits from St. Luke's and use it for any purpose that it wanted, and ProMedica has the right to unilaterally amend the articles of incorporation or the bylaws of St. Luke's. (Black, Tr. 5676; PX00058 at 018, 023-025 (Joinder Agreement §§ 4.1, 7).

Response to Finding No. 47:

The proposed finding mischaracterizes the record. As Mr. Oostra testified, these "reserve powers" "really aren't used or needed" anymore with St. Luke's, but ProMedica has them in place "to make sure the whole system works together." (Oostra, Tr. 5856-5658). Indeed, ProMedica has never not approved any of the directors that St. Luke's has nominated to its board. (Oostra, Tr. 6239). Mr. Black, Chairman of the Board of St. Luke's Hospital, testified that regarding the relationship between St. Luke's and ProMedica with respect to governance, he has "had nothing to indicate, either in action or in words, that ProMedica has any intention of altering the current governance system." (Black, Tr. 5665).

48. ProMedica's acquisition of St. Luke's and the other OHS Affiliates was not reportable under the Hart-Scott-Rodino Antitrust Improvements Act of 1976. (15 U.S.C. § 18a; PX00057 at 001 (Jan. 2010 e-mail from FTC to ProMedica counsel)).

Response to Finding No. 48:

Respondent has no specific response.

IV. PROCEDURAL HISTORY

A. Complaint Counsel's Antitrust Investigation

49. In July 2010, the FTC and the State of Ohio staff began preliminary investigations into the Acquisition's potential effects on competition for hospital services in Toledo, Ohio, and the surrounding area.

Response to Finding No. 49:

Respondent has no specific response.

50. On August 9, 2010, the Commission issued a resolution authorizing the use of compulsory process, including subpoenas and civil investigative demands ("CIDs"), to obtain relevant information for the investigation. (*See* Emergency Petition for an Order Enforcing Subpoenas *Duces Tecum* and Civil Investigative Demands ("FTC Petition"), Petition Ex. 2, *FTC v. ProMedica Health Sys., Inc.*, No. 3:10-cv-02340-DAK (N.D. Ohio Oct. 13, 2010)).

Response to Finding No. 50:

Respondent has no specific response.

51. On August 13, 2010, the Commission issued six subpoenas to ProMedica and four subpoenas to St. Luke's, compelling named persons to provide testimony under oath in investigational hearings. (FTC Petition, Petition Ex. 1 at ¶ 14 (Liu, Decl.), *ProMedica Health Sys., Inc.*, No. 3:10-cv-02340-DAK). Three additional subpoenas requiring testimony from the merging parties were issued subsequently. The 13 investigational hearings resulting from these subpoenas were held between September 13 and October 15, 2010.

Response to Finding No. 51:

Respondent has no specific response.

52. On August 25, 2010, the FTC issued subpoenas and CIDs to ProMedica, Paramount, and St. Luke's, with a return date of September 24, 2010. (FTC Petition, Petition Ex. 1 at ¶ 17 (Liu, Decl.), *ProMedica Health Sys., Inc.*, No. 3:10-cv-02340-DAK). ProMedica, Paramount, and St. Luke's failed to comply with the CIDs and subpoenas by September 24, 2010, or in the days thereafter. (*See* FTC Petition, Petition Ex. 1 at ¶¶ 36-37). Ultimately, on October 13, 2010, the FTC filed an emergency petition in the Northern District of Ohio to enforce its subpoenas and CIDs. (FTC Petition, *ProMedica Health Sys., Inc.*, No. 3:10-cv-02340-DAK).

Response to Finding No. 52:

The proposed finding mischaracterizes the record. To begin, Respondent produced materials on a rolling basis to Complaint Counsel, but was unable to produce all materials by September 24, 2010, due to the breadth of the subpoenas and CIDs. (Respondent's Answer to FTC Petition, Resp. Ex. 1 (Wu, Decl.), *FTC v. ProMedica Health Sys., Inc.*, No. 1:10-mc-00586-

RMC). Ultimately, Respondent produced over 1.5 million documents to Complaint Counsel in response to the ProMedica, Paramount, and St. Luke's subpoenas and CIDs.

53. On January 3, 2011, ProMedica certified substantial compliance with all subpoenas and CIDs issued to it (including those issued to Paramount and St. Luke's) by the FTC. (Answer at ¶ 16, *ProMedica Health Sys., Inc.*, No. 3:10-cv-02340-DAK).

Response to Finding No. 53:

Respondent has no specific response.

B. The Voluntary Hold-Separate Agreement

54. On August 18, 2010, the FTC and ProMedica entered into a limited, 60-day Hold-Separate Agreement ("HSA"), to allow the expedited FTC investigation to continue. (PX00069 (HSA); FTC Petition, Petition Ex. 1 at ¶ 15 (Liu, Decl.), *ProMedica Health Sys., Inc.*, No. 3:10-cv-02340-DAK).

Response to Finding No. 54:

Respondent has no specific response.

55. Though not comprehensive, the HSA includes several key provisions designed to temporarily preserve St. Luke's viability, competitiveness, and marketability. The HSA prevents, among other things: (1) ProMedica's termination of St. Luke's health-plan contracts (while allowing health plans the option to extend their contracts with St. Luke's past the termination date, if a new agreement is not reached); (2) the elimination, transfer, or consolidation of any clinical service at St. Luke's; and (3) the termination of employees at St. Luke's without cause. (PX00069 at 001 (¶¶ 1-5) (HSA)).

Response to Finding No. 55:

Respondent has no specific response.

56. On October 15, 2010, following the FTC's emergency petition to enforce the subpoenas and CIDs, ProMedica agreed to extend the HSA to expire 15 days after ProMedica substantially complied with the subpoenas and CIDs (including those issued to Paramount and St. Luke's). (Answer at ¶ 16, *ProMedica Health Sys., Inc.*, No. 3:10-cv-02340-DAK). On the same day, the FTC granted ProMedica's request for a modification to the HSA to allow ProMedica to move inpatient rehabilitation beds at St. Luke's to Flower to create additional medical/surgical rooms at St. Luke's.

Response to Finding No. 56:

Respondent has no specific response.

C. Federal District Court Proceedings

57. On January 6, 2011, by a unanimous 5-0 vote, the Commission found reason to believe that the Acquisition would violate Section 7 of the Clayton Act by substantially reducing competition in two lines of commerce (general acute-care inpatient hospital services and inpatient obstetrical services), and initiated an administrative proceeding. (Complaint at ¶ 17, ProMedica Health Sys., Inc., No. 3:10-cv-02340-DAK; *see also* Commission Complaint, FTC Dkt. #9346 (In the Matter of ProMedica Health System, Inc.)).

Response to Finding No. 57:

Respondent has no specific response.

58. Also on January 6, 2011, the Commission authorized FTC staff to seek preliminary relief in federal district court that would require ProMedica to preserve St. Luke's as a viable, independent competitor during the FTC's administrative proceeding and any subsequent appeals. (Complaint at ¶ 18, *ProMedica Health Sys., Inc.*, No. 3:10-cv-02340-DAK).

Response to Finding No. 58:

Respondent has no specific response.

59. On January 7, 2011, the FTC and the State of Ohio filed an action for a temporary restraining order ("TRO") and preliminary injunction ("PI"), under Sections 13(b) and 16 of the FTC Act, 15 U.S.C. §§ 53(b), 26. (Complaint, *ProMedica Health Sys., Inc.*, No. 3:10-cv-02340-DAK). Plaintiffs' complaint alleged that the Acquisition "threatens to substantially lessen competition" for general acute-care inpatient hospital services and inpatient obstetrical services in Lucas County, Ohio, in violation of Section 7 of the Clayton Act, as amended, 15 U.S.C. § 18. (Complaint at ¶¶ 1, 4, 17, *ProMedica Health Sys., Inc.*, No. 3:10-cv-02340-DAK). Accordingly, Plaintiffs sought temporary and preliminary injunctive relief from the Court to prevent further integration of St. Luke's until the conclusion of the full administrative proceeding on the merits. (Complaint at ¶ 7, *ProMedica Health Sys., Inc.*, No. 3:10-cv-02340-DAK).

Response to Finding No. 59:

Respondent has no specific response.

60. On January 10, 2011, ProMedica answered the complaint and filed a response in opposition to Plaintiffs' motion for a TRO. (Answer, *ProMedica Health Sys., Inc.*, No. 3:10-cv-02340-DAK; Def.'s Resp. in Opp. to Pltfs.' Motion for TRO, *ProMedica Health Sys., Inc.*, No. 3:10-cv-02340-DAK).

Response to Finding No. 60:

Respondent has no specific response.

61. A TRO hearing was held before Judge Katz of the Northern District of Ohio on January 13, 2011. After the TRO hearing, ProMedica agreed to extend the HSA (with one modification) until 5:00 p.m. on the second day following the District Court's ruling on Plaintiffs' Motion for Preliminary Injunction. (Mem. in Support of Pltfs.' Motion to Withdraw Without Prejudice Pltfs.' Motion for TRO) ("Brief for Withdrawal of TRO Motion") at 2, *ProMedica Health Sys., Inc.*, No. 3:10-cv-02340-DAK). Plaintiffs granted ProMedica's request to modify the HSA to allow ProMedica to provide health plans with notice that, if the District Court denies preliminary relief, ProMedica will negotiate new rates with health plans as soon as the current contracts expire. Plaintiffs thereafter moved to withdraw without prejudice their motion for a temporary restraining order, and the District Court granted the motion on January 18, 2011. (Brief for Withdrawal of TRO Motion, *ProMedica Health Sys., Inc.*, No. 3:10-cv-02340-DAK; Order Granting Withdrawal of TRO Motion, *ProMedica Health Sys., Inc.*, No. 3:10-cv-02340-DAK).

Response to Finding No. 61:

The proposed finding is misleading. The HSA was also modified to allow for ProMedica to negotiate contracts with MCOs on behalf of St. Luke's if the MCOs so chose. (PX00069 at 001).

62. Pursuant to the District Court's Order Scheduling the PI Hearing, Plaintiffs and Defendant conducted expedited discovery, including 12 fact-witness and expert depositions. (Order Scheduling the PI Hearing, *ProMedica Health Sys., Inc.*, No. 3:10-cv-02340-DAK).

Response to Finding No. 62:

Respondent has no specific response.

63. On February 10 and 11, 2011, the District Court held a one and a half-day hearing regarding the motion for a preliminary injunction. (*FTC v. ProMedica Health Sys.*, No. 3:11 CV 47, 2011 U.S. Dist. LEXIS 33434 at *2-3, *5 (N.D. Ohio March 29, 2011)).

Response to Finding No. 63:

Respondent has no specific response.

64. On March 29, 2011, U.S. District Court Judge, David A. Katz, issued his decision. (*ProMedica,* 2011 U.S. Dist. LEXIS 33434). Judge Katz ordered that the HSA was to continue until either the completion of all legal proceedings by the Commission, including all appeals, or further order of the District Court, with an update on November 30, 2011, if the FTC had not completed actions by that date. (*FTC v. ProMedica,* 2011 U.S. Dist. LEXIS 33434 at *164).

Response to Finding No. 64:

Respondent has no specific response.

D. FTC Administrative Litigation

65. The administrative complaint, filed on January 6, 2011, alleges that the Acquisition substantially lessens competition in the relevant markets – inpatient general acute-care services and obstetrical inpatient services – in violation of Section 7 of the Clayton Act, as amended, 15 U.S.C. § 18. (Commission Complaint at ¶¶ 39-40).

Response to Finding No. 65:

Respondent has no specific response.

66. On January 26, 2011, ProMedica filed an answer to the administrative complaint. (Answer).

Response to Finding No. 66:

Respondent has no specific response.

67. During discovery, Complaint Counsel and Respondent conducted 28 depositions – 22 fact depositions and six expert depositions, and exchanged five expert reports and three rebuttal expert reports.

Response to Finding No. 67:

Respondent has no specific response.

68. The administrative trial began May 31, 2011. During the administrative trial, 18 fact witnesses and three experts testified during Complaint Counsel's case in chief, and 11 fact witnesses and two experts testified during Respondent's case in chief. The last day of the administrative trial was August 18, 2011.

Response to Finding No. 68:

Respondent has no specific response.

V. FUNDAMENTALS OF HOSPITAL COMPETITION AND PRICING

A. Types of Insurance and the Role of Health Plans

69. Most of the patients treated by hospitals fall into one of three broad payment categories: Medicare/Medicaid, self-pay/indigent, and private commercial insurance. (Wachsman, Tr. 4860; Town, Tr. 3608; PX02148 at 010 (¶ 14) (Town Expert Report), *in camera*; RX-71(A) at 46-47 (Guerin-Calvert Expert Report), *in camera*; *see* Korducki, Tr. 551; Radzialowski, Tr. 627-629; Oostra, Tr. 5783).

Response to Finding No. 69:

Respondent has no specific response.

70. In Lucas County, Ohio, roughly 65 percent of patients receiving inpatient care are covered by Medicare or Medicaid, roughly 29 percent are privately insured, and roughly 6 percent are self-pay. (PX02148 at 010 (¶ 14) (Town Expert Report), *in camera*).

Response to Finding No. 70:

Respondent has no specific response.

71. The reimbursement rates that hospitals receive for Medicare or Medicaid patients are not negotiated. (Town, Tr. 3608). Rather, administrative processes at federal and state agencies establish these rates. (Wachsman, Tr. 4848, 4860; PX02117 at 003 (¶ 7 n.1) (Wachsman, Decl.), *in camera*; Town, Tr. 3608).

Response to Finding No. 71:

Respondent does not disagree with this proposition, but clarifies that the reimbursement rates for Medicare and Medicaid patients set by the federal or state agencies do not cover a hospital's costs. (RPF 251; Korducki, Tr. 551; Wachsman, Tr. 4848).

72. Self-pay patients, including indigent patients, are billed directly at hospitals' chargemaster rates (*i.e.*, at hospitals' list prices). (*See* PX01923 at 025-026 (Town, Dep. at 99-101); PX02117 at 002 (Wachsman, Decl.)). For those self-pay patients who cannot afford their charges, hospitals often provide indigent and charity care at a discount or at the hospitals' own expense. (Wachsman, Tr. 4848-4849; *see* Gold, Tr. 268-269; Town, Tr. 3608)).

Response to Finding No. 72:

There is no support in the record cited by Complaint Counsel for the proposition that self-pay patients are billed directly at hospital chargemaster rates. For patients without insurance who cannot afford their charges, hospitals do often provide indigent and charity care at the hospital's own expense. (Wachsman, Tr. 4849; Gold, Tr. 268-269).

73. Privately-insured patients obtain health insurance coverage primarily through commercial health plans. (PX02148 at 010 (¶ 15) (Town Expert Report), *in camera*). These health plans typically use a variety of methods to manage the cost of the medical care provided to their members. (Town, Tr. 3616; PX02148 at 010 (¶ 15) (Town Expert Report), *in camera*).

Response to Finding No. 73:

Respondent has no specific response.

74. Cost-management techniques implemented by health plans include contracting selectively with providers, requiring referrals for members to visit specialists, introducing financial incentives for providers to reward more efficient care, encouraging the use of preventative care, and reviewing the necessity and appropriateness of the care provided to their members. (Town, Tr. 3616; PX02148 at 10 (¶ 15) (Town Expert Report), *in camera*; *see* Wachsman, Tr. 5039-5040, *in camera*)).

Response to Finding No. 74:

The proposed finding is inaccurate. Cost management techniques are not limited to the mechanisms identified by Complaint Counsel. Other methods include the creation and implementation of tiering or steerage programs that provide financial incentives or informational tools to encourage and educate patients to employ lower cost and/or higher quality providers (RPF 1272-1273). The benefit design of an employer's health plan offerings also provides cost management opportunities. (RPF 1285, 1291).

75. All else equal, hospitals receive higher reimbursements for treating commercially insured patients than for treating Medicare/Medicaid and self-pay/indigent patients. (Gold, Tr. 268-269; Wachsman, Tr. 4848-4849; Town, Tr. 3609.) Therefore, commercially insured patients are important to a hospital's bottom line. (Gold, Tr. 268-269; Wachsman, Tr. 4848-4849; Town, Tr. 3609.)

Response to Finding No. 75:

This proposed finding is misleading. Hospitals do generally receive higher reimbursements for treating commercially insured patients than for treating Medicare/Medicaid and indigent charity patients (Wachsman, Tr. 4848-4949). In their contracts with MCOs, hospitals seek to be able to cover their costs and achieve a small margin for reinvesting back into their hospital. (Wachsman, Tr. 4849). Complaint Counsel mischaracterize witness testimony, however, to the extent that they suggest that reimbursements from MCOs for the treatment of their members are the only factor important to a hospital's bottom line. Many factors affect a hospital's financial bottom line. (RPF 1664-1665, 1670, 1709, 1716, 1724). Moreover, for some

of its contracts with MCOs, St. Luke's did *not* receive higher reimbursements than it received from Medicare. (RPF 1796-1797, *in camera*).

B. Relationships Between Employees, Employers, Health Plans, and Hospitals

76. Commercially insured patients generally obtain health insurance through their employer. (Town, Tr. 3609-3610; PX02148 at 005 (¶ 14) (Town Expert Report), *in camera*). Health insurance is a pre-tax benefit, so it is essentially subsidized if purchased through one's employer. (Town, Tr. 3610). The risk-sharing nature of health insurance generates benefits from grouping, such that health insurance costs are lowered as more people buy into a health insurance pool. (Town, Tr. 3610).

Response to Finding No. 76:

Respondent has no specific response.

77. Employers offer their employees health insurance as part of their employees' total compensation package, making health insurance very important to employees. (Town, Tr. 3610; PX02148 at 010 (¶ 16) (Town Expert Report), *in camera*).

Response to Finding No. 77:

Complaint Counsel's expert has not conducted any surveys of employees in Lucas County and therefore cannot assess the relative importance employees place upon their health insurance benefit. (Town, Tr. 4090).

78. Employers generally do not negotiate directly with hospitals, but rather rely on health plans to do so. (Neal, Tr. 2095, 2106; Pugliese, Tr. 1432-1433, 1547; Radzialowski, Tr. 748; PX01914 at 014 (Pirc, IHT at 49); Town, Tr. 3611; *see also* Caumartin, Tr. 1839-1839, 1873; Buehrer, Tr. 3062, 3089; PX02065 at 001 (¶ 3-4) (Szymanski, Decl.).

Response to Finding No. 78:

Complaint Counsel improperly cites the Declaration (PX02065) of a witness who was not deposed and who did not testify.

79. Even large and sophisticated employers rely on health plans to manage their employees' health insurance options. (Town, Tr. 3611; Neal, Tr. 2095, 2106 (Chrysler); *see also* Caumartin, Tr. 1838-1839, 1873 (Wood County Schools Consortium)). This is the case because such employers can benefit from the bargaining leverage of the health plan's additional membership and because health plans specialize in the often complex tasks involved in managing health benefits. (Caumartin, Tr. 1838-1839, 1872; Town, Tr. 3611; *see also* Neal, Tr. 2106; Pugliese, Tr. 1432-1433).

Response to Finding No. 79:

Respondent has no specific response.

80. The health insurance products that health plans offer to employers fall into two broad categories: self-insured and fully-insured. (Town, Tr. 3612; PX02148 at 011-012 (¶ 18) (Town Expert Report), *in camera*; Pugliese, Tr. 1430-1432; Pirc, Tr. 2175; Radzialowski, Tr. 622; McGinty, Tr. 1226-1227; Sheridan, Tr. 6701, *in camera*; Sandusky, Tr. 1293).

Response to Finding No. 80:

Respondent has no specific response.

81. Under a self-insured plan, the employer collects premiums from its employees and pays the full costs of employees' healthcare claims, bearing the risk that healthcare costs may exceed the premiums collected by the employer. (Town, Tr. 3612-3613; PX02148 at 011-012 (¶ 18) (Town Expert Report), *in camera*; Pirc, Tr. 2175-2176; Pugliese, Tr. 1431-1432, 1534; Radzialowski, Tr. 622, 625).

Response to Finding No. 81:

Complaint Counsel mischaracterize the amount of an employee's healthcare costs that a self-insured employer may be obliged to bear. The amount that the employer pays depends upon the benefit design of the plan. (Sandusky, Tr. 1296). In addition, an employee may have additional insurance coverage that limits his or her employer's ultimate responsibility. (Read, Tr. 5287).

82. Under a self-insured plan, the employer pays the health plan a fee in exchange for access to the health plan's provider network at the rates negotiated by the health plan and for administration of its employees' claims. (PX02148 at 011-012 (¶ 18) (Town Expert Report), *in camera*; Pirc, Tr. 2175-2176; Pugliese, Tr. 1431-1432; Radzialowski, Tr. 622, 629-30).

Response to Finding No. 82:

Complaint Counsel provide an incomplete characterization of the fees paid to MCOs by self-insured employers. These fees are not limited to network access and claims administration, but may include various other services, such as benefit design. (RPF 288, 434; Radzialowski, Tr. 630).

83. Therefore, under a self-insured plan, an increase in a hospital's reimbursement rates will directly increase the employer's healthcare expenditures for employees who use that hospital as soon as the rate increase takes effect. (Response to RFA at ¶ 35; Town, Tr. 3612; PX01944 at 020 (Pirc, Dep. at 74-75); Radzialowski, Tr. 840-841, *in camera*; *see also* Pugliese, Tr. 1456).

Response to Finding No. 83:

Complaint Counsel mischaracterize the impact of a potential increase in a hospital's rates. For example, MCOs and hospitals negotiate { } a hospital's rate increase and the costs borne by MCO members, including self-insured members. (RPF 649, *in camera*, 1837, *in camera*, 1866-1867, *in camera*, 1873, *in camera*).

84. Approximately 70 percent of commercially insured employees in Lucas County receive coverage through self-insured plans. (Town, Tr. 3612-3613; PX02148 at 012 (¶ 18) (Town Expert Report), *in camera*).

Response to Finding No. 84:

Complaint Counsel exaggerate and misrepresent the percentage of employees covered by self-insured plans. Testimony at trial revealed that self-insured employers represent a smaller segment of the Lucas County market than Complaint Counsel suggest. (RPF 265, 287, 307, 381, 407, *in camera*). For example, MMO testified that only 60 percent of its commercially insured business is for self-insured products. (RPF 265). Other majors MCOs also reported lower percentages: Anthem: 55 percent (RPF 287); Paramount: 50 percent (RPF 307); Aetna: 66 percent (RPF 381); Humana: { } (RPF 407, *in camera*).

85. Under a fully-insured plan, the health plan collects premiums from the employer and pays the cost of the employees' healthcare, bearing the risk that healthcare costs may exceed the premiums collected by the health plan. (Town, Tr. 3612; PX02148 at 011-012 (¶ 18) (Town Expert Report), *in camera*; Pugliese, Tr. 1430-1431; Pirc, Tr. 2175; Radzialowski, Tr. 622, 624).

Response to Finding No. 85:

Complaint Counsel mischaracterize the amount of an employee's healthcare costs that a given MCO may be required to bear in the case of fully-insured employers. The amount paid out

by the MCO depends upon the benefit design of the plan. (Sandusky, Tr. 1296). In addition, an employee may have additional insurance coverage that limits a given MCO's ultimate responsibility. (Read, Tr. 5287).

86. Therefore, under a fully-insured plan, an increase in a hospital's reimbursement rates will increase the employer's healthcare expenditures via the premium paid to the health plan. (Town, Tr. 3612; Pugliese, Tr. 1554-55, 1560-1561; PX01938 at 030 (Radzialowski, Dep. at 114), *in camera*; Sheridan, Tr. 6701-6702, *in camera*).

Response to Finding No. 86:

Complaint Counsel mischaracterize the impact of a potential increase in a hospital's rates; an increase in premium is neither immediate nor guaranteed. Fully-insured employers lock in a fixed premium for the entire duration of their contract, which may be up to three years. (RPF 444-446). A change in hospital rates will not affect their premium during the term of their contract. (RPF 444, 447).

In addition, an employer's healthcare expenses may not increase in spite of any potential increase in hospital rates because general acute-care inpatient hospital rates are only one, small component of its total healthcare costs. (RPF 653-657). Only about 6 percent of commercial insureds actually go to a hospital for inpatient service each year. (RPF 441). This low level of usage factors into premium rates; rates also depend upon myriad other factors including non-hospital, medical expenses as well as the nature and demographic make-up of the employee population being insured. (RPF 654). Indeed, the vast majority of premium costs depend upon costs other than general acute-care inpatient services. (RPF 656).

Increases in premiums are also not necessarily attributable to actual increases in general acute-care inpatient rates. MCO testimony revealed that MCOs anticipate *possible* increases and build these increases into their premiums before such increases occur, if in fact they occur at all. (RPF 450, 757). When the increase does not occur or a lower than anticipated increase is

successfully negotiated by the MCO, the MCOs do not reduce the employer premium. (RPF 450, 757)

87. Health plans pass on some or all of the increase in the price of hospital care to their fully-insured customers. (Pirc, Tr. 2174; Pugliese, Tr. 1554-1555; Radzialowski, Tr. 779; Sheridan, Tr. 6701, *in camera*; PX01944 at 020, 027 (Pirc, Dep. at 75-76, *in camera*, 104-105); PX01938 at 030 (Radzialowski, Dep. at 114, *in camera*); PX01939 at 019 (Sheridan, Dep. at 70, *in camera*)). Any profit-maximizing business will pass on some or all of a cost increase to its customers. (Town, Tr. 3615).

Response to Finding No. 87:

Complaint Counsel neglect to specify that health plans are unable to pass along any increases in the price of hospital care to fully-insured customers for the duration of their contracts. (RPF 444, 447). Increases may only be passed on at policy renewal, if at all. (RPF 444).

In addition, Complaint Counsel oversimplify the relationship between hospitals and their customers. While a profit maximizing business may *try* to pass along some or all of a cost increase to its customers, the customer may refuse to accept such an increase. {

} (RPF 1794-1818, *in camera*, 1839-1859, *in camera*). Similarly, after the joinder, ProMedica proposed a rate increase to { } that would allow St. Luke's to improve its cost-coverage; { } flatly rejected this request. (RPF 1409-1414, *in camera*).

88. Testimony in this matter and economic studies indicate that employers generally pass on to employees increases in the cost of health insurance, or reduce or eliminate healthcare benefits altogether. (PX02148 at 012 (¶ 18 n. 29) (Town Expert Report), *in camera*; Town, Tr. 3604-3605, 3614; Neal, Tr. 2114-2115, 2117-2118, 2158; Caumartin, Tr. 1837-1838; *see also* Buehrer, Tr. 3072).

Response to Finding No. 88:

Complaint Counsel misrepresents the testimony in this trial and the importance of the economic studies. None of the economic studies cited specifically focuses on the geographic market at issue in this litigation. Testimony also indicated that employers face many options when faced with a possible premium increase and may elect not to pass on such increases. (RPF 451, 452). Agreements with union employees also constrain the ability of employers to pass along premium increases. (RPF 453-458).

Employers may also choose to obtain the same level of benefits with a limited provider network at lower cost to themselves and their employees. (RPF 566, 567). Employers in Lucas County have historically supported this option and limited networks have been an effective means of keeping costs lower. (RPF 709-718). Employers may also create incentives within their plan offerings to encourage employees to independently select plans that are more cost-efficient. (RPF 1285, 1291).

89. If an employer chooses to increase its employees' health insurance costs or reduce its employees' health insurance benefits, the employees' healthcare costs will increase. (Town, Tr. 3615).

Response to Finding No. 89:

Complaint Counsel cite to no evidence in the record that this scenario has occurred in Lucas County. Complaint Counsel further mischaracterize the effect of an increase in premiums or reduction in benefits. First, health insurance cost increases may not be attributable to the product market in question. General-acute care inpatient hospital services account for only a portion of the cost of a health insurance premium; the vast majority of the cost derives from other health services and MCO administrative costs. (RPF 427, 653-656). Second, an increase in premiums does not automatically translate to an increase in an employee's healthcare costs. Health insurance premiums are only one part of an employee's total healthcare costs. Employees

also often have other insurance coverage that affects their total healthcare costs. (Read, Tr. 5287).

90. Those employers who do not pass on all of the increase in healthcare costs will face higher labor costs and may respond by reducing employment. (Town, Tr. 3604.)

Response to Finding No. 90:

Complaint Counsel's assertion that employers who do not pass on increases in healthcare costs will reduce employment is speculative and inconsistent with the prior assertion above in CCPF 87 that profit-maximizing employers pass along costs to customers. Complaint Counsel has not and cannot cite any testimony that any employer in Lucas County has reduced employment due to health insurance premium increases.

91. Because the burden of increased healthcare costs is ultimately passed on to insured individuals, the price increase for hospital services resulting from the Acquisition will harm these consumers. (PX02148 at 012-013 (¶ 18) (Town Expert Report), *in camera*).

Response to Finding No. 91:

As discussed in responses to CCPF 83-90, the facts advanced by Complaint Counsel do not support the inference that any possible increase in the price of hospital services will harm consumers.

General acute-care inpatient services comprise only a small part of the overall health insurance premium for both fully-insured and self-insured employers. (RPF 653-657). The largest share of healthcare costs is attributable to other medical costs and MCO administrative costs, which by themselves comprise 15 percent of an employer's healthcare costs. (RPF 384, 656).

The impact of increases to the small portion of premiums represented by general acute-care inpatient services is further reduced during the term of an MCO-hospital contract by protective language like { }. (RPF 649, *in camera*, 1837, *in camera*, 1866-

1867, *in camera*, 1873, *in camera*). Fully-insured members are further protected by the fact that rates are locked in by long-term contracts and premiums cannot increase during the term of these contracts. (RPF 444-447). When contracts do finally expire, MCOs may and do successfully resist increases proposed by hospitals. (RPF 1409-1414, *in camera*, 1794-1818, *in camera*, 1839-1859, *in camera*). Even if a premium does eventually increase, testimony demonstrates that employers do not automatically pass along premium increases and have many options available to them including absorbing the cost of the increase and offering additional options to employees to provide incentives for using lower cost options. (RPF 451-52, 1285, 1291).

Finally, to the extent that an increase in premiums does occur, MCO testimony indicates that such increase may not be attributable to an actual increase in rates for general acute care inpatient hospital services, but merely the MCOs *projected* view of what such increases might have been. (RPF 450). No MCO testified that it ever adjusted rates downward when it guessed wrong about general acute care inpatient hospital service rates or when it managed to negotiate a reduction in such rates. (RPF 450, 757)

C. Rate Negotiations Between Health Plans and Hospitals

1. Health Plans' Criteria for Creating Hospital Networks

92. Health plans compete with one another to be offered by employers in the menu of insurance products that employers offer to their employees. (Town, Tr. 3616-3617; PX02148 at 011 (¶ 17) (Town Expert Report), *in camera*; PX01944 at 028 (Pirc, Dep. at 106); *see also* Neal, Tr. 2092, 2099-2100; Caumartin, Tr. 1839; Buehrer, Tr. 3066).

Response to Finding No. 92:

Respondent has no specific response.

93. Health plans compete for employers' business along various dimensions, particularly over the price of their insurance products and the breadth and quality of their provider networks. (Town, Tr. 3616-3617; PX02148 at 011 (¶ 17) (Town Expert Report), *in camera*; Neal, Tr. 2101-2104; Caumartin, Tr. 1848-1849; Buehrer, Tr. 3068, 3074-3075; *see also* Pirc, Tr. 2284; Pugliese, Tr. 1455; Radzialowski, Tr. 583, 588-589, 595, 598-600, 652-654).

Response to Finding No. 93:

The proposed finding is misleading. Hospital networks are relatively unimportant in the competition for employers' business. Only about 6 percent of commercial insureds actually go into a hospital each year. (RPF 441). The main competition among health plans relates to the 94 percent of the business that affects health plan members on a daily basis, including the cost, breadth and quality of physician networks, outpatient services, and pharmacy benefits. (RPF 435-442; Randolph, Tr. 6935).

94. Generally, the lower the premium, the more attractive the health plan's product is to employers and their employees, provided the health plan's network offers the employees' preferred set of providers. (PX02148 at 011 (¶ 17) (Town Expert Report), *in camera*; Sandusky, Tr. 1287-1288; Lortz, Tr. 1699-1700, 1707; Caumartin, Tr. 1848-1849; *see also* Pirc, Tr. 2284; Pugliese, Tr. 1455).

Response to Finding No. 94:

This proposed finding is misleading. Among other factors, employers and employees also evaluate a health plan on the basis of its overall benefit design. (RPF 424, 435, 438, 1285, 1291).

95. Employers that offer health insurance negotiate with health plans and select the combination of rates, benefit structures, and healthcare provider networks that best meets the needs of the employer and its employees. (PX02148 at 013 (¶ 19) (Town Expert Report), *in camera*; Town, Tr. 3616-3617; Neal, Tr. 2099-2100, 2102; Caumartin, Tr. 1848-1849; Buehrer, Tr. 3066, 3068, 3074-3075; Pugliese, Tr. 1432-1434; Radzialowski, Tr. 620-622).

Response to Finding No. 95:

Complaint Counsel mistakenly represent that employers always negotiate directly with health plans themselves to select health insurance products for their employees. Testimony indicated that Lucas County employers use brokers or consultants to manage their negotiations with health plans. (RPF 461-462). In fact, the testimony cited by Complaint Counsel expressly

indicates that employers worked with agents and consultants who conducted negotiations for employers. (Caumartin, Tr. 1848-1849; Buehler, Tr. 3066).

96. Once included in the employer's menu of health insurance products, health plans compete with one another to attract enrollees. (PX02148 at 011 (¶ 17) (Town Expert Report), *in camera*; PX01944 at 028 (Pirc, Dep. at 106, 107); Neal, Tr. 2099-2100; McGinty, Tr. 1175; *see* Sandusky, Tr. 1302-1303).

Response to Finding No. 96:

Respondent has no specific response.

97. Health plans regularly conduct market research about their members' preferences in order to maintain attractive and marketable provider networks that appeal to employers and employees. (*See* Pirc, Tr. 2178-2180; Radzialowski, Tr. 588-590; PX02067 at 002 (¶ 6) (Radzialowski, Decl.), *in camera*; PX02072 at 002 (¶ 6) (Firmstone, Decl.), *in camera*; PX01914 at 014-015 (Pirc, IHT at 49-51)).

Response to Finding No. 97:

Complaint Counsel improperly cite to the Declaration (PX02072) of a witness who was not deposed and who did not testify. Complaint Counsel further misrepresent witness testimony with respect to market research. In fact, as MCO testimony reveals, no MCO has conducted any studies or analyses of patient preferences or travel and utilization patterns of members within Lucas County. (RPF 1261-1271).

98. Health plans will find it difficult to market products to employers if their networks do not include the hospitals desired by current and potential members. (PX02148 at 011 (¶ 17) (Town Expert Report), *in camera*; Sandusky, Tr. 1302-1303; Lortz, Tr. 1700, 1704; Caumartin, Tr. 1848-1849; Neal, Tr. 2102-2103; Sheridan, Tr. 6691-6693, *in camera*; *see* Pugliese, Tr. 1434)).

Response to Finding No. 98:

This proposed finding is misleading. The ability to market a health plan product depends upon its price and other factors, including the physician network. (RPF 435-442). No health plan that included all Lucas County hospitals in its network when major competitors offered limited networks was able to gain membership at the expense of those limited network plans.

(RPF 800-808). Aetna testified that its failure to compete successfully with limited networks was driven by its unfavorable pricing. (Radzialowski, Tr. 742). By contrast, narrower networks have been successful in part because they offer more attractive pricing. (RPF 562-563; Randolph, Tr. 6935-6936).

Furthermore, Complaint Counsel's proposed finding relies upon the biased and unfounded testimony of Messrs. Lortz and Caumartin and Ms. Neal. Respondent refers to its response to CCPF 534, which it incorporates by reference. Mr. Lortz has no basis for his opinion as he has conducted no surveys within the last five years of his union members' utilization of hospital services. Mr. Lortz is furthermore biased against the Respondent due to a long-lasting conflict over unionization at ProMedica hospitals. (Lortz, Tr. 1727).

99. In deciding whether to add a hospital to its network, a health plan balances the value its current and prospective members place on having in-network access to the hospital – and the resulting increase in the marketability of the health plan's network – against the costs of adding that hospital to the network. (PX02148 at 013 (¶ 20) (Town Expert Report), *in camera*; Town, Tr. 3621-3622; Pirc, Tr. 2167-2169, 2208-2211; *see* Radzialowski, Tr. 675-677).

<u>Response to Finding No. 99:</u>

Complaint Counsel's proposed finding is inaccurate and misleading. Among many factors, MCOs also consider the benefit adding a hospital has for the MCO. (RPF 267, 357). MCOs assess the total costs of adding another hospital. Limited networks have succeeded in Lucas County through their ability to manage costs efficiently. (Randolph, Tr. 6935-6936). Health plan costs, however, include more than just the cost on inpatient hospital services. (RPF 653-658). Physician networks are a critical part of the MCO plan offering as well. (RPF 439).

100. The greater the increase in the marketability of a health plan's products as a result of adding a hospital to the provider network, the higher the reimbursement rates the health plan will be willing to pay to have that hospital as an in-network provider and, therefore, the greater the hospital's bargaining leverage against the health plan. (Pirc, Tr. 2168-2169, 2208-2211, 2296; PX02148 at 016 (¶ 27) (Town Expert Report), *in camera*; Town, Tr. 3641-3643; PX02065 at 004 (¶ 13) (Szymanski, Decl.); PX02067 at 004 (¶ 13)

(Radzialowski, Decl.), *in camera*; Radzialowski, Tr. 663-666; Pugliese, Tr. 1458-1461; Sandusky, Tr. 1348-1349, *in camera*; Pirc, Tr. 2167-2169).

Response to Finding No. 100:

Complaint Counsel improperly cites the Declaration (PX02065) of a witness who was not deposed and who did not testify at trial.

Complaint Counsel further ignores the role of a plan's premium cost and other factors that affect employer choice of health plan products. (RPF 435-442, 654-655; Randolph, Tr. 6935-6936). Adding a hospital to its network is less important than the scope of other everyday services provided by a plan including its physician and pharmacy networks. (RPF 435-442).

101. Among the factors that health plans consider when deciding whether to add a hospital to their provider networks are the reimbursement rates that the hospital is requesting, the hospital's location, the number of hospitals it has in the market (if it is a system), its reputation for delivering quality care, its market share, and the breadth of its service offering. (Pugliese, Tr. 1458-1459; Pirc, Tr. 2189; PX02072 at 002-003(¶ 9) (Firmstone, Decl.), *in camera*; PX01917 at 019-020 (Radzialowski, Dep. at 72-74), *in camera*; Town, Tr. 3627-3628; McGinty, Tr. 1164-1165, 1172-1173; *see* Radzialowski, Tr. 663-666).

Response to Finding No. 101:

The proposed finding cites testimony (PX01917) that improperly derives from leading questions and mischaracterized testimony. Complaint Counsel also improperly cites the Declaration (PX02072) of a witness who was not deposed and who did not testify at trial.

Complaint Counsel do not provide a complete list of factors that MCOs consider in deciding whether to contract with a given hospital and, to the extent that the ordering of their truncated list suggests an order of importance, they misrepresent the relative weights of these factors. For example, Complaint Counsel ignore testimony that demonstrates the physicians working and treating patients at a hospital are a key issue of concern for MCOs. (Pugliese, 1459). Complaint Counsel also relegate breadth of service to last place on their truncated list of factors, but MCOs acknowledged that their primary concern in creating their networks was being

able to provide members a complete complement of services, which meant it was essential for them to obtain hospitals that could provide tertiary services. (RPF, 345, 347, 388-389, 414, 365, *in camera*).

102. A hospital's location is a significant factor for health plans because patients do not like to travel very far for hospital care. (Town, Tr. 3628; Radzialowski, Tr. 632-634; Sandusky, Tr. 1305-1306; Caumartin, Tr. 1831; Andreshak, Tr. 1754-1755). This holds true for patients in Lucas County, Ohio. (Town, Tr. 3628; Sandusky, Tr. 1314-1315; Caumartin, Tr. 1851-1852; Andreshak, Tr. 1754-1755; Marlowe, Tr. 2402-2404; *see also* Pirc, Tr. 2182-2183; Radzialowski, Tr. 642-643).

Response to Finding No. 102:

The proposed finding is inaccurate and misleading and Complaint Counsel mischaracterize witness testimony regarding patient travel. First, no MCO has studied their members' travel patterns or preferences. (RPF 1261-1265, 1266, *in camera*, 1267, 1268, *in camera*, 1269-1271). Any MCO testimony that reports on travel preferences for patients obtaining general acute-care inpatient services in Lucas County is anecdotal and based on personal opinion at best. Such opinion lacks even the most basic foundation. With the exception of FrontPath's Ms. Sandusky, none of the representatives of any testifying MCO even resides in Lucas County. (Radzialowski, Tr. 591-592; McGinty, Tr. 1167; Sandusky, Tr. 1282; Pugliese, Tr. 1437; Pirc, Tr. 2165). Ms. Sandusky affirmatively testified that travel within Lucas County was easy and that "Everything is twenty minutes away... in Toledo." (Sandusky, Tr. 1282). Even if the testimony of remaining MCO representatives were credible, Complaint Counsel misrepresents such testimony. (Radzialowski, Tr. 632-634 (never indicating how far patients are willing to travel); Pirc, Tr. 2183 (confirming patients in Lucas County will travel within Lucas County for care)).

Other testimony cited by Complaint Counsel is similarly vague, misleading or irrelevant. Mr. Caumartin testified as to travel patterns (again without specifically identifying how far is

"far") in Wood County, which is not in the geographic market identified by Complaint Counsel. (Caumartin, Tr. 1831). Testimony by the doctors cited by Complaint Counsel again offered no specific data about patient preferences other than the opinion testimony of lay witnesses. Dr. Marlowe expressly testified that it is "not far from one end of Toledo to the other." Dr. Andreshak's testimony amounts to stating nothing more than that patients want to go to a hospital where their physician has privileges. (Andreshak, Tr. 1755). The only doctor who offered specific testimony about patient travel preferences was Dr. Read, who testified that when she moved offices from the eastern side of Toledo to the other side of town, patients were willing to travel to her new location to receive services. (Read, Tr. 5286, 5297-5298).

103. This preference for local care stems from the fact that a hospital's location affects not only a patient's travel time, which can significantly affect the health outcomes of patients with time-sensitive acute conditions, but also the travel time of the people likely to visit and support the patient while he or she is in the hospital. (Pirc, Tr. 2183-2185; McGinty, Tr. 1180-1181; Marlowe, Tr. 2406; Town, Tr. 3631-3632).

Response to Finding No. 103:

The proposed finding is inaccurate and misleading. For the reasons described in the response to CCPF 102, Complaint Counsel has not demonstrated a "preference" for, or even properly defined, "local care." Expert analysis has confirmed that travel times in Lucas County are minimal and that patients do not always travel to the closest hospital for care. (RPF 221-243; 1210-1218).

104. Therefore, the marketability of a health plan's insurance products depends, in part, on the geographic coverage of the health plan's hospital network, with broader coverage translating to broader marketability. (Pugliese, Tr. 1449; Sandusky, Tr. 1315-1316; Town, Tr. 3628).

Response to Finding No. 104:

Complaint Counsel mischaracterizes witness testimony to suggest broader coverage translates into broader marketability and ignores contradictory evidence. For nearly a decade,

Paramount has offered a limited network in Lucas County and has successfully established itself as one of the top three MCOs in Lucas County. (RPF 709-717, 779-783).

Ms. Sandusky testified that FrontPath offers a broad network as a basic "philosophy." (Sandusky, Tr. 1316). FrontPath has no recent experience offering a limited network; the last time that FrontPath attempted a narrow network was more than a decade ago at the end of the 1990s. (Sandusky, Tr. 1288-1289). FrontPath offered a narrow network to a few members, at their request, but was unable to achieve an acceptable level of sales. (Sandusky, Tr. 1290). Interestingly, the narrow network that did not succeed was comprised of ProMedica and St. Luke's, the configuration Complaint Counsel targets in this litigation. (Sandusky, Tr. 1289). FrontPath's limited network may not have succeeded in the late 1990s, but there has been ample evidence in the intervening years that limited networks can be marketed successfully in Lucas County and even offer result in lower rates for employers. (RPF 562-563, 709-717, 730-732, *in camera*).

During the period when major MCOs offered limited networks in Lucas County, several MCOs offered broad networks but were unable to obtain any marketing advantage as a result. (RPF 800-808). MCO testimony revealed that price was the primary factor driving the success of a health plan product. (RPF 435-438; Radzialowski, Tr. 742).

105. All else equal, health plans and their members generally value a broad network of providers, desiring to have in-network access to physicians and hospitals that span the geographic areas in which the members work and reside. (Pirc, Tr. 2203-2204, 2281; PX01944 at 020 (Pirc, Dep. at 76); Pugliese, Tr. 1449, 1451-1452, 1458-1459, 1543; PX02148 at 011 (¶ 17), 013 (¶ 20) (Town Expert Report), *in camera*; Radzialowski, Tr. 657-658; Buehrer, Tr. 3074-3075; Sandusky, Tr. 1287-1288; Lortz, Tr. 1700-1703; Caumartin, Tr. 1861; Neal, Tr. 2102-2103).

Response to Finding No. 105:

The proposed finding is inaccurate and misleading. Complaint Counsel flatly ignore the role of cost in health plan product selection. Employers do not ignore costs; it is one of their

primary considerations. (RPF 435). Depending on their price sensitivity, many employers prefer narrow networks because they may be able to offer employees health benefits at a lower cost. (RPF 562, 566-567).

106. Health plans that do not have sufficient geographic coverage in a market will have difficulty marketing their insurance products to employers and their employees. (PX02148 at 011 (¶ 17) (Town Expert Report), *in camera*; Sandusky, Tr. 1316; Sheridan, Tr. 6691-6693, *in camera*).

Response to Finding No. 106:

The proposed finding is inaccurate and misleading. Complaint Counsel mischaracterize the cited MCO testimony, which fails completely to support this proposition. As explained in the response to CCPF 104, FrontPath's unsuccessful attempt to develop a narrow network dates back to the late 1990s. (Sandusky, Tr. 1288-1289). Even if the evidence was not nearly a dozen years old, FrontPath's experience would still fail to support Complaint Counsel's proposition. Ms. Sandusky testified that the failed network comprised the ProMedica hospitals and St. Luke's. (Sandusky, Tr. 1289). This configuration covers all areas of Lucas County and thus plainly contradicts Complaint Counsel's equation of geographic coverage and marketing success.

Complaint Counsel makes the same fatal mistake with respect to { }. Nothing in { } testimony supports the proposition that geographic coverage is the essential element in a successful network. { } network included Mercy and St. Luke's, again spanning all of Lucas County. (Sheridan, Tr. 6691-6693, *in camera*). Moreover, while Complaint Counsel apparently meant to suggest that United's network was not successful, Mr. Sheridan's testimony affirms that United's membership totals remained steady for the last six years. (RPF 363-364) { } further undermined Complaint Counsel's proposition when {

.} (RPF 365, *in camera*)

2. Hospitals Compete for Network Inclusion and for Selection by Health-Plan Members

107. Hospitals compete with one another on multiple levels. (Town, Tr. 3625-3626, 3630-3631; PX02148 at 013-014 (¶¶ 21-22) (Town Expert Report), *in camera*).

Response to Finding No. 107:

Respondent has no specific response.

108. Hospitals compete with one another for inclusion in health plans' provider networks. (Town, Tr. 3626; PX02148 at 013-014 (¶¶ 20-21) (Town Expert Report), *in camera*; Sheridan, Tr. 6676; Pugliese, Tr. 1456-1457; Wachsman, Tr. 4852-4855). Health plan members have access to in-network hospitals at rates substantially lower than out-of-network hospitals. (Town, Tr. 3618; PX02148 at 013 (¶ 19) (Town Expert Report), *in camera*; Radzialowski, Tr. 584; Sandusky, Tr. 1396; Pirc, Tr. 2208).

Response to Finding No. 108:

Respondent has no specific response.

109. The difference between a member's out-of-pocket cost for an in-network provider and an out-of-network provider can be as high as ten-fold. (Town, Tr. 3619). Generally, a member's out-of-pocket costs do not vary across in-network providers. (Town, Tr. 3618; *see* McGinty, Tr. 1184-1185; Pirc, Tr. 2213-2216).

Response to Finding No. 109:

Member's out-of-pocket expenses can and do vary across in-network providers when the member's plan includes mechanisms to steer members to certain providers. Testimony demonstrated that some of the largest employers within Lucas County already use various mechanisms to steer employees toward certain providers. (RPF 1272-1273, 1274-1284, *in camera*, 1285, 1286-1290, *in camera*, 1292-1293, *in camera*, 1294-1305, 1306, *in camera*, 1307-1315).

110. Once included in a health plan's network, hospitals in that network compete with one another to attract the health plan's members. (Town, Tr. 3630-3631; PX02148 at 014 (¶ 22) (Town Expert Report), *in camera*; Pugliese, Tr. 1456-1457; Sheridan, Tr. 6676).

Response to Finding No. 110:

Respondent has no specific response.

111. Because members generally face little or no out-of-pocket price difference between in-network hospitals, in-network hospitals compete primarily on non-price dimensions, such as location, quality of care, patient experience, and other factors. (Town, Tr. 3630-3631; PX02148 at 014 (¶ 22) (Town Expert Report), *in camera*; Wachsman, Tr. 5115-5116; *see* Sandusky, Tr. 1304-1305; Wachsman, Tr. 5110-5111; Shook, Tr. 946; *see also* JX00002A at 002 (¶ 11) (Joint Stipulations of Law and Fact)).

Response to Finding No. 111:

Respondent has no specific response.

112. A hospital's volume of patients from a specific health plan is largely determined by whether the hospital is part of the health plan's provider network. (Town, Tr. 3621-3622, 3626-3627; PX02148 at 014 (¶ 23) (Town Expert Report), *in camera*; Wachsman, Tr. 4852-4855).

Response to Finding No. 112:

Financial incentives also exist to encourage MCO members to utilize in-patient networks. (RPF 560-61). Actual market experience in Lucas County, however, has shown that hospitals have successfully deployed strategies to attract a significant volume of a health plan's members even when the hospitals were not participating in that MCO's network. (RPF 742-746, *in camera*, 765-766).

113. Because a health plan's members face significantly higher out-of-pocket costs for using out-of-network hospitals, these members almost always choose in-network providers for their healthcare needs, and an in-network hospital will treat a significantly larger portion of a health plan's members than an out-of-network hospital. (Town, Tr. 3619-3620, 3621-3622, 3626-3627; PX02148 at 014 (¶ 23) (Town Expert Report), *in camera*; Shook, Tr. 941).

Response to Finding No. 113:

The proposed finding is inaccurate and misleading. Complaint Counsel mischaracterizes Mr. Shook's testimony. Members need not *always* select in-network hospitals to receive insurance benefits at in-network rates. Emergency care is one exception to this rule, as Mr. Shook accurately testified. (Shook, Tr. 941). Furthermore, whether patients *actually* pay higher out-of-network costs depends upon the hospital's policy and strategy. When they were out-of-

network with {   } and St. Luke's both agreed to waive out-of-pocket rates members normally would pay and to accept the MCO's out-of-network payment as payment in full. (RPF 742-746, *in camera*, 765-766) The result of this strategy as that each hospital retained a significant volume of out-of-network volume. (RPF 742-746, *in camera*, 765-766).

114. The volume of patients that one in-network hospital will treat versus another in-network hospital depends upon patient preferences, the location and characteristics of the hospital, the admitting patterns of physicians, and the location and characteristics of other competing in-network hospitals. (PX02148 at 14 (¶ 23) (Town Expert Report), *in camera*).

Response to Finding No. 114:

Location is not a determinant factor in patient choice of hospitals. (RPF 210-1218). Patients consider many other factors in addition to the limited list identified by Complaint Counsel, including quality of care, past personal or family experience, level of services, and nature of the facilities. (RPF 43-51, 52-56, *in camera*).

115. A hospital may bargain with a health plan about the participation of other hospitals in the health plan's network. (Town, Tr. 3628-3629; Pugliese, Tr. 1488-1489, *in camera*, 1499-1501, *in camera*; Wachsman, Tr. 4874-4875, 5184-5185, *in camera*, 5201-5202, *in camera*).

Response to Finding No. 115:

Respondent has no specific response.

116. A hospital may wish to exclude competitors from the health plan's network because these competitors could draw the health plan's members away from that hospital, thereby reducing that hospital's revenues. (Town, Tr. 3629; Pugliese, Tr. 1488-1489, *in camera*, 1499-1501, *in camera*; Wachsman, Tr. 5184-5185, *in camera*, 5201-5202, *in camera*; Wakeman, Tr. 2588; *see* Shook, Tr. 954).

Response to Finding No. 116:

Complaint Counsel mischaracterize witness testimony with relation to this proposed finding. For example, Mr. Pugliese's testimony explained the interactions between ProMedica and Anthem in the context of Anthem's desire to terminate its pre-existing exclusive contractual

relationship with ProMedica. (Pugliese, Tr. 1488-1489). {

.} (RPF 759, 760-764, *in camera*, 768-773, *in camera*). With respect to Paramount, Complaint Counsel cite no witness who contends that ProMedica's hospital MCO contracting team sought to have Paramount exclude other hospitals from Paramount's network. Instead, they cite the opinions of the heads of two competing hospitals who believe that, as part of an integrated healthcare system, Paramount's goal was to work closely with the system's hospitals. (Wakeman, Tr. 2588; Shook, Tr. 954)

117. For example, ProMedica contracted with Anthem to have St. Luke's excluded from Anthem's network for a period of time, in exchange for lower reimbursement rates at ProMedica's hospitals. (JX00002A at 003 (¶ 18) (Joint Stipulations of Law and Fact); PX00380 at 001 (Anthem "will have to pay PHS for the privilege" of adding St. Luke's to its network); PX00231 at 015, *in camera*; PX01919 at 016 (Pugliese, Dep. at 60), *in camera*; Town, Tr. 3629-3630).

Response to Finding No. 117:

To the extent that Complaint Counsel rely upon Mr. Pugliese's deposition, Respondent has objected to this testimony as hearsay.

Complaint Counsel again fail to provide the complete depiction of *all* the relevant facts and mischaracterize the limited facts they do provide. {

.}

(RPF 760-763, *in camera*). Complaint Counsel's frequent reference to the statement that Anthem would have to "pay for the privilege" of adding St. Luke's to its network is misleading. The statement refers merely to the fact that {

.}

(Wachsman, Tr. 5206, *in camera*). They would "pay" with {

.} (Wachsman, Tr. 5205, *in camera*).

118. Such exclusions benefit the excluded hospital's competitors in the health plan's network by eliminating in-network competition from the excluded hospital. (PX02148 at 014 (¶2 22), 018 (¶ 31) (Town Expert Report), *in camera*; Pugliese, Tr. 1499-1501, *in camera*; Wachsman, Tr. 5184-5185, *in camera*, 5201-5202, *in camera*; Wakeman, Tr. 2588; *see* Shook, Tr. 954).

Response to Finding No. 118:

Complaint Counsel mischaracterize witness testimony, which fails to support the proposition advanced by Complaint Counsel.

Complaint Counsel further ignore the benefits of limited networks, which include lower rates for employers and plan members. (RPF 562-563). Further, nothing prevents a hospital excluded from one provider network from contracting with other provider networks to achieve the same benefits. Lucas County has a long history of limited networks. (RPF 709-717). During this period, no hospital has ever been excluded from all limited networks. (RPF 709-717).

119. Competition among hospitals benefits actual and potential consumers of hospital services by leading to lower prices for hospital care and, in turn, to lower premiums, higher wages, more healthcare benefits, and increased access to health care. (Town, Tr. 3635; PX02148 at 006-007 (¶ 7) (Town Expert Report), *in camera*; Caumartin, Tr. 1864-1865; Rupley, Tr. 1964-1966; Wachsman, Tr. 5116-5118; Oostra, Tr. 6039-6040). Testimony from health plans in this matter indicates that this proposition holds true in Lucas County, Ohio. (Pirc, Tr. 2260-2261, *in camera*; *see* Radzialowski, Tr. 700-704, *in camera*; Pugliese, Tr. 1461-1462).

Response to Finding No. 119:

Respondent has no specific response.

120. A hospital becomes part of a health plan's network by entering into a provider contract with that health plan. (Town, Tr. 3622; *see* Radzialowski, Tr. 658-661; Pugliese, Tr. 1454-1456; Pirc, Tr. 2205-2207).

Response to Finding No. 120:

Respondent has no specific response.

3. Bargaining Dynamics That Shape Provider Contracts Between Hospitals and Health Plans

121. Health plans negotiate with hospitals to determine the scope of coverage for their members and the reimbursement rates for services. (Town, Tr. 3609, 3624-3625, 3637, 3641; PX02148 at 014-015 (¶ 24) (Town Expert Report), *in camera*; *see* Pugliese, Tr. 1434, 1456, 1547-1548; Pirc, Tr. 2177, 2208-2209; Radzialowski, Tr. 658-660; Sandusky, Tr. 1287-1289, 1325-1326; Sheridan, Tr. 6622, 6688, 6703, *in camera*; Shook, Tr. 948-950; Beck, Tr. 406-408).

Response to Finding No. 121:

Respondent has no specific response.

122. The reimbursement rates over which health plans and hospitals negotiate determine the compensation that a hospital will receive in exchange for treating that health plan's members. (Town, Tr. 3622-3623; *see* Shook, Tr. 949-950; Gold, Tr. 207-300).

Response to Finding No. 122:

Complaint Counsel's proposed finding is incomplete. The reimbursement rates are only one component in determining a hospitals final compensation. (RPF 1070). Many other provisions negotiated by hospitals and MCO affect ultimate compensation. (RPF 1089). So-called "non-compensation" provisions are as important as compensation provisions and affect a hospital's final compensation. (RPF 1084, 1085).

123. Other items of negotiation include the payment methodology, the length of the contract, and outlier provisions. (Town, Tr. 3623; Pugliese, Tr. 1472-1473, *in camera*, 1550-51; Pirc, Tr. 2288-2289; Radzialowski, Tr. 760-761).

Response to Finding No. 123:

Complaint Counsel provides a truncated and incomplete list that fails to reflect the voluminous testimony by MCO representatives describing the variety of terms negotiated by hospitals and MCOs. Negotiations between MCOs and hospitals are highly complex (RPF 1063, 1064; Radzialowski, Tr. 750 (Q: And I think you said that the process can take several months

back and forth before you ultimately reach agreement? A: Yes. Q: And that's because you are negotiating a number of different items that relate to the contract, isn't that right? A. It's very complex. Yes)). All MCOs acknowledged that negotiations encompass many price and non-price terms. (RPF 1070-1071, 1086).

124. Notwithstanding multiple other items in contracts between health plans and hospitals, the reimbursement rates are the most important point of negotiation because they determine the cost of care at the hospital to the health plan and its members and the amount of revenue the hospital stands to earn from contracting with the health plan. (Town, Tr. 3623-3624; Pugliese, Tr. 1514, *in camera*; Sandusky, Tr. 1318; Wachsman, Tr. 5139-5140, *in camera*; Gold, Tr. 209-210, 300; Beck, Tr. 407-408; Shook, Tr. 1050). In the ordinary course of business, health plans compare the reimbursement rates that they pay to the hospitals in their provider networks. (Pugliese, Tr. 1512-1513, *in camera*; Pirc, Tr. 2227, *in camera*; Radzialowski, Tr. 595; *see* Sandusky, Tr. 1332-1334, *in camera*; McGinty, Tr. 1191-1192).

Response to Finding No. 124:

Complaint Counsel misrepresent the testimony of numerous MCO witnesses who indicated that price was *not* the only or most important point of negotiations. (Pugliese, Tr. 1514 ("Rates are probably number one on the list and second to that would be *contractual provisions that impact rates.*") (emphasis added); Sandusky, Tr. 1319("It's not only price, but it's the *whole application of the contract* in the reimbursement process.") (emphasis added). Non-compensation terms and provisions are just as important as compensation provisions because they can affect overall compensation. (RPF 1084, 1085).

In addition, MCOs and hospitals have a holistic view of "rates" that Complaint Counsel have misrepresented. MCOs examine their entire package of compensation with a hospital and this examination includes all inpatient and outpatient rates and all other services for which they contract with a hospital. (RPF 1071, 1082). Outpatient services are the largest and a growing portion of a hospital's business and, to the extent that MCOs or hospitals suggest rates are the most important part of negotiations, they are not necessarily referring to general acute-care

inpatient rates. (RPF 35, 36, *in camera*, 37, 42). Ultimately, contract negotiations between MCOs and hospitals involve numerous trade-offs between *all* the provisions under negotiation to arrive at a final, comprehensive compensation package. (RPF 1081-1082, 1089-1090, 1095).

125. Hospitals and health plans may negotiate over the reimbursement methodology to be used to calculate the actual payments from the health plan to the hospital. (Town, Tr. 3622-3623; Pirc, Tr. 2205; McGinty, Tr. 1241).

Response to Finding No. 125:

Testimony in this matter demonstrated that MCOs and hospitals in Lucas County actually do negotiate over the multiple reimbursement methodolog*ies* that are used in their contracts. (Pirc, 2205; RPF 584).

126. Most hospitals offer a broad array of services. (Town, Tr. 3637; Shook, Tr. 892, 895-896, 899-900, 902-903; PX02064 at 001 (¶ 2) (Gold, Decl.); Pugliese, Tr. 1440-1441, 1443; Wakeman, Tr. 2753-2755; Oostra, Tr. 5771-5778).

Response to Finding No. 126:

Testimony by all MCOs established that St. Luke's offers no unique service not already offered by other Lucas County hospitals. (RPF 1149).

127. Rather than negotiate a separate reimbursement rate for each of these services, health plans and hospitals typically decide on a reimbursement methodology that allows them to negotiate rates across the entire array of services. (Pugliese, Tr. 1550; Pirc, Tr. 2286-2287; Radzialowski, Tr. 750-751; McGinty, Tr. 1240; Town, Tr. 3637; PX02148 at 019-020 (¶ 33) (Town Expert Report), *in camera*).

Response to Finding No. 127:

The MCO witness testimony cited by Complaint Counsel fails to support the stated proposition. None of the MCO witness testimony cited by Complaint Counsel here makes any separate reference to reimbursement methodologies. MCO witnesses confirmed Respondent's view that contract negotiations cover a wide variety of hospital services and that MCOs negotiate for all of the services they require, including obstetrics services, in one comprehensive negotiation. (RPF 1020, 1071).

128. Such methodologies include per-diem, percent-of-charges, and DRG-based payments. (Town, Tr. 3639-3640; PX02148 at 019-020 (¶ 33) (Town Expert Report), *in camera*; *see* Pugliese, Tr. 1645-1646, *in camera*; Pirc, Tr. 2218-2219, *in camera*, 2224-2225, *in camera*; Radzialowski, Tr. 672-673; Sandusky, Tr. 1320).

Response to Finding No. 128:

Respondent has no specific response.

129. A per diem reimbursement methodology involves a negotiated base reimbursement rate, which is then multiplied by the number of days a patient stayed in the hospital to determine the total reimbursement owed to the hospital for that patient. (Town, Tr. 3639, Radzialowski, Tr. 672-673; PX02117 at 006 (¶ 12) (Wachsman, Decl.), *in camera*).

Response to Finding No. 129:

Respondent has no specific response.

130. A percent-of-charges reimbursement methodology involves a negotiated base percentage, which is then multiplied by the total charges for a patient, generated from the hospital's chargemaster (*i.e.*, list prices), to determine the reimbursement owed to the hospital for that patient. (Town, Tr. 3639; Pirc, Tr. 2224-2225, *in camera*).

Response to Finding No. 130:

Respondent has no specific response.

131. A DRG-based reimbursement methodology involves a negotiated base reimbursement rate, which is then multiplied by the weight assigned to each Diagnosis Related Group ("DRG") associated a patient's treatment to determine the total reimbursement owed to the hospital for that patient. (Town, Tr. 3639-3640; Pirc, Tr. 2218-2219, *in camera.*)

Response to Finding No. 131:

Respondent has no specific response.

132. DRGs are categories, created by the Centers for Medicare & Medicaid Services ("CMS"), which classify hospital services based on similar diagnoses and procedures. (Town, Tr. 3639-3640; Pirc, Tr. 2218-2219, *in camera.*)

Response to Finding No. 132:

Respondent has no specific response.

133. The weights attached to each DRG are also created by CMS, with each weight reflecting the average amount of resources used for the services covered by the corresponding DRG. (Town, Tr. 3639-3640; Pirc, Tr. 2218-2219, *in camera.*) DRGs with higher

weights correspond to services with greater resource use and, generally, with higher severity. (Town, Tr. 3676-3677; Pirc, Tr. 2218-2219, *in camera*.)

Response to Finding No. 133:

Respondent has no specific response.

134. Hospitals and health plans can impose a separate rate structure for particular services by negotiating a "carve-out," also referred to as a "case rate." (Town, Tr. 3637-3638; PX02148 at 019-020 (¶ 33) (Town Expert Report), *in camera*; PX01925 at 020 (Guerin-Calvert, Dep. at 73)). For example, a contract might contain a carve-out for open-heart services or for obstetrics services to have these services reimbursed according to a different formula than the one that applies to other hospital services covered by the contract. (Town, Tr. 3638; Sheridan, Tr. 6683-6684).

Response to Finding No. 134:

Complaint Counsel's characterization of carve-outs is misleading. A carve-out is a separate rate structure applied to particular services as a result of negotiations between the MCO and the hospital. (RPF 529). Such a carve-out need not necessarily be a case rate, which is an all-inclusive price applied regardless of the amount of services or duration of treatment. (Radzialowski, Tr. 673 (describing case rate based on DRG base rates)). Carve-outs may also apply percent-of-charge or per diem methodologies. (RPF 583, *in camera*, 584).

135. Reimbursement rates for hospital services are determined through the bargaining process between hospitals and health plans. (PX02148 at 014-015 (¶ 24) (Town Expert Report), *in camera*; Pugliese, Tr. 1472, *in camera*, 1547-1548; Radzialowski, Tr. 658-661; Korducki, Tr. 527-528; Shook, Tr. 948-950).

Response to Finding No. 135:

Respondent has no specific response.

136. Health plans negotiate rates for hospital services on behalf of their customers, who are both self-insured and fully-insured employers. (Pugliese, Tr. 1432-1433, 1547; PX01914 at 014 (Pirc, IHT at 49); Radzialowski, Tr. 748; PX02072 at 003 (¶ 12) (Firmstone, Decl.), *in camera*; PX02148 at 15 (¶ 25) (Town Expert Report), *in camera*; Sandusky, Tr. 1297).

Response to Finding No. 136:

Respondent has no specific response.

137. These negotiations typically involve a series of offers and counteroffers, and result in either the inclusion of a hospital in a health plan's network or the failure of the health plan and hospital to reach an agreement. (PX02148 at 15 (¶ 25) (Town Expert Report), *in camera*; PX02065 at 003 (¶ 11) (Szymanski, Decl.); Radzialowski, Tr. 658-661; Sandusky, Tr. 1318-1322).

Response to Finding No. 137:

Complaint Counsel improperly cites the Declaration (PX02065) of a witness who was not deposed and who did not testify at trial.

Complaint Counsel further mistakenly imply that failure to reach agreement automatically means the hospital is no longer participating in the MCO's network. However, when contracted rates expire before agreement is reached on a new contract, the old rates remain in effect. (RPF 607-608).

Furthermore, even if a hospital is not participating within an MCO's network, the hospital's physicians may still be in-network with the MCO. (Randolph, Tr. 6933). Physician networks are separate from hospital provider networks. (Radzialowski, Tr. 731).

138. Because the reimbursement rates that health plans pay to hospitals on behalf of commercially insured members are determined through negotiations in a market setting, a merger's effect on the bargaining dynamic and, thus, on these rates (*i.e.*, prices) is the logical focus of merger analysis. (Town, Tr. 3609, 3624-3625; PX02148 at 014-015 (¶ 24) (Town Expert Report), *in camera*).

Response to Finding No. 138:

The proposed finding is inaccurate. Merger analysis is designed to evaluate competition with and without the merger to determine whether the merger substantially lessens competition. (RX-71(A) at 000012, *in camera*). Evaluation of the "no-merger" scenario involves assessment of the market and its competitors with the merging firms remaining independent taking into consideration the likely competitive significance of these firms. (RX-71(A) at 000012, *in camera*). Evaluation of the merger scenario involves assessment of incentives and actions of the merged firm and the reactions of rivals to the merger. (RX-71(A) at 000012, *in camera*).

139. The rates and terms of the contracts that are negotiated by a hospital and a health plan are a function of the bargaining leverage that each party brings to bear in the negotiation. (Pirc, Tr. 2208; Radzialowski, Tr. 659-660; Shook, Tr. 978, *in camera*; PX01914 at 015 (Pirc, IHT at 53), *in camera* ("Q: Do the rates that are ultimately agreed upon in a negotiation between Medical Mutual and a given hospital depend on the relative bargaining leverage that [each has]? A: . . . That's a primary factor, yes."); PX02065 at 003 (¶ 11) (Szymanski, Decl.) ("[T]he resulting reimbursement rates are determined largely by the amount of bargaining leverage that FrontPath and the negotiating hospital/system have relative to each other."); Town, Tr. 3637, 3640-3641).

Response to Finding No. 139:

Complaint Counsel improperly cites the Declaration (PX02065) of a witness who was not deposed and who did not testify at trial.

Respondent does not disagree with this proposed finding but clarifies that bargaining leverage does not equate to or cause any anticompetitive effect. (RPF 1320-1321).

140. In bargaining relationships, the bargaining leverage of each party and, therefore, the terms of the agreement depend principally upon how each party would fare if it failed to enter into an agreement with the other party. (PX02148 at 015-016 (¶ 26) (Town Expert Report), *in camera*; Town, Tr. 3641; Pirc, Tr. 2208-2211; Sandusky, Tr. 1323-1324; Wachsman, Tr. 5123-5126; PX02067 at 004 (¶ 13) (Radzialowski, Decl.), *in camera*; PX02072 at 002-003 (¶ 9) (Firmstone, Decl.), *in camera*).

Response to Finding No. 140:

Complaint Counsel improperly cites the Declaration (PX02072) of a witness who was not deposed and who did not testify at trial.

Complaint Counsel misrepresent witness testimony. Witnesses testified that many factors provide leverage in negotiations, such as the number of members an MCO has and whether members prefer a certain hospital. (Pirc, 2209). This testimony confirms the definition of bargaining leverage advanced by Respondent's Expert. Bargaining leverage depends on the advantage, or the perception of advantage, of a particular entity at the bargaining table based on certain attributes in the negotiation. (RPF 1320-1321).

141. In other words, each party considers the cost it would face if the negotiations failed. (Sandusky, Tr. 1323-1324; Wachsman, Tr. 5123-5126; PX02148 at 015-016 (¶ 26) (Town Expert Report), *in camera*; Town, Tr. 3641-3642)).

Response to Finding No. 141:

Respondent has no specific response.

142. The success or failure of a negotiation depends on the hospital's and health plan's respective "walk-away" points. (PX02148 at 015-016 (¶ 26) (Town Expert Report), *in camera*; PX01914 at 015-016 (Pirc, IHT at 51-53), *in camera*; Radzialowski, Tr. 660).

Response to Finding No. 142:

Respondent does not disagree with this proposition, but clarifies that a walk-away point can refer to any of the provisions under negotiation and not only "rate" provisions because contract provisions are inter-related. (RPF 1070, 1081, 1084-1085, 1089).

143. If a hospital demands rates above a health plan's walk-away point, the health plan will refuse to contract with the hospital. (PX02148 at 015-016 (¶ 26) (Town Expert Report), *in camera*; Radzialowski, Tr. 675-677; Pirc, Tr. 2207-2208; Sheridan, Tr. 6688).

Response to Finding No. 143:

Respondent does not disagree with this proposition. St. Luke's decision not to contract with Paramount is an example of this dynamic. (RPF 791-796).

144. If a health plan refuses to pay rates above a hospital's walk-away point, the hospital will decline to contract with the health plan. (PX02148 at 015-016 (¶ 26) (Town Expert Report), *in camera*; Radzialowski, Tr. 675-677).

Response to Finding No. 144:

Respondent has no specific response.

145. The threat of termination is implicit, if not explicit, in negotiations between hospitals and health plans, and it influences these negotiations. (Pugliese, Tr. 1458; Pirc, Tr. 2207; PX01917 at 011, 024-025 (Radzialowski, Dep. at 41, 93-94), *in camera*; PX01919 at 006 (Pugliese, Dep. at 21), *in camera*; PX01914 at 015 (Pirc, IHT at 51-52), *in camera*).

Response to Finding No. 145:

Respondent dos not disagree with this proposition, but clarifies that termination is usually avoidable. Instances of termination are relatively rare and, far more often, parties usually reach agreement on a mutually acceptable contract. (RPF 1334, 1341, 1342, 1349, 1355-1356, 1383).

146. In the past, hospitals and health plans in Lucas County have sometimes failed to reach agreement in contract negotiations, resulting in the health plans offering narrower or exclusive provider networks. (PX02148 at 019 (¶ 32) (Town Expert Report), *in camera*; *see also* PX02136 at 032 (¶ 27) (Guerin-Calvert, Supp. Decl.), *in camera*).

Response to Finding No. 146:

Respondent has no specific response.

147. The bargaining leverage of a hospital against a health plan depends on the value that the hospital adds to the health plan's network. (Town, Tr. 3643; Pirc, Tr. 2208-2210; Radzialowski, Tr. 663-666; Pugliese, Tr. 1458-1461).

Response to Finding No. 147:

Complaint Counsel adopt a narrow view of bargaining leverage that is inconsistent with witness testimony. A hospital's bargaining leverage depends upon a variety factors, both actual and perceived, and is not limited to the value the hospitals adds to the health plan's network. (RPF 1320-1321, 1097-1104). Other factors including historical factors and trade-offs parties make that affect bargaining leverage as well. (RPF 1097-1104).

148. Put differently, a hospital's bargaining leverage against a health plan depends on the amount of value the health plan's network would lose if the health plan failed to contract with the hospital. (Town, Tr. 3641; Pirc, Tr. 2210-2211; Radzialowski, Tr. 665-666; Pugliese, Tr. 1458-1461).

Response to Finding No. 148:

Complaint Counsel adopt a narrow view of bargaining leverage that is inconsistent with witness testimony. A hospital's bargaining leverage depends upon a variety factors, both actual and perceived, and is not limited to the value that the hospital adds to the health plan's network. (RPF 1320-1321, 1097-1104). Other factors including historical factors and trade-offs parties make affect bargaining leverage as well. (RPF 1097-1104).

149. This, in turn, depends on the value that the health plan's current and potential members place on having in-network access to that hospital. (PX02148 at 016 (¶ 27) (Town Expert Report), *in camera*; Pirc, Tr. 2168, 2189, 2208-2211; PX01914 at 015 (Pirc, IHT at 50), *in camera* ("Q: Is it fair to say, then, that the more important a particular provider is to your member[s], the more MMO might be willing to pay to have that provider in its network? A: That's a fair statement, yes.")).

Response to Finding No. 149:

Complaint Counsel improperly cite and provide excerpts of testimony (PX01914) that relies upon a leading question.

The value members place on having a particular hospital in-network is only one factor among many that affect the relative bargaining leverage of MCOs and hospitals in their negotiations. (RPF 1320-1321, 1097-1104).

150. This value is reflected by the number of the health plan's members who use or would use the hospital. (PX02072 at 002-003 (¶ 9) (Firmstone, Decl.), *in camera*; Radzialowski, Tr. 665).

Response to Finding No. 150:

This finding improperly cites the Declaration (PX02072) of a witness who was not deposed and who did not testify at trial.

151. The more a health plan's members value a hospital, the more bargaining leverage the hospital possesses in its negotiations with the health plan, because the worse off would be the health plan's ability to market its insurance products without the hospital in-network. (Pirc, Tr. 2168-2169, 2209-2210, 2296; PX02148 at 016 (¶ 27) (Town Expert Report), *in camera*; Town, Tr. 3641-3643, 3649-3650; PX02065 at 004 (¶ 13) (Szymanski, Decl.); PX02067 at 004 (¶ 13) (Radzialowski, Decl.), *in camera*; Radzialowski, Tr. 665-666; Pugliese, Tr. 1458-1461; Sheridan, Tr. 6686-6687).

Response to Finding No. 151:

This finding improperly cites the Declaration (PX02065) of a witness who was not deposed and who did not testify at trial.

Complaint Counsel also ignore contradictory evidence. No MCO has conducted any study or survey to confirm the anecdotal, opinion testimony of the MCO representatives. (RPF

1261-1271). MCOs have no data to confirm their supposed inability to market products lacking any hospital in Lucas County, including St. Luke's. (RPF 1261-1271).

152. The more bargaining leverage a hospital has against a health plan, the higher the reimbursement rates that the hospital will be able to obtain from the health plan. (Pirc, Tr. 2168-2169, 2211, 2296; Radzialowski, Tr. 658-659; Pugliese, Tr. 1523-1525, *in camera*; Sandusky, Tr. 1348-1349, *in camera*; McGinty, Tr. 1209-1210; Sheridan, Tr. 6700-6701, *in camera*).

Response to Finding No. 152:

Complaint Counsel mischaracterize MCO witness testimony. For example, Ms. Sheridan offered no opinion on the impact of a hospital's leverage. Her testimony focused on the added complexity of negotiating with large hospital systems. (Sheridan, Tr. 6700-6701). Similarly, Ms. Sandusky's testimony acknowledged ProMedica was an important hospital for FrontPath, but admitted that FrontPath was nevertheless able to negotiate various contract provisions and rate trade-offs that offset rate requests. (Sandusky, Tr. 1349).

153. Health plans regularly conduct market research regarding members' preferences in order to maintain marketable and attractive provider networks, thus ensuring that their insurance products appeal to employers and employees. (Pirc, Tr. 2167-2168, 2182-83; Radzialowski, Tr. 588-590; *see* PX02067at 002 (¶ 6) (Radzialowski, Decl.), *in camera*; PX02072 at 002 (¶ 6) (Firmstone, Decl.), *in camera*; PX01914 at 014-015 (Pirc, IHT at 49-51)).

Response to Finding No. 153:

Complaint Counsel misrepresent witness testimony with respect to market research. In fact, as MCO testimony reveals, no MCO has conducted any studies or analyses of patient preferences or travel and utilization patterns of members within Lucas County. (RPF 1261-1271).

154. Assuming a market has been properly defined, a hospital's market share can be a useful metric of the hospital's bargaining leverage because it reflects the number of patients who are choosing that hospital given the other options in the market. (Town, Tr. 3645-46; PX02148 at 035 (¶ 62) (Town Expert Report), *in camera*; *see* Pirc, Tr. 2209-2212).

Response to Finding No. 154:

Complaint Counsel's proposed finding is inaccurate and misleading. Market share measures may provide insight into substitution among products, historical success of a firm in attracting customers, and may be informative for comparing the competitive significance of firms in a market. (RX-71(A) at 000035, *in camera*). Market shares, however, are imprecise and are only a starting point for the assessment of the competitive significance of a firm or the effect of a merger. (RX-71(A) at 000035, *in camera*). Market shares based on different metrics may yield different results, as may shares measured at different time periods. (RX-71(A) at 000035, *in camera*). Differences across measures or among time periods may signal that single type of share measures may not capture the actual competitive dynamics. (RX-71(A) at 000035, *in camera*). Finally, shares may be artificially lower or higher due to contracting practices – for example, a hospital that is one of a few in a narrower network of a very large payor may have a higher share than a hospital that does not participate in that network but does so in several small payors' networks. (RX-71(A) at 000035, *in camera*).

155. A more popular hospital will have a higher market share, will add more value to a health plan's network by virtue of its popularity with patients, and will, therefore, be more important to the health plan's marketability and will have more bargaining leverage against the health plan. (Town, Tr. 3646; PX02148 at 035 (¶62) (Town Expert Report), *in camera*; Pugliese, Tr. 1523-1525, *in camera*; Pirc, Tr. 2209-2212; *see* Sheridan, Tr. 6686-6687, 6700-6701, *in camera*).

Response to Finding No. 155:

Complaint Counsel's proposed finding is inaccurate and misleading. Market shares are imprecise and are only a starting point for the assessment of the competitive significance of a firm or the effect of a merger. (RX-71(A) at 000035, *in camera*). Market shares based on different metrics may yield different results, as may shares measured at different time periods. (RX-71(A) at 000035, *in camera*). Differences across measures or among time periods may signal that single type of share measures may not capture the actual competitive dynamics. (RX-

71(A) at 000035, *in camera*). Finally, shares may be artificially lower or higher due to contracting practices – for example, a hospital that is one of a few in a narrower network of a very large payor may have a higher share than a hospital that does not participate in that network but does so in several small payors' networks. (RX-71(A) at 000035, *in camera*).

156. In Lucas County, there is a strong, positive correlation between a hospital's market share and the reimbursement rates that the hospital has obtained from health plans. (PX02148 at 039 (¶ 71), 147 (Ex. 8) (Town Expert Report), *in camera*).

Response to Finding No. 156:

Complaint Counsel's proposed finding is inaccurate. Professor Town's market shares for inpatient general acute care services are flawed because he limits his "market" to only those general acute care inpatient services (identified as "diagnostic related groups" or "DRGs") that both ProMedica and St. Luke's provided to at least three commercially-insured patients (RPF 1491), thereby eliminating from his "market" (and his share calculations) many services that ProMedica, Mercy, and UTMC offer and provide. (RPF 1489-1493, 1504, 1510, *in camera*). Professor Town also excluded overlapping St. Luke's and ProMedica DRGs for which St. Luke's and ProMedica compete with hospitals outside of Lucas County (RPF 1494-1495), and DRGs with a case weight index, which reflects complexity of care, greater than two. (RPF 1496). {

} (RX-71(A) at 000015-000018, *in camera*). Professor Town included, however, some DRGs with case weights higher than four, which captures some services that could be classified as tertiary or quaternary medical services. (RPF 1500). His separate inpatient OB services product market share calculation is similarly flawed because it is also based on less than one year's worth of data and 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. (RPF 1501).

Moreover, Professor Town's market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

Professor Town's case-mix-adjusted price estimations do not indicate the reason for the difference in prices across hospitals in Lucas County, and Professor Town agrees that the presence of price differences alone are not sufficient to determine the exercise of market power. (RPF 1515, *in camera*). No theoretical or empirical basis exists on which to draw inferences of market power from a comparison of price levels across hospitals. (RX-71(A) at 000069, *in camera*). {

} (RPF 1527, *in camera*). However, Professor Town's case-mix-adjusted price calculations result in Mercy's prices being higher. (RPF 1527). {

}. (RPF 1528, *in camera*) {

} (RPF 1528, *in camera*). Professor 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. (RPF 1525).

157. In other words, the higher a hospital's market share, the higher the rates it is able to demand and receive from health plans: St. Luke's has the smallest market share in Lucas County – 11.5 percent for GAC – and receives the lowest rates; UTMC has a 13.0 percent GAC market share and its average rates are { } higher than St. Luke's; Mercy has a 28.7 percent GAC market share and its average rates are { } greater than St. Luke's; and ProMedica has a 46.8 percent GAC market share, with average rates exceeding St. Luke's by { }. (PX02148 at 036 (¶ 66), 143 (Ex. 6), 145 (Ex. 7), 147 (Ex. 8) (Town Expert Report), *in camera*).

Response to Finding No. 157:

Complaint Counsel's proposed finding relies upon a flawed analysis that improperly excludes services that are part of the relevant product market alleged in the Complaint. (RPF 1486-1514). The proposed finding further relies upon an analysis that overstates St. Luke's competitive importance because it relies upon a geographic area other than the relevant geographic market. (RPF 1036-1049).

Furthermore, if Professor 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. (RFP 1531). Professor 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. (RPF 1532). 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. (RPF 1533). For Blue Cross Blue Shield of Michigan ("BCBS of Michigan"), St. Vincent's price is higher than that of TTH's. (RPF 1534). For FrontPath, St. Anne's price is higher than TTH's, St. Vincent's, UTMC's, and Flower's. (RPF 1535).

Moreover, Professor Town's price computations are also contradicted by St. Luke's ordinary course documents showing ProMedica's prices are not highest among Lucas County

hospitals; instead they show { } having the highest prices among Lucas County hospitals. *See e.g.*, (PX01016 at 009, *in camera*). Professor Town's price computations also do not take into account payor testimony explaining the rate differences, such as {

} (Pirc, Tr. 2316-2315, *in camera*). {

.} (Pirc, Tr. 2316, *in camera*). {

.} (Pirc, Tr. 2316, *in camera*).

158. The Willingness-To-Pay ("WTP") measure is another measure of the value that a hospital brings to a given health plan's network. (Town, Tr. 3645-46).

Response to Finding No. 158:

Complaint Counsel's proposed finding is inaccurate. Willingness-to-pay measures bargaining power at a system level. (Town, Tr. 4206). It measures 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).

159. A hospital system that owns two or more substitute hospitals within a given market will have greater bargaining leverage against health plans than an independent hospital in that market. (Town, Tr. 3645; *see* Pirc, Tr. 2209-2210; Radzialowski, Tr. 663; Pugliese, Tr. 1459). This is the case because failure to contract with the hospital system will harm the marketability of the health plans' products more than failure to contract with the independent hospital. (Town, Tr. 3644-3645; Pirc, Tr. 2209-2210; Radzialowski, Tr. 663).

Response to Finding No. 159:

Complaint Counsel fail to identify the characteristics of the independent hospital in this hypothetical scenario. The characteristics of the hospital are what define its bargaining leverage. (RPF 1320; Sheridan, Tr. 6687 ("Q: And you'd agree that in general a hospital system with several facilities in a local area has a stronger bargaining position than a single, independent

facility, correct? Ms. Sheridan: It depends on what that facility is."). For example, MCOs testified that the only essential feature for their networks is to have at least one tertiary hospital in their network. (RPF 345, 388). In this scenario, an independent hospital offering an essential array of services has greater leverage than the system hospitals.

160. The fewer the substitutes for a particular hospital in a particular market, the harder it would be for health plans to market a network without that hospital and, therefore, the more valuable that hospital is to health plans and the greater that hospital's bargaining leverage is against health plans. (Pirc, Tr. 2199-2200, 2210-2211; Pugliese, Tr. 1461-1462; PX01944 at 008 (Pirc, Dep. at 28-29), *in camera*; PX01914 at 016 (Pirc, IHT at 54), *in camera*; PX02065 at 003 (¶ 11), 004 (¶ 13) (Szymanski, Decl.); Town, Tr. 3652-3653; PX02148 at 017 (¶ 29) (Town Expert Report), *in camera*; *see* Radzialowski, Tr. 662-663; PX02072 at 002-003 (¶ 9) (Firmstone, Decl.), *in camera*; PX02067 at 004 (¶ 13) (Radzialowski, Decl.), *in camera*).

Response to Finding No. 160:

This proposed finding is misleading. This proposed finding ignores the history of narrow networks in Lucas County. If an MCO has a narrow provider network, it may negotiate lower hospital reimbursement rates; in contrast, MCOs with open networks tend to have to pay higher reimbursement rates. (RPF 493, *in camera*, 563, 565, 737, 740, *in camera*, 775, 1103). For example, when Mercy was in MMO's network before 2008, Mercy's rates were approximately { } lower for an MMO network that excluded { } (RPF 734, 735-736, *in camera*, 737). Effectively Mercy was providing an { } discount to MMO for the exclusivity and potential for greater volume. (RPF 734, 735-736, *in camera*, 737). Narrow networks were and are competitive in Lucas County. (RPF 709-718, 779).

In addition, this finding improperly cites the Declaration (PX02065) of a witness who was not deposed and who did not testify at trial.

161. A health plan's bargaining leverage with a hospital is determined by how much the hospital values being included in the health plan's network. (PX02148 at 016-017 (¶ 28) (Town Expert Report), *in camera*; PX02065 at 003-004 (¶ 12) (Szymanski, Decl.); JX00002A at 002 (¶ 13) (Joint Stipulations of Law and Fact).

Response to Finding No. 161:

Respondent also adds that a health plan's bargaining leverage is affected by the health plan's national presence and number of members. *See* Response to CCPF 162.

In addition, this finding improperly cites the Declaration (PX02065) of a witness who was not deposed and who did not testify at trial.

162. This depends on the size of the health plan's membership, or the patient volume, that the health plan can offer to the hospital. (Pugliese, Tr. 1461; Pirc, Tr. 2209; PX02072 at 002-003 (¶ 9) (Firmstone, Decl.), *in camera*; PX02067 at 004 (¶ 12) (Radzialowski, Decl.), *in camera*; PX02148 at 016-017 (¶ 28) (Town Expert Report), *in camera*; Radzialowski, Tr. 661-662; *see* Wachsman, Tr. 5125).

Response to Finding No. 162:

This finding improperly cites the Declaration (PX02072) of a witness who was not deposed and who did not testify at trial.

Health plans also have other characteristics that affect their relative leverage. Among the many characteristics that define a health plan's leverage is its brand recognition. Many of the health plans operating in Lucas County are large national or regional companies. (RPF 259, 274, 350, 370). National MCOs frequently offer their members nation-wide benefits (and thus enable out-of-area members the ability to use participating hospitals in Lucas County). (RPF 298). These national companies tout their brand attributes: Blue Cross Blue Shield is "the most recognized brand in the healthcare industry." (RPF 300); Aetna says hospitals like to say "We are an Aetna provider." (RPF 395). These MCOs actively market their national brand recognition to hospitals. (RPF 302, 366, 394) and this branding provides substantial leverage in negotiations. (RPF 300-303, 366-369, 394-395).

163. The more patient volume that a hospital stands to lose if it fails to reach an agreement with the health plan, the greater the bargaining leverage the health plan will have with the hospital. (PX02148 at 016-017 (¶ 28) (Town Expert Report), *in camera*; PX02072 at 002-003 (¶ 9) (Firmstone, Decl.), *in camera*; *see* Radzialowski. Tr. 661-662).

Response to Finding No. 163:

This finding improperly cites the Declaration (PX02072) of a witness who was not deposed and who did not testify at trial.

164. A merger between substitute hospitals changes the bargaining leverage of the merged entity by changing health plans' cost of failing to reach an agreement with the merged entity. (Town, Tr. 3651-3652; PX02148 at 018 (¶ 30) (Town Expert Report), *in camera*).

Response to Finding No. 164:

This proposed finding is inaccurate. The magnitude of the change in bargaining leverage depends on the substitutability of the merging hospitals. (Town, Tr. 3652). Professor Town's willingness-to-pay is based on a bargaining model characterizing negotiations between hospital systems and commercial payors to set prices. (RX-71(A) at 000072, *in camera*). However, Professor Town's bargaining model is too simplistic to accurately represent the bargaining dynamics in Lucas County because it ignores elements such as the history a provider and MCO have that can affect bargaining. *See* (RPF 1097-1104).

165. In other words, a merger between substitute hospitals changes the value of the health plans' walk-away network—the network of alternative hospitals that health plans can offer to their members if they fail to contract with the merged entity. (Town, Tr. 3654-3655; Pirc, Tr. 2261-2262, *in camera*).

Response to Finding No. 165:

Complaint Counsel's proposed finding is inaccurate. Respondent refers to its response to CCPF 164, which it incorporates here by reference.

166. The degree to which the merging hospitals are substitutes for each other (*i.e.*, the degree of substitutability between them) is directly related the merger's impact on the health plans' walk-away network, on its cost failing to reach an agreement with the merging hospitals, and thus on the change in the merged hospitals' bargaining leverage. (Town, Tr. 3563-3655; PX02148 at 018 (¶ 30) (Town Expert Report), *in camera*).

Response to Finding No. 166:

Complaint Counsel's proposed finding is inaccurate. Respondent refers to its response to CCPF 164, which it incorporates here by reference.

167. The degree of substitutability between the merging hospitals depends on the number of patients who view the merging hospitals as their first- and second-choice hospitals. (Town, Tr. 3654).

Response to Finding No. 167:

Respondent has no specific response.

168. The greater the degree of substitutability between the merging hospitals, the larger the number of patients who will lose in-network access to their first- and second-choice hospitals if health plans' fail to contract with the merged hospitals. (Town, Tr. 3653-3654).

Response to Finding No. 168:

Complaint Counsel's proposed finding is misleading and inaccurate. Diversion analysis shows that there is actually more diversion from St. Luke's to Mercy than from St. Luke's to ProMedica. (RPF 1135-1136).

In addition, the data show that for St. Luke's largest payor, MMO, {

} (RPF 1128). {

} (RPF 1133).

In addition, the largest percentage of patients for any MCO would divert to Mercy, not St. Luke's, if ProMedica were not available. (PX01850 at 020, *in camera*).

169. The greater the degree of substitutability between the merged hospitals, the greater the reduction in the value of the health plans' walk-away network, the more the health plans stand to lose from failing to contract with the merged hospitals. (Town, Tr. 3651-3655; PX02148 at 018 (¶ 30) (Town Expert Report), *in camera*). Therefore, the higher the price that the health plans will be willing to pay the merged hospitals and the greater the increase of the merged hospitals' bargaining leverage against health plans as a result of

the merger. (Town, Tr. 3651-55; PX02148 at 018 (¶ 30) (Town Expert Report), *in camera*).

Response to Finding No. 169:

Complaint Counsel's proposed finding is misleading. A diversion analysis for Lucas County showed that there is actually more diversion from St. Luke's to Mercy than from St. Luke's to ProMedica. (RPF 1135-1136). In addition, the data show that for St. Luke's largest payor, MMO, {

.} (RPF 1128). {

.} (RPF 1133). The largest percentage of patients for any MCO would divert to Mercy, not St. Luke's, if ProMedica were not available. (PX01850 at 020, *in camera*). Therefore, in Lucas County there is greater substitutability between non-merging hospitals than merging hospitals. (RPF 1135-1136; PX01850 at 020, *in camera*).

Complaint Counsel's proposed finding is also misleading because it is based on Professor Town's simplistic bargaining model. Professor Town's bargaining model does not accurately represent the bargaining dynamics in Lucas County because it ignores elements such as the history a provider and MCO have that can affect bargaining. *See* (RPF 1097-1104). Professor 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). This proposed finding also does not take into account the value to consumers a narrow network at a reduced price, like Paramount, has. (*See, .e.g.*, RPF 737; Randolph, Tr. 6935-6936).

170. Mergers between non-substitute hospitals (*e.g.*, hospitals located in different geographic markets) generally will not affect the bargaining leverage of the merged hospitals and, therefore, generally will not produce anticompetitive effects. (Town, Tr. 3652; *see* PX01944 at 009 (Pirc, Dep. at 32), *in camera*).

Response to Finding No. 170:

Respondent has no specific response.

4. Application of Bargaining Dynamics to ProMedica's Acquisition of St. Luke's Hospital

171. Prior to the Acquisition, both ProMedica and St. Luke's independently engaged in extensive negotiations with health plans over rates for services and other contractual terms, with the goal of reaching a multi-year contract with each health plan. (PX02148 at 015 (¶ 25) (Town Expert Report), *in camera*; Radzialowski, Tr. 681-687, *in camera*; Pugliese, Tr. 1474-1476, *in camera*).

Response to Finding No. 171:

Respondent has no specific response.

172. Prior to the Acquisition, the health plans' walk-away network with respect to ProMedica's Lucas County hospitals consisted of St. Luke's, Mercy's Lucas County hospitals and UTMC. (Town, Tr. 3656-3657). As a result of the Acquisition, this walk-away network shrank to only Mercy's Lucas County hospitals and UTMC. (Town, Tr. 3656-3657; PX02067 at 004, 006 (¶ 13, 21) (Radzialowski, Decl.), *in camera*; PX02073 at 004 (¶ 15) (McGinty, Decl.), *in camera*; *see* PX02148 at 064-065 (¶ 116) (Town Expert Report), *in camera*).

Response to Finding No. 172:

Complaint Counsel's hypothetical assumes that the MCO would be able to reach an acceptable contract with the hospitals identified in the "walk-away network." No payor testified that it could or would substitute St. Luke's for ProMedica; in fact, MCOs repeatedly affirmed that St. Luke's is not essential and that they could not build a network with St. Luke's alone unless they also had a provider of advanced services. (RPF 273, 344-348, 365, 389).

173. Because St. Luke's is valued by health plan members, failure to contract with ProMedica has become more costly for health plans as a result of the Acquisition, because their walk-away network becomes significantly less valuable from the exclusion of ProMedica and St. Luke's than from the exclusion of only ProMedica. (Town, Tr. 3658-59; Radzialowski, Tr. 715-716, *in camera*; McGinty, Tr. 1201; Sandusky, Tr. 1312-1313,

1351, *in camera*; Pugliese, Tr. 1477-1478, *in camera*, 1481-1482, *in camera*; Pirc, Tr. 2201-2203, 2262-2263, *in camera*).

Response to Finding No. 173:

Complaint Counsel has repeatedly suggested above that the value of a hospital translates to higher rates. By this measure, St. Luke's was not valued in Lucas County because its rates were the { }. (RPF 1771, 1777-1786, *in camera*). MCOs also did not value St. Luke's for its alleged high quality. (RPF 1456-1460). { } did not believe St. Luke's was sufficiently valued {

.} (RPF 1794-1818, *in camera*, 1839-1859, *in camera*).

174. Consequently, as a result of the Acquisition, health plans will be willing to pay higher rates to keep the merged ProMedica/St. Luke's in their networks, increasing ProMedica's bargaining leverage against the health plans. (Town, Tr. 3658-59; PX02148 at 054 (¶ 94) (Town Expert Report), *in camera*; Radzialowski, Tr. 715-716, *in camera*,841-842, *in camera*; Pugliese, Tr. 1525, *in camera*; McGinty, Tr. 1209-1210; Pirc, Tr. 2262-2263, *in camera*).

Response to Finding No. 174:

Complaint Counsel has failed to establish the premise upon which this speculative finding is based. St. Luke's was not so valued by members that health plans will now be willing to pay higher rates to keep ProMedica and St. Luke's in their networks. (RPF 1771, 1777-1786, *in camera*, 1794-1818, *in camera*, 1839-1859, *in camera*).

175. Prior to the Acquisition, the health plans' walk-away network with respect to St. Luke's consisted of ProMedica's Lucas County hospitals, Mercy's Lucas County hospitals, and UTMC. (Town, Tr. 3661). As a result of the Acquisition, this walk-away network shrank to only Mercy's Lucas County hospitals and UTMC. (Town, Tr. 3662-63; PX02067 at 004, 006 (¶¶ 13, 21) (Radzialowski, Decl.), *in camera*; PX02073 at 004 (¶ 15) (McGinty, Decl.), *in camera*).

Response to Finding No. 175:

Complaint Counsel's hypothetical again assumes that the MCOs would be able to reach an acceptable contract with the hospitals identified in the "walk-away network." Even if this

"walk-away" network is correctly identified, the post-Joinder network consists of St. Luke's substitutes. The data show that for St. Luke's largest payor, MMO, {

.} (RPF 1128). {

.} (RPF 1133).

In addition, the largest percentage of patients for any MCO would divert to Mercy, not St. Luke's, if ProMedica were not available. (PX01850 at 020, *in camera*).

176. Because ProMedica's Lucas County hospitals are highly valued by health plan members, failure to contract with St. Luke's has become much more costly for health plans as a result of the Acquisition, because their walk-away network becomes dramatically less valuable from the exclusion of St. Luke's and ProMedica's Lucas County hospitals than from the exclusion of only St. Luke's. (Town, Tr. 3661-3663; *see* Sheridan, Tr. 6693, *in camera*; Pirc, Tr. 2262, *in camera*; Radzialowski, Tr. 715-716, *in camera*; McGinty, Tr. 1201; Sandusky, Tr. 1348-1349, *in camera*, 1351, *in camera*; Pugliese, Tr. 1477-1478, *in camera*, 1523-1525, *in camera*; Pirc, Tr. 2262, *in camera*).

Response to Finding No. 176:

Complaint Counsel's proposed finding is purely speculative. No MCO has studied patient preferences relating to alternative market configuration and none has any data to suggest a Mercy-UTMC network would be unsuccessful. (RPF 1261-1271). Complaint Counsel's expert has not done any analysis to determine whether such a network would be marketable for MCOs. (RPF 1598). The success of networks in Lucas County has repeatedly been shown to be dependent upon price. (RPF 435, Radzialowski, 742 (indicating Aetna was unable to profit from having all hospitals in-network while competitors offered limited networks because it had poor pricing)).

177. Consequently, as a result of the Acquisition, health plans will be willing to pay higher rates to keep the merged ProMedica/St. Luke's in their networks, increasing St. Luke's bargaining leverage against the health plans. (Town, Tr. 3662-63; PX02148 at 053-054

(¶ 93) (Town Expert Report), *in camera*; Radzialowski, Tr. 700-704, *in camera*, 842, *in camera*; McGinty, Tr. 1209-1210).

Response to Finding No. 177:

Complaint Counsel cite to testimony from Aetna and Humana who *speculate* that after the joinder they may have to pay higher rates. Humana has had no discussions with ProMedica about its contracts with either ProMedica or St. Luke's. (RPF 1421-1422). Aetna, on the other hand, *has* had post-joinder discussions with ProMedica and flatly refused to increase rates for St. Luke's. (RPF 1409-1414, *in camera*).

178. The Acquisition asymmetrically increased ProMedica's and St. Luke's respective bargaining leverage. (Town, Tr. 3602, 3660-3664; PX02148 at 036 (¶¶ 64-65), 053-054 (¶¶ 93-94) (Town Expert Report), *in camera*).

Response to Finding No. 178:

This proposed finding is misleading. This finding relies upon Professor Town's "willingness-to-pay" model. However, Professor Town's "willingness-to-pay" calculation is unreliable for the reasons listed in CCPF 437, which is incorporated here by reference. Moreover, Professor Town's willingness-to-pay is based on a bargaining model characterizing negotiations between hospital systems and commercial payors to set prices. (RX-71(A) at 000072, *in camera*). However, Professor Town's bargaining model is too simplistic to accurately represent the bargaining dynamics in Lucas County because it ignores elements such as the history a provider and MCO have that can affect bargaining. *See* (RPF 1097-1104).

179. Prior to the Acquisition, the health plans' walk-away network with respect to St. Luke's was more valuable than the health-plans' walk away network with respect to ProMedica, because the former contained more alternative hospitals than the latter. (Town, Tr. 3662). In other words, prior to the Acquisition, St. Luke's had less bargaining leverage against health plans than ProMedica, because health plans would lose less from failing to contract with St. Luke's than from failing to contract with ProMedica. (Town, Tr. 3662).

Response to Finding No. 179:

Complaint Counsel's hypothetical assumes that the MCO would be able to reach an acceptable contract with the hospitals identified in the "walk-away network." No payor testified that it could or would substitute St. Luke's for ProMedica; in fact, MCOs repeatedly affirmed that St. Luke's is not essential and that they could not build a network with St. Luke's alone unless they also had a provider of advanced services. (RPF 273, 344-348, 365, 389).

180. As a result of the Acquisition, health plans have the same walk-away network with respect to St. Luke's and to ProMedica. (Town, Tr. 3663; PX02148 at 061-062 (¶¶ 110-111) (Town Expert Report), *in camera*).

Response to Finding No. 180:

Respondent has no specific response.

181. Therefore, the walk-away network with respect to St. Luke's lost significantly more value as a result of the Acquisition than the walk-away network with respect to ProMedica. (Town, Tr. 3656-57, 3661-62; *see* PX02148 at 061-062 (¶¶ 110-111) (Town Expert Report), *in camera*).

Response to Finding No. 181:

This proposed finding is misleading. MCOs repeatedly affirmed that St. Luke's is not essential and that they could not build a network with St. Luke's alone unless they also had a provider of advanced services. (RPF 273, 344-348, 365, 389).

182. Consequently, the Acquisition increased St. Luke's bargaining leverage against health plans significantly more than it increased ProMedica's bargaining leverage. (*See* Town, Tr. 3657-59, 3662-63; PX02148 at 053-054 (¶ 93) (Town Expert Report), *in camera*).

Response to Finding No. 182:

This proposed finding is inaccurate. Bargaining leverage does not equate to or cause an anti-competitive effect. (RPF 1321). There is no evidence of any anticompetitive effect resulting from any supposed increase in bargaining leverage. (RPF 1409-1414, *in camera*). On the contrary, there is substantial evidence that any supposed increase in bargaining leverage has, in fact, not resulted in anticompetitive effects. Post-joinder contracts negotiated for St. Luke's

by ProMedica reflect rate increases less than increases obtained by St. Luke's in pre-joinder negotiations. (RPF 1384, 1821, 1398-1399, 1876).

183. While health plans in Lucas County have marketed virtually every configuration of hospital network, none have marketed a network consisting of only Mercy and UTMC in the past 10 years. (Randolph, Tr. 7066, 7069-7070; Pirc, Tr. 2204; Pugliese, Tr. 1474, *in camera*, 1476-1478, *in camera*; Radzialowski, Tr. 670-671; PX02065 at 003 (¶ 10) (Szymanski, Decl.); Sandusky, Tr. 1288-1289, *in camera*; McGinty, Tr. 1194, 1199; Sheridan, Tr. 6690-6692, 6694; JX00002A at 003 (¶ 19) (Joint Stipulations of Law and Fact)).

Response to Finding No. 183:

This finding improperly cites the Declaration (PX02065) of a witness who was not deposed and who did not testify at trial.

Complaint Counsel exaggerate the number of different configurations of network plans that have been marketed in Lucas County. The Mercy-UTMC is one of several possible combinations that has not previously been marketed, there is no evidence showing why such a plan could not be successfully marketed at the right price. (RPF 1249-1254, 1597-1602) .

184. Testimony from health plans indicates that a hospital network comprised of only Mercy and UTMC would be extremely difficult to market in Lucas County, OH. (Radzialowski, Tr. 715-716, *in camera*; McGinty, Tr. 1201; Sandusky, Tr. 1351, *in camera*; Pugliese, Tr. 1477-1478, *in camera*; Pirc, Tr. 2262, *in camera*; *see also infra* Section XI.D.1.).

Response to Finding No. 184:

MCO testimony about the viability of a Mercy-UTMC network is not credible. No MCO has conducted any studies of patient preferences within Lucas County. (RPF 1261-1271). None has any data showing the results of a Mercy-UTMC network. (RPF 1250, *in camera*, 1602). Any testimony on this matter is unsubstantiated opinion.

5. A Hospital's Rates Reflect A Hospital's Relative Bargaining Leverage Against Health Plans

185. If a health plan's network is substantially less attractive or less marketable to employers due to the exclusion of a hospital, that hospital will be able to command higher rates for its inclusion in the health plan's network than a less-valued hospital. (PX02148 at 016 (¶

27), 019-020 (¶ 33) (Town Expert Report), *in camera*; PX02067 at 004 (¶¶ 12-13) (Radzialowski, Decl.), *in camera*; Town, Tr. 3640-3643, 3806, *in camera*; Pirc, Tr. 2209-2211).

Response to Finding No. 185:

Complaint Counsel's proposed finding is misleading and inaccurate. Professor 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).

A health plan's network could be less attractive for many reasons, not just a hospital's inclusion or exclusion. 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. (RPF 654). 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). In addition, there are certain circumstances where narrow networks can be attractive because they offer a lower price. (Randolph, Tr. 6935-6936). Moreover, Professor Town's willingness-to-pay model does not connect price with preference for a hospital. (RPF 1551, 1572, 1597)

186. Because reimbursement contracts typically specify only a limited number of prices, a hospital with greater bargaining leverage over some of its services will generally exercise that bargaining leverage by negotiating a higher price for all of its services. (PX02148 at 019-020 (¶33) (Town Expert Report), *in camera*; Town, Tr. 4054-4055).

Response to Finding No. 186:

Complaint Counsel's proposed finding ignores voluminous opposing testimony from MCOs that confirms that negotiations involve trade-offs between services. (RPF 1081). Higher prices for some services are compensated for with lower prices on other services or agreement on other contract provisions desired by one of the parties. (RPF 1081, 1089).

187. This higher price can be viewed as reflecting the average market power that the hospital possesses over all of the services it provides. (PX02148 at 019-020 (¶ 33) (Town Expert Report), *in camera*; Town, Tr. 4054-4055).

Response to Finding No. 187:

As discussed above in the response to CCPR 186, Complaint Counsel can cite to no testimony that confirms its theoretical position. In fact, MCO testimony contradicts Complaint Counsel's proposed finding. Further, market power is defined as the ability of an entity to price above its marginal cost because of some differentiation compared to its competitors. (RPF 1325). Complaint Counsel has failed to show that any prices allegedly negotiated in the manner described are above marginal cost.

188. A hospital may have greater bargaining leverage with respect to some of its services by virtue of the attractiveness of its offerings and/or the lack of alternative providers for those services. (PX02148 at 016 (¶ 27), 018 (¶30), 019-020 (¶ 33) (Town Expert Report), *in camera*; Town, Tr. 3638). This hospital may exercise this greater bargaining leverage by negotiating carve-outs or case rates for the specific services to which this greater bargaining leverage applies. (Town, Tr. 3638; PX02148 at 019-020 (¶ 33) (Town Expert Report), *in camera*).

Response to Finding No. 188:

Complaint Counsel again can point to no testimony by any market participant that supports its theoretical propositions. In Lucas County, there is no evidence that the process described by Complaint Counsel matches actual market experience. In fact, there is evidence that this theoretical process has not played out on the ground. (RPF 1024-1026). Specifically, with respect to high-risk OB procedures, the limited number of providers should always lead to the results Complaint Counsel describe, but, in fact, contracts with major MCOs in Lucas County

do not separately carve out high-risk OB rates from general acute care inpatient rates. (RPF 1024-1026).

VI. GENERAL ACUTE-CARE INPATIENT HOSPITAL SERVICES SOLD TO COMMERCIAL HEALTH PLANS CONSTITUTE A RELEVANT PRODUCT MARKET

189. General acute-care ("GAC") inpatient hospital services sold to commercial health plans is a relevant product market in which to evaluate the competitive effects of the Acquisition. (Joint Stipulations of Law and Fact, JX00002A ¶ 3; Response to RFA at ¶ 1; Answer at ¶ 12).

Response to Finding No. 189:

Respondent has no specific response.

190. GAC services are a broad "cluster market" of inpatient surgical, medical, and supporting services provided in a hospital setting to commercially-insured patients. (PX02148 at 021-023 (¶¶ 38, 40) (Town Expert Report), *in camera*); *see* Gold, Tr. 195; Korducki, Tr. 481-482).

Response to Finding No. 190:

Respondent has no specific response.

191. Individual services within the GAC cluster market are not clinical substitutes for each other. (Guerin-Calvert, Tr. 7631-7632; Town, Tr. 3665). Therefore, each service line is a relevant product market from a demand-side analysis. (Guerin-Calvert, Tr. 7631-7633; Town, Tr. 3665-3667). The purpose of the cluster market is to provide a convenient and efficient way to conduct a competitive analysis across a multitude of different services, instead of evaluating each individual service separately. (Guerin-Calvert, Tr. 7633; Town, Tr. 3666-3667).

Response to Finding No. 191:

Respondent has no specific response.

192. Analyzing services as part of a cluster market is appropriate when competitive conditions, such as market concentration and entry barriers, are similar across the services. It is not appropriate to analyze products or services as part of a cluster when such competitive conditions are dissimilar. (Town, Tr. 3667-3668; *see* Guerin-Calvert, Tr. 7637, 7640, 7649-7650).

Response to Finding No. 192:

Respondent disagrees that market concentration and entry barriers are the proper factors on which to base a cluster market. Rather, a cluster market is appropriate when the services included involve demands for the same kinds of services and facilities. (RPF 1005). Also, 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. (RPF 1512).

193. The GAC product market excludes "tertiary" and "quaternary" services. Respondent admits that the more sophisticated and specialized tertiary and quaternary services, such as major surgeries and organ transplants, are properly excluded from the relevant market. (Answer at ¶ 13). Tertiary services are higher acuity than general acute-care services, and require more resources and specialized technology. (Korducki, Tr. 481-482; Gold, Tr. 194-195; Shook, Tr. 892-894; Sheridan, Tr. 6671-6672).

Response to Finding No. 193:

The relevant product market is *all* general acute care inpatient services available to commercially insured patients. (RPF 1001). 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 physicians are demanding. (RPF 1003). 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. (RPF 1017).

194. Patients are willing to travel farther for tertiary and quaternary services, resulting in different market participants and different market concentration levels for such services as compared to GAC services. (Guerin-Calvert, Tr. at 7649-7650; Gold, Tr. 212-213; Sheridan, Tr. 6679; Town, Tr. 3676-3678). The different market structure for tertiary and quaternary services makes it inappropriate to include these services within the GAC product market. (Town, Tr. 3677-3679, *see* Guerin-Calvert, Tr. 7649-7650).

Response to Finding No. 194:

Respondent's expert, Ms. Guerin-Calvert testified that she included primary, secondary, and tertiary services in her general acute care market. (RX-6 (Guerin-Calvert, Dep. at 51)). Ms.

Guerin-Calvert testified that federal district courts have included tertiary services in the general acute care inpatient product markets. (RX-6 (Guerin-Calvert, Dep. at 53)). Moreover, Complaint Counsel's economic expert includes several tertiary services in the relevant markets he analyzes. (RPF 1488).

195. Additionally, St. Luke's currently performs few, if any, tertiary services and no quaternary services. (Joint Stipulations of Law and Fact, JX00002A ¶ 6). Services not performed by St. Luke's should not be included in the GAC product market, because the Acquisition does not potentially create or enhance market power for those services. (Town, Tr. 3668-3669).

Response to Finding No. 195:

Complaint Counsel improperly excludes from the general acute care inpatient product market services that St. Luke's performs for two or fewer commercially insured patients per year. That analysis contradicts Complaint Counsel's Complaint because the Complaint does not limit the relevant product market to only those services that both St. Luke's and ProMedica provide, or to services that St. Luke's and ProMedica provide to three or more commercially insured patients in a year. (RPF 1491-1492; Town, Tr. 3983-3984; Complaint at ¶ 12). In addition, MCOs do not purchase from or negotiate with ProMedica, Mercy, or UTMC for just the limited subset of services offered at St. Luke's. (RX-71(A) at 000017, *in camera*). Moreover, Complaint Counsel's economic expert includes several tertiary services in the relevant markets he analyzes. (RPF 1488). Because Professor Town excludes significant competition that occurs between Mercy, ProMedica and UTMC for services that St. Luke's does not provide, his analysis magnifies St. Luke's importance beyond anything reflected in the real world negotiations among MCOs and providers in Toledo. (RX-71(A) at 000015-000018, *in camera)*. In turn, this prevents Professor Town from correctly evaluating the true competitive dynamics of the Toledo area hospital market. (Guerin-Calvert, Tr. 7227-7228). The proper approach is to look directly at the alternatives facing buyers, here, the MCOs. (RX-71(A) at 000018, *in camera*).

196. Respondent admits that the GAC market also excludes outpatient services because health plans and patients could not substitute outpatient services for inpatient care in response to a price increase. (Answer at ¶ 13; Response to RFA at ¶ 3; Guerin-Calvert, Tr. 7637). Outpatient services are services that do not require an overnight stay in the hospital. (Joint Stipulations of Law and Fact, JX00002A ¶ 3; Korducki, Tr. 483-484).

Response to Finding No. 196:

Respondent has no specific response.

197. Patients would not substitute outpatient services in response to price increases for inpatient services, because such substitution is instead based on clinical considerations. (Radzialowski, Tr. 638-639; PX01914 at 007-008 (Pirc, IHT at 21-22); Town, Tr. 3669-3671).

Response to Finding No. 197:

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, which means that some procedures that were treated as inpatient services in the past have become outpatient services. (RPF 37, 39). Further, many medical conditions that currently require hospital admissions could be substituted with outpatient services due to advances in technology. (RPF 41).

198. It is also inappropriate to include outpatient services within GAC services because they have different competitive conditions than inpatient services. For example, there may be a different set or mix of market competitors, not just hospitals. (Guerin-Calvert, Tr. at 7637, 7640; *see* Town, Tr. 3672-3673 (It is important to only cluster services that have the same competitive conditions.).

Response to Finding No. 198:

The proposed finding is misleading because it mischaracterizes Ms. Guerin-Calvert's testimony. Outpatient services are excluded from the general acute care inpatient services market because they are often excluded or contracted for separately. (RPF 1013).

VII. INPATIENT OBSTETRICAL SERVICES SOLD TO COMMERCIAL HEALTH PLANS CONSTITUTE A RELEVANT PRODUCT MARKET

199. Inpatient obstetrical ("OB") services are a cluster of procedures relating to pregnancy, labor, and post-delivery care provided to patients for the labor and delivery of newborns. (Response to RFA at ¶ 4; Marlowe, Tr. 2388, 2432; Read, Tr. 5275).

Response to Finding No. 199:

Respondent has no specific response.

200. No other hospital services are reasonably interchangeable with inpatient obstetrical services. (Guerin-Calvert, Tr. at 7633, 7667-7668; PX01935 at 005 (Read, Dep. at 11); PX02148 at 023-024 (¶ 41) (Town Expert Report), *in camera*; *see* Response to RFA at ¶ 4).

Response to Finding No. 200:

Respondent has no specific response.

201. Inpatient obstetrical services are only offered in a hospital setting, and outpatient obstetrical services are not acceptable substitutes. (PX01935 at 005 (Read, Dep. at 10); *see* Marlowe, Tr. 2431-2433).

Response to Finding No. 201:

Respondent has no specific response.

202. In this case, it would be inappropriate and misleading to analyze OB services as part of the cluster market of GAC services because OB services are offered by a different set of providers in Lucas County and, thus, are subject to different competitive conditions than are GAC services. (Town, Tr. 3595, 3667-3668, 3672-3673; *see also* Complaint Counsel's Proposed Conclusions of Law at Section XX.E.). Most significantly, two Lucas County hospitals that offer GAC services, UTMC and Mercy St. Anne Hospital, do not provide OB services. (Answer at ¶ 15; Gold, Tr. 203, 220-221; Shook, Tr. 901).

Response to Finding No. 202:

The evidence does not support a separate obstetrics market in this case. Negotiations between hospital providers and MCOs cover the full range of inpatient services that the MCO members may need, including inpatient obstetrical services. (RPF 1020). There is no evidence that hospitals can or do price discriminate for inpatient obstetrical services. (RPF 1021). Inpatient obstetrical services are provided in conjunction with other services, and the terms and

conditions on which they are being negotiated are very similar. (RPF 1025). In fact, contracts with major MCOs in Lucas County {

} (RPF 1026, *in camera*). To the extent inpatient obstetrical rates are listed separately in the contracts, that is the preference of { }

(Wachsman, Tr. 5158, *in camera*). Further, in prior hospital merger cases, inpatient obstetrical services have been included in the general acute care inpatient services market. (RPF 1027).

203. ProMedica and St. Luke's acknowledge this reality by obtaining and tracking separate market shares and other data for OB services. (*See, e.g.*, Response to RFA at ¶ 5; PX01016 at 003 (Dec. 2009 St. Luke's Affiliation Update), *in camera*; PX01077 at 003, 005 (2008 St. Luke's Market Report); PX00009 at 022 (ProMedica Credit Presentation)).

Response to Finding No. 203:

Complaint Counsel's selective citation of exhibits mischaracterizes the evidence. ProMedica and St. Luke's track market shares for a variety of services, of which inpatient obstetrical services are just one example. (Response to RFA at ¶ 5; PX01077 at 004 (also tracking cardiac cases); PX00009 at 022 (tracking heart, orthopedics, and cancer services)).

204. Leading up to the Joinder Agreement, St. Luke's executives specifically discussed OB market shares and the implications of such high market shares in analyzing the legality of the Acquisition. (Wakeman, Tr. 2695-2696, *in camera*; Rupley, Tr. 1978-1982; PX01030 at 017 (Oct. 2009 St. Luke's Affiliation Update), *in camera*; PX01016 at 003 (Dec. 2009 St. Luke's Affiliation Update), *in camera*).

Response to Finding No. 204:

Complaint Counsel mischaracterizes their own exhibit. Leading up the Joinder Agreement, St. Luke's executives reviewed proposed market shares for Mercy, UTMC, and ProMedica, and stated that discussions with ProMedica involved only cardiac services, so an obstetrics affiliation would also have to be reviewed. (PX01030 at 017).

205. Moreover, in the process of negotiating rates with commercial health plans, hospitals often "carve-out" OB services from other GAC services and separate back and forth rate negotiations are had specifically for OB services. (Radzialowski, Tr. 808, *in camera;* 752-753; Sheridan, Tr. 6662, *in camera*, 6683-6684; *see, e.g.*, PX00365 at 030

(ProMedica-United Contract), *in camera*; PX00363 at 019, 022 (ProMedica-Aetna Contract)).

Response to Finding No. 205:

Complaint Counsel's argument that negotiations occur specifically for obstetrics services is contrary to the evidence in this case that shows that negotiations between hospital providers and MCOs cover the full range of inpatient services, including inpatient obstetrical services. (RPF 1020). Further, contracts with major MCOs in Lucas County {

} (RPF 1026, *in camera*). To the extent inpatient obstetrical rates are listed separately in the contracts, that is the preference of { } (Wachsman, Tr. 5158, *in camera*).

206. Respondent's economic expert testified that if Mercy no longer offered OB services - which would result in ProMedica having a monopoly for OB services in Lucas County - prices of OB services in Lucas County would likely increase. (Guerin-Calvert, Tr. at 7679-7680).

Response to Finding No. 206:

Contrary to Complaint Counsel's assertion, Respondent's expert testified that in such a hypothetical, prices for inpatient obstetrical services "possibly could" increase because ProMedica and Mercy are the main competitors for inpatient obstetrical services, and the only providers for high-risk inpatient obstetrical services. (Guerin-Calvert, Tr. 7679-7680; RPF 1022-1023).

207. Complaint Counsel's economic expert also concluded that inpatient obstetrical services constitute a separate relevant market. (Town, Tr. 3672-3673; PX02148 at 023-024 (¶ 41) (Town Expert Report), *in camera*).

Response to Finding No. 207:

In prior hospital merger cases, no other expert has categorized inpatient obstetrical services as its own relevant market; rather, inpatient obstetrical services have been included in the general acute care inpatient services market. (RPF 1027).

VIII. LUCAS COUNTY IS THE RELEVANT GEOGRAPHIC MARKET

208. The relevant geographic market for both product markets is Lucas County, Ohio. (Town, Tr. 3688; PX02148 at 025-031 (¶¶ 45-55) (Town Expert Report), *in camera*; *see* PX00900 (Map of Northwest Ohio)).

Response to Finding No. 208:

Respondent asserts that the proper relevant geographic market for general acute care inpatient services is Lucas County, Ohio. (RPF 1028; RX-71(A) at 000021, *in camera*). Because inpatient obstetrical services does not constitute a proper separate relevant product market, it is unnecessary to define a geographic market for that alleged product market. (RPF 1027 (no prior hospital merger case has separated inpatient obstetrical services from general acute care inpatient services into its own product market)).

A. Lucas County is the Relevant Geographic Market for Inpatient General Acute-Care Services

209. Indeed, Respondent has admitted Lucas County constitutes a relevant geographic market for the purposes of analyzing the likely effects of the Acquisition in the general acute-care services product market. (Response to RFA at ¶ 7). As Respondent's counsel stated in his opening statement, "[W]e don't disagree with Lucas County as the relevant geographic market." (Respondent's Opening Statement, Tr. 109; *see also* Respondent's Pre-Trial Brief at 31; Guerin-Calvert, Tr. 7683 ("[T]he complaint counsel and the respondent counsel and both experts have agreed that the narrowest relevant geographic market applying those principles is Lucas County hospitals.")).

Response to Finding No. 209:

In Respondent's opening statement, however, counsel for Respondent also stated that "We do disagree, however, with the FTC's analysis of what it calls St. Luke's core service area of eight zip codes as a meaningful geographic area for analysis of the competitive effects." (Respondent's Opening Statement, Tr. 109).

210. This conclusion is compelled by the fact that a hypothetical monopolist controlling every hospital in Lucas County could increase the price of inpatient general acute-care services in Lucas County by at least 5 to 10 percent, a small but significant amount. (Guerin-Calvert, Tr. 7681; PX01954 at 042-043 (Guerin-Calvert, Dep. at 164-165), *in camera*;

Town, Tr. 3688-3690; PX02148 at 016, 025-026, 029 (¶¶ 27, 45, 51) (Town Expert Report), in camera).

Response to Finding No. 210:

Respondent has no specific response.

211. ProMedica and St. Luke's only focus on other Lucas County hospitals in its market analyses. For example, in its presentation to a credit rating agency, ProMedica presented market share information including only Lucas County hospitals. (PX00009 at 021-022 (ProMedica Credit Presentation Jul. 2010); *see also* PX00392 at 068-076 (2009 Draft Environmental Assessment Apr. 2009), *in camera*).

Response to Finding No. 211:

Complaint Counsel mischaracterize the exhibits to which they cite in their Finding No. 211. The documents do not state that ProMedica and St. Luke's "only focus" on other Lucas County hospitals in their market analyses. Rather, the documents reflect that in some circumstances, ProMedica and St. Luke's draw comparisons with other Lucas County hospitals. (PX00009 at 021-022; PX00392 at 068-076, *in camera*).

212. In a St. Luke's marketing analysis, patients residing in St. Luke's core service area had such a low awareness of Wood County Hospital it was placed in the "Other Hospitals" category. (PX01169 at 010 (Great Lakes Marketing Survey)). The only hospitals listed by name were Lucas County hospitals. (PX01169 at 010 (Great Lakes Marketing Survey); *see also* PX01418 at 005 (St. Luke's Market Share Analysis), *in camera*; PX01352 at 006 (St. Luke's Board and Medical Staff Planning Retreat Apr. 2008); PX01016 at 003 (St. Luke's Board Meeting Affiliation Update Dec. 2009), *in camera*).

Response to Finding No. 212:

Complaint Counsel's selective citation is misleading. Complaint Counsel state that the "only hospitals listed by name were Lucas County hospitals;" however, Wood County Hospital is listed "by name" on many pages of this study, including pages 9, 11, 14, and 15 of exhibit PX01169. (PX01169 at 009, 011, 014-015).

213. When ProMedica retained Navigant to perform a clinical integration study for ProMedica's Toledo-area hospitals, Navigant examined the geographic area in which ProMedica competed. (Nolan, Tr. 6253, 6275-6276, *in camera*; PX01216 at 004-008 (Navigant Service Line and Clinical Integration Market Trends and Facilities Assessment

Aug. 2010), *in camera*). Navigant examined only {
} from its market share analysis. (Nolan, Tr. 6326-6327, *in camera*).

Response to Finding No. 213:

Respondent has no specific response.

214. ProMedica acknowledges that it competes only with other Lucas County hospitals for general acute-care services. (PX01903 at 008, 020 (Hanley, IHT at 22, 72-73), *in camera*; Rupley, Tr. 2054 ("members of our community were choosing, if not St. Luke's Hospital, then they would be choosing most likely Toledo Hospital, St. Vincent Medical Center, Flower Hospital, and University of Toledo); *see also* Oostra, Tr. 5757-6059 (not once mentioning Wood County Hospital or Fulton County Health Center in a full day of trial testimony)). Respondent's counsel has noted that: "[P]ayers and their patients have alternative hospitals to turn to that are conveniently located in the market. And those alternative hospitals are Mercy's three hospitals and UTMC." (TRO Hearing, Tr. at 50).

Response to Finding No. 214:

The proposed finding violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record and by citing the transcript of the TRO Hearing which is not relevant to this proceeding.

215. Within Lucas County, the two remaining competitors to ProMedica for general acute care services after the Acquisition are Mercy and UTMC. (Joint Stipulations of Law and Fact, JX00002A ¶ 8; *see* PX00900 (Map of Northwest Ohio)).

Response to Finding No. 215:

Respondent has no specific response.

1. Lucas County Patients Have a Strong Preference to Remain Close to Home for Inpatient General Acute-Care Services

216. Patients have a preference for local care and close access to healthcare providers. (Pirc, Tr. 2184; Pugliese, Tr. 1450-1451; Randolph, Tr. 7102; Rupley, Tr. 1962; Sandusky, Tr. 1306; Sheridan, Tr. 6681; Shook, Tr. 942; Town, Tr. 3694, 3759, *in camera*; *see also* PX01917 at 008 (Radzialowski, Dep. at 26-27), *in camera*).

Response to Finding No. 216:

While some MCOs indicated that they believe that travel distance and geographic proximity are important factors to patients, several have not performed any recent analyses to test this assumption. (RX-71(A) at 000021, n.22, *in camera*).

217. Donald Pirc from MMO, for example, testified that "if you live in Lucas County, you stay there." (Pirc, Tr. 2183; *see also* Pugliese, Tr. 1451 (Anthem's Lucas County members "will stay closer to home for common services, preventative care services.")). Mr. Pirc stated that Lucas County residents stay in Lucas County for hospital care because "people want to stay close to home for care." (Pirc, Tr. 2184; *see also* Wakeman, Tr. 2510; Pugliese, Tr. 1451 (hospitals in adjacent counties are not acceptable alternatives for Lucas County members); Rupley, Tr. 1962 (community members prefer hospitals closer to them)).

<u>Response to Finding No. 217:</u>

Respondent has no specific response.

218. Mr. Pirc also testified that Lucas County residents will not travel because they can receive quality care close to home. (Pirc, Tr. 2184; *see also* Radzialowski, Tr. 739; Andreshak, Tr. 1781).

<u>Response to Finding No. 218:</u>

Respondent has no specific response.

219. Finally, Mr. Pirc testified that Lucas County residents prefer to stay in Lucas County for hospital care because "if a loved one is in the hospital, you'd rather be ten minutes away than an hour away . . . ." (Pirc, Tr. 2184; *see also* Wakeman, Tr. 2509; *cf.* Radzialowski, Tr. 634 (" . . . people do develop connections with their local hospital. You know, their babies, that's where they have babies. Their parents might have died there. They know people that work there. They sit on the board.")).

<u>Response to Finding No. 219:</u>

Respondent has no specific response.

220. With extremely rare exceptions, Lucas County residents do not use more distant providers of general acute-care services. (Sheridan, Tr. 6680-6682; Town, Tr. 3691; PX02148 at 026, 155-159 (¶ 46, Ex. 10) (Town Expert Report), *in camera*).

<u>Response to Finding No. 220:</u>

Respondent has no specific response.

221. In the ordinary course of business, health plans analyze the Lucas County market. (*See, e.g.*, PX02210 at 003 (Aetna Lucas County Marketshare Analysis), *in camera*). Health plans agree that patients are unwilling to travel outside of Lucas County for general acute-care services. (Pirc, Tr. 2183, 2186; Pugliese, Tr. 1450-1451; Radzialowski, Tr. 648-649; Sandusky, Tr. 1314-1315; Sheridan, Tr. 6681).

Response to Finding No. 221:

MCOs testified that they have not performed any recent analyses to test their assumption that travel distance and geographic proximity are important to patients. (RX-71(A) at 000021, n.22, *in camera*). Further, major MCOs testified that they have not performed market studies to determine how far their members would travel for general acute care services. (RPF 1261-1262, 1264-1265, 1268, *in camera*, 1269-1270).

222. Physicians in Lucas County have also testified that their patients seek inpatient hospital care close to home. (Marlowe, Tr. 2403; *see also* Andreshak, Tr. 1773; PX01948 at 027 (Peron, Dep. at 99) (approximately 98% of the patients Dr. Peron sees in his Toledo office are from Lucas County)).

Response to Finding No. 222:

The proposed finding is misleading because it implies that patients consider location of a hospital above other considerations when deciding where to seek inpatient hospital services. Instead, 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. (RPF 1484, RX-71(A) at 000021, n.22, *in camera*).

2. Data Analysis Confirms Patients Do Not Travel for Inpatient General Acute-Care Services in Lucas County

223. Patient-flow data reveals that nearly all Lucas County residents (97.9 percent) stay within Lucas County for general acute-care services. (PX02148 at 026 (¶ 46) (Town Expert Report), *in camera*; *see also* Sheridan, Tr. 6682). In other words, only 2.1 percent of Lucas County residents leave the county for general acute-care services. (PX02148 at 026 (¶ 46) (Town Expert Report), *in camera*). "[P]atients residing in Lucas County have an obvious and strong preference for hospitals located within Lucas County." (PX02148 at 026 (¶ 46) (Town Expert Report), *in camera*).

Response to Finding No. 223:

Respondent has no specific response.

224. After analyzing state hospital admissions data and its own marketing studies, Mercy also found that patients want to use hospitals that are convenient and located close to their home. (Shook, Tr. 878-879).

Response to Finding No. 224:

The proposed finding is misleading. The context in which Mr. Shook testified was that more services are being rendered on an outpatient basis and those patients want convenient locations to obtain those services, which are not part of either of Complaint Counsel's alleged markets. (Shook, Tr. 878-879). {

.} (RX-252 at 000013, *in camera*).

225. This is confirmed by Professor Town's hospital market share by zip code analysis, which shows that Lucas County hospitals typically draw more patients in zip codes closer to the hospital than in more distant zip codes. (Town, Tr. 3752, 3757-3759, *in camera*).

Response to Finding No. 225:

However, patient origin analysis reveals that patients are willing to travel across county lines, across areas, and across the metro area to receive hospital services in Toledo. (RPF 1482). In fact, the vast majority of patients that reside in St. Luke's service area, approximately 60%, travel to hospitals other than St. Luke's for general acute care inpatient services. (RPF 1480). Further, patient origin and drive time analyses show that patients do not necessarily go to the next closest hospital. (RPF 1483).

226. The average travel time from home to hospital for Lucas County general acute-care patients is 11.5 minutes, with 50 percent of patients traveling less than 8.7 minutes. (Town, Tr. 3693-3694; PX02148 at 030, 140 (¶ 52, Ex. 5) (Town Expert Report), *in camera*).

Response to Finding No. 226:

Respondent has no specific response.

227. Ms. Guerin-Calvert has also observed that the vast majority of patients travel less than 20 minutes for healthcare services. (RX-71(A) at 32 (¶ 52) (Guerin-Calvert Expert Report), *in camera*).

Response to Finding No. 227:

Respondent has no specific response.

228. Professor Town's analysis of St. Luke's core service area demonstrates that for inpatient general acute-care services, only Lucas County hospitals have significant market share. Prior to the Acquisition, ProMedica had a market share of **{38.4}** percent, St. Luke's had a share of **{33.2}** percent, Mercy had a share of **{13.4}** percent, and UTMC had a share of **{11.9}** percent. (Town, Tr. 3764, *in camera*; PX02148 at 161 (Ex. 11) (Town Expert Report), *in camera*).

Response to Finding No. 228:

Professor's Town's analysis of "St. Luke's core service area" is irrelevant because it is contrary to the geographic market both Respondent and Complaint Counsel have agreed is proper in this case – Lucas County, Ohio. (CCPF 208, 229; RPF 1028). Further "St. Luke's core service area" represents only 60% of St. Luke's discharges, 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, and neither St. Luke's or ProMedica have a separate chargemasters applicable to Maumee residents. (RPF 1037-1039).

B. Lucas County is the Relevant Geographic Market for Inpatient Obstetrical services

229. The conclusion that Lucas County is the relevant geographic market for inpatient obstetrical services is compelled by the fact that a hypothetical monopolist controlling every hospital in Lucas County could increase the price of inpatient obstetrical services in Lucas County by at least 5 to 10 percent, a small but significant amount. (Guerin-Calvert, Tr. 7681; PX01954 at 042-043 (Guerin-Calvert, Dep. at 164-165), *in camera*; Town, Tr. 3688-3690; PX02148 at 025-026, 029 (¶¶ 45, 51) (Town Expert Report), *in camera*).

Response to Finding No. 229:

Respondent has no specific response.

230. St. Luke's ordinary course planning documents analyze obstetrical services utilization for Lucas County only. (*See, e.g.*, PX01077 at 003 (St. Luke's Market Report Nov. 2008)).

Response to Finding No. 230:

Respondent has no specific response.

231. ProMedica's ordinary course planning documents similarly analyze women's services for the metro Toledo area. (*See, e.g.*, PX00392 at 075 (2009 Draft Environmental Assessment Apr. 2009), *in camera*).

Response to Finding No. 231:

Respondent has no specific response.

232. ProMedica's President of Acute Care testified that, after the Acquisition of St. Luke's, ProMedica's only competition for obstetrical services is Mercy. (PX01904 at 035 (Steele, IHT at 132-133), *in camera* ("St. Vincent is Toledo's competition. St. Charles is Bay Park's competition. Flower doesn't really have competition."))

Response to Finding No. 232:

The proposed finding mischaracterizes the witness's testimony because the quoted sentences make no connection between competition for each ProMedica hospital and the St. Luke's joinder. (PX01904 (Steele, IHT at 132-133), *in camera*).

233. Within Lucas County, the only remaining competitor to ProMedica for inpatient obstetrical services after the Acquisition is Mercy. (Answer at ¶ 4; Response to RFA at ¶ 10; Gold, Tr. 203).

Response to Finding No. 233:

Before the joinder, ProMedica's only competitor for high-risk inpatient OB services was Mercy. (RPF 1022). Thus, the joinder does not change the number of competitors offering more complex, high-risk OB services. (RPF 1023).

1. Lucas County Patients Have a Strong Preference to Remain Close to Home for Inpatient Obstetrical services

234. Patients "typically want to be closer" to a hospital for delivery – "they have this perception that they're going to deliver so quickly that they're not going to get there." (Marlowe, Tr. 2406). It is more convenient for patients, as well as for friends and family who want to come to visit, to utilize a hospital close to home. (Marlowe, Tr. 2406; *see*

also Andreshak, Tr. 1772). Physicians, as well, prefer not to travel to see their patients. (Marlowe, Tr. 2398-2399; *see also* Gbur, Tr. 3109).

Response to Finding No. 234:

Distance is not as big a deterrent for patient travel in Lucas County as much as the out-of-pocket costs required by insurers. (RPF 1485). In determining which hospital to choose for inpatient obstetrical services, a hospital's status as an in-network provider for their insurance company is a very important factor for patients. (RPF 46). Further, patients also 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. (RPF 47). Finally, patients consider whether the hospital uses LDRP or LDR rooms for their inpatient obstetrical patients. (RPF 48).

235. With extremely rare exceptions, Lucas County residents do not use more distant providers of obstetrical services. (Sheridan, Tr. 6680-6682; Town, Tr. 3691; PX02148 at 026, 155-159 (¶ 46, Ex. 10) (Town Expert Report), *in camera*; PX01939 at 027 (Sheridan, Dep. at 104), *in camera*).

Response to Finding No. 235:

Distance is not as big a deterrent for patient travel in Lucas County as much as the out-of-pocket costs required by insurers. (RPF 1485). In determining which hospital to choose for inpatient obstetrical services, a hospital's status as an in-network provider for their insurance company is a very important factor for patients. (RPF 46). Further, patients also 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. (RPF 47). Finally, patients consider whether the hospital uses LDRP or LDR rooms for their inpatient obstetrical patients. (RPF 48).

236. Dr. Marlowe, an obstetrician in Lucas County, testified that patients seek inpatient hospital care close to home, especially for obstetrical services. (Marlowe, Tr. 2402-2403).

Response to Finding No. 236:

Distance is not as big a deterrent for patient travel in Lucas County as much as the out-of-pocket costs required by insurers. (RPF 1485). In determining which hospital to choose for inpatient obstetrical services, a hospital's status as an in-network provider for their insurance company is a very important factor for patients. (RPF 46). Further, patients also 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. (RPF 47). Finally, patients consider whether the hospital uses LDRP or LDR rooms for their inpatient obstetrical patients. (RPF 48).

237. As Mr. Radzialowski from Aetna testified: "I would be hard-pressed to explain to [my wife] why I'm driving by the local hospital and going 15 miles into the country to deliver the baby." (Radzialowski, Tr. 634).

Response to Finding No. 237:

Respondent has no specific response.

238. Mr. Pirc of MMO testified that MMO would have trouble marketing a hospital network to Lucas County residents that included only Wood County Hospital and Fulton County Health Center because Lucas County residents would be unwilling to travel to these facilities for obstetrical services. (Pirc, Tr. 2193).

Response to Finding No. 238:

Respondent has no specific response.

2. Data Analysis Confirms Patients Do Not Travel for Inpatient Obstetrical Services in Lucas County

239. *Fewer* obstetrical services patients (0.6 percent) leave Lucas County for care than do patients in need of other hospital services (2.1 percent), which is not surprising in light of

the nature of obstetrical services (delivering babies). (PX02148 at 026 (¶ 46) (Town Expert Report), *in camera*; *see also* PX01939 at 027 (Sheridan, Dep. at 104), *in camera*).

Response to Finding No. 239:

Respondent has no specific response.

240. In the ordinary course of his business, Mr. Pirc of MMO has reviewed hospital utilization data and found that Lucas County residents do not leave Lucas County for obstetrical services. (Pirc, Tr. 2186).

Response to Finding No. 240:

Respondent has no specific response.

241. Ninety-five percent of Lucas County residents drive fewer than 24.5 minutes for obstetrical services, and residents' average drive time is just 11.3 minutes with 50 percent of obstetrical services patients travelling less than 10 minutes. (Town, Tr. 3694-3695; PX02148 at 030-031, 141 (¶ 53, Ex. 5) (Town Expert Report), *in camera*).

Response to Finding No. 241:

Respondent has no specific response.

242. Professor Town's analysis of St. Luke's core service area also demonstrates that for inpatient obstetrical services, only Lucas County hospitals have significant market share. Prior to the Acquisition, ProMedica had a market share of { } percent, St. Luke's had a share of { } percent, and Mercy had a share of { } percent. (Town, Tr. 3764-3765, *in camera*; PX02148 at 161 (Ex. 11) (Town Expert Report), *in camera*).

Response to Finding No. 242:

Professor's Town's analysis of "St. Luke's core service area" is irrelevant because it is contrary to the geographic market both Respondent and Complaint Counsel have agreed is proper in this case – Lucas County, Ohio. (CCPF 229, RPF 1028). Moreover, Professor Town's own shares show that { } of expectant mothers residing closest to St. Luke's were willing to travel to more distant ProMedica or Mercy hospitals to receive inpatient obstetrical services. (PX02148 at 161, *in camera*) Further, "St. Luke's core service area" represents only 60% of St. Luke's discharges, 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, and neither

St. Luke's or ProMedica have a separate chargemasters applicable to Maumee residents. (RPF 1037-1039).

C. Health Plan Provider Networks Must Include Lucas County Hospitals

243. According to health plans, the residents of Lucas County are not willing to and do not travel outside of Lucas County for inpatient hospital care, and that health plans would not be able to market hospital networks to Lucas County residents that consist solely of hospitals outside of Lucas County. (*See, e.g.*, Randolph, Tr. 7064-7065; Pirc, Tr. 2183, 2193; Pugliese, Tr. 1450-1451; PX01944 at 023 (Pirc, Dep. at 88), *in camera*; PX01914 at 009-011, 019 (Pirc, IHT at 29-30, 33-34, 66); PX01917 at 008 (Radzialowski, Dep. at 26-27), *in camera*; McGinty, Tr. 1193; Sandusky, Tr. 1314; Sheridan, Tr. 6682; PX02065 at 002-003 (¶ 9) (Szymanski, Decl.)).

<u>Response to Finding No. 243:</u>

Respondent has no specific response.

244. Donald Pirc of MMO testified that, if all of the hospitals in Lucas County raised their rates, MMO would not be able to avoid or to resist the rate increase by { } (PX01944 at 023 (Pirc, Dep. at 88, *in camera*).

<u>Response to Finding No. 244:</u>

Respondent has no specific response.

245. Even John Randolph, President of ProMedica's health plan division, Paramount, testified: "To not have any facility in Lucas County for the provision of services to a health plan membership . . . would not be a very viable or marketable option." (Randolph, Tr. 7065 (continuing "[t]o have to go outside of town entirely and not have a single hospital? Yes, that would be unmarketable and highly unrealistic.")).

<u>Response to Finding No. 245:</u>

Respondent has no specific response.

246. Employers require that health plan provider networks include hospitals that are close to employees' homes. (Neal, Tr. 2103 ("It's very important to Chrysler that our employees have adequate representation within the provider networks, that they have hospitals within certain limits within those networks."); Caumartin, Tr. 1831; *see also* Buehrer, Tr. 3069).

<u>Response to Finding No. 246:</u>

Respondent has no specific response.

D. Non-Lucas County Hospitals Are Not in the Relevant Geographic Market for Either Relevant Service

247. The primary reason patients do not travel outside of Lucas County is distance. (Radzialowski, Tr. 649; Sheridan, Tr. 6681; *see also* Pirc, Tr. 2184). Patients do not want to travel 15 to 20 miles or more to a hospital, and Lucas County residents' mindset is not to travel outside of the metro-Toledo area. (Radzialowski, Tr. 649; Pugliese, Tr. 1451; Andreshak, Tr. 1768).

Response to Finding No. 247:

Respondent has no specific response.

248. James Pugliese of Anthem testified that hospitals in adjacent counties are not acceptable alternatives for their Lucas County members. (Pugliese, Tr. 1451).

Response to Finding No. 248:

Respondent has no specific response.

249. Wood County Hospital, located in Bowling Green, Ohio, is approximately 25 miles and 35 minutes from downtown Toledo. (Korducki, Tr. 475, 504-505; *see* PX00900 (Map of Northwest Ohio)).

Response to Finding No. 249:

Respondent has no specific response.

250. Wood County Hospital routinely reviews Ohio Hospital Association data to track patient flow. (Korducki, Tr. 469-470). Wood County Hospital primarily serves the area south of Route 582 in Wood County, southward to the bottom of Wood County, and westward into the eastern half of Henry County. (Korducki, Tr. 506, 508-509).

Response to Finding No. 250:

Respondent has no specific response.

251. Eighty-one percent of Wood County Hospital's patient admissions are from 10 contiguous zip codes in this area. (Korducki, Tr. 506). No Lucas County zip codes are included in this area. (Korducki, Tr. 509).

Response to Finding No. 251:

Respondent has no specific response.

252. Wood County Hospital has approximately 3,600 to 3,700 patient admissions per year. (Korducki, Tr. 511). In each of the last two years, approximately 100 Lucas County

residents have sought inpatient hospital services at Wood County Hospital. (Korducki, Tr. 510-511). In other words, approximately 2.7% of Wood County Hospital's inpatient admissions are of Lucas County residents. (*See* Korducki, Tr. 510-511). Some of these Lucas County residents are coming to Wood County Hospital for bariatric services, for which Wood County Hospital is the only hospital in northwest Ohio that is a Center of Excellence. (Korducki, Tr. 511-512).

Response to Finding No. 252:

Respondent has no specific response.

253. Stanley Korducki, the President of Wood County Hospital testified that less than one percent of Lucas County patients – approximately 12 patients – deliver babies at Wood County Hospital each year. (Korducki, Tr. 512-513).

Response to Finding No. 253:

Respondent has no specific response.

254. Mr. Korducki testified that Wood County Hospital does not actively compete for patients in Lucas County. (Korducki, Tr. 515-516). Mr. Korducki testified that he doesn't "spend a lot of time really looking at what [Lucas County Hospitals are] doing, because our focus is on our community, and we see [Lucas County] as really a separate market." (Korducki, Tr. 474). For example, when Wood County Hospital advertises either general acute-care or obstetrical services, it does not specifically target Lucas County residents. (Korducki, Tr. 514).

Response to Finding No. 254:

Respondent has no specific response.

255. Fulton County Health Center is approximately 30 miles and a 45 minute drive from St. Luke's. (Beck, Tr. 384-385; *see* PX00900 (Map of Northwest Ohio)).

Response to Finding No. 255:

Respondent has no specific response.

256. Like Wood County Hospital, Fulton County Health Center looks at data provided by the Ohio Hospital Association to track patient flow. (Beck, Tr. 386-388). Most of Fulton County Health Center's patients come from the area around the hospital in Fulton County. (Beck, Tr. 388).

Response to Finding No. 256:

Respondent has no specific response.

257. Patients in Lucas County do not come to Fulton County Health Center for inpatient general acute-care services or inpatient obstetrical services. (Beck, Tr. 389). The President of Fulton County Health Center testified that Lucas County residents do not travel to Fulton County Health Center because of the distance and that hospital services are more available in the hospitals in Lucas County. (Beck, Tr. 392-393 (noting that "there's sufficient healthcare in Lucas County that there's no need to come to [Fulton County Health Center]")).

Response to Finding No. 257:

Respondent has no specific response.

258. Moreover, Fulton County Health Center does not advertise its services in Lucas County to attract Lucas County residents. (Beck, Tr. 396-397). As a result, Fulton County Health Center does not view itself as a competitor to the Lucas County Hospitals. (Beck, Tr. 388-390).

Response to Finding No. 258:

Respondent has no specific response.

259. St. Luke's did not view Wood County Hospital or Fulton County Health Center as significant competitors. (PX01933 at 047 (Oppenlander, Dep. at 178-179), *in camera*).

Response to Finding No. 259:

Respondent has no specific response.

260. Even Respondent's counsel admitted that "[r]elatively few patients go to Wood County to deliver babies." (Respondent, Scheduling Hearing, Tr. 51).

Response to Finding No. 260:

The proposed finding violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record.

261. In addition, the only practicing physician that Respondent called to testify at trial, Dr. Elizabeth Read, has never even performed a delivery at Wood County Hospital. (PX01935 at 016 (Read, Dep. at 57)).

Response to Finding No. 261:

Dr. Read also testified that distance is not as big a deterrent for patient travel in Lucas County as much as the out-of-pocket costs required by insurers. (RPF 1485).

262. Health plans have also testified that Wood County Hospital and Fulton County Health Center do not compete with Lucas County hospitals for inpatient general acute-care *or* obstetrical services patients. (Pirc, Tr. 2191-2193; Radzialowski, Tr. 648-651; Sandusky, Tr. 1315).

Response to Finding No. 262:

Respondent has no specific response.

263. Mr. Radzialowski of Aetna testified that he does not believe Fulton County Health Center offers a full complement of hospital services. (Radzialowski, Tr. 650).

Response to Finding No. 263:

Respondent has no specific response.

E. Even Within the Relevant Geographic Market, Location Matters

264. A hospital's location within Lucas County is also important because community members prefer hospitals close to them. (Rupley, Tr. 1962; Pugliese, Tr. 1451-1452; Radzialowski, Tr. 634; Town, Tr. 3628, 3757, *in camera*; Shook, Tr. 878-879; Korducki, Tr. 511, 558 ("People prefer to stay close to home if the hospital close to home can provide the service.")).

Response to Finding No. 264:

Hospital location is not as important as Complaint Counsel suggest because patient origin and drive time analyses show that patients do not necessarily go to the next closest hospital. (RPF 1483). 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. (RPF 1482). For example, the vast majority of patients that reside in St. Luke's service area travel to hospitals other than St. Luke's to receive general acute care inpatient services. (RPF 1480). Physicians note that some of their patients drive past St. Luke's to seek services from hospitals located further away from their homes. (RPF 218). To the extent drive times matter to patients, 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. (RPF 219). This drive time analysis shows that hospitals in Toledo 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 in minimal. (RPF 1210). 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 obstetric services, indicating that location is not a material factor when patients choose a hospital. (RPF 1218).

265. Most of St. Luke's patients come from the area immediately surrounding St. Luke's. (Rupley, Tr. 1945; Town, Tr. 3628, 3757, *in camera* ("Patients do not like to travel far for inpatient care."); *see also* Shook, Tr. 879 ("If you build concentric rings of one mile out from the hospitals, you will see a greater concentration of percentage of the admissions to that particular hospital the closer in you are. It begins to dissipate the farther out you travel.")).

Response to Finding No. 265:

Hospital location is not as important as Complaint Counsel suggest because patient origin and drive time analyses show that patients do not necessarily go to the next closest hospital. (RPF 1483). 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. (RPF 1482). For example, the vast majority of patients that reside in St. Luke's service area travel to hospitals other than St. Luke's to receive general acute care inpatient services. (RPF 1480). Physicians note that some of their patients drive past St. Luke's to seek services from hospitals located further away from their homes. (RPF 218). To the extent drive times matter to patients, 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. (RPF 219). This drive time analysis shows that hospitals in Toledo 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 in minimal. (RPF 1210). 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 obstetric services, indicating that location is not a material factor when patients choose a hospital. (RPF 1218).

266. Health plans have also testified to the importance of a hospital's location in Lucas County in contract negotiations. (Radzialowski, Tr. 663; Pirc, Tr. 2199; Pugliese, Tr. 1451-1452, 1459).

Response to Finding No. 266:

Representatives from MCOs testified that the MCOs have not performed any recent analyses in Lucas County to determine how far their insureds would travel for hospital services. (RPF 1261-1271).

267. Specifically, St. Luke's location was important to health plan networks. (Pirc, Tr. 2195; Pugliese, Tr. 1442-1443; Radzialowski, Tr. 713-714, *in camera*; Sheridan, Tr. 6672-6673; *see also* Town, Tr. 3627, 3651).

Response to Finding No. 267:

The vast majority of patients that reside in St. Luke's service area, approximately 60 percent, travel to hospitals other than St. Luke's to receive general acute care inpatient services. (RPF 1480). Physicians note that some of their patients drive past St. Luke's to seek services from hospitals located further away from their homes. (RPF 218).

268. When St. Luke's analyzed its market in the ordinary course of its business, it focused on its core service area. (PX01418 at 005 (St. Luke's Market Share Analysis), *in camera*; PX01352 at 006 (St. Luke's Board and Medical Staff Planning Retreat Apr. 2008); PX01016 at 003 (St. Luke's Board Meeting Affiliation Update Dec. 2009), *in camera*). St. Luke's core service area consists of eight zip codes in southwest Lucas County and north Wood County. (PX01016 at 003 (St. Luke's Board Meeting Affiliation Update Dec. 2009), *in camera*).

Response to Finding No. 268:

Complaint Counsel's reference to and Professor's Town's analysis of "St. Luke's core service area" is irrelevant because it is contrary to the geographic market both Respondent and Complaint Counsel have agreed is proper in this case – Lucas County, Ohio. (CCPF 208, 229, RPF 1028). Further "St. Luke's core service area" represents only 60% of St. Luke's discharges,

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, and neither St. Luke's or ProMedica have a separate chargemasters applicable to Maumee residents. (RPF 1037-1039).

269. Southwest Lucas County is a desirable area for a hospital to be located. (Oostra, Tr. 6037). Upon his arrival, Mr. Wakeman believed that St. Luke's location placed it in a "favorable" position, and, at the time of the trial, St. Luke's location was "terrific." (Wakeman, Tr. 2477). The area surrounding St. Luke's contains "very good demographics" with "a reasonably well-affluent community." (Shook, Tr. 926-927; *see also* Wakeman, Tr. 2477, 2479).

Response to Finding No. 269:

Respondent has no specific response.

270. The area surrounding St. Luke's is growing and "more and more [is] being built in the adjoining communities to Maumee." (Shook, Tr. 927). St. Luke's location makes it convenient both for patients and their families. (Wakeman, Tr. 2509-2510).

Response to Finding No. 270:

Respondent has no specific response.

271. Both { } and { } have had strategies to establish a presence in southwestern Lucas County. (Oostra, Tr. 5898, *in camera*; Shook, Tr. 971, 986, *in camera*). { } and { } would not contemplate building additional facilities in southwest Lucas County if distance and a hospital's location were not important factors. (Town, Tr. 3756, *in camera*; PX01850 at 025 (¶ 35) (Town Rebuttal Report), *in camera*).

Response to Finding No. 271:

{

} (RPF 1175, *in camera*}. Mercy recruits physicians with the hope that the physicians will refer patients to Mercy's hospitals for inpatient services. (RPF 1186).

272. A hospital's location is important, and this is consistent with ProMedica's strategy when it built Bay Park Hospital. Mr. Oostra testified that ProMedica built Bay Park Hospital in order to access patients on the east side of Toledo. (Oostra, Tr. 5804-5805).

Response to Finding No. 272:

ProMedica's and Mercy's Toledo-area hospitals are all positioned near one of each other's hospitals. (RPF 144). Bay Park is located less than a mile from Mercy's St. Charles Hospital. (RPF 161).

IX. EXTRAORDINARILY HIGH MARKET CONCENTRATION LEVELS ESTABLISH A STRONG PRESUMPTION OF HARM TO COMPETITION IN BOTH RELEVANT MARKETS

273. The calculation of market concentration is an important tool for performing merger analysis, as it provides relevant information regarding the current competitive conditions in a market. (PX02148 at 032 (¶ 56) (Town Expert Report, *in camera*)).

Response to Finding No. 273:

Market concentration and analysis based on the number and relative size of competitors is only the starting point of a merger analysis. (RPF 1050). Here, market share computation does not provide a comprehensive view of competitive effects because the transaction 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 beyond just market share numbers. (RPF 1059). Moreover, Professor Town's market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

274. Markets that are highly concentrated are presumed to be less competitive than less concentrated markets. In less competitive markets, firms will charge higher prices to consumers, and generally have less incentive to innovate and offer high quality goods and services. (PX02148 at 032 (¶ 56) (Town Expert Report, *in camera*)). Indeed, in Lucas County, market shares of the hospital systems are an accurate predictor of each hospital's relative rates. (*See supra* Section V.C.3).

Response to Finding No. 274:

The first sentence of the proposed finding is not a fact, but an improper legal argument. The first sentence of the proposed finding also violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record. Market concentration and analysis based on the number and relative size of competitors is only the starting point of a merger analysis. (RPF 1050). Here, market share computation does not provide a comprehensive view of competitive effects because the transaction 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 beyond just market share numbers. (RPF 1059).

A. Market Structure

1. Additional Market Participants

275. Within Lucas County, the two remaining competitors to ProMedica for general acute care inpatient services after the acquisition are Mercy Health Partners ("Mercy") and the University of Toledo Medical Center ("UTMC"). (Joint Stipulations of Law and Fact, JX00002A ¶ 8); *See supra* Section VIII.A.).

Response to Finding No. 275:

Respondent has no specific response.

a. Mercy

276. Mercy is a not-for-profit health system in northwestern Ohio. (Shook, Tr. 890).

Response to Finding No. 276:

Respondent has no specific response.

277. Mercy offers general acute care inpatient services. (Joint Stipulations of Law and Fact, JX00002A ¶ 7).

Response to Finding No. 277:

Respondent has no specific response.

278. Mercy offers inpatient obstetric services in the Toledo area. (Shook, Tr. 887, 896, 902).

Response to Finding No. 278:

Before and after the joinder, ProMedica and Mercy were the only two providers of high-risk obstetrics services in Lucas County. (Guerin-Calvert, Tr. 7230-7231).

279. Mercy is affiliated with the Catholic Church and serving the poor is emphasized in its mission. (Shook, Tr. 889, 895).

Response to Finding No. 279:

Respondent has no specific response.

280. Due to its Catholic affiliation, Mercy operates subject to the ethical and religious directives of Catholic hospitals. Therefore, Mercy does not and cannot offer the full range of obstetric services such as tubal ligations. (Shook, Tr. 1065-1066).

Response to Finding No. 280:

Respondent has no specific response.

281. In Lucas County, Mercy has three general acute-care hospitals: Mercy St. Vincent Medical Center ("St. Vincent"), Mercy St. Charles Hospital ("St. Charles"), and Mercy St. Anne Hospital ("St. Anne"). (Shook, Tr. 892).

Response to Finding No. 281:

Respondent has no specific response.

282. St. Vincent is a 445-bed critical care regional referral and teaching center in downtown Toledo. St. Vincent is a tertiary facility that also houses a children's hospital on its campus. (Shook, Tr. 895-896; PX02068 at 001 (¶¶ 3-4) (Shook, Decl.), *in camera*). St. Vincent provides obstetrical services including a Level III perinatal referral center with a licensed neonatal intensive care unit for obstetrical cases and very sick babies. (Shook, Tr. 887, 895).

Response to Finding No. 282:

St. Vincent has 568 registered beds, but only staffs 445. (RPF 148).

283. Despite being located near ProMedica's Toledo Hospital, St. Vincent serves a higher percentage of Medicaid and self-insured patients and a lower share of commercially-insured patients as compared to the Toledo Hospital. (Shook, Tr. 899, 914-915; PX02068 at 002 (¶ 9) (Shook, Decl.), *in camera*). In fact, St. Vincent has the largest number of Medicaid cases in Ohio. (Shook, Tr. 888-889).

Response to Finding No. 283:

Respondent has no specific response.

284. St. Charles is a 294-bed, full-service community hospital located in an eastern suburb of Toledo. (Shook, Tr. 902-903; PX02068 at 001-002 (¶ 5) (Shook, Decl.), *in camera*). St. Charles operates a Level II perinatal referral center with a licensed neonatal intensive care unit. (Shook, Tr. 902).

Response to Finding No. 284:

St. Charles has 390 registered beds, but only staffs 264. (RPF 163).

285. St. Charles draws most of its patients from the east side of the Maumee River. (Shook, Tr. 946-947; PX02068 at 002 (¶ 10) (Shook, Decl.), *in camera*).

Response to Finding No. 285:

Respondent has no specific response.

286. St. Anne is a 100 bed, small community hospital in northwestern Toledo. (Shook, Tr. 899-900; PX02068 at 002 (¶ 6) (Shook, Decl.), *in camera*).

Response to Finding No. 286:

St. Anne has 128 registered beds, but only staffs 96. (RPF 155).

287. St. Anne is the closest Mercy hospital to ProMedica's Flower Hospital. (Shook, Tr. 917; Oostra, Tr. 5802-5803).

Response to Finding No. 287:

Respondent has no specific response.

288. St. Anne does not provide inpatient obstetrical services. (Answer at ¶ 15; Oostra, Tr. 5972-5973; Shook, Tr. 901).

Response to Finding No. 288:

Mercy discontinued obstetrics services at St. Anne in early 2008 because it determined that St. Anne no longer performed enough deliveries to maintain quality standards or to break-even financially. (RPF 156). Prior to closing, St. Anne delivered about 400 babies a year, but Mercy estimated that the hospital needed to deliver 800 or 900 babies a year to break-even financially. (RPF 157). By comparison, St. Vincent delivered 1180 babies in 2010. (RPF 158).

289. Mercy has a GAC market share of 28.7%, and an OB market share of 19.5% as measured by patient days. (PX02148 at 143 (Town Expert Report, Ex. 6, *in camera*); *see also* PX02150 at 001-002 (Market share chart)). ProMedica's market share is 60% higher than Mercy's for GAC services and three times larger for OB services. (PX02148 at 036 (¶ 66) (Town Expert Report, *in camera*)).

Response to Finding No. 289:

Mercy's share of the general acute care inpatient services based on billed charges, including obstetrics services for Lucas County was { } in 2009, and based on discharges was { }. (RPF 1057, *in camera*). For obstetrics, only, Mercy's market share based on billed charges for Lucas County was { } in 2009, and based on discharges was { }. (RPF 1057, *in camera*). Professor Town improperly has tried to make ProMedica, Mercy, and St. Luke's appear more similar by examining discharges and patient days, rather than revenues or billed charges, which give greater weight to higher acuity, and therefore more costly, services. (RX-71(A) at 000016-000017, *in camera*). Revenue-based (or billed charges) shares provide a mean to reflect the fact that many DRGs and service lines cost more, require longer stays and, therefore, generate higher revenues; shares based on patient days or discharges do not reflect these differences. (RX-71(A) at 000036, *in camera*). Because St. Luke's has primarily low-risk and low-acuity patients and large number of them, while Mercy, ProMedica, and UTMC have both high and low-risk patients, the use of discharge or patient day shares artificially inflates St. Luke's shares relative to these hospitals, and fails to capture these important differences. (RX-71(A) at 000036, *in camera*).

Further, Professor Town's market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby

understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

290. In southwestern Lucas County, Mercy has only a 9% market share for GAC services. (Shook, Tr. 934-935, 1012-1013, *in camera*; *see* PX02290 at 003, *in camera*).

Response to Finding No. 290:

The proposed finding is inaccurate and misleading. Complaint Counsel's reference to and Professor's Town's analysis of "St. Luke's core service area" or "southwestern Lucas County" is irrelevant because it is contrary to the geographic market both Respondent and Complaint Counsel have agreed is proper in this case – Lucas County, Ohio. (CCPF 208, 229, RPF 1028). Further "St. Luke's core service area" represents only 60% of St. Luke's discharges, 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, and neither St. Luke's or ProMedica have a separate chargemasters applicable to Maumee residents. (RPF 1037-1039).

291. Immediately prior to the Acquisition, ProMedica's severity-adjusted rates were { } higher than Mercy's rates, on average. (Town, Tr. 3721, *in camera*; PX01850 at 031-032 (¶ 46) (Town Rebuttal Report, *in camera*)).

Response to Finding No. 291:

Professor Town's case-mix-adjusted price estimations do not indicate the reason for the difference in prices across Lucas County hospitals, and Professor Town agrees that the presence of price differences alone is not sufficient to determine the exercise of market power. (RPF 1515). Further, Professor Town's case-mix-adjusted price estimations do not control for the differences in the cost of care across hospitals, even though hospitals do not necessarily incur the same costs to deliver general acute care inpatient services. (RPF 1519). The case-mix-adjusted prices also do not take into consideration the complexity of the bargaining process. (RPF 1521). Moreover, Professor Town's price computations are contradicted by St. Luke's ordinary course

documents showing ProMedica's prices are not highest among Lucas County hospitals; instead they show { } having the highest prices among Lucas County hospitals. *See e.g.*, (PX01016 at 009, *in camera*). Finally, Professor Town's case-mix-adjusted prices assume that reimbursement rates are in equilibrium, which is not necessarily true. (RPF 1523).

b. UTMC

292. UTMC was formed when the University of Toledo and the Medical College of Ohio merged in 2006. (Gold, Tr. 186; PX02064 at 001 (¶ 1) (Gold, Decl.)).

Response to Finding No. 292:

Respondent has no specific response.

293. UTMC is the only academic medical center in the area, and has a mission to support the academic needs of the University of Toledo. (Gold, Tr. 192-193, 252-253).

Response to Finding No. 293:

Respondent has no specific response.

294. UTMC's primary focus is on tertiary and quaternary hospital services, as well as clinical research and education. (Gold, Tr. 192-194; PX02064 at 001, 003 (¶ 2, 10) (Gold, Decl.)).

Response to Finding No. 294:

Respondent has no specific response.

295. UTMC also provides general acute care services. (Joint Stipulations of Law and Fact, JX00002A ¶ 7; PX02064 at 001 (¶ 2) (Gold, Decl.)).

Response to Finding No. 295:

Respondent has no specific response.

296. UTMC does not offer inpatient obstetrical services. (Answer at ¶¶ 4, 15, 20; Oostra, Tr. 5972; Gold, Tr. 203, 220). UTMC does not plan to offer inpatient obstetrical services in the future. (Gold, Tr. 220).

Response to Finding No. 296:

Respondent has no specific response.

297. UTMC is licensed for 300 beds, but only has and staffs 225 beds. (Gold, Tr. 199-201).

Response to Finding No. 297:

UTMC has 319 registered beds, but only staffs 226. (RPF 181).

298. UTMC is harder for patients to get to than St. Luke's Hospital. It is mainly surrounded by commercial buildings and has minimal access to the expressway. (Shook, Tr. 924, 929).

Response to Finding No. 298:

Respondent has no specific response.

299. UTMC depends on its relationship with other local hospitals. Only half of UTMC's residents gain clinical experiences at UTMC; the rest rotate through other community hospitals in northwestern Ohio and southeast Michigan. (Gold, Tr. 196).

Response to Finding No. 299:

Respondent has no specific response.

300. In 2010, UTMC and ProMedica began a six-year clinical education and research partnership. According to which, UTMC provides day-to-day management of academic programs in the ProMedica system. (Gold, Tr. 191-192, 210-211; PX02064 at 002-003 (¶ 7) (Gold, Decl.)).

Response to Finding No. 300:

Respondent has no specific response.

301. UTMC has a 13% market share for GAC services in Lucas County, which is less than one-third of ProMedica's market share. (*See* PX02148 at 143 (Town Expert Report, Ex. 6, *in camera*); PX02150 at 001 (Market share chart)).

Response to Finding No. 301:

UTMC's share of the general acute care inpatient services based on billed charges for Lucas County in 2009 was { }, and based on discharges was { }. (RPF 1058, *in camera*). By comparison, ProMedica's market share in 2009 for Lucas County for all general acute care inpatient services, based on billed charges was { } and based on discharges was (}. (RPF 1056, *in camera*). Professor Town improperly has tried to make ProMedica, Mercy, and

St. Luke's appear more similar by examining discharges and patient days, rather than revenues or billed charges, which give greater weight to higher acuity, and therefore more costly, services. (RX-71(A) at 000016-000017, *in camera*). Revenue-based (or billed charges) shares provide a mean to reflect the fact that many DRGs and service lines cost more, require longer stays and, therefore, generate higher revenues; shares based on patient days or discharges do not reflect these differences. (RX-71(A) at 000036, *in camera*). Because St. Luke's has primarily low-risk and low-acuity patients and large number of them, while Mercy, ProMedica, and UTMC have both high and low-risk patients, the use of discharge or patient day shares artificially inflates St. Luke's shares relative to these hospitals, and fails to capture these important differences. (RX-71(A) at 000036, *in camera*).

Further, Professor Town's market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

302. Immediately prior to the Acquisition, ProMedica's severity-adjusted rates were {51%} higher than UTMC's rates, on average. (Town, Tr. 3721-3722, *in camera*; PX02148 at 037 (¶ 68) (Town Expert Report, *in camera*)).

Response to Finding No. 302:

Professor Town's case-mix-adjusted price estimations do not indicate the reason for the difference in prices across Lucas County hospitals, and Professor Town agrees that the presence of price differences alone is not sufficient to determine the exercise of market power. (RPF 1515). Further, Professor Town's case-mix-adjusted price estimations do not control for the differences in the cost of care across hospitals, even though hospitals do not necessarily incur the

same costs to deliver general acute care inpatient services. (RPF 1519). The case-mix-adjusted prices also do not take into consideration the complexity of the bargaining process. (RPF 1521). Moreover, Professor Town's price computations are contradicted by St. Luke's ordinary course documents showing ProMedica's prices are not highest among Lucas County hospitals; instead they show { } having the highest prices among Lucas County hospitals. *See e.g.*, (PX01016 at 009, *in camera*). Finally, Professor Town's case-mix-adjusted prices assume that reimbursement rates are in equilibrium, which is not necessarily true. (RPF 1523).

2. The Acquisition Left Only Three Competitors in the Lucas County GAC Services Market

303. In Lucas County prior to the Acquisition, ProMedica and St. Luke's competed with UTMC and Mercy. (Answer at ¶ 20).

Response to Finding No. 303:

Respondent has no specific response.

304. Within Lucas County, the only two remaining competitors to ProMedica for general acute care services after the Acquisition are Mercy and UTMC. (Joint Stipulations of Law and Fact, JX00002A ¶ 8).

Response to Finding No. 304:

Respondent has no specific response.

3. The Acquisition Results in a Duopoly in the Lucas County OB Services Market

305. In Lucas County, the Acquisition is a merger to duopoly for OB services. Following the Acquisition, Mercy is the only remaining competitor in Lucas County that provides OB services. (Response to RFA at ¶ 10; Answer at ¶¶ 4, 15, 20; Oostra, Tr. 5972-5973; Gold, Tr. 220).

Response to Finding No. 305:

The first sentence of the proposed finding is not a fact, but an improper legal argument. The proposed finding also fails to mention that there has always been only two providers of high-risk obstetrics services – Mercy and ProMedica. (RPF 1022).

B. Market Shares, Concentration, and the Presumption of Competitive Harm

306. Both before and after the Acquisition, ProMedica's market share is higher than its competitors in Lucas County, whether calculated by registered beds, beds-in-use, or occupancy. (Joint Stipulations of Law and Fact, JX00002A ¶ 17).

Response to Finding No. 306:

Professor Town's calculation of market shares is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

307. The Acquisition significantly increases concentration in the already highly-concentrated Lucas County markets for GAC and OB services. ProMedica's post-Acquisition market share is 58.3% in the GAC market, where only two competitors remain, and 80.5% in the OB market, where only one competitor remains. (Town, Tr. 3702-3705; PX02148 at 033-034 (¶¶ 60-61), 143 (Ex. 6) (Town Expert Report, *in camera*); PX02150 (Market share chart)).

Response to Finding No. 307:

Professor Town's calculation of market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

308. Under the U.S. Department of Justice and the Federal Trade Commission *Horizontal Merger Guidelines* ("*Merger Guidelines*"), which guide federal courts in applying antitrust merger analysis, a merger or acquisition is presumed likely to create or enhance market power when the post-merger HHI exceeds 2500 points and the merger or acquisition increases the HHI by more than 200 points. (Answer at ¶ 22).

Response to Finding No. 308:

The proposed finding is not a fact, but an improper legal argument.

309. This Acquisition far exceeds the *Merger Guidelines* concentration thresholds: in the GAC market, concentration rises 1,078 points to 4,391; in the OB market, concentration rises 1,323 points to 6,854. (Town, Tr. 3703-3704; PX02148 at 034 (¶ 61), 143 (Ex. 6) (Town Expert Report, *in camera*); PX02150 at 002 (Market share chart)). Therefore, the Acquisition is presumptively anticompetitive by a wide margin in both relevant markets based on these high levels of market concentration, and is presumed likely to enhance ProMedica's market power in both markets. (PX02214 at 021-022 (§ 5.3) (*Merger Guidelines*); *see* Complaint Counsel's Proposed Conclusions of Law at Section XX.G.).

Response to Finding No. 309:

The first sentence of the proposed finding is not a fact, but an improper legal argument. Further, market concentration and analysis based on the number and relative size of competitors is only the starting point of a merger analysis. (RPF 1050). Here, market share computation does not provide a comprehensive view of competitive effects because the transaction 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 beyond just market share numbers. (RPF 1059). Moreover, Professor Town's market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*)

310. The strong presumption that the Acquisition is anticompetitive is insensitive to potential changes in the relevant product and/or geographic markets. While the exact market shares of the individual hospitals would change slightly, the inclusion of tertiary and quaternary services does not affect the strong presumption of anticompetitive harm because the market would still be highly concentrated according to post-Acquisition HHIs. (Town, Tr. 3714-3715; Guerin-Calvert, Tr. at 7730-7731, 7695). The market shares also do not change materially if Wood County Hospital and Fulton County Health Center are included. (Town, Tr. 3711-3712).

Response to Finding No. 310:

The first sentence of the proposed finding is not a fact, but an improper legal argument. Market concentration and analysis based on the number and relative size of competitors is only the starting point of a merger analysis. (RPF 1050). Here, market share computation does not provide a comprehensive view of competitive effects because the transaction 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 beyond just market share numbers. (RPF 1059). Further, Moreover, Professor Town's market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*)

311. Market shares can be accurately based on number of discharges, revenue, or patient days. No matter which one is selected, the calculated market shares "would be unaffected." (Town, Tr. 3701-3702, 3709-3710). It is not accurate to calculate market shares based on billed charges, such as those made by the Respondent's expert. Commercial insurers pay discounted prices for services, not the full charge master price, so it would provide a distorted view of the market. (Town, Tr. 3707-3708).

Response to Finding No. 311:

Market concentration and analysis based on the number and relative size of competitors is only the starting point of a merger analysis. (RPF 1050). Here, market share computation does not provide a comprehensive view of competitive effects because the transaction 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 beyond just market share numbers. (RPF 1059). Moreover, Professor Town's market share is

based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

Further, Professor Town improperly has tried to make ProMedica, Mercy, and St. Luke's appear more similar by examining discharges and patient days, rather than revenues or billed charges, which give greater weight to higher acuity, and therefore more costly, services. (RX-71(A) at 000016-000017, *in camera*). Revenue-based (or billed charges) shares provide a mean to reflect the fact that many DRGs and service lines cost more, require longer stays and, therefore, generate higher revenues; shares based on patient days or discharges do not reflect these differences. (RX-71(A) at 000036, *in camera*). Because St. Luke's has primarily low-risk and low-acuity patients and large number of them, while Mercy, ProMedica, and UTMC have both high and low-risk patients, the use of discharge or patient day shares artificially inflates St. Luke's shares relative to these hospitals, and fails to capture these important differences. (RX-71(A) at 000036, *in camera*).

312. Respondent's expert concedes that even using her relevant market definition, the market is still highly concentrated and presumed to increase market power with post-Acquisition HHIs over 4000. (Guerin-Calvert, Tr. at 7730-7731).

Response to Finding No. 312:

Market concentration and analysis based on the number and relative size of competitors is only the starting point of a merger analysis. (RPF 1050). Here, market share computation does not provide a comprehensive view of competitive effects because the transaction 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 beyond just market share numbers. (RPF 1059).

313. Additionally, ProMedica's market dominance is even greater in southwestern Lucas County where it now controls { } of the market for GAC services. (PX02290 at 003, *in camera*; Wakeman, Tr. 2523-2525; *see* PX01352 at 006). Mercy has only a { } market share and UTMC has an { } market share. (Shook, Tr. 934-936, 1012-1013, *in camera*; PX02290 at 003, *in camera*).

Response to Finding No. 313:

Complaint Counsel's reference to and Professor's Town's analysis of "southwestern Lucas County" is irrelevant because it is contrary to the geographic market both Respondent and Complaint Counsel have agreed is proper in this case – Lucas County, Ohio. (CCPF 208, 229, RPF 1028). As Complaint Counsel and their economic expert agree, all of Lucas County is the relevant market; thus an analysis of market shares in any smaller area is irrelevant. (RPF 1028-1030).

314. St. Luke's was fully aware that an affiliation with ProMedica would generate antitrust concerns due to the high HHI levels. (PX01030 at 017, *in camera* ("significant legal, regulatory considerations . . . ProMedica: HHI with St. Luke's is 34.7% and 29.9% without . . . Any obstetrics affiliation may need to be carefully reviewed. Note: Anything [referring to HHIs] over 18% throws up a red flag."); Wakeman, Tr. 2695-2696, *in camera*; Black, Tr. 5734, *in camera*; PX01125 at 002, *in camera*).

Response to Finding No. 314:

The proposed finding mischaracterizes the record. To begin, Mr. Wakeman testified that he did not anticipate an antitrust challenge, just a review. (Wakeman, Tr. 2684-2685, *in camera*). Furthermore, the proposed finding is filled with unfounded legal analysis and conclusions. Mr. Wakeman had no foundation to speak to the legal and antitrust implications of a proposed affiliation. Complaint Counsel notably omit from their proposed finding St. Luke's calculation of the HHI, 18,000, as it underscores St. Luke's lack of familiarity with antitrust law. (PX01125 at 002, *in camera*). Mr. Rupley further testified that he didn't know what it meant to

have a high HHI, and yet he still included it in a board presentation. (Rupley, Tr. 2001; PX01124, *in camera*; PX01030, *in camera*). Moreover, the document that Complaint Counsel cites indicates that St. Luke's believed a joinder between St. Luke's and either Mercy or UTMC, Complaint Counsel's suggested alternative partners, also would result in a presumptively unlawful *Merger Guidelines* violation in a highly concentrated market. (PX01030 at 017, *in camera*) (calculating HHIs for affiliations with Mercy, UTMC, and ProMedica).

X. PROMEDICA AND ST. LUKE'S WERE SIGNIFICANT COMPETITORS PRIOR TO THE ACQUISITION

A. Because ProMedica's Lucas County Hospitals and St. Luke's Hospital Were Close Substitutes, the Acquisition Eliminates Significant Competition

1. St. Luke's Hospital and ProMedica's Lucas County Hospitals Were Close Substitutes

315. Under a unilateral effects theory, a merger will lead to increased bargaining leverage and higher prices if the hospitals that are parties to the merger are close substitutes. (Town, Tr. 3778-3779, *in camera*; PX02148 at 040-041 (¶¶ 75-76) (Town Expert Report), *in camera*). The more substitutable the hospitals are in the eyes of health plans and patients, the greater the harm from the transaction. (Town, Tr. 3772, *in camera*; PX02148 at 046-047 (¶¶ 87-88) (Town Expert Report), *in camera*).

Response to Finding No. 315:

Respondent has no specific response

316. Patients generally prefer to seek treatment in the hospital that is closest to them. (Randolph, Tr. 7102, *in camera*; Pugliese, Tr. 1450; Sheridan, Tr. 6680-6681; PX02148 at 041 (¶ 77) (Town Expert Report), *in camera*). Hospitals that are located close to one another and to a patient's residence are closer substitutes than more distant hospitals. (PX02148 at 041 (¶ 77) (Town Expert Report), *in camera*). So, within the geographic market of Lucas County, some hospitals are closer substitutes than others. (PX02148 at 041 (¶ 77) (Town Expert Report), *in camera*).

Response to Finding No. 316:

The proposed finding is inaccurate and misleading. No major MCO or employer testified they had analyzed their insureds' or employees' willingness to travel for inpatient

hospitalization. (Radzialowski, Tr. 637-638; Pugliese, Tr. 1563; Neal, Tr. 2155; Pirc, Tr. 2268-2269, 2298). A study of actual travel times, however, reveals that 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. (RPF 1218). 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. (RPF 1212). Thus, the drive time analysis shows that a large number and proportion of patients are not choosing the hospital located closest to them. (RPF 1217).

Moreover, evidence has shown that Mercy and ProMedica are each other's closest substitutes. (*See, e.g.*, RPF 1116, 1135-1137; PX01850 at 020; Oostra, Tr. 5803-5804, 6040)

317. Professor Town concluded that for inpatient general acute-care services, ProMedica is St. Luke's closest competitor. (Town, Tr. at 3759-3760, *in camera*). Professor Town also concluded that for obstetrics services, ProMedica is St. Luke's closest competitor. (Town, Tr. at 3760-3761, *in camera*).

Response to Finding No. 317:

The proposed finding is inaccurate and misleading. Not only did Professor Town testify that "Mercy is ProMedica's closest substitute" (RPF 1116), but he also admitted that a payor could substitute ProMedica for Mercy in its network and market its product. (Town, Tr. 4057).

{

} (RPF 1110, *in camera*). 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. (RPF 1111). {

.} (RPF 1112, *in camera*). Finally, a draw area analysis shows that ProMedica hospitals draw from almost exactly the same zip codes as their Mercy counter-parts. (RPF 1117).

318. Notably, two merging parties do not have to be each other's closest substitutes for competitive harm to result from a merger. (Town, Tr. 3782, *in camera*).

Response to Finding No. 318:

Respondent has no specific response.

319. It is also not necessary for St. Luke's to be a stand-alone substitute for ProMedica in order for the merger to result in anticompetitive harm. (Town, Tr. 3784, *in camera*).

Response to Finding No. 319:

Respondent has no specific response.

a. A Host of Evidence Demonstrates that St. Luke's and ProMedica Were Close Substitutes

320. Testimony, documents and data demonstrate that St. Luke's and ProMedica hospitals were considered close substitutes by patients seeking inpatient hospital services, especially those residing in southwest Lucas County. (*See, e.g.*, PX01235 at 003, 005; PX02148 at 042-046 (¶¶ 79-87) (Town Expert Report), *in camera*; PX01077 at 009-015 (St. Luke's Market Report 2008); Wakeman, Tr. 2511, 2523-2525, 2527; Rupley, Tr. 1945).

Response to Finding No. 320:

The proposed finding is inaccurate and misleading. This proposed findings ignores evidence that shows that St. Luke's and ProMedica were not each other's *closest* substitutes, which is the primary question. More importantly this proposed finding mischaracterizes the evidence cited. Document PX01235 merely shows estimated market shares of hospitals in and around Lucas County from 1997 through the first quarter of 2010 for St. Luke's "core service area." (PX01235). St. Luke's core service area is the combination of seven zip codes from where St. Luke's draws about 55 percent of its patients. (RPF 127, 1037; Rupley, Tr. 1944-1945), and as Complaint Counsel and their economic expert agree, St. Luke's core service area is

not the relevant market. (RPF 1028-1030). Complaint Counsel assumes that market share based on slightly more than half of St. Luke's patient population has a direct relation to what patients consider close substitutes and ignores contrary evidence, such as the inability to price discriminate. (RPF 1036-1041). Document PX01077 sampled only 400 residents immediately after St. Luke's conducted an advertising campaign and represents only where patients would prefer to go, not where they actually would go for treatment. (PX01077 at 007). In addition, Mr. Rupley testified that St. Luke's patients could go to *any* of the other hospitals in the area, not just ProMedica. (Rupley, Tr. 1945).

321. ProMedica and St. Luke's competed to attract patients, especially those who reside between ProMedica's hospitals and St. Luke's. (Oostra, Tr. 6041-6042).

Response to Finding No. 321:

Respondent has no specific response.

322. Prior to the Acquisition, ProMedica was St. Luke's "most significant competitor." (Wakeman, Tr. 2511, 2523-2525, 2527; Rupley, Tr. 2036, *in camera*; Oostra, Tr. 6040). ProMedica's CEO viewed ProMedica and St. Luke's as "[s]trong competitors" prior to the Acquisition. (Oostra, Tr. 6038-6039). Mercy does not consider itself to be "in any way, shape or form a primary competitor to" St. Luke's. (Shook, Tr. 1038).

Response to Finding No. 322:

The proposed finding is inaccurate and misleading. This statement does not accurately represent witness testimony. Mr. Oostra testified that ProMedica "didn't view [St. Luke's] as our primary competitor, but they are our competitor. . . . Mercy was our -- is a significant competitor." (Oostra, Tr. 5803-5804, 6040). Mr. Shook testified that { } most significant competitor. (Shook, Tr. 1091-1092, *in camera*). Moreover, a diversion analysis showed that there is actually more diversion from St. Luke's to Mercy than from St. Luke's to ProMedica, which is evidence that Mercy and St. Luke's do compete. (RPF 1135-1136). In addition, Complaint Counsel's economic expert agrees that at least with respect to MMO

members, Mercy and St. Luke's are closer substitutes than ProMedica and St. Luke's. (RPF 1137). Not only did Professor Town testify that "Mercy is ProMedica's closest substitute" (RPF 1116), but he also admitted that a payor could substitute ProMedica for Mercy in its network and been able to market its product. (Town, Tr. 4057). Finally, {

} (RPF 1110, *in camera*).

323. Market shares can identify which competitors are the most significant in a given area. (Wakeman, Tr. 2507). Hospitals with the highest and next-highest market share in a given area will likely be the closest competitors in that area. (PX02148 at 042 (¶ 78) (Town Expert Report), *in camera*).

Response to Finding No. 323:

The proposed finding is inaccurate and misleading. The proposed finding mischaracterizes Mr. Wakeman's testimony. Mr. Wakeman testified that when using market shares, the significance of a competitor can vary by service line. (Wakeman, Tr. 2507). Moreover, Mr. Wakeman testified that the method he would use to define a competitor would include evaluating other hospitals by service line and geographic proximity. (PX01911 (Wakeman, IHT at 246)).

In addition, this proposed finding mischaracterizes the citation to Professor Town's report. In paragraph 78 of his report, Professor Town discusses {

} not within Lucas County. (PX02148 at 042, *in camera*). However, as Complaint Counsel and their economic expert agree, all of Lucas County is the relevant market; thus an analysis of market shares in any smaller area is irrelevant. (RPF 1028-1030).

324. According to internal documents, in St. Luke's core service area, St. Luke's and ProMedica had the first- and second-highest market shares, respectively, for GAC. (PX01235 at 003). ProMedica and St. Luke's had the first- and second-highest market shares, respectively, for OB in St. Luke's core service area. (PX01235 at 005). St. Luke's defines its core service area in the ordinary course of business as the zip codes where 80 percent of its admission base, by service line, comes from. (Wakeman, Tr. 2508).

Response to Finding No. 324:

The proposed finding is misleading. St. Luke's core service area is not the relevant geographic market and distorts St. Luke's competitive significance. (RPF 1036-1049). As Complaint Counsel's economic expert agrees, the relevant geographic market is all of Lucas County and hospitals compete for patients across that market. (RPF 1028-1030). Moreover, there is no evidence that hospitals can or do price discriminate based on St. Luke's core service area. (RPF 1029, 1513; Guerin-Calvert, Tr. 7248-7249). But even in St. Luke's core service area, the data, from Complaint Counsel's own economic expert, show that the majority of patients seek care from hospitals other than St. Luke's. (RFP 1480-1481).

Moreover, this proposed finding is misleading because it is unclear whether the market shares presented in PX01235 represent all patients including government insured and charity care or only commercially insured patients, which are the patients at issue in this case. (PX01235 at 003).

325. A December 2009 joinder presentation to the board reflected that St. Luke's and ProMedica treated the { } of general acute-care patients in St. Luke's core service area. (Rupley, Tr. 1978-1983, *in camera*; PX01016 at 003, *in camera*). For OB, { } was shown to have the greatest share, followed by { }. (Rupley, Tr. 1978-1983, *in camera*; PX01016 at 003, *in camera*). St. Luke's, TTH, and Flower had a combined { } market share in St. Luke's core service area for OB in 2008. (Rupley, Tr. 1978-1983, *in camera*; PX01016 at 003, *in camera*).

Response to Finding No. 325:

The proposed finding is misleading. St. Luke's core service area is not the relevant geographic market and distorts St. Luke's competitive significance. (RPF 1036-1049). As Complaint Counsel's economic expert agrees, the relevant geographic market is all of Lucas County and hospitals compete for patients across that market. (RPF 1028-1030). Also, there is no evidence that hospitals can or do price discriminate based on St. Luke's core service area.

(RPF 1029, 1513; Guerin-Calvert, Tr. 7248-7249). But even in St. Luke's core service area, the data, from Complaint Counsel's own economic expert, show that the majority of patients seek care from hospitals other than St. Luke's. (RFP 1480-1481).

Moreover, this proposed finding is misleading because the market shares presented in PX01016 reflect {

} (Rupley, Tr. 2038-2039,*in camera*). Thus, the shares presented overstate St. Luke's share of commercially insured patients, which are the patients at issue in this case. (RPF 1001).

326. Internal documents similarly reflect that in 2007, ProMedica and St. Luke's accounted for 66 percent of the inpatient market share in St. Luke's core service area, compared to 13 percent for UTMC and only 8 percent for Mercy St. Vincent's. (Wakeman, Tr. 2519; PX01352 at 006). Since 2007, St. Luke's inpatient market share in the core service area has increased. (Wakeman, Tr. 2519-2520).

Response to Finding No. 326:

The proposed finding is misleading. St. Luke's core service area is not the relevant geographic market and focusing on market share in this area distorts St. Luke's competitive significance. (RPF 1036-1049). As Complaint Counsel's economic expert agrees, the relevant geographic market is all of Lucas County and hospitals compete for patients across that market. (RPF 1028-1030). But even in St. Luke's core service area, the data from Complaint Counsel's own economic expert, show that the majority of patients seek care from hospitals other than St. Luke's. (RFP 1480-1481).

Moreover, this proposed finding is misleading because the market shares presented in PX01352 reflect all patients admitted to St. Luke's and other hospitals, including government insured and charity care patients. (PX01352 at 006). Thus, the shares presented overstate St. Luke's share of commercially insured patients, which are the patients at issue in this case. (RPF 1001).

327. Based on Ms. Guerin-Calvert's own calculations, in St. Luke's top ten zip codes by volume, (accounting for { } of admissions), ProMedica ({ }) and St. Luke's ({ }) rank first and second in market share. (PX02148 at 076 (¶ 137) (Town Expert Report), *in camera*; PX02123 at 041-042 (Guerin-Calvert, Decl. Exhibits)). In eight of St. Luke's top ten zip codes, and in all of St. Luke's "core" zip codes, St. Luke's and ProMedica had the first- and second-highest shares of the GAC market. (PX02123 at 042 (Guerin-Calvert, Decl. Exhibits); PX02148 at 043, 064-065, 161 (¶¶ 82, 116-117, Exhibit 11) (Town Expert Report), *in camera*).

Response to Finding No. 327:

The proposed finding is misleading. St. Luke's core service area is not the relevant geographic market and focusing on market share in this area distorts St. Luke's competitive significance. (RPF 1036-1049). As Complaint Counsel's economic expert agrees, the relevant geographic market is all of Lucas County and hospitals compete for patients across that market. (RPF 1028-1030). When measured for Lucas County as a whole, {

} (RPF 1054). {

.} (RPF 1054). {

} (RPF 1054).

{ } (RPF 1054).

{

.} (RPF 1054). {

.} (RPF 1056). {

.} (RPF 1056). {

} (RPF 1056).

{ .} (RPF 1056).

328. ProMedica's and St. Luke's market shares in southwestern Lucas County are significantly higher than Mercy's in both relevant product markets. (Town, Tr. 3752-3754, *in camera*; PX02148 at 062-065 (¶¶ 111-117), 156-159 (Exhibit 10) (Town Expert Report), *in camera*). Professor Town's analysis of market shares in St. Luke's core service area demonstrates that for inpatient general acute-care services ProMedica has a market share of { }, St. Luke's has a share of { }, Mercy has a share of { }, and UTMC has a share of { }. (Town, Tr. 3764, *in camera*; PX02148 at 161 (Exhibit 11) (Town Expert Report), *in camera*). Professor Town's analysis of St. Luke's core service area demonstrates that for inpatient obstetrics services ProMedica has a market share of { }, St. Luke's has a share of { }, and Mercy has a share of { }. (Town, Tr. 3764, *in camera*; PX02148 at 161 (Exhibit 11) (Town Expert Report), *in camera*).

<u>Response to Finding No. 328:</u>

The proposed finding is misleading. St. Luke's core service area is not the relevant geographic market and focusing on market share in this area distorts St. Luke's competitive significance. (RPF 1036-1049). As Complaint Counsel's economic expert agrees, the relevant geographic market is all of Lucas County and hospitals compete for patients across that market. (RPF 1028-1030).

Moreover, Professor Town's market shares for inpatient general acute care services are flawed because he limits his "market" to only those general acute care inpatient services (identified as "diagnostic related groups" or "DRGs") that both ProMedica and St. Luke's provided to at least three commercially-insured patients (RPF 1491), thereby eliminating from his "market" (and his share calculations) many services that ProMedica, Mercy, and UTMC offer and provide. (RPF 1489-1493, 1504, 1510, *in camera*). Professor Town also excluded overlapping St. Luke's and ProMedica DRGs for which St. Luke's and ProMedica compete with hospitals outside of Lucas County (RPF 1494-1495), and DRGs with a case weight index, which reflects complexity of care, greater than two. (RPF 1496). {

} (RX-71(A) at 000015-000018, *in camera*). Professor Town included, however, some DRGs with case weights higher than four, which captures some services that could be classified as tertiary or quaternary medical services. (RPF 1500). His separate inpatient OB services product market share calculation is similarly flawed because it is also based on less than one year's worth of data and 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. (RPF 1501).

Moreover, Professor Town's market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

When market shares are measured using billed charges, rather than patient days, to reflect the fact that many DRGs and service lines cost more, require longer stays and, hence, generate higher revenues, St. Luke's has only a { } percent share of the general acute care inpatient services market, inclusive of inpatient OB services, for Lucas County. (RX-71(A)-000036-000037, *in camera*). { } combined have a higher share than ProMedica in Lucas County. (RX-71(A) at 000036-000037, *in camera*). Looking only at inpatient OB services, St. Luke's share is only { } percent based on billed charges in Lucas County. (RX-71(A) at 000036-000037, *in camera*). For all {

} of all hospitals in Lucas County based on billed charges. (RX-71(A)-000036-000037, *in camera*).

Finally, the proposed finding is misleading because it overlooks the fact that St. Luke's only treats about ten commercially insured patients per day, only one of which is an expectant mother. (RFP 1147; PX02137 at 055, *in camera*).

329. Scott Shook, Mercy's Senior Vice President of Business Development, testified that Mercy has a { } percent market share for inpatient services in its primary service area, compared to only { } percent in the southwest quadrant of Lucas County. (Shook, Tr. 934-935, 980-981, *in camera*). Similarly, a 2010 Mercy analysis concluded that, in southwestern Lucas County, St. Luke's had a { } percent market share, ProMedica had a { } percent market share, UTMC had an { } percent market share, and Mercy had a { } percent market share. (PX02290 at 002-003, *in camera*; Shook, Tr. 1012-1013, *in camera*).

Response to Finding No. 329:

The proposed finding is misleading. First, St. Luke's core service area is not the relevant geographic market and focusing on market share in this area distorts St. Luke's competitive significance. (RPF 1036-1049). As Complaint Counsel's economic expert agrees, the relevant geographic market is all of Lucas County and hospitals compete for patients across that market. (RPF 1028-1030).

Second, this proposed finding misstates Mr. Shook's testimony. Mr. Shook testified that Mercy has a 30-32 percent market share for all of Lucas County. (Shook, Tr. 934-935). In addition, Mr. Shook's testimony did not specify whether his market share calculations included higher end tertiary services. (Shook, Tr. 934-935, 980-981, *in camera*). Mr. Shook also agreed that, using his estimated St. Luke's market share, approximately "66 percent [of patients in St. Luke's core service area] go someplace else." (Shook, Tr. 1039). It is also unclear from the testimony whether Mr. Shook's testimony referred to market shares only for commercially insured patients or all patients. (Shook, Tr. 1039).

Finally, the proposed finding is misleading because it overlooks the fact that St. Luke's only treats about ten commercially insured patients per day, only one of which is an expectant mother. (RFP 1147; PX02137 at 055, *in camera*).

330. Based on Mr. Shook's review of market share information, St. Luke's had a slim majority of the southwest Lucas County market, with "a fair degree of inpatient admissions going to Flower and Toledo." (Shook, Tr. 934).

Response to Finding No. 330:

The proposed finding is misleading. St. Luke's core service area is not the relevant geographic market and focusing on market share in this area distorts St. Luke's competitive significance. (RPF 1036-1049). As Complaint Counsel and their economic expert agree, the relevant geographic market is all of Lucas County and hospitals compete for patients across that market. (RPF 1028-1030).

This proposed response is misleading because it is incomplete with regard to Mr. Shook's testimony. In the very next sentences, Mr. Shook testified that "We can only speculate on the reasons why [inpatient admissions were going to Flower and Toledo]. There were some going to the university." (Shook, Tr. 934). Mr. Shook also agreed that, using his estimated St. Luke's market share, approximately "66 percent [of patients in St. Luke's core service area] go someplace else." (Shook, Tr. 1039).

331. Mercy does not have a hospital in southwestern Lucas County and has no plans to build one. (Shook, Tr. 963-65, 968; PX02068 at 002, 006 (¶¶ 8, 24) (Shook, Decl.), *in camera*); PX02148 at 064-065 (¶ 116) (Town Expert Report), *in camera*). Despite Mercy's efforts to {

} (Shook, Tr. 988, *in camera*). *See infra* Section XIV.D.

Response to Finding No. 331:

The proposed finding is misleading. This fact is misleading because it implies that the reason Mercy has not been able to grow its market share in southwest Lucas County is due to the

competitiveness of St. Luke's. Moreover, St. Luke's core service area is not the relevant geographic market and focusing on market share in this area distorts St. Luke's competitive significance. (RPF 1036-1049). As Complaint Counsel and their economic expert agree, the relevant geographic market is all of Lucas County and hospitals compete for patients across that market. (RPF 1028-1030). Finally, the proposed finding is contradicted by Mercy's own documents which show that {

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

332. Based on market shares, Professor Town concluded that patients residing in St. Luke's core service area prefer St. Luke's and ProMedica for inpatient services. (Town, Tr. 3753-3754, *in camera*). Mercy and UTMC have much lower market shares and are therefore preferred less by patients in St. Luke's core service area. (Town, Tr. 3754-3755, *in camera*).

Response to Finding No. 332:

The proposed finding is misleading. St. Luke's core service area is not the relevant geographic market and focusing on market share in this area distorts St. Luke's competitive significance. (RPF 1036-1049). As Complaint Counsel and their economic expert agree, the relevant geographic market is all of Lucas County and hospitals compete for patients across that market. (RPF 1028-1030). But even in St. Luke's core service area, the data from Complaint Counsel's own economic expert, show that the majority of patients seek care from hospitals other than St. Luke's. (RFP 1480-1481). In addition, a diversion analysis showed that there is actually more diversion from St. Luke's to Mercy than from St. Luke's to ProMedica, which is evidence that Mercy and St. Luke's do compete. (RPF 1135-1136).

Moreover, Professor Town's market shares for inpatient general acute care services are flawed because he limits his "market" to only those general acute care inpatient services

(identified as "diagnostic related groups" or "DRGs") that both ProMedica and St. Luke's provided to at least three commercially-insured patients (RPF 1491), thereby eliminating from his "market" (and his share calculations) many services that ProMedica, Mercy, and UTMC offer and provide. (RPF 1489-1493, 1504, 1510, *in camera*). Professor Town also excluded overlapping St. Luke's and ProMedica DRGs for which St. Luke's and ProMedica compete with hospitals outside of Lucas County (RPF 1494-1495), and DRGs with a case weight index, which reflects complexity of care, greater than two. (RPF 1496). {

} (RX-71(A) at 000015-000018, *in camera*). Professor Town included, however, some DRGs with case weights higher than four, which captures some services that could be classified as tertiary or quaternary medical services. (RPF 1500). His separate inpatient OB services product market share calculation is similarly flawed because it is also based on less than one year's worth of data and 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. (RPF 1501).

Moreover, Professor Town's market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

When market shares are measured using billed charges, rather than patient days, to reflect the fact that many DRGs and service lines cost more, require longer stays and, hence, generate higher revenues, St. Luke's has only a { } percent share of the general acute care inpatient services market, inclusive of inpatient OB services, for Lucas County. (RX-71(A)-000036-000037, *in camera*). { } combined have a higher share than ProMedica in Lucas County. (RX-71(A) at 000036-000037, *in camera*). Looking only at inpatient OB services, St. Luke's share is only { } percent based on billed charges in Lucas County. (RX-71(A) at 000036-000037, *in camera*). For all {

} of all hospitals in Lucas County based on billed charges. (RX-71(A)-000036-000037, *in camera*).

Finally, the proposed finding is misleading because it overlooks the fact that St. Luke's only treats about ten commercially insured patients per day, only one of which is an expectant mother. (RFP 1147; PX02137 at 055, *in camera*). Also, the proposed finding is contradicted by Mercy's own documents which show that {

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

b. Overlapping Service Areas and Patient Origin Data Further Reflect the Close Competition Between St. Luke's and ProMedica Before the Acquisition

333. There is significant overlap between the primary service areas of St. Luke's and ProMedica hospitals, which is direct evidence that they were head-to-head competitors before the Acquisition. (PX02148 at 041 (¶ 76) (Town Expert Report), *in camera*; Shook, Tr. 933-934).

Response to Finding No. 333:

This proposed finding is inaccurate and misleading. ProMedica hospitals draw from almost exactly the same zip codes as their Mercy counterparts. (RPF 1117). On the other hand, St. Luke's has significantly less overlap with ProMedica hospitals' draw areas. (RPF 1118). Even within its own zip code, St. Luke's is unable to attract a majority of patients seeking general acute care inpatient services. (RPF 224). In fact, St. Luke's attracts only ten commercially insured patients per day. (RPF 1147; PX02137 at 055, *in camera*).

334. Based on patient origin data, patients in St. Luke's service area choose TTH the most if they do not go to St. Luke's. (Rupley, Tr. 1945). For OB, if patients in St. Luke's primary service area do not go to St. Luke's, they also are most likely to go to TTH. (Rupley, Tr. 1946).

Response to Finding No. 334:

This proposed finding is inaccurate and misleading. First, St. Luke's core service area is not the relevant geographic market and focusing on market share in this area distorts St. Luke's competitive significance. (RPF 1036-1049). As Complaint Counsel and their economic expert agree, the relevant geographic market is all of Lucas County and hospitals compete for patients across that market. (RPF 1028-1030).

Second, this proposed finding mischaracterizes the data and the issue. The data show that for St. Luke's largest payor, MMO, {

.} (RPF 1133). In addition, the largest percentage of patients for any MCO would divert to Mercy, not St. Luke's, if ProMedica were not available. (PX01850 at 020, *in camera*). {

}

(RPF 1139, *in camera*).

c. Consumer Preference Surveys Confirm that St. Luke's and ProMedica Were the Top Two Choices for Many Patients

335. A 2006 survey conducted for St. Luke's revealed that in St. Luke's core service area, St. Luke's (45%) and TTH (24%) were the top two hospitals that came to mind when consumers were asked about hospitals in the area. (PX01352 at 007; Wakeman, Tr. 2521). The consumer survey found that St. Luke's was preferred by 44% of consumers in the core service area and TTH was second with 21%. (PX01352 at 007; Wakeman, Tr. 2522).

Response to Finding No. 335:

The proposed finding is misleading. The document cited, PX01352, does not reveal the number of residents contacted for the survey. (PX01352). Also, St. Luke's core service area is not the relevant geographic market and focusing on shares in this area distorts St. Luke's competitive significance. (RPF 1036-1049). As Complaint Counsel and their economic expert agree, the relevant geographic market is all of Lucas County and hospitals compete for patients across that market. (RPF 1028-1030). Actual data presented by Complaint Counsel's own economic expert show that even in St. Luke's core service area, the majority of patients seek care from hospitals other than St. Luke's. (RFP 1480-1481). In addition, a diversion analysis showed that there is actually more diversion from St. Luke's to Mercy than from St. Luke's to ProMedica. (RPF 1135-1136).

In addition, the data show that for St. Luke's largest payor, MMO, {

} (RPF 1128). {

} (RPF 1133).

In addition, the largest percentage of patients for any MCO would divert to Mercy, not St. Luke's, if ProMedica were not available. (PX01850 at 020, *in camera*).

336. In a 2008 survey conducted for St. Luke's in the ordinary course of business, consumers ranked St. Luke's and TTH first and second in patient preference and awareness within St. Luke's primary service area. (PX01077 at 009-014; Wakeman, Tr. 2523). Forty-two percent of residents in St. Luke's primary service area selected TTH as St. Luke's most direct competitor and another 8 percent selected Flower Hospital. (PX01169 at 042; Rupley, Tr. 1958-1959). UTMC was selected by 8 percent and St. Vincent by 16 percent of residents. (PX01169 at 042; Rupley, Tr. 1958-1959).

Response to Finding No. 336:

The proposed finding is misleading. St. Luke's core service area is not the relevant geographic market and focusing on market share in this area distorts St. Luke's competitive significance. (RPF 1036-1049). As Complaint Counsel and their economic expert agree, the relevant geographic market is all of Lucas County and hospitals compete for patients across that market. (RPF 1028-1030). Actual data presented by Complaint Counsel's own economic expert show that even in St. Luke's core service area, the majority of patients seek care from hospitals other than St. Luke's. (RFP 1480-1481). In addition, a diversion analysis showed that there is actually more diversion from St. Luke's to Mercy than from St. Luke's to ProMedica. (RPF 1135-1136). The data show that for St. Luke's largest payor, MMO, {

} (RPF 1128). {

.} (RPF 1133).

The largest percentage of patients for any MCO would divert to Mercy, not St. Luke's, if ProMedica were not available. (PX01850 at 020, *in camera*).

This proposed finding is also inaccurate as to the documents cited. The document cited, PX01077, reveals that only 400 people responded to the survey out of a population that

generated over 16,000 discharges in 2007. (*Compare* PX01077 at 7 *with* PX01077 at 5). The survey referred to in PX01077 also sampled those 400 residents immediately after St. Luke's conducted an advertising campaign and represents only where patients would prefer to go, not where they actually would go for treatment. (PX01077 at 007). Document PX01169 also reflects answers to questions asked immediately after a St. Luke's advertising campaign. (Rupley, Tr. 2061-2062).

337. In the same 2008 survey, St. Luke's was selected most often as the preferred hospital for "routine care," followed by TTH. (PX01169 at 015; Rupley, Tr. 1953-1955). For obstetrics ("[m]aternity"), TTH, St. Luke's, and Flower ranked as the top three preferred hospitals. (PX01077 at 013).

Response to Finding No. 337:

This proposed finding is also inaccurate as to the documents cited. Document PX01169 reflects answers to questions asked immediately after a St. Luke's advertising campaign that promoted St. Luke's heart services and provided information on what St. Luke's perceived to be its "value equation." (Rupley, Tr. 2061-2062). The 400 telephone interviews on which the study was based were conducted during a narrow window, between September 3, 2008 and September 13, 2008, near the conclusion of St. Luke's advertising campaign. (PX01169-003; Rupley, Tr. 2061-2062). In addition, a diversion analysis of actual patient data showed that there is actually more diversion from St. Luke's to Mercy than from St. Luke's to ProMedica. (RPF 1135-1136). The data show that for St. Luke's largest payor, MMO, {

} (RPF 1128). {

} (RPF 1133).

d. Diversion Analysis Demonstrates that ProMedica and St. Luke's Were Close Substitutes

338. Diversion analysis is a commonly used method to quantify the degree of substitutability between hospitals or hospital systems. In the context of a hospital merger, the exercise is: if a given hospital was not available to patients, where would they go to seek inpatient care? (Town, Tr. 3771, *in camera*).

Response to Finding No. 338:

Respondent has no specific response.

339. Diversion analysis relies on hospital claims data, and estimates a hospital choice model by examining the choices patients make with respect to which hospital to use. (Town, Tr. 3772-3773, *in camera*; PX02148 at 046-047 (¶ 88) (Town Expert Report), *in camera*).

Response to Finding No. 339:

Respondent has no specific response.

340. The higher the diversion, the higher is the substitutability of the hospitals. (Town, Tr. 3773, *in camera*; PX02148 at 046-047 (¶ 88) (Town Expert Report), *in camera*).

Response to Finding No. 340:

Respondent has no specific response.

341. For { } patients, if St. Luke's were not available to patients, { } of those patients would have gone to a ProMedica hospital, { } would have gone to a Mercy hospital and { } would have gone to UTMC. (Town, Tr. 3775-3776, *in camera*; PX01850 at 020 (Table 3) (Town Rebuttal Report), *in camera*). Diversion analysis for { } patients reveals that ProMedica is St. Luke's closest competitor. (Town, Tr. 3775-3776, *in camera*; PX01850 at 020 (Table 3) (Town Rebuttal Report), *in camera*).

Response to Finding No. 341:

This proposed finding is misleading. Professor Town's own diversion analysis shows that, in 2010, for { } patients, if *ProMedica* were not available to patients, { } of those patients would have gone to a *Mercy* hospital, while only { } would have gone to St. Luke's. (PX01850 at 020, *in camera*). This shows that for { }, ProMedica and Mercy were each other's closest competitors. (RX-71(A) at 000028, *in camera*). Professor Town's diversion analysis using 2010 data shows similar results for { } (PX01850 at

020, *in camera*). {

} (RPF 1139, *in camera*).

342. For { } patients, if ProMedica were not available, the second largest number of patients ({ }) would have gone to St. Luke's. (Town, Tr. 3776, *in camera*; PX01850 at 020 (Table 3) (Town Rebuttal Report), *in camera*).

Response to Finding No. 342:

This proposed finding is misleading. Professor Town's own diversion analysis shows that, in 2010, for { } patients, if ProMedica were not available to patients, the largest percentage of patients - { } – would have gone to a *Mercy* hospital, while only { } would have gone to St. Luke's. (PX01850 at 020, *in camera*). This shows that for { }, ProMedica and Mercy were each other's closest competitors. (RX-71(A) at 000028, *in camera*). Professor Town's diversion analysis using 2010 data shows similar results for { } (PX01850 at 020, *in camera*). { }

(RPF 1139, *in camera*).

343. Professor Town's diversion analysis demonstrates that ProMedica is St. Luke's closest substitute for { } For { }, St. Luke's is ProMedica's closest substitute and for { }, ProMedica is the second-closest substitute for St. Luke's. (Town, Tr. 3777, *in camera*; PX01850 at 020 (Table 3) (Town Rebuttal Report), *in camera*).

Response to Finding No. 343:

This proposed finding mischaracterizes the data and the issue. The data show that ProMedica and Mercy are closest substitutes as the largest percentage of patients for any MCO would divert to Mercy, not St. Luke's, if ProMedica were not available. (PX01850 at 020, *in camera*). {

} (RPF 1139, *in camera*). But even for St. Luke's largest payor, MMO, St. Luke's faces a greater risk of loss to Mercy (and UTMC) than to ProMedica. (RX-71(A) at 000028, *in camera*). MMO also {

} (RX-71(A) at 000191-193, *in camera*).

344. In a year-by-year diversion analysis, { } enrollees' diversion from St. Luke's to ProMedica is increasing, reflecting the relatively recent addition of ProMedica to { } network. (Town, Tr. 3780-3781, *in camera*; PX01850 at 018 (Table 2) (Town Rebuttal Report), *in camera*).

<u>Response to Finding No. 344:</u>

Respondent has no specific response.

345. Based on the diversion analysis, { } is ProMedica's closest substitute and St. Luke's is ProMedica's second-closest substitute. (Town, Tr. 3777-3778, *in camera*; PX01850 at 020 (Table 3) (Town Rebuttal Report), *in camera*). A higher diversion to { } from ProMedica only implies that a merger between those two systems may be even more anticompetitive than the merger between St. Luke's and ProMedica. (Town, Tr. 3777-3778, *in camera*).

<u>Response to Finding No. 345:</u>

This proposed finding reaches an improper legal conclusion. A higher diversion to Mercy from ProMedica shows that ProMedica and Mercy were and are each other's closest competitors. (RX-71(A) at 000028). {

}

(RPF 1139, *in camera*). Also, with four competitors among Lucas County hospitals, St. Luke's was also by definition ProMedica's second-furthest substitute.

e. St. Luke's is a Significant Competitor in Lucas County

346. St. Luke's provides care to a significant number of commercial patients in the Lucas County market. (PX02148 at 171 (Ex. 16) (Town Expert Report), *in camera*; PX01920 at 014-015 (Wakeman, Dep. at 49-51), *in camera*; PX01409 at 001 (Jul. 2011 Wakeman email)).

Response to Finding No. 346:

This proposed finding is inaccurate and misleading. First, Professor Town's Exhibit 16 is based on less than one year's worth of data – from the third quarter of 2009 to the first quarter of 2010. (PX02148 at 171). Second, looking at full years of data, from 2007 through 2009 shows that St. Luke's provides care to, on average, { } (PX02137 at 055, *in camera*). In contrast, ProMedica provides care to { } (PX02137 at 056, *in camera*).

347. St. Luke's is the third-largest hospital in the market based on commercial volume: St. Luke's had 2,846 commercial discharges between July 1, 2009 and March 31, 2010, exceeded only by St. Vincent and TTH. (PX02148 at 171 (Ex. 16) (Town Expert Report), *in camera*). By July 2010, St. Luke's had surpassed UTMC, Flower Hospital, and St. Charles Hospital to serve the third-largest number of patients in the market based on total discharges and outpatient visits. (Wakeman, Tr. 2599-2560; PX01920 at 014-015 (Wakeman, Dep. at 49-51), *in camera*; PX01409 at 001 (Jul. 2011 Wakeman email)).

Response to Finding No. 347:

This proposed finding is inaccurate and misleading. Professor Town's Exhibit 16 is based on less than one year's worth of data – from the third quarter of 2009 to the first quarter of 2010. (PX02148 at 171, *in camera*). In addition, PX01409 refers to volumes only in the month of May, not through June 2010. (PX01409 at 001). Finally, outpatient visits are not part of the relevant product market, thus including outpatient visits to determine size of hospital based on discharges is misleading. (RPF 1001, 1013).

348. St. Luke's is important to health plans because it enhances the marketability of their provider networks. (Pirc, Tr. 2202-2203).

Response to Finding No. 348:

Respondent has no specific response.

349. Anthem's Regional Vice President, James Pugliese, testified that {MMO advertised having St. Luke's in its network as a "distinguishing area that they could promote as having a broader network than Anthem's."} (Pugliese, Tr. 1481, *in camera*).

Response to Finding No. 349:

Respondent has no specific response.

350. Mr. Pugliese testified that his having written {
} was "probably a reflection on the fact that there were certain health plans that [Anthem] competed against that had St. Luke's and [Anthem] did not." (Pugliese, Tr. 1484-1485, *in camera* (referring to PX02296, *in camera* (Anthem's 2008 ProMedica negotiation notes))).

Response to Finding No. 350:

Respondent has no specific response.

351. "I believe that the notion that there was a competing health plan [{ }] out there that offered a broader access network than we did { }, and I would use that [information] in my conversations with ProMedica to help them understand {
}." (Pugliese, Tr. 1482-1483, *in camera*).

Response to Finding No. 351:

The proposed finding is misleading and contradicted by the fact that between 2005 and 2008 when Anthem only had 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).

352. ProMedica expected that St. Luke's addition to Paramount after the Acquisition would "certainly open up opportunities for membership growth at Paramount." (Randolph, Tr. 7100-7101, *in camera*). Indeed, the addition of St. Luke's to Paramount's network had a positive impact on Paramount's business. (Randolph, Tr. 7062). Since St. Luke's joined Paramount, two employers in the area – the City of Maumee Schools and Anthony Wayne Schools – switched to Paramount from other health plans. (Randolph, Tr. 7008-7010).

Response to Finding No. 352:

The proposed finding is misleading. Mr. Randolph testified that Maumee City Schools switched to Paramount in part because Paramount was a lower cost option. (Randolph, Tr. 7010-7015). Mr. Randolph goes on to testify that the addition of St. Luke's has not been a "significant impact" for Paramount and that Paramount would expect to see a bigger increase in Medicare patients than commercially insured patients due to the addition of St. Luke's. (Randolph, Tr. 7014).

353. Prior to the Acquisition, ProMedica and St. Luke's also competed to attract and retain physicians. (Oostra, Tr. 6040-6041).

Response to Finding No. 353:

Respondent has no specific response.

354. Up until the Acquisition, there were benefits to the community that resulted from competition between St. Luke's and ProMedica because competition "keeps everybody on their toes." (Oostra, Tr. 6043-6044).

Response to Finding No. 354:

This proposed response mischaracterizes Mr. Oostra's testimony. Mr. Oostra's testimony actually stated that "competition keeps everybody on their toes and so a competitive market in that case would keep us all doing, you know, the type of things we need to do for patients." (Oostra, Tr. 6043-6044).

2. Independent St. Luke's Impacted ProMedica's Bottom Line

355. Prior to the Acquisition, St. Luke's goal was to regain patient volume in St. Luke's core and primary service areas from ProMedica. (Wakeman, Tr. 2505).

Response to Finding No. 355:

Respondent disputes this proposed finding as it mischaracterizes the record and is misleading. Mr. Wakeman did believe that the primary issue facing St. Luke's prior to the joinder was its decline in activity and need for growth. (RPF 1895). However, Mr. Wakeman testified that prior to the joinder, St. Luke's "would have liked" to regain patient volume in St.

Luke's core and primary service areas, "and ProMedica was *one* of the systems from which we would have liked to have brought that service back to St. Luke's from those other organizations." (Wakeman, Tr. 2505) (emphasis added). In other words, St. Luke's goal was to regain patient volume from *all* providers in its core and primary service areas, not just from ProMedica. (RPF 1895; Wakeman, Tr. 2505).

356. The 2010 ProMedica Environmental Assessment concluded that

} (PX00159 at 005, *in camera*). The same report noted, {

(PX00159 at 012, *in camera*). One percent of ProMedica's 2009 gross revenue represents tens of millions of dollars. (PX00322 at 001 (ProMedica Gross Revenues 1Q2009)).

Response to Finding No. 356:

Respondent disputes this proposed finding of fact because it is misleading and it mischaracterizes the record. This finding suggests that one percent of ProMedica's inpatient market share corresponds to one percent of ProMedica's gross revenue. Yet, in violation of the ALJ's Order on Post-Trial Briefs, Complaint Counsel fail to cite to specific references in the evidentiary record to support this suggestion. The proposed finding is clearly contradicted by the record. To start, the documents Complaint Counsel cite do not limit market shares to just commercially insured patients and do not reflect the payor mix of ProMedica's inpatient market. (PX00159, *in camera*). In reality, only { } of the Toledo Hospital's 2009 patient days were derived from commercially insured patients. (PX02148 at 171, *in camera*). In other words, approximately { } were derived from government payors, which reimburse *below the cost of care* and are not included within either of Complaint Counsel's alleged relevant markets. (RPF 250-251; Compl. at ¶¶ 12, 14).

Furthermore, "gross revenues" encompass more than just inpatient reimbursement. (Hanley, Tr. 4574 (Gross revenues include all "charges that a hospital would charge.")). Indeed, in the commercial market, a larger portion of MCOs' payments to hospitals are for outpatient services than for inpatient. (RPF 36, *in camera*; RPF 308). Therefore, it is misleading of Complaint Counsel to imply that one percent of ProMedica's inpatient market share corresponds to one percent of ProMedica's gross revenue.

357. The Environmental Assessment is a document created annually by ProMedica and presented to the Board of Trustees, after being reviewed by ProMedica's CEO, among others. (PX01947 at 020-021 (Oostra, Dep. at 72, 74-75), *in camera*). Considerable effort is put into ensuring the accuracy of the Environmental Assessment. (PX01947 at 020 (Oostra, Dep. at 73), *in camera*).

Response to Finding No. 357:

Respondent has no specific response.

358. Real-world natural experiments in the marketplace confirm that St. Luke's successfully competed with ProMedica for a significant number of patients. For example, ProMedica estimated that St. Luke's readmission to { } network in 2009, after being excluded since 2005, would cost ProMedica { } in gross margin annually. (PX00333 at 002, *in camera* (ProMedica's Anthem negotiation notes)) This equates to approximately { } in revenues. (Wachsman, Tr. 5204, *in camera*).

Response to Finding No. 358:

Respondent disputes this proposed finding of fact as it mischaracterizes the record. ProMedica estimated that St. Luke's readmission to { } network would cost it { } in gross margin annually, which equates to approximately { } in revenues, but Complaint Counsel do not cite to any *specific* record evidence, as required by the ALJ's Order on Post-Trial Briefs, that "St. Luke's successfully competed with ProMedica for a significant number of patients," nor do they define what constitutes a "significant number of patients."

359. ProMedica expected that volume shifts to St. Luke's away from ProMedica hospitals would "undoubtedly occur" after St. Luke's joined Paramount pursuant to the Acquisition. (Randolph, Tr. 7099-7100, *in camera*). In particular, ProMedica expected

patients residing in the area around St. Luke's to be most likely to switch from ProMedica hospitals to St. Luke's. (Randolph, Tr. 7100, *in camera*).

Response to Finding No. 359:

Respondent disputes this finding of fact because it mischaracterizes the record and is misleading. To begin, St. Luke's and ProMedica entered into a Joinder Agreement, not an "Acquisition." (RPF 991-1000). In addition, Complaint Counsel do not define what they consider to be the "area around St. Luke's." In fact, ProMedica analyzed St. Luke's top 22 zip codes, where 85 percent of St. Luke's business comes from, and which Mr. Randolph described as "pretty broad." (Randolph, Tr. 7101, *in camera*). Furthermore, ProMedica's analysis {

} (PX00425, *in camera*; Randolph, Tr. 7101, *in camera*). Moreover, St. Luke's believes that {

} (Wakeman, Tr. 3025, *in camera*).

360. According to Dr. Andreshak, after St. Luke's became an in-network provider for Paramount patients, the "majority of patient requests" were to have their surgery at St. Luke's instead of TTH. (Andreshak, Tr. 1759-1760).

Response to Finding No. 360:

Respondent disputes this proposed finding of fact because Complaint Counsel mischaracterize the testimony. Complaint Counsel imply that the majority of *all* patient requests post-joinder were to have their surgery at St. Luke's instead of TTH. Dr. Andreshak testified that since the joinder, he performs more surgeries at St. Luke's than prior to the joinder because, in part, of the "majority of the patient requests" from *his* patients. (Andreshak, Tr. 1759). He did not testify to the requests of all patients and lacks the foundation to do so.

361. ProMedica estimated that St. Luke's readmission to Paramount's network would lead to a reduction of 255-344 commercial inpatient admissions (and hundreds of outpatient procedures) at ProMedica hospitals each year. (PX00040 at 007-008, *in camera* (Compass Lexicon analysis of adding St. Luke's to Paramount); *see also* PX00236 at 002 (ProMedica 2008 analysis)).

Response to Finding No. 361:

Respondent disputes the proposed finding because it mischaracterizes the record. The document Complaint Counsel cite, PX00040, *in camera*, does not state that ProMedica hospitals would have a "reduction" of { } each year. Rather, the document states that an estimated { } if St. Luke's was added to Paramount's network. (PX00040 at 007, *in camera*). Moreover, St. Luke's believes that { } (Wakeman, Tr. 3025, *in camera*).

362. ProMedica estimated that the impact on Flower Hospital alone would be { } of lost margin annually. (PX00240 at 002, *in camera* (ProMedica emails regarding patient diversion from Flower to St. Luke's); PX00291 at 001, *in camera* (ProMedica emails discussing impact of St. Luke's on Flower). The loss of admissions and "the potential for the acute care impact (loss) to be bigger over time" concerned ProMedica executives. (PX00236 at 001 (ProMedica email and analysis of adding St. Luke's to Paramount)).

Response to Finding No. 362:

Respondent disputes this proposed finding of fact as it is a misstatement of the record. ProMedica did not estimate that the impact on Flower Hospital of St. Luke's readmission to Paramount would be { }. Rather, ProMedica estimated that the potential risk of loss to Flower Hospital was { } (PX00240 at 002, *in camera*). It was a worst case scenario, not an impact estimate.

Furthermore, this proposed finding is misleading. Complaint Counsel cite to PX00236 - a document created over a year before the joinder between ProMedica and St. Luke's was even *considered* - as evidence of the estimated impact of adding St. Luke's to Paramount's network as a result of the joinder. Any estimate from this time period fails to take into consideration the system-wide impacts of adding St. Luke's to ProMedica Health System.

363. ProMedica estimated that some of the losses would be offset by an increase in membership for Paramount – up to 15,000 new members – solely from the addition of St. Luke's into the Paramount network. (PX00040 at 008, *in camera* (Compass Lexicon analysis of adding St. Luke's to Paramount); *see also* PX00236 at 002) (ProMedica 2008 analysis)).

Response to Finding No. 363:

Respondent disputes this proposed finding of fact as it is an incomplete statement of the record, mischaracterizes the record, and is misleading. ProMedica did estimate that { } (PX00040 at 008, *in camera*). But the document Complaint Counsel cite does not end there: "The more likely scenario" is that { } (PX00040 at 008, *in camera*). Of those, 3,000 consisted of St. Luke's employees. (Randolph, Tr. 7103, *in camera*).

Complaint Counsel cite to this same document to support their statement that "an increase in membership for Paramount...solely from the addition of St. Luke's into Paramount's network" would offset "some of the losses." Complaint Counsel is presumably referring to the "losses" it described in the previous finding, CCPF 362, which have already been addressed as inaccurate. (*See* RPF 362).

Furthermore, Complaint Counsel cite to PX00236, a document created over a year before the joinder between ProMedica and St. Luke's was even contemplated, as evidence of the estimated impact of adding St. Luke's to Paramount's network as a result of the joinder. This is misleading.

364. St. Luke's believed that if they were readmitted to Paramount that {
}. (Rupley, Tr. 2010, *in camera*).

Response to Finding No. 364:

Respondent disputes this proposed finding as a mischaracterization of the record. Mr. Rupley testified that "some patients from [St. Luke's] service area that were going to Toledo Hospital for services *might* come to St. Luke's Hospital instead" if St. Luke's was in-network at Paramount. (Rupley, Tr. 2010, *in camera*) (emphasis added).

B. ProMedica Took Aim at St. Luke's as a Significant Marketplace Competitor

1. Exclusions from Third-Party Health Plans

365. St. Luke's significance as a competitor is illustrated by the fact that ProMedica sought to have third-party health plans exclude St. Luke's from their hospital provider networks and ProMedica refused to admit St. Luke's into Paramount's provider network. (*See, e.g.,* Joint Stipulations of Law and Fact, JX00002A ¶ 18; PX01127 at 001 (St. Luke's competitor assessment); PX00231 at 015, *in camera* (2008 ProMedica/Anthem Letter of Agreement); PX01233 at 005, *in camera* (Nov. 2009 St. Luke's presentation)).

Response to Finding No. 365:

Respondent disputes the proposed finding because it mischaracterizes the record and is misleading. ProMedica did not seek to "exclude" St. Luke's because of its "significance as a competitor;" it {
} (Guerin-Calvert, Tr. 7813-7814, *in camera*; Wachsman, Tr. 5153, *in camera*; RPF 739-741, 776, *in camera*).

Furthermore, Complaint Counsel's reliance on a St. Luke's pre-joinder document (PX01233, *in camera*) for their statement that "ProMedica refused to admit St. Luke's into Paramount's provider network" is misleading, and clearly contradicted by the record. The record reveals that St. Luke's and Paramount could not come to a mutually acceptable agreement to admit St. Luke's into Paramount's provider network. (Rupley, Tr. 1938-1940; RPF 784-799).

For its part, Paramount decided not to include St. Luke's in its provider network because St. Luke's rate proposals were not acceptable to Paramount. (RPF 799; Randolph, Tr. 6997-7001). Prior to St. Luke's and Paramount being unable to reach a renewal agreement in 2000, Paramount purchased a small health plan called "Medical Value Plan." (RPF 791). Paramount discovered through that purchase 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. (RPF 792). During contract renewal negotiations with St. Luke's in 2000, Paramount wanted the Medical Value Plan pricing to apply to the Paramount business. (RPF 793). St. Luke's, on the other hand, deemed those rates to be too low, and instead asked for the old Paramount pricing to apply to the Medical Value Plan business. (RPF 794-795). St. Luke's and Paramount were unable to come to an agreement on rates, and the two mutually parted ways. (RPF 796; Rupley, Tr. 1938-1940).

366. St. Luke's was out of Anthem's network from 2005 to July 2009. (Pugliese, Tr. 1477, *in camera*). There were "{ } in the contract between Anthem and ProMedica in terms of { }." (Pugliese, Tr. 1483, *in camera*; Rupley, Tr. 1962-1963). The 2007 Letter of Understanding between ProMedica and Anthem "speaks specifically to St. Luke's as a west-side Lucas County hospital and that there was some { } in the LOA related to that." (Pugliese, Tr. 1489, 1491, *in camera* (referring to PX02245)).

Response to Finding No. 366:

Respondent disputes the proposed finding of fact because it mischaracterizes the testimony and is an incomplete statement of the record. Complaint Counsel cite to St. Luke's employee, Mr. Rupley's testimony, regarding the terms of a contract between Anthem and ProMedica prior to the joinder. Mr. Rupley has no foundation for the terms of the Letter of Agreement, and even testified that his understanding "may not have been accurate." (Rupley, Tr. 1963).

In addition, Complaint Counsel cite to Mr. Pugliese's testimony that a 2007 Letter of Understanding "speaks specifically to St. Luke's as a west-side Lucas county hospital and that there was some { } in the LOA related to that." (Pugliese, Tr. 1489, 1491, *in camera* (referring to PX02245)). In fact, PX02245 states: "Preservation of Anthem's agreement under the LOA not to add additional west side Lucas County hospital providers of non-emergency services to its Managed Care Networks." (PX02245).

367. During 2007-2008 contract negotiations, Anthem informed ProMedica that it wanted to add St. Luke's back into its provider network. (Pugliese, Tr. 1479, 1482-1483, *in camera*).

Response to Finding No. 367:

Respondent disputes this proposed finding of fact because the statement is not reflected in Complaint Counsel's citation to the record. Otherwise, Respondent has no specific response.

368. ProMedica resisted Anthem's interest in adding St. Luke's to its network. As Mr. Pugliese testified, "They were arguing that in essence Anthem didn't need to have St. Luke's to be successful in the marketplace and that they would – it was their preference that we would not add them." (Pugliese, Tr. 1488, *in camera*; *see also* Pugliese, Tr. 1493, *in camera* ("They were suggesting that we not add [St. Luke's].")). ProMedica did not want Anthem to add St. Luke's because it would have resulted in ProMedica losing volume by virtue of another competing hospital (St. Luke's) being available to Anthem's members. (Pugliese, Tr. 1488-1489, *in camera*). Anthem told ProMedica that { } (Pugliese, Tr. 1493, *in camera*).

Response to Finding No. 368:

Respondent has no specific response.

369. Ultimately, the issue was resolved by { } the time when St. Luke's would be added to the Anthem network and "there was a { } associated with bringing St. Luke's in." (Pugliese, Tr. 1493, *in camera*).

Response to Finding No. 369:

Respondent has no specific response.

370. ProMedica provided Anthem a discount to continue to exclude St. Luke's { }. (Joint Stipulations of Law and Fact, JX00002A

¶ 18; PX00231 at 015, *in camera* (2008 ProMedica/Anthem Letter of Agreement)). St. Luke's was added to Anthem's network on July 1, 2009 and, as a result, Anthem was required under its contract with ProMedica to pay ProMedica { } higher rates at all of its Lucas County hospitals. (Pugliese, Tr. 1497-1498, *in camera*; PX00231 at 015, *in camera* (2008 ProMedica/Anthem Letter of Agreement)).

Response to Finding No. 370:

Respondent disputes this proposed finding because it is an incomplete statement of the record. The agreement between { } and ProMedica to exclude St. Luke's was the result of mutual agreement. (RPF 761-764, *in camera*, 765-766, 767-773, *in camera*). {

} (RPF 761, *in camera*). In return, {

} (RPF 764, *in camera*). 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. (RPF 774). 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. (RPF 775). Moreover, {

.} (RPF 776, *in camera*). Volume discounts are based on the fact that when there are more providers in a MCOs product, each providers' volume decreases, and the corresponding discount the providers give the MCO also decreases. (Hanley, Tr. 4772, *in camera*). Therefore, the differences in rates are tied to volume changes. (Hanley, Tr. 4772-

4773, *in camera*). The volume discounts that ProMedica negotiated with { } were not tied specifically to { } but were based on the overall number of providers in the market. (Hanley, Tr. 4773, *in camera*). Such an arrangement is not unusual; other hospitals, including Mercy, "extend lower rates for exclusivity or a narrower panel and higher rates as the panel expands." (Shook, Tr. 1063).

{

} (RPF 778, *in camera*).

371. During the 2008 contract negotiations with Anthem, Ronald Wachsman, ProMedica's executive responsible for managed care contracting, wrote in an internal e-mail that Anthem "would add [St. Luke's] as soon as they are able" but that they "will have to pay PHS for the privilege." (PX00380 at 001 (May 2008 Wachsman e-mail)).

Response to Finding No. 371:

Respondent disputes this proposed finding because it is an incomplete statement of the record and it mischaracterizes the record. The "privilege" Mr. Wachsman was referring to was the term of the agreement for which Anthem had negotiated; that is, an increase in reimbursement rates to ProMedica if Anthem added St. Luke's. (Wachsman, Tr. 5205-5206). Once Anthem broadened its network to include St. Luke's, its contract with ProMedica 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. (RPF 774). 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. (RPF 775). The volume discounts that ProMedica negotiated with { } were not tied specifically to { } but were based on the overall number of providers in the market and anticipated volume changes.

(Hanley, Tr. 4773, *in camera*). Such an arrangement is not unusual; other hospitals, including Mercy, "extend lower rates for exclusivity or a narrower panel and higher rates as the panel expands." (Shook, Tr. 1063).

{

} (RPF 778, *in camera*).

372. The issue of St. Luke's exclusion from Anthem's network was described as the "main deal breaker" for ProMedica in its negotiations with Anthem and as requiring a "huge effort" to accomplish. (PX00295 at 001, *in camera* (2008 ProMedica email regarding Anthem negotiations)). The issue was important enough that ProMedica's then-CEO Alan Brass, who only rarely participated directly in managed care contracting issues, became involved. (PX00295 at 001, *in camera* (2008 ProMedica email regarding Anthem negotiations); Wachsman, Tr. 4894, 5207-5208, *in camera*).

Response to Finding No. 372:

Respondent disputes this finding because it is an incomplete statement of the record and is misleading. Mr. Wachsman clarified in his testimony that he meant that St. Luke's "exclusion" was a key term in the negotiation, not a literal deal breaker, and that ProMedica { }

(Wachsman, Tr. 5005, *in camera*, 5209-5210).

373. ProMedica wanted to have Anthem exclude St. Luke's because ProMedica and St. Luke's compete for the same patients, and St. Luke's inclusion in Anthem's network would have a negative impact on ProMedica. (Wachsman, Tr. 5153-5154, 5200-5201, *in camera*; PX00328 at 001, *in camera* (ProMedica's Anthem notes).

Response to Finding No. 373:

Respondent disputes this proposed finding because it is an incomplete statement of the record and is misleading. ProMedica {

} (Guerin-Calvert, Tr. 7813-7814, *in camera*; Wachsman, Tr. 5153, *in camera*).

Although ProMedica did anticipate that { } inclusion in { } network would have some impact on ProMedica, the record clearly shows that ProMedica was more concerned with the impact from { } inclusion in { } network. For example, {

} (RPF 776, *in camera*).

374. ProMedica told Mr. Pugliese that { } was needed to compensate ProMedica for the expected loss in volume from ProMedica to St. Luke's. (Pugliese, Tr. 1499-1500, *in camera*). ProMedica sought the { } in order to offset an expected loss in revenues of approximately { } at ProMedica's Lucas County hospitals. (Wachsman, Tr. 5203-5204, *in camera*).

Response to Finding No. 374:

Respondent has no specific response.

375. Mercy was added back to Anthem's network 18 months before St. Luke's. (Pugliese, Tr. 1539).

Response to Finding No. 375:

Respondent has no specific response.

376. ProMedica sought to exclude St. Luke's from { } network because St. Luke's is a close competitor to ProMedica. (Town, Tr. 3768-3769, *in camera*).

Response to Finding No. 376:

The proposed finding violates the ALJ's Order on Post-Trial Briefs by citing testimony that was elicited for a purpose other than the truth of the matter asserted. It is a statement of opinion by Complaint Counsel's expert witness, not fact, and Respondent's counsel objected at the hearing. (Town, Tr. 3767-3768, *in camera*).

Furthermore, the proposed finding is an incomplete statement of the record. Complaint Counsel do not cite to any factual evidence for support, and the record clearly contradicts the proposed finding. {

} (RPF 776, *in camera*). Indeed, Complaint Counsel's economic expert admitted that "Mercy is ProMedica's closest substitute," not St. Luke's. (Town, Tr. 4058; RPF 1116).

377. ProMedica also sought to exclude St. Luke's from { } network and indicated to { } that this would be "an advantage to them." (PX02267 at 001, *in camera* (Cigna internal email)).

Response to Finding No. 377:

The proposed finding mischaracterizes the record. To begin, ProMedica did not seek to "exclude St. Luke's" from MCO networks; it {

} (Guerin-Calvert, Tr. 7813-7814, *in camera*; Wachsman, Tr. 5153, *in camera*).

In addition, Complaint Counsel do not support this finding with any specific reference to a ProMedica document or witness, even though the finding purports to explain ProMedica's point of view. Rather, Complaint Counsel only cite to a third party document (PX02267, *in camera*) as evidence of ProMedica's intentions. Even then, the finding misstates the evidence. The document states that "ProMedica would like to see St. Luke's out of the { } network." Even ignoring the foundation issue, the document does *not* state that ProMedica took any steps to exclude St. Luke's from { } network. (PX00267 at 001, *in camera*).

378. ProMedica evaluated opportunities to exclude St. Luke's from { } network. (PX00407 at 001, *in camera* (ProMedica's managed care strategy recommendations); Wachsman, Tr. 5215-5216, *in camera*).

Response to Finding No. 378:

The proposed finding mischaracterizes the record. ProMedica did not seek to "exclude St. Luke's" from MCO networks; it {

} (Guerin-Calvert, Tr. 7813-7814, *in camera*; Wachsman, Tr. 5153, *in camera*).

379. ProMedica also evaluated opportunities to exclude St. Luke's from { } network. (PX00407 at 001, *in camera* (ProMedica's managed care strategy recommendations); Wachsman, Tr. 5215-5216, *in camera*).

Response to Finding No. 379:

The proposed finding mischaracterizes the record. ProMedica did not seek to "exclude St. Luke's" from MCO networks; it {

} (Guerin-Calvert, Tr. 7813-7814, *in camera*; Wachsman, Tr. 5153, *in camera*).

380. Unlike ProMedica, Mercy did not take any action or engage in any practices to exclude St. Luke's from health plan provider networks. (Wakeman, Tr. 2538).

Response to Finding No. 380:

Respondent disputes this finding because it misstates the testimony. Mr. Wakeman stated that, *to his knowledge*, Mercy did not engage in any acts or practices to exclude St. Luke's from Paramount's and Anthem's networks. (Wakeman, Tr. 2538). Mr. Wakeman lacks the foundation to attest to the proposed finding advanced by Complaint Counsel.

2. ProMedica Excluded St. Luke's From Paramount's Provider Network

381. St. Luke's was not a Paramount provider from 2001 until August 31, 2010. (Joint Stipulations of Law and Fact , JX00002A ¶ 46; Rupley, Tr. 1940-1941; Randolph, Tr. 7078). Paramount had wanted to add St. Luke's back into its network "from time to time" during that time. (Oostra, Tr. 6045). However, Alan Brass, former CEO of ProMedica, had concerns about St. Luke's participation in Paramount's network. (Randolph, Tr. 7077). Similarly, Mr. Oostra did not think it was worthwhile to add St. Luke's and "cannibalize" the existing ProMedica hospitals. (Oostra, Tr. 6045-6046).

Response to Finding No. 381:

Respondent disputes this finding of fact as it misstates and mischaracterizes the record. Mr. Oostra did not state that "Paramount had wanted to add St. Luke's back into its network 'from time to time.'" Rather, he testified that "Paramount has from time to time *talked about* adding...St. Luke's back." (Oostra, Tr. 6045) (emphasis added). Furthermore, the record clearly shows that after St. Luke's left Paramount's network in 2001, neither St. Luke's nor Paramount pursued adding St. Luke's to Paramount's network until 2008. (RPF 786-790, 798; Rupley, Tr. 1938-1940) In fact, Paramount's President, Jack Randolph, repeatedly testified that he didn't advocate adding St. Luke's to Paramount's network until Dan Wakeman arrived at St. Luke's in 2008, and even then only if Paramount could get St. Luke's in at the "right economic terms" and an "effective cost ratio." (Randolph, Tr. 7015, 7018, 7079-7080; RPF 798; PX01910 (Randolph, IHT at 118-125)). Further, Ms. Hanley, ProMedica's Chief Financial Officer, testified that from a business-standpoint and based on the minor membership changes that occurred when St. Luke's left Paramount, St. Luke's did not add sufficient value to Paramount that would justify bringing St. Luke's back into Paramount. (Hanley, Tr. 4786). After Wakeman's arrival, St. Luke's submitted rate proposals to Paramount, but they were not cost-effective or acceptable to Paramount. (RPF 799; PX01910 (Randolph, IHT at 125-126)). Any concerns of Mr. Oostra's, or of Mr. Brass, did not impact Paramount's review of St. Luke's proposal. (PX01910 (Randolph, IHT at 118-125, 130, 136-137)).

Furthermore, the proposed finding is an incomplete statement of the record. Mr. Oostra did not think it was worthwhile to add St. Luke's to Paramount's network because "there was no reason to add them back into the system." (Oostra, Tr. 6045). Specifically, the loss of St. Luke's

as a hospital provider in Paramount's network in 2001 had little effect on Paramount's membership. (RPF 797; Oostra, Tr. 6045).

382. In 2008, after Mr. Wakeman became president and CEO, St. Luke's wanted to rejoin Paramount but was unsuccessful. (Rupley, Tr. 1940-1941). Mr. Rupley's understanding was that Paramount wanted to readmit St. Luke's, but that ProMedica overall did not, due to concerns that St. Luke's would draw Paramount patients away from ProMedica hospitals. (Rupley, Tr. 1940-1941; *see also* Randolph, Tr. 7077-7078).

Response to Finding No. 382:

This findings misleadingly cites to a Paramount employee's testimony as evidence to support a St. Luke's employee's personal understanding. Mr. Randolph has no foundation to testify to Mr. Rupley's personal understanding.

In addition, the finding is contradicted by the record. Paramount's President, Mr. Randolph, testified that Paramount only considered adding St. Luke's if it could get them in at the "right economic terms" and an "effective cost ratio." (Randolph, Tr. 7015, 7018, 7079-7080; 798). St. Luke's submitted rate proposals, but they were not cost-effective or acceptable to Paramount. (RPF 799; PX01910 (Randolph, IHT at 125-126)). Any concerns of Mr. Oostra's did not impact Paramount's review of St. Luke's proposal. (PX01910 (Randolph, IHT at 130, 136-137)).

383. Mr. Randolph, the President of Paramount, confirmed that he wanted to pursue the opportunity to bring St. Luke's back into Paramount in 2008. (Randolph, Tr. 7079-7080; PX00405 at 001). It was also clear to Mr. Oostra that in 2008 Mr. Randolph wanted to add St. Luke's to the Paramount network. (Oostra, Tr. 6053). The issue of St. Luke's participation in Paramount was important for both ProMedica and Paramount in 2008. (Randolph, Tr. 7082-7084).

Response to Finding No. 383:

Respondent disputes this finding of fact as it misstates and mischaracterizes the testimony and is an incomplete statement of the record. Mr. Randolph testified that the issue of St. Luke's participation in Paramount was only important to Paramount "to the extent [Paramount] could

add St. Luke's at a cost-effective rate that did not impede [Paramount's] ability to be cost effective. [Paramount] never got to that point because [St. Luke's] never [proposed a cost-effective rate], so...the issue of it being important to anyone else is...a moot point." (Randolph, Tr. 7084). Mr. Randolph did not testify to whether St. Luke's participation in Paramount was an important issue for ProMedica, and Complaint Counsel cites to no evidence on this issue.

384. Mr. Randolph wrote in a May 2008 email to ProMedica's top executives that "Since Anthem has been given this right to add St. Luke's within a year, Paramount must have an ability to add them." (PX00405 at 001). Mr. Oostra interpreted Mr. Randolph's statement to mean that Mr. Randolph felt that Paramount was going to be at a competitive disadvantage to Anthem without St. Luke's. (Oostra, Tr. 6047-6048 (discussing PX00405 (2008 Oostra/Randolph emails) ("[Mr. Randolph] was, you know, suggesting that they wouldn't be able to compete.")). Mr. Oostra agreed that a fair reading of Mr. Randolph's email is that Mr. Randolph was afraid of being at a competitive disadvantage. (Oostra, Tr. 6049-6050).

Response to Finding No. 384:

This proposed finding is an incomplete statement of the record, mischaracterizes the record, and is clearly contradicted by the record. Mr. Randolph testified that what he meant by his statement "Paramount must have an ability to add [St. Luke's]," was that Paramount needed to have the ability to add St. Luke's if they could do so at an effective rate. (Randolph, Tr. 7085-7086). When asked at trial if he thought that Paramount would be at a marketing disadvantage to Anthem without St. Luke's in its network, Mr. Randolph testified that, "all things being equal, without respect to cost," Paramount would be at a "*slight* [marketing] disadvantage" to Anthem. (Randolph, Tr. 7080) (emphasis added). Mr. Wachsman disagreed with Mr. Randolph on this point. (Wachsman, Tr. 5186-5187, *in camera*).

Furthermore, Paramount continued to successfully market its products without St. Luke's in its network until the joinder. (RPF 783). In addition, other MCOs that did not have St. Luke's in their network were able to serve their members and remain competitive in Lucas County. (RPF 1155, *in camera*).

385. Mr. Randolph confirmed that some of ProMedica's hospital presidents "who were direct competitors of St. Luke's had concerns about St. Luke's joining Paramount. (Randolph, Tr. 7077). ProMedica management, including Mr. Oostra, were also concerned in 2008 specifically about the impact on Flower Hospital and TTH of adding St. Luke's back into the Paramount network. (Randolph, Tr. 7087).

Response to Finding No. 385:

This proposed finding is an incomplete statement of the record and is misleading. Although Mr. Randolph did testify that some ProMedica hospital presidents had concerns about the impact of St. Luke's joining Paramount, he also testified in his investigational hearing that their concerns did not affect Paramount's analysis of St. Luke's proposal. (PX01910 (Randolph, IHT at 118-125, 130, 136-137)). Mr. Randolph further testified that Paramount "never got to the point of getting cost-effective options that even made it viable for Paramount to consider [adding St. Luke's]," so the hospitals' concerns were not a factor. (PX01910 (Randolph, IHT at 119)).

386. St. Luke's noted that "Paramount leaders want SLH in; ProMedica leaders want to keep SLH out." (PX01233 at 005, *in camera* (Nov. 2009 St. Luke's presentation)). A 2008 St. Luke's internal document stated that Paramount would "only let us back in when we give them [ProMedica] the keys." (PX01119 at 004, *in camera*).

Response to Finding No. 386:

This finding is misleading. Complaint Counsel cite to a pre-joinder St. Luke's document (PX01233, *in camera*) as evidence of the viewpoint of Paramount's and ProMedica's leaders prior to the joinder. St. Luke's had no foundation to know what Paramount leaders wanted, or when Paramount would "let [them] back in." Furthermore, the finding is contradicted by the record. Paramount's President, Mr. Randolph, testified that Paramount only considered adding St. Luke's if it could get them in at the "right economic terms" and an "effective cost ratio." (Randolph, Tr. 7015, 7018, 7079-7080; 798). St. Luke's submitted rate proposals, but they were not cost-effective or acceptable to Paramount. (RPF 799; PX01910 (Randolph, IHT at 125-126)).

C. St. Luke's Executives Knew St. Luke's Was Being Targeted by ProMedica and Feared Retaliation If St. Luke's Chose Other Affiliation Partners

387. In 2007, St. Luke's considered filing an antitrust suit against ProMedica in response to perceived efforts by ProMedica to exclude or disadvantage St. Luke's in the market. (Rupley, Tr. 1969; PX01144 at 003 (Rupley 2007 notes); PX01207 at 002-003 (2007 St. Luke's CEO's monthly memo).

Response to Finding No. 387:

This proposed finding is misleading. The 2007 documents cited by Complaint Counsel actually focused on potential actions against Anthem and ProMedica (PX01207 at 002- 003).

388. A St. Luke's competitor assessment document observed that "ProMedica desires the SLH geographic area, so they will continue to starve SLH through exclusive managed care contracts and owned physicians. They will do this until we sign up with them or are weakened[.]" (PX01127 at 001).

Response to Finding No. 388:

This proposed finding is misleading. The document cited by Complaint Counsel also states: "[Mercy] will no longer be neutral towards St. Luke's. Like ProMedica, highly desire our geographic service area. Will attempt to develop medical complex, in some form, 2 miles away from St. Luke's. Will attempt to make further inroads with our physicians through financial / legal arrangements or outright employment." (PX01127 at 002).

389. A St. Luke's document noted that ProMedica is "continuing an aggressive strategy to take over St. Luke's or put us out of business." (PX01152 at 001).

Response to Finding No. 389:

This proposed finding is misleading. The document cited by Complaint Counsel is from 2000, a full ten years before the joinder (PX01152). The document appears to be notes written by St. Luke's in the context of its negotiations with Paramount in 2000. (PX01152; *See* RPF 785-799).

390. In a speech to the Perrysburg Chamber of Commerce in 2008, St. Luke's CEO Daniel Wakeman stated that in order to "provide the best value to employers and consumers," hospitals should compete on "price, quality and service," but instead were competing on

"how well you can lock out hospitals and other healthcare providers [from] health insurance networks." (PX01380 at 001; PX01920 at 036-037 (Wakeman, Dep. at 137-140, *in camera*) (confirming that speech referred to ProMedica and { } and that St. Luke's was at the time excluded from { } and Paramount)).

Response to Finding No. 390:

This proposed finding is misleading. Mr. Wakeman's notes of this 2008 speech to employers in adjacent Wood County highlight St. Luke's attempts to be relevant in an environment characterized by vigorous competition between and Mercy and ProMedica. (Wakeman, Tr. 2532-2537; RPF III.B.). Large MCOs like Anthem and Paramount maintained viable networks without St. Luke's (RPF 725-729, 779-799) and Mr. Wakeman was trying to convince employers to "create pressure upon those health plans, through employers and community efforts, to include us in those networks." (Wakeman, Tr. 2534-2535). As Mr. Wakeman explained when Complaint Counsel asked him about this document at trial, "we were trying to position ourselves to compete with the systems in the community." (Wakeman, Tr. 2534-2535).

391. In 2008, Mr. Wakeman described ProMedica as "[t]he organization that has taken the greatest resources from the community, made the best bottom line and perform[ed] poorly in terms of costs and outcomes." (PX01378 at 001 (Wakeman email); PX01920 at 027 (Wakeman, Dep. at 98, *in camera*) (confirming that reference is to ProMedica)).

Response to Finding No. 391:

This proposed finding is misleading. It highlights one of St. Luke's many attempts to remain relevant in an environment characterized by vigorous competition between and Mercy and ProMedica. (*See* RPF III.B.) Mr. Wakeman wrote this email to his director of Business Development in the context of discussing how to improve St. Luke's publicity in the local paper, the Blade, which was about to put out an article comparing hospitals in Lucas County. (PX01378 at 001; Wakeman, Tr. 2500). St. Luke's expected that the newspaper would highlight St. Luke's financial losses. (PX01378 at 001). To counter this likely bad publicity, Mr.

Wakeman instructed his business development director to develop a message for the paper that would highlight St. Luke's quality, low costs, and the drawbacks of Anthem's exclusive agreement with ProMedica. (PX01378 at 001). Anthem had negotiated an exclusive arrangement with ProMedica {

} (RPF 740-741, *in camera,* 1252-1256). Anthem did not need St. Luke's to have a viable network; it marketed a network that did not include Mercy or St. Luke's from 2005-2008. (RPF 725-729). This email gives a glimpse into St. Luke's communications and marketing efforts to try to stay relevant in this highly competitive environment. Also, Mr. Wakeman testified at trial that "the organization" to which Mr. Wakeman is referring in this quotation is the Toledo Hospital not ProMedica. (Wakeman, Tr. 2501-2502).

392. An August/September 2009 presentation to St. Luke's Board of Directors noted that if St. Luke's became a stronger independent competitor, ProMedica might { }, which would be a "hard hit" to St. Luke's. (PX01018 at 009, *in camera*; Wakeman, Tr. 2660-2661, *in camera*). The same presentation also expressed concern that attempts would again be made to { }. (Wakeman, Tr. 2659, *in camera*).

Response to Finding No. 392:

This proposed finding is misleading. The St. Luke's presentation cited by Complaint Counsel entitled, { } actually encapsulates St. Luke's challenges as an independent hospital within a highly competitive environment concluding that { } (PX01018 at 007). The presentation highlights that { } and that {

} (PX01018 at 003). It emphasizes that both

{ }

(PX01018 at 006). The presentation also {

} (PX01018 at 20). The presentation adds that

{

} (PX01018 at 20). It concludes that to stay independent St. Luke's

{

} (PX01018 at 008). It is in this context that St. Luke's management made the statements cited by Complaint Counsel for this proposed finding – St. Luke's was trying to figure out whether it could remain independent and if it did, how the MCO's, physicians and competitors might react. (Wakeman, Tr. 2668-2670). For example, Anthem did not need St. Luke's to have a viable network; for three years it marketed a network that did not include Mercy or St. Luke's {i }. (RPF 725-729, 740-741, *in camera*). The statements cited by Complaint Counsel are consistent with St. Luke's concern that this might happen again or that NWOCC and ProMedica might come to a similar arrangement. (PX01018 at 009).

393. After years of competing vigorously against ProMedica, St. Luke's decided to become part of the ProMedica system, primarily to gain access to ProMedica's extraordinary health plan rates and out of concern over ProMedica's retaliation if St. Luke's were instead to affiliation with a different partner. In October 2009, in describing a possible affiliation with ProMedica, Mr. Wakeman advised leaders of the St. Luke's Board of Directors that ProMedica would bring "strong market/capital position" and "incredible access to outstanding pricing on managed care agreements" to St. Luke's. (PX01125 at 002, *in camera*; Wakeman, Tr. 2685-2686, *in camera*).

Response to Finding No. 393:

This proposed finding is inaccurate. {

}

(Wakeman, Tr. 2961, *in camera*; Black, Tr. 5642, *in camera*). {

}

(PX01030 at 007, *in camera*; Wakeman, Tr. 2959-2960, *in camera*; Black, Tr. 5634-5635, *in camera*).

{

} (Wakeman, Tr. 2961, *in camera*; Black, Tr. 5636, *in camera*). {

} (Wakeman, Tr. 2888-2889, *in camera*).

{

} (Wakeman, Tr. 2996–2997, *in camera*); (PX01457 at 004, *in camera*)).

{

} (PX01457 at 004, *in camera*). {

} (PX01457 at 004, *in camera*; Black, Tr. 5646, *in camera*).

The October 2009 email from Mr. Wakeman to the Board that Complaint Counsel cite for this proposed finding anticipated many of the reasons that St. Luke's Board would ultimately chose to move forward with ProMedica:

- "Our focus is to strengthen and stabilize St. Luke's ability to serve adjacent communities for the long term." (PX01125 at 002);
- "Randy [Oostra]...seems to be open to 'work' with others and not 'just take them over.'" (PX01125 at 002);
- "Working with ProMedica in the spirit of unity to better serve the community could be the catalyst to a tipping point for healthcare delivery in Northwest Ohio." (PX01125 at 002); and
- "With national reform on its way, there has to be a fundamental shift away from increasing volume to increasing value in healthcare." (PX01125 at 002).

Moreover, Complaint Counsel's citations regarding ProMedica's managed care rates were made in the context of St. Luke's large and increasing losses as described by Mr. Wakeman in explaining this document: "[T]he hospital would have lost between one and two million dollars from operations the previous month. It was on a similar track for next month. I was hoping to get some sort of increase in commercial rates from somewhere to try to stem those losses." (Wakeman, Tr. 2688). St. Luke's did not know ProMedica's rates or that of its other potential joinder partners and hoped it would obtain rates that would cover its costs if it joined with any of the partners it was considering. (Wakeman, Tr. 2643, 2654, *in camera*, 2995-2996, *in camera*).

394. Mr. Wakeman concluded: "Taking advantage of [ProMedica's] strengths may not be the best thing for the community in the long run. Sure would make life easier right now though." (PX01125 at 002, *in camera*; Wakeman, Tr. 2687, *in camera*).

Response to Finding No. 394:

This proposed finding is misleading, incomplete, and inaccurate. In this same email, Mr. Wakeman also writes as follows:

- "Working with ProMedica in the spirit of unity to better serve the community could be the catalyst to a tipping point for healthcare delivery in Northwest Ohio." (PX01125 at 002);
- "Our focus is to strengthen and stabilize St. Luke's ability to serve adjacent communities for the long term." (PX01125 at 002);
- "Randy [Oostra]...seems to be open to 'work' with others and not 'just take them over.'" (PX01125 at 002);
- "With national reform on its way, there has to be a fundamental shift away from increasing volume to increasing value in healthcare." (PX01125 at 002).

The actual reasons that St. Luke's Board ultimately chose to join with ProMedica and the context of the quotation cited by Complaint Counsel are further described in Respondent's reply to CPPF 393 above.

395. St. Luke's feared that ProMedica would retaliate or respond aggressively if St. Luke's affiliated with { }. (Wakeman, Tr. 2701-2702, *in camera*; Rupley, Tr. 2000-2001, 2036, *in camera*; PX01030 at 021, *in camera* (St. Luke's Affiliation Analysis Update Oct. 2009); PX01232 at 003, *in camera* (2009 email Wakeman/Oppenlander); PX01130 at 006, *in camera* (St. Luke's due diligence meeting notes)).

Response to Finding No. 395:

This proposed finding is misleading and incomplete. The documents and testimony Complaint Counsel use to support this proposed finding highlight the intense competition between Mercy and ProMedica in Lucas County (*see* RPF III.B.) and St. Luke's serious challenges in trying to make itself competitively relevant. In the testimony cited by Complaint Counsel for this finding, Mr. Wakeman emphasized that {

} (Wakeman, Tr. 2701, *in camera*). Similarly, Mr. Wakeman

testified that St. Luke's expected Mercy to respond aggressively if St. Luke's joined with ProMedica. (Wakeman, Tr. 2770, 2962, *in camera*).

The documents Complaint Counsel cite also show that St. Luke's anticipated a competitive response from Mercy if it joined with ProMedica. For example, the August 2009 compilation of opinions of St. Luke's middle managers reflected in PX01130 postulates that, if St. Luke's joined with ProMedica, {

}

(PX01130 at 006, *in camera*). More importantly, St. Luke's management and Board also anticipated an aggressive reaction from Mercy as reflected in the October 30, 2009 affiliation update cited by Complaint Counsel for this finding. Specifically, St. Luke's management and Board expected that Mercy would {

} if St. Luke's joined with ProMedica. (PX01030 at 021, *in camera*).

Respondent also refers to the reply to CPPF 393 above, which describes the actual reasons that St. Luke's joined with ProMedica.

396. St. Luke's determined that choosing ProMedica "[w]ould reduce or eliminate significant ProMedica actions that are bound to happen if St. Luke's partners with { }." (PX01030 at 016, *in camera* (St. Luke's Affiliation Analysis Update Oct. 2009)).

Response to Finding No. 396:

This proposed finding is misleading. The document Complaint Counsel cite in support of this proposed finding highlights the intense competition between Mercy and ProMedica in Lucas County (*see*, RPF III.B.) and St. Luke's serious challenges in trying to make itself competitively relevant. St. Luke's management and Board also anticipated an aggressive reaction from Mercy as reflected in the October 30, 2009 affiliation update cited by Complaint Counsel for this finding. Specifically, St. Luke's management and Board expected that Mercy

would { } if St. Luke's joined with ProMedica. (PX01030 at 021, *in camera*).

Respondent also refers to the reply to CPPF 393 above, which describes the actual reasons that St. Luke's joined with ProMedica.

397. If St. Luke's partnered with { }, St. Luke's expected a "[s]corched [e]arth [r]esponse" from ProMedica and "the wrath of Alan [Brass, then-CEO of ProMedica]." (PX01030 at 021, *in camera* (St. Luke's Affiliation Analysis Update Oct. 2009); Wakeman, Tr. 2701-2702, *in camera*, 2890, *in camera*).

Response to Finding No. 397:

This proposed finding is misleading. The document cited by Complaint Counsel in support of this proposed finding highlights the intense competition between Mercy and ProMedica in Lucas County (*see*, RPF III.B.) and St. Luke's serious challenges in trying to make itself competitively relevant. St. Luke's anticipated a competitive response from Mercy if it joined with ProMedica. For example, the August 2009 compilation of opinions of St. Luke's middle managers reflected in PX01130 postulates that, if St. Luke's joined with ProMedica, { } (PX01130 at 006, *in camera*). More importantly, St. Luke's management and Board also anticipated an aggressive reaction from Mercy as reflected in the October 30, 2009 affiliation update cited by Complaint Counsel for this finding. Specifically, St. Luke's management and Board expected that Mercy would { } if St. Luke's joined with ProMedica. (PX01030 at 021, *in camera*).

Respondent also refers to the reply to CPPF 393 above, which describes the actual reasons that St. Luke's joined with ProMedica.

398. St. Luke's suspected that ProMedica was "threatening { }" in order to "keep St. Luke's Hospital out of potential affiliations[.]" (PX01130 at 006, *in camera* (St. Luke's due diligence meeting notes)).

Response to Finding No. 398:

This proposed finding is misleading. First, PX01130 (the same notes as appear on PX01560) are notes from a meeting surveying St. Luke's middle managers. (Rupley, Tr. 2006-2007, 2017-2022, *in camera*; Wakeman, Tr. 2673-2674, 2927-2930, *in camera*). They are not statements from St. Luke's CEO or Board of Directors. (Rupley, Tr. 2006-2007, 2017-2022, *in camera*; Wakeman, Tr. 2673-2674, 2927-2930, *in camera*). Other than the vague suggestion in these notes, Complaint Counsel presents no evidence that such threats occurred despite extensive access to UTMC and ProMedica documents and witnesses. Moreover, when examined as a whole, this document is consistent with the intense competition in Lucas County where Mercy and ProMedica are each other's primary competitors and UTMC is a third important player (*see*, RPF III.B.). For example, these notes also postulate that, if St. Luke's joined with ProMedica, {

} (PX01130 at 006, *in camera*). The notes also speculate that, if St. Luke's joins with ProMedica, "U.T. may pull cardiologists out of St. Luke's Hospital and transfer them to St. Vincent's." (PX01130 at 006).

XI. THE ACQUISITION ENABLES PROMEDICA TO RAISE RATES FOR ST. LUKE'S AND PROMEDICA'S OTHER LUCAS COUNTY HOSPITALS

A. By Joining a Dominant System, St. Luke's Can Obtain Higher Rates Than It Could On Its Own

1. ProMedica and St. Luke's Understood that the Acquisition Would Increase St. Luke's Bargaining Leverage and Rates

399. ProMedica was aware of its bargaining leverage before the Acquisition, and it advertised this strength to entice potential affiliation partners. (PX00226 at 008 (ProMedica Health Network ProMedica Partnerships) ("Why ProMedica? . . . Payer System Leverage")).

Response to Finding No. 399:

The proposed finding is inaccurate and misleading. Respondent specifically objects to and disputes this finding of fact as a blatant misstatement of the record. Mr. Oostra testified that, to his knowledge, the version of the document Complaint Counsel cite (PX00226) was *never* shared with anyone outside of ProMedica. (Oostra, Tr. 5983-5990; *see also* Oostra, Tr. 6201-6226 for Mr. Oostra's testimony regarding the version of the document that was sent outside of ProMedica, notably lacking the "payor system leverage" language).

400. A St. Luke's planning document, dated August 10, 2009, and reflecting a brainstorming session by St. Luke's senior leaders, notes that an option for St. Luke's would be to "enter[] into an affiliation/partnership with a local health system with the express purpose to raise reimbursement rates to the level of our competitors." (PX01390 at 002 (Framing the St. Luke's Strategy Discussion for Dan Wakeman and the Board), *in camera*; Wakeman, Tr. 2640, 2643, *in camera*).

Response to Finding No. 400:

Respondent disputes this proposed finding of fact because it is an incomplete statement of the record, and it is misleading. Mr. Wakeman testified with respect to the planning document (PX01390, *in camera*) that at the time that the statement {

} was written, in August of 2009, St. Luke's was losing money every month due to its below-cost reimbursement rates from its major MCOs. (Wakeman, Tr. 2900, *in camera*; RPF 1794-1799, *in camera*; 1839, *in camera*). Consequently, improving St. Luke's reimbursement rates was discussed as a potential option in this brainstorming session. (Wakeman, Tr. 2900, *in camera*). However, Mr. Wakeman testified that this was not "not the most important reason for the affiliation" and that the St. Luke's Board did *not* enter into the affiliation with {

} (Wakeman, Tr. 2644-2645, *in camera*; RPF 823, *in camera*). Mr.

Wakeman further testified that improving St. Luke's reimbursement rates was {

} (Wakeman, Tr. 2645, 2900, *in camera*; RPF 820-826, *in camera*).

401. St. Luke's CEO, Daniel Wakeman, and its Director of Marketing & Strategic Planning, Scott Rupley, both noted that an independent St. Luke's acts as a competitive constraint in the market and that St. Luke's merger with a larger system would lead to higher rates. (PX01144 at 003 (Rupley Notes from Planning Session, Jan. 9, 2007); PX01229 (Email from Wakeman (St. Luke's) to Oppenlander (St. Luke's), Aug. 20, 2009), *in camera*).

Response to Finding No. 401:

The proposed finding of fact misstates and mischaracterizes the record. To begin, the document Complaint Counsel cite for the statement that "an independent St. Luke's acts as a competitive restraint in the market" actually states that "an independent St. Luke's Hospital keeps the system a little more honest. The MCOs lose clout if St. Luke's is no longer an independent." (PX01144 at 003). Mr. Rupley did not testify that this meant St. Luke's acted as a "competitive constraint," nor does he have the foundation to evaluate whether St. Luke's acts as a "competitive constraint." (Rupley, Tr. 1966-1969).

Furthermore, the finding is misleading because St. Luke's anticipated increasing its reimbursement rates whether it affiliated with a system or not. A St. Luke's planning document, dated August 10, 2009, describes the two options St. Luke's senior leaders brainstormed. (PX01390 at 002, *in camera*). St. Luke's could either {

} (PX01390 at 002, *in camera*). St. Luke's was losing money every month due to its below-cost reimbursement rates from its major MCOs. (Wakeman, Tr. 2900, *in camera*; RPF 1794-1799, *in camera*; 1839, *in camera*). Its rates with its largest MCOs were below cost. (RPF 1794-1799, *in*

camera). Therefore, St. Luke's both needed and intended to increase its rates with its major MCOs, regardless of whether it affiliated with a system or not.

402. Mr. Rupley noted that health plans should care about St. Luke's independence because "St. Luke's Hospital keeps the systems a little more honest," and that health plans "lose clout if St. Luke's is no longer independent." (PX01144 at 003 (Rupley Notes from Planning Session, Jan. 9, 2007); Rupley, Tr. 1966-1969). This statement was based on Mr. Rupley's belief that providing health plans with an alternative benefits not only the health plans, but also the community through more affordable healthcare rates and better services and amenities. (Rupley, Tr. 1966-1969).

Response to Finding No. 402:

The proposed finding of fact is a misstatement of the record. Although Mr. Rupley did testify that "giving managed care organizations an alternative is a good thing for not only managed care organizations but also the community," he did *not* testify that this benefited the community through "more affordable healthcare rates and better services and amenities," as Complaint Counsel state in their finding. (Rupley, Tr. 1966-1969). Complaint Counsel's failure to cite to a specific reference in the evidentiary record for this point is a violation of the ALJ's Order on Post-Trial Briefs.

In addition, the proposed finding mischaracterizes the record. The document Complaint Counsel cite and quote (PX01144 at 003) was a strategic planning document regarding new objectives for St. Luke's and highlighting ways St. Luke's could promote itself to the community. (Rupley, Tr. 1967-1968). The document notes the reasons MCOs "*should* care" about an independent St. Luke's ("MCOs lose clout if St. Luke's is no longer independent"). (PX01144 at 003) (emphasis added). However, the record shows that MCOs did not care about an independent St. Luke's enough. When St. Luke's realized that its reimbursement rates were below its costs of providing care, it reached out to its major MCOs to renegotiate rates. (RPF 1794-1799, 1804-1806, *in camera*). In these renegotiations, St. Luke's informed the MCOs that in order to remain independent, it would need to increase its rates. (RPF 1804-1806, *in camera*).

However, St. Luke's was unable to reach an agreement with its two largest MCOs, {

} (RPF 1818-1819, 1859 *in camera*).

403. In an email, Mr. Wakeman wrote to Mr. Oppenlander, St. Luke's VP and Treasurer at the time, that St. Luke's "need[s] to show {| } that we intend to merge with another system, and all the value we produce will [be] diluted, as our payments skyrocket." (PX01229 at 001 (Email from Wakeman (St. Luke's) to Oppenlander (St. Luke's), Aug. 20, 2009), *in camera*; Wakeman, Tr. 2651-2655, *in camera*).

Response to Finding No. 403:

The proposed finding is an incomplete statement of the record and mischaracterizes the record. The email Complaint Counsel cite was a discussion of strategy between Mr. Wakeman and St. Luke's Treasurer, Mr. Oppenlander, regarding St. Luke's efforts to increase its reimbursement rates with its largest MCO, { }. (PX01229, *in camera*). Mr. Wakeman testified regarding this email that St. Luke's had seen data from The Commonwealth Fund and Ingenix, and "at the time, there seemed to be a pretty significant gap between us and comparable hospitals within the community. If we only received half the increase of what some of the other parties were being paid on average case per revenue, {

} (Wakeman, Tr. 2651-2655, *in camera*). However, Mr. Wakeman further testified that at the time this email was written, St. Luke's did not specifically know the gap between St. Luke's and other hospitals regarding commercially reimbursed rates, as St. Luke's had not yet received Navigant's report on this issue. (Wakeman, Tr. 2655, *in camera*). Therefore, St. Luke's did not specifically know how joining a system would impact its reimbursement rates. Rather, it simply "hoped" that joining a system would increase its rates, based on the data it had reviewed. (Wakeman, Tr. 2654, *in camera*). St. Luke's intended to use this data to take a "hard stance" with { } in negotiations to increase its reimbursement rates. (Wakeman, Tr. 2653, *in camera*).

404. A 2009 presentation made by Mr. Wakeman, to educate and inform St. Luke's Board of Directors states: "In essence, the message [to payors] would be pay us now (a little bit more) or pay us later (at the other hospital system contractual rates)." (PX01018 at 009 (Options for St. Luke's: St. Luke's is now at a cross-roads), *in camera*; PX01911 at 047 (Wakeman, IHT at 181-182), *in camera*; Wakeman, Tr. 2655-2656, *in camera*). Mr. Wakeman testified that the message he intended to convey to health plans "was pay us a little bit more now as an independent or pay us more if we're part of another system in Lucas County." (Wakeman, Tr. 2658, *in camera*). This same presentation states: "Option 3: Affiliate with ProMedica. What do they bring? Strong managed care contracts." (PX01018 at 014 (Options for St. Luke's: St. Luke's is now at a cross-roads), *in camera*).

Response to Finding No. 404:

This proposed finding of fact is an incomplete statement of the record and mischaracterizes the record. At the time of the presentation cited by Complaint Counsel (PX01018, *in camera*), St. Luke's believed that its "reimbursement rates were below those of other organizations, not only in [its] area, but throughout the region." (Wakeman, Tr. 2657, *in camera*). The "message [to MCOs]" option that Mr. Wakeman presented to the board in the 2009 presentation was a "negotiation tactic [St. Luke's] was framing at that time," in which St. Luke's was planning to offer MCOs a cost-based model, with bonuses built in for performance and quality. (Wakeman, Tr. 2658; PX01018, *in camera*). However, at the time of this presentation, St. Luke's did not specifically know the gap between St. Luke's and other hospitals regarding commercially reimbursed rates, as St. Luke's had not yet received Navigant's report on this issue. (Wakeman, Tr. 2655, *in camera*). Therefore, St. Luke's did not specifically know how joining a system would impact its reimbursement rates, particularly as compared to its negotiation tactic with MCOs that it was still developing. Mr. Wakeman's "message" to MCOs to {

}

(Wakeman, Tr. 2658, *in camera*). In any event, the "message" was not well-received. St.

Luke's tried to renegotiate its reimbursement rates with its largest MCOs in order to remain independent, but the negotiations failed. (RPF 1794-1799, 1818-1819, 1859, *in camera*).

The proposed finding also omits Mr. Wakeman's testimony regarding "Option 3," and ProMedica's { } (PX01018 at 014, *in camera*). Mr. Wakeman testified that this was an "assumption" on the part of St. Luke's. (Wakeman, Tr. 2665-2666, *in camera*). Furthermore, Mr. Wakeman testified repeatedly that a potential affiliate's managed care contracts was { } (Wakeman, Tr. 2666, *in camera*; RPF 820, *in camera*).

405. Both Mr. Wakeman, and St. Luke's Director of Marketing and Strategy, Scott Rupley, testified that, at the time St. Luke's was considering its affiliation options, ProMedica was believed to enjoy the highest reimbursement rates in the area. (Wakeman, Tr. 2681-2682, *in camera*; *see* Rupley, Tr. 1998, *in camera*).

Response to Finding No. 405:

The proposed finding is an incomplete statement of the record. Although Mr. Wakeman and Mr. Rupley testified that they { } in the area at that time, St. Luke's did not have specific knowledge of ProMedica's rates, or knowledge of how ProMedica's rates compared to other hospitals in the area. (Wakeman, Tr. 2655, 2666, 2681-2682, *in camera*). In fact, Mr. Wakeman testified that he { } (Wakeman, Tr. 2681, *in camera*).

Furthermore, the finding is misleading. The level of reimbursement rates was only { } (RPF 820, *in*

camera). St. Luke's Board was more concerned with {

} (RPF 820, *in camera*).

406. Mr. Wakeman, hoped that an affiliation with ProMedica would allow St. Luke's to obtain the higher reimbursement rates that ProMedica was receiving. (Wakeman, Tr. 2685-2686, *in camera*).

Response to Finding No. 406:

The proposed finding is an incomplete statement of the record, and is misleading. To begin, St. Luke's did not have specific knowledge of ProMedica's reimbursement rates. (Wakeman, Tr. 2685-2686, *in camera*). However, they knew that {

} (Wakeman, Tr. 2686, *in camera*). In addition, St. Luke's was facing "losses of a million to $2 million a month from operations." (Wakeman, Tr. 2685-2686, *in camera*). St. Luke's needed to increase its reimbursement rates in order to continue providing healthcare services to the community, but its attempts to negotiate higher rates with its major MCOs had failed. (RPF 1794-1799, 1818-1819, 1859 *in camera*). However, the level of reimbursement rates was only {

} (RPF 820, *in camera*). St. Luke's Board was more concerned with { } (RPF 821, *in camera*).

407. Statements from St. Luke's leadership to St. Luke's Board left the Board's Chairman, James Black, with the understanding that "we [St. Luke's] would receive higher reimbursements through our affiliation with ProMedica." (Black, Tr. 5738-5740, *in camera* (discussing PX01030)). Mr. Black viewed the potential for "[r]evenue/ reimbursement enhancement" as an important factor in the evaluation of potential affiliation partners by St. Luke's board. (Black, Tr. 5634-5635; *in camera* (discussing PX01030 at 007); PX01030 at 007 (Affiliation Analysis Update, Oct. 30, 2009), *in camera*).

Response to Finding No. 407:

This proposed finding of fact mischaracterizes the record by overemphasizing the importance of reimbursement enhancement within St. Luke's affiliation analysis. St. Luke's analyzed { } when evaluating potential affiliation partners. (PX01030 at 007, *in camera*; RPF 820, *in camera*). Mr. Black viewed all { } but felt that the way they were ranked in the presentation to the board (PX01030 at 007, *in camera*) {

} (Black, Tr. 5634-5635, *in camera*). In that presentation,

{

}

(PX01030 at 007, *in camera*).

Furthermore, Mr. Black believed that all three potential affiliation partners, {

}, were "being reimbursed at a higher rate" than St. Luke's. (Black, Tr. 5639, *in camera*). Complaint Counsel state that Mr. Black understood that St. Luke's would receive higher reimbursement rates through an affiliation with ProMedica. In fact, Mr. Black testified that he understood that St. Luke's "would get a higher rate, regardless of who [they affiliated] with." (Black, Tr. 5643, *in camera*).

408. St. Luke's Board member, Dr. Stephen Bazeley, testified that the decision of St. Luke's Board to pursue an affiliation with a larger system was driven by the hope that a merger with such a system would allow St. Luke's to negotiate higher reimbursement rates. (PX01932 at 015 (Bazeley, Dep. at 55-56), *in camera*).

Response to Finding No. 408:

The proposed finding of fact misstates the testimony. Dr. Bazeley testified that "better contractual relationships" with MCOs were one of the benefits of a closer affiliation with a larger system, as opposed to a joint-venture relationship. (PX01932 at 015 (Bazeley, Dep. at 56)). Dr. Bazeley considered this a benefit because "the reimbursement [St. Luke's was getting from its

MCOs] was not adequate to meet [its] needs." (PX01932 at 015 (Bazeley, Dep. at 56)). The record clearly shows that St. Luke's efforts to explore joint venture relationships failed because the financial results did not merit moving forward. (RPF 883, *in camera*).

409. ProMedica's Senior VP for Managed Care, Reimbursement and Revenue Cycle Management, Ronald Wachsman, believes that St. Luke's gave MMO notice of its intent to terminate its contract in order to preserve its ability to negotiate higher reimbursement rates in 2011. (Wachsman, Tr. 4833, 5224, *in camera*).

Response to Finding No. 409:

This proposed finding mischaracterizes the record. To begin, Complaint Counsel cite to a ProMedica employee, Mr. Wachsman, regarding the intent of St. Luke's senior leaders. Mr. Wachsman has no foundation to testify as to the intent of St. Luke's senior leaders, particularly with respect to this issue, since {

} (RPF 1365, *in camera*). Furthermore, St. Luke's former interim treasurer, Dennis Wagner, testified that St. Luke's wanted to renegotiate its rates at the end of the contract because it believed it was being underpaid, and not receiving market rates. (RPF 1364).

410. A presentation regarding potential affiliation partners, made to St. Luke's Board of Directors by Mr. Wakeman and other members of St. Luke's leadership team, states: "An SLH affiliation with ProMedica has the greatest potential for higher hospital rates. A ProMedica-SLH partnership would have a lot of negotiating clout." (PX01030 at 020 (Affiliation Analysis Update, Oct. 30, 2009), *in camera*; Wakeman, Tr. 2689-2690, *in camera*; Black, Tr. 5634, *in camera*). This statement conveyed the belief that "ProMedica had a significant leverage on negotiations with some of the [health plans]," that this leverage would allow St. Luke's to obtain higher reimbursement rates, and that an affiliation with ProMedica could "[h]arm the community by forcing higher hospital rates on them." (Wakeman, Tr. 2698-2700, *in camera*; Rupley, Tr. 2003, *in camera* (discussing PX01124 at 009, which contains the contents of PX01030 at 020)).

Response to Finding No. 410:

The proposed finding is an incomplete statement of the record, and mischaracterizes the record. In October, 2009, St. Luke's neither knew what ProMedica's rates actually were, nor

how they compared to other hospitals in the area, as Navigant had not yet presented its report on commercially reimbursed rates. (Wakeman, Tr. 2655, *in camera*; Rupley, Tr. 2032, *in camera*). Consequently, the statement in the document that {

} was speculative. Furthermore, Mr. Rupley testified that the statement referred to getting "rates that were higher than [St. Luke's was] currently getting, which at times [were] either at cost or below cost." (Rupley, Tr. 2003, 2035, *in camera*).

Furthermore, the proposed finding misstates the testimony. When asked if he believed that an affiliation with ProMedica could harm the community by raising hospital rates, Mr. Wakeman testified { } (Wakeman, Tr. 2700, *in camera*). Long-term though, Mr. Wakeman believed that an affiliation with ProMedica was in the community's best interest. (Wakeman, Tr. 3014-3015, *in camera*).

411. In an email on October 11, 2009, to St. Luke's Board members and managers tasked with searching for possible affiliation partners, Mr. Wakeman wrote that "incredible access to outstanding pricing on managed care agreements" is among the important "things Pro[M]edica brings to the table" as an affiliation partner, and that "[t]aking advantage" of this strength "may not be the best thing for the community in the long run" but that it "[s]ure would make life much easier right now though." (PX01125 at 002, *in camera*; Wakeman, Tr. 2682-2683, *in camera*; *see also* PX01130 at 004 (Notes from Due Diligence Meetings, Aug. 26, 2009), *in camera* ("Concern that U.T.[M.C.] does/ may not have as high of [sic] reimbursement rates as ProMedica and/ or Mercy.")). Mr. Wakeman wrote this statement under the assumption that "if our [St. Luke's] rates would have went up to the insurers, the insurers would have then passed those rates off to the employers and the community." (Wakeman, Tr. 2682, *in camera*, 2687, *in camera* (discussing PX01125 at 002)).

<u>Response to Finding No. 411:</u>

The proposed finding mischaracterizes the record. To begin, Mr. Wakeman never characterized ProMedica's managed care agreements as "important" in the email Complaint Counsel cite. (PX01125, *in camera*). Indeed, St. Luke's analyzed { } when evaluating potential affiliation partners. (PX01030 at 007, *in camera*; RPF 820, *in camera*). { } was not the primary factor that the board considered. (RPF

821, 823, *in camera*). Furthermore, in October, 2009, St. Luke's neither knew what ProMedica's managed care rates actually were, nor how they compared to other hospitals in the area, as Navigant had not yet presented its report on commercially reimbursed rates. (Wakeman, Tr. 2655, *in camera*; Rupley, Tr. 2032, *in camera*). Therefore, Mr. Wakeman's statement that ProMedica had { } was speculation.

The proposed finding is also an incomplete statement of the record. Although Mr. Wakeman wrote at the time that { } he clarified in his testimony that, due to changes in national healthcare policies, particularly the move to "more capitated risk-shifting," employers and the community should not feel the affects of reimbursement rate shifts. (Wakeman, Tr. 2689, *in camera*).

412. Formal notes generated by the due diligence team in charge of finding the best affiliation options for St. Luke's point out that a "ProMedica or Mercy affiliation could still stick it to employers, that is, to continue forcing high rates on employers and insurance companies." (PX01130 at 005 (Notes from Due Diligence Meetings, Aug. 26, 2009), *in camera*; Wakeman, Tr. 2673, *in camera*). Mr. Rupley confirmed that the due diligence team believed that an affiliation with a large system in Toledo could perpetuate high healthcare rates in the area. (Rupley, Tr. 2013-2014, *in camera*).

Response to Finding No. 412:

The proposed finding mischaracterizes the record. The due diligence team that created this document (PX01130, *in camera*) was made up of "first-line" or "middle" managers at St. Luke's, and the document only reflects the views of some of those middle managers. (Wakeman, Tr. 2673, *in camera*; Rupley, Tr. 2013, 2021, *in camera*). Indeed, Mr. Wakeman testified that he disagreed with the statement that a ProMedica or Mercy affiliation could { }

(Wakeman, Tr. 2679-2680, *in camera*). He further testified that at the time this document was written, St. Luke's and ProMedica had not exchanged due diligence materials with each other.

(Wakeman, Tr. 2929, *in camera*). Therefore, the due diligence team that drafted this document had no foundation for their statement that a ProMedica or Mercy affiliation could force high rates on employers and insurance companies.

413. During the process of selecting an affiliation partner, St. Luke's CEO, Daniel Wakeman, believed that a "ProMedica-St. Luke's affiliation could force higher rates on employers and insurance companies." (Wakeman, Tr. 2680-2681, *in camera*).

Response to Finding No. 413:

The proposed finding misstates and mischaracterizes the record. Mr. Wakeman clarified that at that time, he believed such an affiliation {

} because St. Luke's needed to get higher reimbursement rates to continue offering services. (Wakeman, Tr. 2681, *in camera*). St. Luke's was losing money every month due to its below-cost reimbursement rates from its major MCOs. (Wakeman, Tr. 2900, *in camera*; RPF 1794-1799, *in camera*; 1839, *in camera*). Therefore, St. Luke's both needed and intended to increase its rates with its major MCOs, regardless of whether it affiliated with a system or not.

Mr. Wakeman further testified that he believed an affiliation with Mercy would also allow St. Luke's to achieve higher rates; again because St. Luke's needed higher reimbursement rates to continue offering services. (Wakeman, Tr. 2681, *in camera*).

414. St. Luke's anticipated as much as { } in additional revenues from { }, and Paramount as a result of joining ProMedica. (PX01231 (Email from Wakeman (St. Luke's) to Oppenlander (St. Luke's), Oct. 12, 2009), *in camera* ("Yes we asked { } for { }, but if we go over to the dark green side [i.e., ProMedica] ... we may pick up as much as { } in additional { } and Paramount fees")).

Response to Finding No. 414:

The proposed finding mischaracterizes the record. When this email (PX01231) was written in October of 2009, St. Luke's neither knew what ProMedica's rates actually were, nor

how they compared to other hospitals in the area, as Navigant had not yet presented its report on commercially reimbursed rates. (Wakeman, Tr. 2655, *in camera*; Rupley, Tr. 2032, *in camera*). St. Luke's estimate that they could get as much as { } in additional revenues from { } has no basis in the record.

In fact, post-joinder, { } previous contract with St. Luke's is still in effect, and ProMedica has not sought to modify its rates. (RPF 1357-1359).

415. St. Luke's anticipated that the transaction with ProMedica, and its potential for higher prices, could trigger antitrust scrutiny. (*See* PX01125 at 002, *in camera*; PX01228 at 002, *in camera*; PX01030 at 017, *in camera*). In an email, dated October 11, 2009, to St. Luke's Board members and managers tasked with searching for possible affiliation partners, St. Luke's CEO, Daniel Wakeman, wrote: "Promedica [sic] and MHP [Mercy] already have a high degree of concentration in the market ... [t]hat's antitrust speak for possible challenge of [sic] we merge with either . . . [b]etter chance with MHP than Promedica [sic]." (PX01125 at 002, *in camera*; Wakeman, Tr. 2682-2684, *in camera*).

Response to Finding No. 415:

The proposed finding mischaracterizes the record. To begin, Mr. Wakeman testified that he did not anticipate an antitrust challenge, just a review. (Wakeman, Tr. 2684-2685, *in camera*). Furthermore, the proposed finding is filled with unfounded legal analysis and conclusions. Mr. Wakeman had no foundation to speak to the legal and antitrust implications of a proposed affiliation. Complaint Counsel notably omit from their proposed finding St. Luke's calculation of the HHI, 18,000, as it underscores St. Luke's lack of familiarity with antitrust law. (PX01125 at 002, *in camera*). Mr. Rupley further testified that he didn't know what it meant to have a high HHI, and yet he still included it in a board presentation. (Rupley, Tr. 2001; PX01124, *in camera*; PX01030, *in camera*).

416. An email from St. Luke's former VP and Treasurer, David Oppenlander, to St. Luke's Director of Marketing and Strategy, Scott Rupley, states: "Slides 6, 11 and 17 will need some modification in your discussion of managed care rates/leverage ... we can't talk about raising rates, managed care leverage and the like due to anti-trust issues." (PX01228 at 002, *in camera* (dated Oct. 15, 2009)).

Response to Finding No. 416:

Respondent has no specific response.

417. A presentation regarding potential affiliation partners, made to St. Luke's Board of Directors by St. Luke's CEO, Daniel Wakeman, and other members of St. Luke's leadership team, states: "[S]ignificant legal, regulatory considerations ... ProMedica: HHI with St. Luke's is 34.7% and 29.9% without ... Any obstetrics affiliation may need to be carefully reviewed. Note: Anything [referring to HHIs] over 18% throws up a red flag." (PX01030 at 017 (Affiliation Analysis Update, Oct. 30, 2009), *in camera*; Wakeman, Tr. 2689-2690, *in camera*, 2695-2696, *in camera*).

Response to Finding No. 417:

The proposed finding is filled with unfounded legal analysis and conclusions. Mr. Wakeman had no foundation to speak to the legal and antitrust implications of a proposed affiliation. Furthermore, Mr. Rupley testified that he didn't know what it meant to have a high HHI, and yet he still included it in the board presentation. (Rupley, Tr. 2001; PX01124, *in camera*; PX01030, *in camera*).

2. Every Health Plan Believes That The Acquisition Has Increased ProMedica's Bargaining Leverage, Which Will Likely Lead To Higher Rates

418. Anthem's Regional VP for Provider Engagement and Contracting in northern Ohio, James Pugliese, testified:

a. Less competition in the marketplace is not desirable for Anthem, because less competition leads to less choice and likely higher prices. (Pugliese, Tr. 1523-1524, *in camera*).

b. Lack of competition leads to higher costs and lower quality relative to markets in which "competitive forces [are] in play." (PX01942 at 026 (Pugliese, Dep. at 98), *in camera*).

c. The Acquisition will likely lead to higher healthcare costs because St. Luke's has been absorbed into a larger system, ProMedica, with a great deal of leverage that it can exercise during the contract negotiation process. (Pugliese, Tr. 1524-1525, *in camera*).

d. The addition of St. Luke's to ProMedica will give ProMedica more hospitals and greater geographic coverage in Lucas County, OH. (Pugliese, Tr. 1524-1525, *in camera*). {

} (Pugliese, Tr. 1524-1525, *in camera*; PX01919 at 014 (Pugliese, Dep. at 51), *in camera*). {

} (*See* Pugliese, Tr. 1525, *in camera*).

e. Mr. Pugliese's boss, Anthony Firmstone, characterized the Acquisition as a "low cost provider [i.e., St. Luke's]" being "absorbed by the high cost provider [i.e., ProMedica]." (PX01942 at 024 (Pugliese, Dep. at 91, 93), *in camera*; PX02377 at 001-002 (Email from Firmstone, Feb. 1, 2010)).

f. Prior to the Acquisition, the reimbursement rates that Anthem paid to St. Luke's were { } the rates that Anthem paid to other community hospitals in Ohio. (Pugliese, Tr. 1505-1506, *in camera*).

g. Prior to the Acquisition, the reimbursement rates that Anthem paid to St. Luke's were { } than the rates Anthem paid to ProMedica community hospitals, Flower and Bay Park. (Pugliese, Tr. 1506, *in camera*).

h. Anthem is concerned that ProMedica will raise the rates that Anthem pays to St. Luke's towards the rates that Anthem pays to ProMedica's community hospitals in Lucas County. (Pugliese, Tr. 1517, *in camera*; *see also* PX02072 at 005 (¶ 18) (Firmstone, Decl.), *in camera*).

i. Anthem conducted an analysis of the change in reimbursements to St. Luke's that would result if Anthem's rates to St. Luke's were increased to Anthem's rates to ProMedica's { }. (Pugliese, Tr. 1506-1508, *in camera*; PX02380 (Email chain among Anthem employees, Aug. 19 to Nov. 2, 2010), *in camera*). According to this analysis, if ProMedica brings Anthem's rates to St. Luke's in line with Anthem's rates to { }, Anthem's rates to St. Luke's will { }—between roughly { } and { }. (Pugliese, Tr. 1517-1519, *in camera*; PX02380, *in camera*).

j. Anthem's concerns about the Acquisition's likely impact on the reimbursement rates it pays to ProMedica and to St. Luke's pre-date Anthem's first contact with the FTC regarding the Acquisition. (Pugliese, Tr. 1519, *in camera*; *see also* PX02377 (Email from Firmstone, Feb.1, 2010)).

k. ProMedica represents a { } of Anthem's overall member utilization. (Pugliese, Tr. 1667, *in camera*).

l. Nothing in the current contract between Anthem and St. Luke's prevents { } after the expiration of the contract on { }. (PX01942 at 031 (Pugliese, Dep. at 120-121), *in camera*).

Response to Finding No. 418:

418 (a) Mr. Pugliese's opinion is not substantiated by any evidence relating to general acute-care inpatient services within Lucas County. Specifically, Mr. Pugliese offers no evidence beyond his unsubstantiated apprehensions that higher prices may result from the joinder. In fact, evidence of post-joinder contracting demonstrates that these fears have not been realized. (RPF 1384, *in camera*, 1821, *in camera*, 1398-1399, *in camera*, 1876, *in camera*).

418 (b) Respondent refers to its response to CCPF 418(a) which it incorporates here by reference.

418 (c) Mr. Pugliese's suggestion that the joinder will lead to higher healthcare costs due to ProMedica's leverage is speculative. All parties in every negotiation have bargaining leverage, and leverage alone does not automatically lead to anticompetitive effects. (RPF 1320-1321). Mr. Pugliese's company, Anthem Blue Cross Blue Shield, is well positioned to resist any future attempt by ProMedica to increase prices in Lucas County. Anthem is a large and profitable healthcare company that brings the vast resources of its national network to each negotiation. (RPF 274-277). Mr. Pugliese acknowledged that Blue Cross Blue Shield is the most recognized brand in the healthcare industry and it successfully leverages this brand recognition in its negotiations with hospitals like ProMedica. (RPF 300-303).

418 (d) Adding another geographic location does not necessarily increase bargaining leverage. Location is a factor that may influence bargaining leverage, but in Lucas County location is not a determinant factor. (RPF 1483-1485). Limited networks have thrived for much of the past decade; broad networks have not been able to profit at the expense of limited networks. (RPF 707-717, 779-781, 800-808). Many factors influence bargaining leverage including the range of services that a hospital offers. (RPF 1320). St. Luke's offers no services that members cannot obtain at other Lucas County hospitals and its joinder with ProMedica does

not offer any additional leverage from a service perspective. (RPF 1149). In any case, additional bargaining leverage would not necessarily or automatically translate into higher reimbursement rates for general acute-care inpatient services. Negotiations between MCOs and hospitals are complex and involve many trade-offs that can affect the ultimate outcome on rates. (RPF 1063, 1070-1071, 1081, 1085).

418 (e) Complaint Counsel misquote Mr. Firmstone's statement in PX02377, which refers to "our [i.e. Anthem's] low cost provider," rather than "a" or "the" low cost provider as they suggested both here and in Mr. Pugliese's deposition (PX01942). As originally written, this statement merely indicates that Anthem's rates with St. Luke's were lower than with ProMedica. There are many reasons why this would be so, including the greater complexity of services offered by ProMedica, or Anthem's longer contracting history with ProMedica in contrast to St. Luke's. (RPF 11, 1104). It is also well documented in the evidentiary record that {

} and this further limits the significance of Anthem's characterization of St. Luke's as its low-cost provider. (RPF 1839-1859, *in camera*).

418 (f) Whether Anthem paid St. Luke's rates that were comparable to "other community hospitals in Ohio" is irrelevant. None of these other hospitals operates within the relevant geographic market, and the fact that the rates were comparable does not address whether they exceeded any hospital's costs. Even if such testimony were relevant, it is contradicted by data from unbiased sources: documentary evidence and testimony confirmed that St. Luke's was paid less than comparably sized hospitals that were {

,} including those within Ohio. (RPF 1785, 1786).

418 (g) Respondent has no specific response.

418 (h) Complaint Counsel improperly cites the Declaration (PX02072) of a witness who was not deposed and who did not testify for the truth of the matter asserted.

Mr. Pugliese's statement is speculation that has been contradicted by the evidence of post-joinder contracting. (RPF 1381-1383, *in camera*; 1397-1402, *in camera*).

418 (i) The analysis cited by Complaint Counsel is speculation fueled perhaps by apprehension, but no evidence. There have been no negotiations between ProMedica and Anthem relating to St. Luke's since the joinder. (RPF 1357). Since the Joinder, ProMedica has not sought to modify St. Luke's rates to the level that it receives for other ProMedica hospitals. (RPF 1358). Nor has it sought to terminate St. Luke's contract with Anthem. (RPF 1359). Anthem has {

} (RPF 1354, *in camera*). Anthem and ProMedica have {

} in their prior negotiations, which date back more than twenty years. (RPF 292, 1356, *in camera*).

418 (j) Respondent has no specific response.

418 (k) Mr. Pugliese's testimony is vague as to what constitutes as large or very large proportion of Anthem's business.

418 (l) Nothing in Anthem's current contract with St. Luke's { } Anthem's rates with St. Luke's **{to increase}** after it expires, either. (RX-1027 at 000001, *in camera*). And nothing in the contract { } (RX-1027 at 000001). Anthem's contract does, however, contain a {

}

(RX-1027 at 000011, *in camera*).

419. MMO's VP of Network Management for Ohio, Indiana and Kentucky, Donald Pirc, testified:

a. Prior to the Acquisition, competition between St. Luke's and ProMedica's Lucas County hospitals benefited MMO's members, because competition generally allows MMO to obtain lower rates. (Pirc, Tr. 2260-2261, *in camera*).

b. The Acquisition reduced competition in the market for general acute-care services in Lucas County. (PX01914 at 017 (Pirc, IHT at 60), *in camera*).

c. When competition is reduced in a market, the healthcare costs and the reimbursement rates that MMO has to pay typically rise. (PX01914 at 017 (Pirc, IHT at 61, *in camera*)).

d. { } (Pirc, Tr. 2261, *in camera*).

e. { } (Pirc, Tr. 2261-2263, *in camera*).

f. {ProMedica's increased leverage will likely lead to higher healthcare costs for patients.} (PX01944 at 027 (Pirc, Dep. at 103), *in camera*).

g. { } (Pirc, Tr. 2262-2263, *in camera*).

h. { } (PX01944 at 013-014 (Pirc, Dep. at 49-50, *in camera*)).

Response to Finding No. 419:

419 (a) Respondent has no specific response.

419 (b) The proposed finding is not a fact but an improper legal argument. The finding cites investigational hearing testimony that was not subject to cross-examination, is based on leading questions, assumes facts not in evidence and is an improper lay opinion. (PX01914 at 017 (Pirc, IHT at 61, *in camera*))

419 (c) The proposed finding cites investigational hearing testimony that was not subject to cross-examination, is an improper lay opinion and is based on leading questions. (PX01914 at 017 (Pirc, IHT at 61, *in camera*))

419 (d) The proposed finding assumes that MMO would have been able to contract with other Lucas County hospitals. MMO retains the ability to market insurance products without ProMedica hospitals, assuming it can successfully reach agreement with other Lucas County hospitals. (RPF 1249, 1250-1251, *in camera*, 1252-1254).

419 (e) Complaint Counsel blatantly mischaracterize Mr. Pirc's actual testimony. First, they neglect to mention that he qualified his statement as speculation. When asked about MMO's ability to offer a network that does not include ProMedica and St. Luke's, he prefaced his remarks by emphasizing that { .} (Pirc, Tr. 2262, *in camera* ({ })). When pressed for an explanation behind his speculative response, he retreated into a claim that {

} (Pirc, Tr. 2262, *in camera*). Yet, Mr. Pirc acknowledged that MMO has never conducted any study of member travel preferences. (RPF 1264-1265, 1267, *in camera*, 1267). He also conceded that customers would travel at least twenty minutes to obtain care if no hospital were located closer. (RPF 1263). As local residents have indicated and expert study has confirmed, travel times in Lucas County are minimal and patients currently receiving care at St. Luke's already regularly travel past St. Luke's to receive care at other Lucas County hospitals. (RPF 218-243, 442, 1210-1218, Sandusky, Tr. 1282-1283).

419 (f) Complaint Counsel cite testimony that is speculation and based upon leading questions. (PX01944 at 027 (Pirc, Dep. at 103), *in camera*).

419 (g) Mr. Pirc's offers no substantiation for this speculative assessment of the future state of business in Lucas County. Such unsubstantiated apprehensions are entitled no credit. Moreover, they are disproved by the actual course of events. In post-joinder negotiations between ProMedica and MMO for St. Luke's, ProMedica and MMO agreed to rates that were

{

} (RPF 1384, *in camera*). Prior to the joinder St. Luke's sought an

{ }; ProMedica and MMO agreed only to semi-annual

increases of {7.5} percent for the first two years and annual increases at and below {

} after that. (RPF 1381, *in camera*).

419 (h) For the reasons described in response to CCPF 419 (g), Mr. Pirc's statement is not credible.

420. Aetna's Senior Network Manager, Greg Radzialowski, testified:

a. The Acquisition has eliminated competition between ProMedica and St. Luke's and has increased ProMedica's bargaining leverage against Aetna. (PX02067 at 006 (¶ 20) (Radzialowski, Decl.), *in camera*).

b. Although it was not easy to walk away from ProMedica before it acquired St. Luke's, the Acquisition has made the prospect of walking away from ProMedica substantially more unattractive for Aetna. (Radzialowski, Tr. 712-713, *in camera*; PX02067 at 006 (¶ 21) (Radzialowski, Decl.), *in camera*; PX01917 at 023 (Radzialowski, Dep. at 86), *in camera*).

c. The Acquisition's addition of St. Luke's to ProMedica's Lucas County network has made it harder for Aetna to walk away from ProMedica because the attractiveness of Aetna's network would fall to a greater degree from the loss of not only at ProMedica's three pre-Acquisition hospitals, but also from the loss of St. Luke's, which would leave Aetna without coverage in southwestern Lucas County. (Radzialowski, Tr. 712-713, *in camera*; PX02067 at 006 (¶ 21) (Radzialowski, Decl.), *in camera*; PX01917 at 020 (Radzialowski, Dep. at 74-77), *in camera*).

d. The Acquisition has increased the importance of ProMedica to Aetna's network, as "it would be exponentially more difficult to market a network in Lucas County without ProMedica *and* St. Luke's." (PX02067 at 006 (¶ 21) (Radzialowski, Decl.), *in camera* (emphasis in original); *see also* PX01917 at 020 (Radzialowski, Dep. at 76), *in camera*).

e. If ProMedica were to walk-away from negotiations with Aetna today, { } (PX01917 at 023 (Radzialowski, Dep. at 86), *in camera*).

f. Therefore, the Acquisition has substantially increased not only St. Luke's bargaining leverage, but also the bargaining leverage of ProMedica's entire

hospital network in Lucas County. (Radzialowski, Tr. 712-713, *in camera*; *see also* PX02067 at 006 (¶ 21) (Radzialowski, Decl.), *in camera*).

g. This additional leverage flowing from the Acquisition gives ProMedica the ability to raise the reimbursement rates that Aetna pays to St. Luke's and to ProMedica's other Lucas County hospitals. (Radzialowski, Tr. 713, *in camera*; *see also* PX02067 at 006-007 (¶ 22) (Radzialowski, Decl.), *in camera*).

h. Mr. Radzialowski expects that ProMedica, as a first step, will increase Aetna's rates to St. Luke's to the level of Aetna's rates to ProMedica and, as a second step, will use the additional leverage it gained from the Acquisition to raise rates even further. (PX01938 at 023 (Radzialowski, Dep. at 88-89), *in camera*; *see also* PX02067 at 006-007 (¶¶ 20, 22) (Radzialowski, Decl.), *in camera*).

i. In early December 2010, ProMedica asked Aetna to increase St. Luke's reimbursement rates to {{ }. (Radzialowski, Tr. 717, *in camera*).

j. Aetna performed a "hard-number analysis" of the Acquisition's impact on Aetna's rates to St. Luke's. (Radzialowski, Tr. 704, *in camera*; *see also* PX01938 at 026 (Radzialowski, Dep. at 99), *in camera*). This analysis assumed, based on the typical pattern experienced by Aetna, that the acquiring system would raise the acquired hospital's rates to the system-wide rates. (Radzialowski, Tr. 704, *in camera*; *see also* PX01938 (Radzialowski, Dep. at 99), *in camera*). This analysis projected a { } increase in Aetna's rates to St. Luke's if these were to rise to the level of Aetna's rates to ProMedica, accounting for differences in severity between ProMedica and St. Luke's. (Radzialowski, Tr. 704, *in camera*, 848-49; *see also* PX01938 at 026 (Radzialowski, Dep. at 99), *in camera*).

k. Mr. Radzialowski believes that the actual impact on rates could be higher, because this analysis did not account for the additional bargaining leverage that the acquisition gave to ProMedica as a whole. (Radzialowski, Tr. 843, *in camera*; *see also* PX01938 at 023 (Radzialowski, Dep. at 89), *in camera*).

l. Mr. Radzialowski is not aware of anyone at Aetna who has predicted or estimated that the Acquisition will not lead to higher reimbursement rates at St. Luke's. (Radzialowski, Tr. 843, *in camera*).

Response to Finding No. 420:

420 (a). The proposed finding is not a fact, but , but an improper legal conclusion.

420 (b). The proposed finding is inaccurate and misleading. Complaint Counsel mischaracterize Mr. Radzialowski's testimony. Mr. Radzialowski testified that {

} was facilitated by the {

}. (Radzialowski, Tr. 712, *in camera*). This {

} does not change after the joinder. Mr. Radzialowski suggests that the lack of an alternative in { } is problematic for Aetna after the joinder. (Radzialowski, Tr. 713, *in camera*). This unfounded claim ignores the availability of UTMC as an alternative. More significantly, Aetna's own past experience in Lucas County contradicts Mr. Radzialowski's speculation. Aetna's broad network failed to gain members when Aetna's competitors maintained limited networks. (RPF 800-803). It failed because of pricing issues. (Radzialowski, Tr. 742). Geographic location is not determinant in a county where travel is easy and rapid; alternative networks—whether broad or narrow—can succeed in Lucas County when they are priced correctly. (RPF 218-243, 1210-1218, 1250-1251, *in camera*, 1602).

420 (c). Respondent refers to its response to CCPF 420(b) which it incorporates here by reference.

420 (d). The proposed finding is inaccurate and misleading. {

} (RPF 1250, *in camera*). No payor has ever attempted to { } (RPF 1250, *in camera*). Lucas County, however, has a long history of successful limited networks. (RPF 709-717, 719-722, 725-728, 779-781).

420 (e). This finding cites testimony that lacks any foundation and is based on leading questions.

Furthermore, Mr. Radzialowski's speculation and unsubstantiated apprehensions about the effect of ProMedica refusing to participate in Aetna's network are not credible. Aetna brings substantial leverage of its own to the bargaining table (RPF 394-395 ("Hospital[s] like to be able

to say, 'We are an Aetna provider.'")). And Aetna has not approached post-joinder negotiations with ProMedica any signs of trepidation. Aetna { } for St. Luke's, even when { } had previously indicated it could accept. (RPF 1406-1410, *in camera*). Aetna instead seized the opportunity to { } in exchange for { }. (RPF 1418, *in camera*).

420 (f). Adding another geographic location does not necessarily increase bargaining leverage. Location is a factor that may influence bargaining leverage, but in Lucas County location is not a determinant factor. (RPF 1483-1485). Limited networks have thrived for much of the past decade; broad networks have not been able to profit at the expense of limited networks. (RPF 707-717, 779-781, 800-808). Many factors influence bargaining leverage including the range of services that a hospital offers. (RPF 1320). St. Luke's offers no services that members cannot obtain at other Lucas County hospitals and its joinder with ProMedica does not offer any additional leverage from a service perspective. (RPF 1149). In any case, additional bargaining leverage would not necessarily or automatically translate into higher reimbursement rates for general acute-care inpatient services. Negotiations between MCOs and hospitals are complex and involve many trade-offs that can affect the ultimate outcome on rates. (RPF 1063, 1070-1071, 1081, 1085).

420 (g). Mr. Radzialowski's statement is speculation that has been { } including by Aetna's own interactions with Respondent. (RPF 1381-1383, *in camera*; 1397-1402, *in camera*, 1406-1410, *in camera*).

420 (h). The proposed finding is inaccurate and misleading. Aetna's post-joinder interactions with ProMedica demonstrate it has had no difficulty {

}. (RPF 1406-1410, *in camera*). As a successful, large, national MCO Aetna brings substantial resources, leverage and brand recognition to every negotiation. (RPF 370, 371, *in camera*, 372, 394-395).

420 (i). The proposed finding is inaccurate and misleading. Complaint Counsel misrepresent Mr. Radzialowski's testimony and the documentary record. When ProMedica approached Aetna about St. Luke's contract, it did *not* ask Aetna to increase St. Luke's rates to the level of those paid by Aetna to ProMedica as Complaint Counsel wrongly assert. Internal Aetna documents show and Mr. Radzialowski's testimony confirms that ProMedica as part of its efforts to improve St. Luke's cost coverage asked Aetna {

} (PX02295 at 003, *in camera* (emphasis added)). ProMedica did not ask Aetna {

.} (PX02295 at 002, *in camera* (ProMedica's Amy Hutt to Aetna's Cindy Breininger: { })).

420 (j). The proposed finding is inaccurate and misleading. Mr. Radzialowski' analysis, {

}, was based on *Mr. Radzialowski's* assumption that ProMedica would

} between St. Luke's and the ProMedica hospital. (Radzialowski, Tr. 704, *in camera*). This was { } (RPF 825, *in camera* (emphasis added)). Mr. Radzialowski testified that this assumption was based on { } in markets other than Lucas County. (Radzialowski, Tr. 704, *in camera*). Nowhere does Mr. Radzialowski indicate that { } sought this analysis or asked for {

}.

420 (k). The proposed finding is inaccurate and misleading. With respect to Aetna's analysis of the impact of the joinder on Aetna rates, Mr. Radzialowski also testified that {

}. (RPF 825, *in camera*).

420 (l). It is ultimately immaterial how many people evaluated the effect of the joinder at Aetna. Mr. Radzialowski is responsible for { } in Lucas County and for { }. (Radzialowski, Tr. 707, *in camera*). His conjecture and unsubstantiated apprehensions, especially apprehensions that fail to match the reality of post-joinder events, are not entitled to any credit.

421. FrontPath's President and CEO, Susan Szymanski, and FrontPath's healthcare management consultant, Barbara Sandusky, testified:

a. A hospital's bargaining leverage against FrontPath depends on the degree to which FrontPath's members value that hospital. (PX02065 at 004 (¶ 13) (Szymanski, Decl)).

b. The greater a hospital's bargaining leverage against FrontPath, "the higher the prices and the less favorable [for FrontPath] the contract terms it will be able to demand from FrontPath." (PX02065 at 003 (¶ 11) (Szymanski, Decl.)).

c. The larger the portion of FrontPath's membership that utilizes a particular hospital system, the more importance that FrontPath places on maintaining a relationship with that system, the better the contractual terms that the hospital will be able to secure for itself from FrontPath. (Sandusky, Tr. 1325-1326).

d. ProMedica is a "significant" provider for FrontPath, and FrontPath's business "would suffer significantly" from the absence of ProMedica from FrontPath's network. (Sandusky, Tr. 1323-24).

e. {

.} (Sandusky, Tr. 1351, *in camera*).

Response to Finding No. 421:

421 (a). This finding improperly cites the Declaration (PX02065) of a witness who was not deposed and who never testified.

421 (b). This finding improperly cites the Declaration (PX02065) of a witness who was not deposed and who never testified.

421 (c). Complaint Counsel misrepresents Ms. Sandusky's testimony. Ms. Sandusky also testified that when more of its members use a particular hospital, its own bargaining leverage with that hospital increases and allows it to obtain better rates for its members. (Sandusky, Tr. 1397). In fact, while FrontPath does not engage in benefit plan design for its "sponsors," FrontPath expressly requires in its contracts that members must provide financial incentives to encourage use of in-network providers by employees. (Sandusky, Tr. 1395-1397). It includes this contractual provision in order to drive volume to participating hospitals and increase its leverage with those hospitals. (Sandusky, Tr. 1397).

421 (d). Ms. Sandusky offered no testimony that suggested that she feared ProMedica would ever cease to be a provider in FrontPath's network. On the contrary, she affirmed that she enters every negotiation with the expectation of a successful outcome. (Sandusky, Tr. 1323-1324). FrontPath has always had all hospitals participating in its network. (RPF 342). ProMedica has been a partner of FrontPath since the beginnings of the organization more than 20 years ago. (Sandusky, Tr. 1293, 1299). There is no evidence on the record that suggests FrontPath expects to lose or fears losing ProMedica as an in-network provider.

421 (e). FrontPath has no experience offering a limited Mercy-UTMC network and thus no basis for an assessment of the marketability of such a network. (RPF 342-343). Limited networks have performed successfully for years in Lucas County, and FrontPath experienced no competitive advantage when it offered a broad network to compete with the limited networks of other MCOs. (RPF 709-717, 807-808).

422. Humana's Director of Network Development for northern Ohio, Thomas McGinty, testified:

a. Humana used its negotiated rates with St. Luke's as a benchmark in negotiations with ProMedica. (PX02073 at 003 (¶ 11) (McGinty, Decl.), *in camera*).

b. The Acquisition eliminated Humana's ability to leverage St. Luke's independence against ProMedica and increased ProMedica "ability to leverage us [Humana] for rates for all of their hospitals and St. Luke's now as well." (McGinty, Tr. 1209; PX02073 at 003 (¶ 11) (McGinty, Decl.), *in camera*).

c. ProMedica's increased leverage applies with respect to both Humana's commercial and Medicare Advantage products, as there is nothing preventing ProMedica from seeking reimbursement rates greater than 100 percent of Medicare. (McGinty, Tr. 1209-1210).

d. Humana will have to choose between accepting higher rates from ProMedica and exiting the Lucas County market altogether. (McGinty, Tr. 12111-212; PX02073 at 004 (¶ 15) (McGinty, Decl.), *in camera*).

e. Were Humana to exit the market, there would be less competition among health plans and, thus, less incentive for the remaining health plans to pass lower rates on to consumers. (McGinty, Tr. 1212-1213).

Response to Finding No. 422:

422 (a). The proposed finding is inaccurate and misleading. In Lucas County, Humana is primarily active in government products like Medicare Advantage, which is not in the relevant product market. (RPF 402, 409). Humana only has 2000 commercially insured members in all of Lucas County, which Humana fears may relegate it to third-tier status among Lucas County MCOs. (RPF 405, 408). Humana has fewer than 100 discharges from St. Luke's *per year*. (RPF 405).

422 (b). The proposed finding is inaccurate and misleading. Given Humana's extremely low membership within Lucas County, the company has never had significant leverage against any provider. (McGinty, Tr. 1195). Mr. McGinty acknowledged Humana's lack of leverage in his discussion of reimbursement methodologies for its contracts in Lucas County. (McGinty, Tr. 1195-1196). He explained that an MCO prefers fixed price contracts and only takes percent-of-charge contracts when it lacks the leverage to insist upon other arrangements. He also reported

that *all* of Humana's hospital contracts in Lucas County are percent-of-charge contracts, reflecting its low leverage vis-à-vis *all* Lucas County hospitals, including St. Luke's. (McGinty, 1195-1196, 1205).

422 (c). Medicare Advantage is one of Humana's government products and is thus not part of the relevant product market. (RPF 409; McGinty, Tr. 1218 ("Q: Does Medicare Advantage replace Medicare coverage?" Mr. McGinty: That's what it does.").

422 (d). Complaint Counsel misrepresent Mr. McGinty's testimony. His statement regarding a possible exit from Lucas County relate to Humana's ability to succeed with its government Medicare Advantage product. (McGinty, Tr. 1211-1212). As Medicare Advantage is not part of the relevant product market, this testimony is irrelevant.

422 (e). As discussed in the response to CCPF 422(e), Mr. McGinty's speculation about leaving the Lucas County market relate to Humana's government product and are not relevant to this litigation.

423. United's VP of Network Management for nearly five years (until Dec. 2010), Gina Sheridan (the only health plan witness classed by ProMedica) testified:

   a. After the Acquisition was announced, Ms. Sheridan expected that rates at St. Luke's would likely increase because "ProMedica's rate structure [with United] was so substantially higher than St. Luke's to begin with" and because she believed that { } (Sheridan, Tr. 6698-6700, *in camera*).

   b. Prior to entering into a contract with ProMedica in September 2010, { } (Sheridan, Tr. 6693, *in camera*).

   c. United would face even greater difficulty serving its membership without ProMedica and St. Luke's than without ProMedica's pre-Acquisition hospital network in Lucas County. (Sheridan, Tr. 6687).

   d. United expects its rates to St. Luke's to rise as a result of the Acquisition. (PX01902 at 018 (Sheridan, IHT at 62), *in camera*).

e. The size of a hospital system is a factor that can influence that system's bargaining leverage against United. (Sheridan, Tr. 6686-6687).

f. It is more difficult for United to negotiate with larger hospitals and hospital systems than with smaller ones, because larger hospitals and hospital systems tend to be more important to United in terms of serving its membership. (Sheridan, Tr. 6686-6687).

g. It would be harder for United to serve its membership if it did not offer access to a large hospital or hospital system than if it did not offer access to a to a smaller one. (Sheridan, Tr. 6687).

h. ProMedica's hospital network in Lucas County has become larger as a result of the addition of St. Luke's. (Sheridan, Tr. 6701, *in camera*).

i. Prior to entering into a contract with ProMedica in September 2010, { .} (Sheridan, Tr. 6691-6693, *in camera*).

Response to Finding No. 423:

423 (a) Complaint Counsel insinuates that higher reimbursement rates are somehow improper, but higher reimbursement rates, in and of themselves, are not anticompetitive. (RPF 1332). The problem Ms. Sheridan identifies is not improperly high rates, but rates that were so low as to cause St. Luke's financial distress. United tracked data in the ordinary course of business that revealed that { }, which explains why Ms. Sheridan understood { }. (Sheridan, Tr. 6646-6651, *in camera*). St. Luke's was { }. Ms. Sheridan testified that she { }. (Sheridan, Tr. 6648, *in camera*). The financial reports she reviewed indicated St. Luke's would { } (Sheridan, Tr. 6648; RX-920 at 000001, *in camera*).

ProMedica's bargaining leverage or any change to its leverage is entirely unrelated to St. Luke's need to seek higher reimbursement rates. In any case, { } explanation of ProMedica's bargaining leverage is incomplete. Bargaining leverage in affected by more than just the number of hospitals in a given hospital system. A hospital's bargaining leverage depends upon many factors, both actual and perceived, including the range of services offers, the doctors with privileges practicing at the hospital, historical aspects of the hospital's relations with MCOs and trade-offs made during negotiations between hospitals and MCOs. (RPF 1320-1321, 1097-1104).

423 (b) Respondent has no specific response.

423 (c) The proposed finding is inaccurate and misleading. Complaint Counsel misrepresent Ms. Sheridan's testimony. Ms. Sheridan actually stated she could not testify to this proposition:

> "Q: And in fact the consequences to United would be more dire post-joinder if United couldn't reach agreement with ProMedica than before, correct?
>
> Ms. Sheridan: When I had that responsibility, St. Luke's was never in the negotiation. That was never ever an issue.
>
> Q. Uh-huh. Okay.
>
> Ms. Sheridan: So I can't – I can't answer that." (Sheridan, Tr. 6687-6688)

423 (d) The proposed finding is inaccurate and misleading. Complaint Counsel mischaracterizes Ms. Sheridan's testimony. Ms. Sheridan testified that she would have expected { } (PX01902 (Sheridan, Dep. at 63), *in camera* ({ }"). The critical factor was not the joining of two hospitals, but the

fact that { } as already described above in response to CCPF 423(a). (PX01902 (Sheridan, Dep. at 63), *in camera*).

423 (e) Bargaining leverage in affected by more than just the number of hospitals in a given hospital system. A hospital's bargaining leverage depends upon many factors, both actual and perceived, including the range of services offers, the doctors with privileges practicing at the hospital, historical aspects of the hospital's relations with MCOs and trade-offs made during negotiations between hospitals and MCOs. (RPF 1320-1321, 1097-1104).

423 (f) Complaint Counsel's proposed finding and the underlying testimony are vague in that there is no definition given of what constitutes a "larger" hospital or hospital system in United's perspective. (*Compare* RPF 87 (showing Fulton County Health Center staffs 25 beds) *with* RPF 213 (showing ProMedica's Bay Park Community Hospital staffs 86 beds) *and* RPF 119 (showing St. Luke's staffs 214 beds); *compare* RPF 68 (showing ProMedica Health System operates 11 hospitals in two states) *with* RPF139-142 (showing Catholic Health Partners operates in five states and has at least six hospitals within its northern division alone). Without any benchmark for Ms. Sheridan's testimony, the proposed finding supports no conclusions.

423 (g) Respondent refers to its response to CCPF 423(f) which it incorporates here by reference.

423 (h) Respondent has no specific response.

423 (i) United's network membership did not change (up or down) when it swapped the Mercy hospitals for ProMedica hospitals in 2006. (RPF 364).

424. Health plan representatives testified that their firms will have little choice but to pass any rate increases at St. Luke's or ProMedica's legacy hospitals after the Acquisition to both their self- and fully-insured members. (Pugliese, Tr. 1554; Pirc, Tr. 2174; PX01944 at 020 (Pirc, Dep. at 76), *in camera*; Radzialowski, Tr. 779; Sandusky, Tr. 1296; McGinty Tr. 1210-1211; PX02073 at 004 (¶ 16) (McGinty, Decl.), *in camera*; Sheridan, Tr. 6701, *in camera*; PX01900 at 011 (Mullins, IHT at 39-40), *in camera*).

Response to Finding No. 424:

The proposed finding is inaccurate and misleading. Complaint Counsel's proposed finding improperly cites investigational hearing testimony (PX01900) that is based upon leading questions and was not subject to cross-examination. Furthermore, Complaint Counsel mischaracterize other witness testimony in several respects.

First, Complaint Counsel portray the MCOs as the passive recipients of rate increases ("...firms will have little choice..."). Testimony in this matter plainly contradicts this view. Negotiations between MCOs and hospitals are complex, drawn-out, and sometimes contentious, with each side striving to achieve the most favorable rates it can. (RPF 1062-1064). MCOs insist upon provisions that protect their members from unexpected rate increases. Whereas some hospitals may prefer flexible percent-of-charge contracts, MCOs seek—and obtain—contracts that include a significant degree of predictable, fixed pricing. (RPF 582, 583, *in camera*, 584). MCOs also insist upon chargemaster limit provisions that prevent hospitals from increasing their rates above an agreed annual inflator percentage. (RPF 1086, 1837, *in camera*, 1866-1867, *in camera*). MCOs also demand most-favored nation clauses that are designed to reduce the MCO's rates whenever a competitor achieves a more favorable bargain in its negotiations with a hospital. (RPF 596, 600). MCO witnesses repeatedly testified that they do not passively accept a hospital's proposed increases and resist all unacceptable increases. (RPF 1368-1380, *in camera*, 1391, *in camera*, 1406-1410, *in camera*).

Second, Complaint Counsel wrongly suggest that "any" increase in rates for general acute-care inpatient services is passed on to members. This statement is also contradicted by witness testimony. As already mentioned above, hospital rate increases are constrained by various contractual provisions such as chargemaster limits, which protect fully and self-insured

members from unexpected increases and annual increases that exceed the amount allowed by the member's contract.

Fully insured members benefit from an extra layer of protection. MCO witnesses consistently testified that an MCO cannot pass along increases in general acute-care inpatient service rates to their fully insured members for the entire duration of the insurance contract, which may be up to three years. (RPF 444-447). A change in rates for general acute-care inpatient services will thus not affect their premium during the term of their contract. (RPF 447).

In addition, Complaint Counsel wrongly suggest that increases in rates for general acute-care inpatient services automatically translate into premium increases. This suggestion overlooks the fact that the premiums MCOs charge to employers cover the cost for a wide range of medical services as well as the MCO's own sizeable administrative expenses. (RPF 384, 427, 656). An employer's total healthcare cost may remain unchanged in spite of any potential increase in rates because general acute-care inpatient hospital rates are only one, small component of its total premium costs. (RPF 653-657). Only about 6 percent of commercial insureds actually go to a hospital for inpatient service each year. (RPF 441). This low level of usage factors into premium levels. Premiums also depend upon myriad other factors including non-hospital, medical expenses as well as the nature and demographic make-up of the employee population being insured. (RPF 654). Ultimately, the vast majority of premium costs depend upon costs other than general acute-care inpatient services, and these costs alone do not necessarily determine whether a premium will increase or decrease. (RPF 656).

Finally, increases in premiums are also not necessarily attributable to actual increases in general acute-care inpatient rates. MCO testimony revealed that MCOs anticipate *possible* increases and build these increases into their premiums before such increases occur, if in fact

they occur at all. When the increase does not occur or a lower than anticipated increase is successfully negotiated by the MCO, the MCOs do not reduce the employer premium. (RPF 450, 757, *in camera*).

3. The Acquisition Has Left ProMedica Even More Dominant Than Before

425. Prior to the Acquisition, ProMedica acknowledged its dominance in the Lucas County market through ordinary course documents:

   a. A Standard & Poor's credit presentation stated: "ProMedica Health System has market dominance in the Toledo MSA." (PX00270 at 025 (ProMedica "Credit Presentation" to Standard & Poor's on 04/02/2008); *see also* Oostra, Tr. 5964-5965, 5973-5974).

   b. A 2009 planning presentation for The Toledo Hospital states: "As Healthcare evolves it is critical that ProMedica evolves to maintain its competitive dominance in the Region." (PX00221 at 002 (Heart Vascular Institute and Toledo Hospital Campus)).

   c. A 2010 presentation noted ProMedica's "leading market position within the Toledo metropolitan area," celebrating "dominant market share[s]" in oncology, orthopedics, and women's services. (PX00320 at 003 (Kaufman Hall Presentation on ProMedica's Credit and Capital Position)).

   d. In its "2010 Environmental Assessment," ProMedica noted its status as a "clear market leader" in cancer services and orthopedics. (PX00159 at 012-013, *in camera*). Regarding obstetrics services, the document states: "ProMedica has expanded on its already commanding share of the women's product line in metro Toledo, growing from 65.0% in 2008 to 65.9% through nine months of 2009." (PX00159 at 013 (ProMedica "2010 Environmental Assessment"), *in camera*).

   e. In documents from 2009, ProMedica noted that it was the "clear market leader" in inpatient women's hospital services for the metro Toledo area, with a "commanding and largely stable market share" of 65% as of June 2008. (PX00249 at 004 (Memorandum from Steele (ProMedica) Re: Market Share Info, March 6, 2009); PX00265 at 060 (ProMedica "2009 Environmental Assessment Draft"), *in camera*).

   f. In a strengths, weaknesses, opportunities and threats ("SWOT") analysis, ProMedica listed its "[d]ominant market share" as a strength. (PX00319 at 001 ("TTH Medical Executive Committee SWOT Analysis Results 2007")).

<u>Response to Finding No. 425:</u>

With regard to document PX00270 at 025, Mr. Oostra testified that the quoted statement does not reflect ProMedica's view of itself today and does not recall anyone at the meeting with Standard & Poor's making that statement. (Oostra, Tr. 5966). Mr. Oostra testified that the quoted statement was just a heading that an unknown person at ProMedica wrote. (Oostra, Tr. 5967).

With regard to document PX00320, this document was created by Kauffman Hall and given to ProMedica; it does not necessarily reflect ProMedica's view. (PX00320 at 001) ("Copyright 2010 Kauffman, Hall & Associates, Inc. All rights reserved."). The same page of the document also notes that ProMedica faces "Strong competition from Mercy Health System." (PX00320 at 003).

With regard to document PX00159, page 12 also states that {

.} (PX00159 at 012, *in camera*). Similarly, page 13 notes that { } (PX00159 at 013, *in camera*). { .} (PX00159 at 013, *in camera*).

On page 4 of PX00249, it also notes that ProMedica's market share decreased for women's services and across all product lines measured in the chart, ProMedica's market share decreased. (PX00249 at 004).

Document PX00265 notes that {

.} (PX00265 at 053, *in camera*). The document also states that {

.} (PX00265 at 057, *in camera*). {

} (PX00265 at 060, *in camera*).

Document PX00319 also noted that one of the threats to ProMedica was "migration of business to Cleveland, Ann Arbor and Detroit." (PX00319).

426. ProMedica's pre-Acquisition dominance was evident in its ability to successfully negotiate { } exclusion from Anthem's network for { }. (PX00231 at 015 (Anthem Letter of Agreement), *in camera*).

Response to Finding No. 426:

This proposed finding is misleading because it assumes that ProMedica forced { } to exclude { } when in reality it was the result of mutual agreement. (RPF 761-764, *in camera*, 765-766, 767-773, *in camera*). { .} (RPF 761, *in camera*). In return, { } (RPF 764, *in camera*). { } (RPF 769, *in camera*). { } (RPF 770-771, *in camera*). { .} (RPF 772, *in camera*).

{ .} (RPF 773, *in camera*).

427. As a result of ProMedica's demands, Anthem was prohibited from adding { } to its network before { }; and if { } was added after that date, ProMedica would increase rates to Anthem by { }. (PX00231 at 015 (Anthem Letter of Agreement), *in camera*; PX00234 at 003-004 (2007 "PHS Managed Care Approach")). In an email, ProMedica's Senior VP for Managed Care, Reimbursement and Revenue Cycle Management, Ron Wachsman, explained that "Anthem cannot sign up st. lukes [sic] until 7/1/09 and will have to pay PHS for the privilege." (PX00380 at 001 (Wachsman (ProMedica) email, 5/7/08)).

Response to Finding No. 427:

This proposed finding is misleading because it assumes the ProMedica forced { } to exclude { } when in reality it was the result of mutual agreement. (RPF 761-764, *in camera*, 765-766, 767-773, *in camera*). { } (RPF 761, *in camera*). In return, { } (RPF 764, *in camera*). 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. (RPF 774). 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. (RPF 775).

Moreover, { } (RPF 776, *in camera*). {

} (RPF 778, *in camera*).

428. Prior to the Acquisition, ProMedica had the highest market shares for inpatient general acute-care and obstetrics services and the highest prices in Lucas County. (PX02148 at 143 (Ex. 6), 145 (Ex. 7) (Town Expert Report), *in camera*; *see also* PX00153 at 001 (Email from Oostra (ProMedica) to Steele (ProMedica), Jan. 14, 2009) ("we hear from payors we are among the most expensive in ohio [sic]")).

Response to Finding No. 428:

Professor Town's market shares for inpatient general acute care services are flawed because he limits his "market" to only those general acute care inpatient services (identified as "diagnostic related groups" or "DRGs") that both ProMedica and St. Luke's provided to at least three commercially-insured patients (RPF 1491), thereby eliminating from his "market" (and his share calculations) many services that ProMedica, Mercy, and UTMC offer and provide. (RPF 1489-1493, 1504, 1510, *in camera*). Professor Town also excluded overlapping St. Luke's and ProMedica DRGs for which St. Luke's and ProMedica compete with hospitals outside of Lucas County (RPF 1494-1495), and DRGs with a case weight index, which reflects complexity of care, greater than two. (RPF 1496). {

} (RX-71(A) at 000015-000018, *in camera*). Professor Town included, however, some DRGs with case weights higher than four, which captures some services that could be classified as tertiary or quaternary medical services. (RPF 1500).

Professor Town's case-mix adjusted prices do not indicate the reason for the difference in prices across hospitals in Lucas County, and Professor Town agrees that the presence of price differences alone are not sufficient to determine the exercise of market power. (RPF 1515). No

theoretical or empirical basis exists on which to draw inferences of market power from a comparison of price levels across hospitals. (RX-71(A) at 000069, *in camera*). Professor 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. (RPF 1520). These case-mix-adjusted prices also do not take into consideration the complexity of the bargaining process. (RPF 1521). Moreover, Professor Town's calculated prices are contradicted by St. Luke's ordinary course documents. (*See e.g.*, PX01016 at 009, *in camera*)

{

}. Finally, Mr. Oostra testified that {

} for the point that ProMedica is expensive. (Oostra, Tr. 5934, *in camera*).

429. Professor Town's examination of hospital prices in Lucas County prior to the Acquisition demonstrates that ProMedica's average price was { } percent higher than Mercy's, { } percent higher than UTMC's, and { } percent higher than St. Luke's. PX02148 at 145 (Ex. 7) (Town Expert Report), *in camera*). Professor Town's analysis of hospital prices used case-mix adjustment to control for variation in case-mix, severity, and patient demographics across hospitals, and to allow for an apples-to-apples comparison of prices. PX02148 at 037 (¶68, n. 107) (Town Expert Report), *in camera*; Town, Tr. 3722-3725, *in camera*). Health plan testimony supports the general conclusion of Professor Town's price comparison. (Pirc, Tr. 2238-2242, *in camera*; Radzialowski, Tr. 684, *in camera*, 687-688, *in camera*, 698-700, *in camera*; Sandusky, Tr. 1338-1348, *in camera*, 1350, *in camera*; *see* Pugliese, Tr. 1512-1513).

<u>Response to Finding No. 429:</u>

Professor Town's case-mix-adjusted price estimations do not indicate the reason for the difference in prices across hospitals in Lucas County, and Professor Town agrees that the presence of price differences alone are not sufficient to determine the exercise of market power. (RPF 1515, in camera). No theoretical or empirical basis exists on which to draw inferences of market power from a comparison of price levels across hospitals. (RX-71(A) at 000069, *in camera*). {

} (RPF 1527, *in camera*). However, Professor Town's case-mix-adjusted price calculations result in Mercy's prices being higher. (RPF 1527). {

}. (RPF 1528, *in camera*) {

} (RPF 1528, *in camera*). Professor 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. (RPF 1525).

Furthermore, if Professor 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. (RFP 1531). Professor 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. (RPF 1532). 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. (RPF 1533). For Blue Cross Blue Shield of Michigan ("BCBS of Michigan"), St. Vincent's price is higher than that of TTH's. (RPF 1534). For FrontPath, St. Anne's price is higher than TTH's, St. Vincent's, UTMC's, and Flower's. (RPF 1535).

Moreover, Professor Town's price computations are also contradicted by St. Luke's ordinary course documents showing ProMedica's prices are not highest among Lucas County hospitals; instead they show { } having the highest prices among Lucas County hospitals.

See e.g., (PX01016 at 009, *in camera*). Professor Town's price computations also do not take into account payor testimony explaining the rate differences, such as {

} (Pirc, Tr. 2316-2315, *in camera*). {

} (Pirc, Tr. 2316, *in camera*). {

} (Pirc, Tr. 2316, *in camera*).

Finally, several of the testimony Complaint Counsel cites either directly contradicts Professor Town's model or does not support the premised for which it is cited. {

} (Radzialowski, Tr. 684, *in camera*).

{

} (Sandusky, Tr. 1338-1348, *in camera*). {

} (Sandusky, Tr. 138-1339, *in camera*). {

} (Pugliese, Tr. 1513, *in camera*).

430. If product and geographic markets are properly defined, market shares are generally indicative of a firm's market power, and this is equally true for hospitals in Lucas County. (PX02148 at 035 (¶ 62) (Town Expert Report), *in camera*; Town, Tr. 3645-3646). The relationship between market share and hospital prices is highly informative in this case. (PX02148 at 039 (¶ 71) (Town Expert Report), *in camera*).

Response to Finding No. 430:

Professor Town's case-mix-adjusted price estimations do not indicate the reason for the difference in prices across hospitals in Lucas County, and Professor Town agrees that the presence of price differences alone are not sufficient to determine the exercise of market power. (RPF 1515, in camera). No theoretical or empirical basis exists on which to draw inferences of market power from a comparison of price levels across hospitals. (RX-71(A) at 000069, *in camera*). Moreover, PX01016 at 9 shows that rates follow costs, not share. (PX01016 at 009). UTMC, an academic medical center that provides transplants has the highest costs and highest rates. (PX01016 at 009). In addition, {

} (RPF 1527, *in camera*). However, Professor Town's case-mix-adjusted price calculations result in Mercy's prices being higher. (RPF 1527). {

}. (RPF 1528, *in camera*) {

} (RPF 1528, *in camera*). Professor 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. (RPF 1525).

Furthermore, if Professor 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. (RFP 1531). Professor 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. (RPF 1532). 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. (RPF 1533). For Blue Cross Blue Shield of Michigan ("BCBS of Michigan"), St. Vincent's price is higher than that of TTH's. (RPF 1534). For FrontPath, St. Anne's price is higher than TTH's, St. Vincent's, UTMC's, and Flower's. (RPF 1535).

431. Professor Town's examination of hospital prices and market shares in Lucas County prior to the Acquisition demonstrates {a high correlation between market shares and prices}. (PX02148 at 039 (¶ 71), 147 (Ex. 8) (Town Expert Report), *in camera*). ProMedica, the system with the highest market share, had the highest prices. (PX02148 at 039 (¶ 71), 147 (Ex. 8) (Town Expert Report), *in camera*). Mercy, the system with the second-highest share, had the second- highest prices. (PX02148 at 039 (¶ 71), 147 (Ex. 8) (Town Expert Report), *in camera*). UTMC, with the third-highest share, had the third-highest prices. (PX02148 at 039 (¶ 71), 147 (Ex. 8) (Town Expert Report), *in camera*). And St. Luke's, with the smallest share, had {the lowest prices}. (PX02148 at 039 (¶ 71), 147 (Ex. 8) (Town Expert Report), *in camera*). Health plans have confirmed Professor Town's analysis of the relative price difference between ProMedica and St. Luke's by testifying that ProMedica's rates are the highest and St. Luke's rates are the lowest in Lucas County. Pirc, Tr. 2238-2242, *in camera*; Radzialowski, Tr. 684, *in camera*, 687-688, *in camera*, 698-700, *in camera*; Sandusky, Tr. 1338-1348, *in camera*, 1350, *in camera*; PX02296 at 001, *in camera*; *see* Pugliese, Tr. 1512-1513, *in camera*; McGinty, Tr. 1210).

Response to Finding No. 431:

Professor Town's case-mix-adjusted price estimations do not indicate the reason for the difference in prices across hospitals in Lucas County, and Professor Town agrees that the presence of price differences alone are not sufficient to determine the exercise of market power. (RPF 1515, in camera). No theoretical or empirical basis exists on which to draw inferences of market power from a comparison of price levels across hospitals. (RX-71(A) at 000069, *in camera*). {

.} (RPF 1527, *in camera*). However, Professor Town's case-mix-adjusted price calculations result in Mercy's prices being higher. (RPF 1527). {

}. (RPF 1528, *in camera*) {

} (RPF 1528, *in camera*). Professor 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. (RPF 1525).

Furthermore, if Professor 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. (RFP 1531). Professor 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. (RPF 1532). 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. (RPF 1533). For Blue Cross Blue Shield of Michigan ("BCBS of Michigan"), St. Vincent's price is higher than that of TTH's. (RPF 1534). For FrontPath, St. Anne's price is higher than TTH's, St. Vincent's, UTMC's, and Flower's. (RPF 1535).

Moreover, Professor Town's price computations are also contradicted by St. Luke's ordinary course documents showing ProMedica's prices are not highest among Lucas County hospitals; instead they show { } having the highest prices among Lucas County hospitals. *See e.g.*, (PX01016 at 009, *in camera*). PX01016 at 9 shows that rates follow costs, not share. (PX01016 at 009). Professor Town's price computations also do not take into account payor testimony explaining the rate differences, such as {

.} (Pirc, Tr. 2316-2315, *in camera*). {

.} (Pirc, Tr. 2316, *in camera*). {

} (Pirc, Tr. 2316, *in camera*).

Finally, several of the testimony Complaint Counsel cites either directly contradicts Professor Town's model or does not support the premised for which it is cited. {

} (Radzialowski, Tr. 684, *in camera*).

{

.} (Sandusky, Tr. 1338-1348, *in camera*). {

.} (Sandusky, Tr. 138-1339, *in camera*). {

.} (Pugliese, Tr. 1513, *in camera*). Mr. McGinty of Humana (which had no commercially insured discharges from St. Luke's in 2010) testified only that in terms of effective discount, the variance between ProMedica's rates and St. Luke's rates is 20 percent; he said nothing about rates at any other hospitals. (McGinty, Tr. 1210).

432. The Acquisition increased ProMedica's market share among Lucas County hospitals from 47 percent to 58 percent for inpatient general acute-care services, and from 71 percent to over 80 percent for inpatient obstetrics services. (PX02148 at 143 (Ex. 6) (Town Expert Report), *in camera*). The increases in ProMedica's market shares, and the resulting increase in market concentration, create a strong presumption of enhanced

market power from the Acquisition. (PX02148 at 035-036 (¶ 63) (Town Expert Report), *in camera*).

Response to Finding No. 432:

Professor Town's market shares for inpatient general acute care services are flawed not only because he uses less than one year's worth of data, (PX02148 at 143, *in camera*) ("Based on hospital discharges with commercial insurance from July 2009 through March 2010"), but also because he limits his "market" to only those general acute care inpatient services (identified as "diagnostic related groups" or "DRGs") that both ProMedica and St. Luke's provided to at least three commercially-insured patients (RPF 1491), thereby eliminating from his "market" (and his share calculations) many services that ProMedica, Mercy, and UTMC offer and provide. (RPF 1489-1493, 1504, 1510, *in camera*). Professor Town also excluded overlapping St. Luke's and ProMedica DRGs for which St. Luke's and ProMedica compete with hospitals outside of Lucas County (RPF 1494-1495), and DRGs with a case weight index, which reflects complexity of care, greater than two. (RPF 1496). Professor Town included, however, some DRGs with case weights higher than four, which captures some services that could be classified as tertiary or quaternary medical services. (RPF 1500).

Moreover, Professor Town's market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

When market shares are measured using billed charges, rather than patient days, to reflect the fact that many DRGs and service lines cost more, require longer stays and, hence, generate

higher revenues, St. Luke's has only a { } percent share of the general acute care inpatient services market, inclusive of inpatient OB services, for Lucas County. (RX-71(A)-000036-000037, *in camera*). { } combined have a higher share than ProMedica in Lucas County. (RX-71(A) at 000036-000037, *in camera*). Looking only at inpatient OB services, St. Luke's share is only { } percent based on billed charges in Lucas County. (RX-71(A) at 000036-000037, *in camera*). For all {

} of all hospitals in Lucas County based on billed charges. (RX-71(A)-000036-000037, *in camera*).

Finally, the last sentence of the proposed finding is not a fact, but an improper legal argument.

433. In St. Luke's core service area, the eight zip codes from which St. Luke's draws most of its patients, the Acquisition increased ProMedica's market share in inpatient general acute care services from 38 percent to 72 percent. (*See* PX02148 at 161 (Ex. 11) (Town Expert Report), *in camera*).

Response to Finding No. 433:

Professor Town's market shares for inpatient general acute care services are flawed not only because he uses less than one year's worth of data, (PX02148 at 143, *in camera*) ("Based on hospital discharges with commercial insurance from July 2009 through March 2010"), but also because he limits his "market" to only those general acute care inpatient services (identified as "diagnostic related groups" or "DRGs") that both ProMedica and St. Luke's provided to at least three commercially-insured patients (RPF 1491), thereby eliminating from his "market" (and his share calculations) many services that ProMedica, Mercy, and UTMC offer and provide. (RPF 1489-1493, 1504, 1510, *in camera*). Professor Town also excluded overlapping St. Luke's and ProMedica DRGs for which St. Luke's and ProMedica compete with hospitals outside of Lucas County (RPF 1494-1495), and DRGs with a case weight index, which reflects complexity of

care, greater than two. (RPF 1496). Professor Town included, however, some DRGs with case weights higher than four, which captures some services that could be classified as tertiary or quaternary medical services. (RPF 1500).

Moreover, Professor Town's market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

Furthermore, St. Luke's core service area is not the relevant geographic market and focusing on market share in this area distorts St. Luke's competitive significance. (RPF 1036-1049). As Complaint Counsel and their economic expert agree, the relevant geographic market is all of Lucas County and hospitals compete for patients across that market. (RPF 1028-1030).

Finally, the proposed finding is misleading because it overlooks the fact that St. Luke's only treats about ten commercially insured patients per day. (RFP 1147; PX02137 at 055, *in camera*).

434. In St. Luke's core service area, ProMedica's post-Acquisition market share in inpatient general acute care services is 183 percent higher than the combined market shares of Mercy and UTMC in this same area. (*See* PX02148 at 161 (Ex. 11) (Town Expert Report), *in camera*).

Response to Finding No. 434:

Professor Town's market shares for inpatient general acute care services are flawed not only because he uses less than one year's worth of data, (PX02148 at 143, *in camera*) ("Based on hospital discharges with commercial insurance from July 2009 through March 2010"), but also because he limits his "market" to only those general acute care inpatient services (identified as

"diagnostic related groups" or "DRGs") that both ProMedica and St. Luke's provided to at least three commercially-insured patients (RPF 1491), thereby eliminating from his "market" (and his share calculations) many services that ProMedica, Mercy, and UTMC offer and provide. (RPF 1489-1493, 1504, 1510, *in camera*). Professor Town also excluded overlapping St. Luke's and ProMedica DRGs for which St. Luke's and ProMedica compete with hospitals outside of Lucas County (RPF 1494-1495), and DRGs with a case weight index, which reflects complexity of care, greater than two. (RPF 1496). Professor Town included, however, some DRGs with case weights higher than four, which captures some services that could be classified as tertiary or quaternary medical services. (RPF 1500).

Moreover, Professor Town's market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

Furthermore, St. Luke's core service area is not the relevant geographic market and focusing on market share in this area distorts St. Luke's competitive significance. (RPF 1036-1049). As Complaint Counsel and their economic expert agree, the relevant geographic market is all of Lucas County and hospitals compete for patients across that market. (RPF 1028-1030).

Finally, the proposed finding is misleading because it overlooks the fact that St. Luke's only treats about ten commercially insured patients per day. (RFP 1147; PX02137 at 055, *in camera*).

435. In St. Luke's core service area, the Acquisition increased ProMedica's market share in inpatient obstetrics services from 69 percent to 87 percent. (*See* PX02148 at 161 (Ex. 11) (Town Expert Report), *in camera*).

Response to Finding No. 435:

Professor Town's market shares for obstetric services are flawed not only because he uses less than one year's worth of data, (PX02148 at 143, *in camera*) ("Based on hospital discharges with commercial insurance from July 2009 through March 2010"), but also because he 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. (RPF 1501).

Furthermore, St. Luke's core service area is not the relevant geographic market and focusing on market share in this area distorts St. Luke's competitive significance. (RPF 1036-1049). As Complaint Counsel and their economic expert agree, the relevant geographic market is all of Lucas County and hospitals compete for patients across that market. (RPF 1028-1030).

Finally, the proposed finding is misleading because it overlooks the fact that St. Luke's only treats about ten commercially insured patients per day. (RFP 1147; PX02137 at 055, *in camera*).

436. In St. Luke's core service area, ProMedica's post-Acquisition market share in inpatient obstetrics services is 653 percent higher than Mercy's market share in this same area. (*See* PX02148 at 161 (Ex. 11) (Town Expert Report), *in camera*).

Response to Finding No. 436:

Professor Town's market shares for obstetric services are flawed not only because he uses less than one year's worth of data, (PX02148 at 143, *in camera*) ("Based on hospital discharges with commercial insurance from July 2009 through March 2010"), but also because he 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. (RPF 1501).

Furthermore, St. Luke's core service area is not the relevant geographic market and focusing on market share in this area distorts St. Luke's competitive significance. (RPF 1036-1049). As Complaint Counsel and their economic expert agree, the relevant geographic market is all of Lucas County and hospitals compete for patients across that market. (RPF 1028-1030).

Finally, the proposed finding is misleading because it overlooks the fact that St. Luke's only treats about ten commercially insured patients per day. (RFP 1147; PX02137 at 055, *in camera*).

437. Professor Town's analysis of willingness-to-pay demonstrates that, before the Acquisition, consumers placed 22 percent more value on having in-network access to ProMedica than to Mercy's Lucas County hospitals. (PX02148 at 066 (¶ 118), 165 (Ex. 13) (Town Expert Report), *in camera*).

Response to Finding No. 437:

Professor Town's "willingness-to-pay" calculation is unreliable for several reasons. First, he includes OB patients in the data, but excludes newborns. (RPF 1550). Professor 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." (RPF 1550). Second, he includes data from hospitals located outside of Lucas County, and therefore outside the relevant geographic market. (RPF 1565). Third, Professor Town's merger simulation model does not allow one to independently or directly observe a patient's second choice of hospitals if his or her first choice becomes unavailable or more expensive. (RPF 1566). Professor Town simply estimates the probability that a given patient would choose a certain hospital if St. Luke's were not available. (Town, Tr. 4243). But, Professor Town admits that the choice a consumer makes "is almost, by

definition, going to be different" from the choice that he estimates. (RPF 1567). Fourth, although Professor Town acknowledges that one must appropriately control for the intrinsic value associated with a hospital, he does not. (RPF 1568-1569). Moreover, his willingness-to-pay is based on a bargaining model characterizing negotiations between hospital systems and commercial payors to set prices. (RX-71(A) at 000072, *in camera*). However, Professor Town's bargaining model is too simplistic to accurately represent the bargaining dynamics in Lucas County because it ignores elements such as the history a provider and MCO have that can affect bargaining. *See* (RPF 1097-1104).

438. Professor Town's analysis of willingness-to-pay demonstrates that the Acquisition has increased willingness-to-pay for ProMedica by 50 percent. (PX02148 at 066 (¶ 118), 165 (Ex. 13) (Town Expert Report), *in camera*).

Response to Finding No. 438:

Professor Town's "willingness-to-pay" calculation is unreliable for several reasons. First, he includes OB patients in the data, but excludes newborns. (RPF 1550). Professor 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." (RPF 1550). Second, he includes data from hospitals located outside of Lucas County, and therefore outside the relevant geographic market. (RPF 1565). Third, Professor Town's merger simulation model does not allow one to independently or directly observe a patient's second choice of hospitals if his or her first choice becomes unavailable or more expensive. (RPF 1566). Professor Town simply estimates the probability that a given patient would choose a certain hospital if St. Luke's were not available. (Town, Tr. 4243). But, Professor Town admits that the choice a consumer makes "is almost, by definition, going to be different" from the choice that he estimates. (RPF 1567). Fourth, although Professor Town acknowledges that one must appropriately control for the intrinsic

value associated with a hospital, he does not. (RPF 1568-1569). Moreover, his willingness-to-pay is based on a bargaining model characterizing negotiations between hospital systems and commercial payors to set prices. (RX-71(A) at 000072, *in camera*). However, Professor Town's bargaining model is too simplistic to accurately represent the bargaining dynamics in Lucas County because it ignores elements such as the history a provider and MCO have that can affect bargaining. *See* (RPF 1097-1104).

439. Professor Town's analysis of willingness-to-pay demonstrates that the Acquisition has increased ProMedica's bargaining leverage by 14 percent. (PX02148 at 066 (¶ 118), 165 (Ex. 13) (Town Expert Report), *in camera*).

Response to Finding No. 439:

Professor Town's "willingness-to-pay" calculation is unreliable for several reasons. First, he includes OB patients in the data, but excludes newborns. (RPF 1550). Professor 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." (RPF 1550). Second, he includes data from hospitals located outside of Lucas County, and therefore outside the relevant geographic market. (RPF 1565). Third, Professor Town's merger simulation model does not allow one to independently or directly observe a patient's second choice of hospitals if his or her first choice becomes unavailable or more expensive. (RPF 1566). Professor Town simply estimates the probability that a given patient would choose a certain hospital if St. Luke's were not available. (Town, Tr. 4243). But, Professor Town admits that the choice a consumer makes "is almost, by definition, going to be different" from the choice that he estimates. (RPF 1567). Fourth, although Professor Town acknowledges that one must appropriately control for the intrinsic value associated with a hospital, he does not. (RPF 1568-1569).

Moreover, his willingness-to-pay is based on a bargaining model characterizing negotiations between hospital systems and commercial payors to set prices. (RX-71(A) at 000072, *in camera*). However, Professor Town's bargaining model is too simplistic to accurately represent the bargaining dynamics in Lucas County because it ignores elements such as the history a provider and MCO have that can affect bargaining. *See* (RPF 1097-1104).

B. ProMedica Will Exercise its Increased Leverage to Extract Higher Rates

1. Nonprofits, Including ProMedica, Seek to Maximize Revenues and Profits

440. ProMedica's documents demonstrate that, despite its nonprofit status, maximizing revenues is one of its central goals. (PX00384 at 014 (ProMedica's Managed Care Strategy, Jul. 23, 2007) (under all health-plan strategies, ProMedica considers the maximization of cost-coverage ratios for managed-care contracts to be an essential element); PX00270 at 054 (ProMedica Credit Presentation to Standard & Poor's, Apr. 2, 2008) ("Improved profitability continues as a key objective for the System.")).

Response to Finding No. 440:

This proposed finding mischaracterizes the record. To begin, Complaint Counsel cite to no evidence characterizing "maximizing revenues" as one of ProMedica's "central goals." (PX00384 at 014). In addition, both non-profit and for-profit hospitals have a margin of revenue that they need and aim to achieve. (RPF 481). Hospitals in and around Lucas County, not just ProMedica, 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. (RPF 482). ProMedica seeks to improve its profitability so that it can cover its full operating expenses, including unfunded charity and government insurance shortfalls. (RPF 496).

441. ProMedica's profit-seeking behavior has caused some confusion in the community concerning ProMedica's nonprofit status. (PX00242 at 017 (2005-2007 ProMedica strategic analysis) ("Threats" to ProMedica's "Philanthropic Strategy": "Continued perception that PHS and its hospitals are for-profit organizations"); PX00271 at 019 ("Listening Tour" Notes, Jan. 8, 2010), *in camera* ("ProMedica is forced to apologize for

our success – why are we a not-for-profit? Should we convert to a for-profit? ProMedica brand: 'successful business pursuing a profit'. . .")).

Response to Finding No. 441:

The proposed finding mischaracterizes the record and is misleading. ProMedica internally noted that there was a perception that "PHS and its hospitals are for-profit organizations," but nowhere did ProMedica attribute that to "profit-seeking behavior," and no community member has testified to that. (PX00242). Complaint Counsel further misstate and mischaracterize the record in their cite to ProMedica's "Listening Tour" Notes (PX00271 at 019, *in camera*). The quote Complaint Counsel cite, {

} is in fact two separate bullet points from a summary of concerns with respect to the ProMedica Continuing Care Services ("PCCS") board, one of ProMedica's many boards. (PX00271 at 019, *in camera*). That is, these are two separate suggestions coming from one of ProMedica's boards. The finding is misleading by suggesting they are meant to be read together, that it speaks for ProMedica as a whole, or that any steps were taken to implement these suggestions.

442. According to health plans, both nonprofit hospitals and for-profit hospitals attempt to maximize commercial reimbursement rates to the full extent that their bargaining leverage will allow. (Pugliese, Tr. 1462-1463; Pirc, Tr. 2212-2213; Radzialowski, Tr. 670, 740; Sandusky, Tr. 1330; McGinty Tr. 1185-1186; Sheridan, Tr. 6684-6685; PX01900 at 010-011 (Mullins, IHT at 34-35, 37), *in camera*).

Response to Finding No. 442:

This proposed finding mischaracterizes the record. The record shows that nonprofit hospitals attempt to maximize commercial reimbursement rates in order to fund capital expenditures, expansion, and maintain a strong balance sheet, as well as cover their full

operating expenses, including unfunded charity and government insurance shortfalls, which benefit the community. (RPF 482, 496).

443. ProMedica's economic expert, Margaret Guerin-Calvert, testified that she has never heard of a hospital knowingly failing to maximize its reimbursements from health plans. (PX01925 at 057 (Guerin-Calvert, Dep. at 220)).

Response to Finding No. 443:

Respondent has no specific response.

444. Other nonprofit hospitals in the area exercise their bargaining leverage to secure the highest possible compensation from commercial health plans. (Shook, Tr. 950, 1050; Gold, Tr. 207-208, 209-210, 300; Beck, Tr. 408).

Response to Finding No. 444:

Respondent has no specific response.

2. ProMedica Will Apply Its Additional Bargaining Leverage From the Acquisition Towards Obtaining Higher Reimbursement Rates

445. ProMedica seeks to maximize its revenues and its reimbursement rates from commercial health plans. (Wachsman, Tr. 5145-5146, *in camera*; PX01906 at 066 (Oostra, IHT at 259-260), *in camera* ("Q: Is ProMedica happy with the rates that they have with managed care organizations? A: No. We would always like more.")).

Response to Finding No. 445:

The proposed finding is an incomplete statement of the record. ProMedica attempts to maximize commercial reimbursement rates in order to fund capital expenditures, expansion, and maintain a strong balance sheet, as well as cover their full operating expenses, including unfunded charity and government insurance shortfalls. (RPF 482, 496).

446. ProMedica would not voluntarily pass along cost savings to commercial health plans in the form of reduced rates. (Wachsman, Tr. 5145, *in camera*).

Response to Finding No. 446:

The proposed finding misstates and mischaracterizes the record. Although Mr. Wachsman testified that ProMedica would not {

} Mr.

Wachsman clarified that ProMedica {

} (Wachsman, Tr. 5145, *in camera*).

447. Two of the individuals at ProMedica responsible for managed care contracting, Ronald Wachsman and Amy Hutt, receive bonus compensation that is based, in part, on the rates achieved from health plans in negotiations. (Wachsman, Tr. 5097-5098).

Response to Finding No. 447:

The proposed finding mischaracterizes the record. Mr. Wachsman testified that his negotiations with health plans only factor into his compensation in "a small way." (PX01945 (Wachsman, Dep. at 20)). "Once you factor in all of the...system goals, it's a very small fraction of the incentive comp." (Wachsman, Tr. 5099). He further testified that the goal related to health plan negotiations is to stay within certain cost-coverage parameters, and the incentive is tied to whether that goal is achieved. (PX01945 (Wachsman, Dep. at 20)). In his words, "it doesn't matter how high the rates are, as long as the goal is achieved. . . .[M]y incentive is not correlated to how high the rates might be." (PX01945 (Wachsman, Dep. at 20)).

448. ProMedica negotiates reimbursement rates with a minimum cost coverage target of { } for health plans offering broad provider networks. (Wachsman, Tr. 4949-4950, *in camera*; *see also* PX00381 at 001, *in camera* (explanation of the cost-coverage ratio as a calculation of operating margin – that is, net revenue as a percentage of cost)).

Response to Finding No. 448:

The proposed finding is an incomplete statement of the record. ProMedica's cost coverage target for insurance companies with a narrow network of providers is { } (Wachsman, Tr. 4950, *in camera*).

449. ProMedica would not turn down a contract with a health plan because ProMedica's cost-coverage ration under contract would exceed { }. (Wachsman, Tr. 5147, *in camera*).

Response to Finding No. 449:

The proposed finding is an incomplete statement of the record. Mr. Wachsman further testified that "[t]he contract has to work for both the [MCO] and the provider, so if both sides feel comfortable with it, then that would be a workable agreement." (Wachsman, Tr. 5147, *in camera*).

450. ProMedica's cost-coverage ratios for significant third-party, commercial health plans range from { } to { }. (PX00233 at 001 (ProMedica's Annualized Cost-Coverage Ratios for 2009), *in camera*; *see also* PX01927 at 011 (Wachsman, Dep. at 37-40), *in camera* (supporting the view that ProMedica seeks to maximize cost-coverage ratios with third-party, commercial health plans, given the bargaining dynamic between ProMedica and each health plan)).

Response to Finding No. 450:

The proposed finding mischaracterizes the record. Mr. Wachsman testified that ProMedica seeks to achieve a cost coverage ratio among all MCOs of { } in the aggregate. (PX01927 (Wachsman, Dep. at 36-37, *in camera*)). The {

.} (PX01927 (Wachsman, Dep. at 34-38, *in camera*)). Nevertheless, ProMedica's aggregate cost coverage ratio for all commercial payors in 2009 was close to target at { }. (PX01927 (Wachsman, Dep. at 35-36, *in camera*); PX00233, *in camera*).

451. ProMedica's internal analyses show that its average cost-coverage ratio for third-party commercial health plans was higher than the { } target in 2009 and 2010, exceeding 151 percent in June 2010. (Wachsman, Tr. 5141-5143, *in camera*; PX00233 at 001 (ProMedica's Annualized Cost-Coverage Ratios for 2009), *in camera*; PX00443 at 002 (ProMedica's Cost-Coverage Ratios for YTD June 2010), *in camera*).

Response to Finding No. 451:

Respondent has no specific response.

452. ProMedica's operating margin for its hospitals is significantly above the { } for the system as a whole, which includes operations that lose money or have low margins. (PX01947 at 012 (Oostra, Dep. at 39), *in camera*).

Response to Finding No. 452:

The proposed finding of fact is an incomplete statement of the record and mischaracterizes the record. ProMedica's operating margin for its obligated group, which includes its hospitals, was { } for the first 9 months of 2010. (PX01947 (Oostra, Dep. at 39, *in camera*)). ProMedica's obligated group also includes continuing care services entities, long-term care services, and ProMedica's home health entity. (RPF 115).

453. The hospitals' operating margin through September 10, 2010 was over 6 percent, a fact significant enough to be presented by ProMedica to investors in January 2011. (PX00532 at 005 (ProMedica Investor Presentation); PX01947 at 012 (Oostra, Dep. at 38-39), *in camera*).

Response to Finding No. 453:

The proposed finding mischaracterizes the record. The { } operating margin for the first 9 months of 2010 refers to ProMedica's obligated group, which includes its hospitals. (PX01947 (Oostra, Dep. at 39, *in camera*)). ProMedica's obligated group also includes continuing care services entities, long-term care services, and ProMedica's home health entity. (RPF 115).

454. In negotiations prior to the Acquisition, ProMedica sought rate increase of approximately { }, plus an annual inflation adjustment, from Aetna. (PX02067 at 005-006 (¶ 18) (Radzialowski, Decl.), *in camera*). These increases were substantially larger than those sought by St. Luke's and other hospitals in Lucas County. (PX02067 at 005-006 (¶ 18) (Radzialowski, Decl.), *in camera*).

Response to Finding No. 454:

The proposed finding is an incomplete statement of the record, mischaracterizes the record, and is contradicted by the record. When ProMedica and Aetna {

} (RPF 1344-1346, *in camera*). Furthermore, {

.} (RPF 1347, *in camera*). Aetna {

.} (RPF 1348, *in camera*).

{

} (RPF 1349, *in camera*).

In fact, Aetna's {

.} (RPF 1350, *in camera*).

455. In early December 2010, ProMedica asked Aetna to increase St. Luke's reimbursement rates to {ı }. (Radzialowski, Tr. 717, *in camera*).

Response to Finding No. 455:

The proposed finding is an incomplete statement of the record and mischaracterizes the record. In December 2010, { } began discussions with ProMedica regarding St. Luke's reimbursement rates. (RPF 1405, *in camera*). ProMedica asked { } what its rate analysis had shown was necessary to get St. Luke's rate's closer to {

}. (RPF 1406, *in camera*). After { } responded that the difference was {

}, Promedica asked { } what it would be able to do with respect to rates for St. Luke's. (RPF 1407, *in camera*). {

.} (RPF 1408, *in camera*). {

.} (RPF 1409, *in camera*). {

} (RPF 1410, *in camera*). {

}, nor did {

} (RPF 1412-1413, *in camera*). {

} (RPF 1414, *in camera*).

456. While negotiating a new contract with MMO on behalf of St. Luke's at the end of 2010, under the hold-separate agreement, ProMedica requested a 50-percent rate increase. (PX01944 at 023 (Pirc, Dep. at 89)).

Response to Finding No. 456:

The proposed finding is a misstatement of the record, and is also contradicted by the record. To begin, Mr. Pirc actually testified that ProMedica requested a 50-percent rate increase "structured over three to four years." (PX01944 (Pirc, Dep. at 89)). The record shows that { }, along with other terms. (RPF 1368-1370, *in camera*). { ,} but continued to negotiate with ProMedica. (RPF 1371-1379, *in camera*). Ultimately, {

} (RPF 1380, *in camera*).

3. Professor Town's Econometric Model of the Acquisition's Effect Predicts Significant Price Increases Due To the Elimination of Competition Between ProMedica and St. Luke's

457. Professor Town's Willingness-to-Pay merger simulation model predicts that inpatient reimbursement rates paid by third-party health plans to ProMedica will increase by 10.8 percent and that inpatient reimbursement rates paid by third-party health plans to St. Luke's will increase by between 38.4 percent and 56.2 percent. (PX02148 at 101 (Appendix ¶ 4) (Town Expert Report), *in camera*).

Response to Finding No. 457:

Respondent has no specific response.

458. Even under the assumption that St. Luke's would have received significantly higher rates even in the absence of the Acquisition, the Willingness-to-Pay merger simulation model predicts that the Acquisition will lead to significant rate increases at St. Luke's, ranging from 33.2 percent to 48.6 percent. (PX02148 at 102 (Appendix ¶ 6) (Town Expert Report), *in camera*).

Response to Finding No. 458:

The estimated predicted increase in rates at St. Luke's of 33.2 percent to 48.6 percent is based on Professor Town's flawed case-mix adjusted prices. (PX02148 at 102, *in camera*). Professor Town's case-mix-adjusted price estimations do not indicate the reason for the difference in prices across hospitals in Lucas County, and Professor Town agrees that the presence of price differences alone are not sufficient to determine the exercise of market power. (RPF 1515, *in camera*). No theoretical or empirical basis exists on which to draw inferences of market power from a comparison of price levels across hospitals. (RX-71(A) at 000069, *in camera*).

459. Professor Town's merger simulation results are consistent with the un-rebutted health plan testimony in this matter. (PX01850 at 059 (¶ 92) (Town Rebuttal Report), *in camera*).

Response to Finding No. 459:

The proposed finding violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record regarding "un-rebutted health plan testimony." In addition, the cite to Professor Town's report does not contain citations to any health plan testimony at all, let alone testimony that is consistent with his merger simulation results. (PX01850 at 059, *in camera*).

Moreover, Professor Town's merger simulation results are inconsistent with the actual post-joinder rates observed in this case. {

} (RPF 1384-1384, *in camera*). {

.} (RPF 1385, *in camera*, 1876, *in camera*). In the first year of the new contract between

{

} (RPF 1399, *in camera*).

460. Professor Town's merger simulation results are consistent with the high concentration in the undisputed relevant geographic market in this matter. (PX01850 at 060 (¶ 92) (Town Rebuttal Report), *in camera*).

Response to Finding No. 460:

Professor Town's merger simulation results are *inconsistent* with the actual post-joinder rates observed in this case. {

} (RPF 1384-1384, *in camera*). {

}

(RPF 1385, *in camera*, 1876, *in camera*). In the first year of the new contract between

{

} (RPF 1399, *in camera*).

461. Professor Town's merger simulation results are consistent with the existing academic literature which shows that hospital mergers in highly concentrated markets typically lead to significant price increases. (PX02148 at 111 (Appendix ¶ 37) (Town Expert Report), *in camera*).

Response to Finding No. 461:

Whether Professor Town's merger simulation results are consistent with other mergers is irrelevant, Professor Town's merger simulation results are *inconsistent* with the actual post-

joinder rates observed in *this* case. {

.} (RPF 1384-1384, *in camera*). {

.} (RPF 1385, *in camera*, 1876, *in camera*). In the first year of the new contract between

{

.} (RPF 1399, *in camera*). Moreover, Professor Town's model is not a structural merger simulation model, but rather a descriptive analysis of the correlation between prices and a hospital or system's share that cannot distinguish what factors drive the observed correlation. (RX-71(A) at 000074-000076, *in camera*). This type of model has been criticized in academic literature, particularly when direct evidence is available. (RX-71(A) at 000074-000076, *in camera*).

462. The Willingness-to-Pay merger simulation model is the state of the art in hospital merger simulation. (Town, Tr. 3862).

Response to Finding No. 462:

Professor Town's model has not been accepted in any other hospital merger cases. (RPF 1583). In addition, the multinomial logit functional form that Professor Town uses has been criticized in economic literature for generating restrictive substitution patterns. (RPF 1584). There are no peer-reviewed studies that Professor Town, or Ms. Guerin-Calvert, are aware of that validate the accuracy of the price predictions Professor Town's merger simulation model generates. (RPF 1585; RX-71(A) at 000076, *in camera*).

Moreover, Professor Town's model is not a structural merger simulation model, but rather a descriptive analysis of the correlation between prices and a hospital or system's share that cannot distinguish what factors drive the observed correlation. (RX-71(A) at 000074-000076, *in camera*). This type of model has been criticized in academic literature, particularly when direct evidence is available. (RX-71(A) at 000074-000076, *in camera*). 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. (RPF 1596, *in camera*). {

.} (RPF 1596, *in camera*).

463. The Willingness-to-Pay merger simulation model is the best existing approach to predicting the price effect of a prospective hospital merger. (PX01850 at 063 (¶ 97) (Town Rebuttal Report), *in camera*; Town, Tr. 3862).

Response to Finding No. 463:

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. (RPF 1596, *in camera*). Professor Town's model is not a structural merger simulation model, but rather a descriptive analysis of the correlation between prices and a hospital or system's share that cannot distinguish what factors drive the observed correlation. (RX-71(A) at 000074-000076, *in camera*). This type of model has been criticized in academic literature, particularly when direct evidence is available. (RX-71(A) at 000074-000076, *in camera*). {

.} (RPF 1596, *in camera*). Moreover, peer-reviewed merger simulation methodologies based on logit demand

models similar to that used by Professor Town have been shown to be wildly inaccurate when compared against evidence of actual merger effects. (RX-71(A) at 000076, *in camera*).

In addition, Professor Town's model has not been accepted in any other hospital merger cases. (RPF 1583). In addition, the multinomial logit functional form that Professor Town uses has been criticized in economic literature for generating restrictive substitution patterns. (RPF 1584). There are no peer-reviewed studies that Professor Town, or Ms. Guerin-Calvert, are aware of that validate the accuracy of the price predictions Professor Town's merger simulation model generates. (RPF 1585; RX-71(A) at 000076, *in camera*).

464. Willingness-to-Pay has been peer-reviewed and published in two prestigious economics journals. (PX01850 at 059 (¶ 91) (Town Rebuttal Report), *in camera*).

Response to Finding No. 464:

Only variants of the basic model Professor Town uses to estimate the predicted price effects in this case have been introduced in peer-reviewed economics literature. (RX-71(A) at 000076, *in camera*). The implication that the model has therefore been peer-reviewed and validated for use in analyzing specific hospital mergers is misleading, and incorrect. (RX-71(A) at 000076, *in camera*). There are no peer-reviewed articles that validate the model's predictions against the outcomes of actual mergers and therefore no way to judge the accuracy of the model's predictions. (RPF 1585; RX-71(A) at 000076, *in camera*). Only one working paper purports to validate the model but that paper has not been published in a peer-reviewed journal. (RX-71(A) at 000076, *in camera*).

465. Willingness-to-Pay is based on, and consistent with, standard intuition and economic analyses of bargaining between hospitals and health plans. (PX02148 at 105 (Appendix ¶¶ 17-18) (Town Expert Report), *in camera*; Town, Tr. 3863).

Response to Finding No. 465:

Only variants of the basic model Professor Town uses to estimate the predicted price effects in this case have been introduced in peer-reviewed economics literature. (RX-71(A) at 000076, *in camera*). There are no peer-reviewed articles that validate the model's predictions against the outcomes of actual mergers and therefore no way to judge the accuracy of the model's predictions. (RPF 1585; RX-71(A) at 000076, *in camera*). Only one working paper purports to validate the model but that paper has not been published in a peer-reviewed journal. (RX-71(A) at 000076, *in camera*). Moreover, peer-reviewed merger simulation methodologies based on logit demand models similar to that used by Professor Town have been shown to be wildly inaccurate when compared against evidence of actual merger effects. (RX-71(A) at 000076, *in camera*). In addition, Professor Town's bargaining framework on which he bases his model does not reflect the overall reality and the richness of how bargaining takes place in Lucas County. (RPF 1097). It fails to account for key elements that take place in setting prices. (RPF 1097).

466. Willingness-to-Pay is consistent with the standard economic theory on mergers in differentiated products markets described in the *Horizontal Merger Guidelines.* (PX01850 at 062 (¶ 94) (Town Rebuttal Report), *in camera*).

Response to Finding No. 466:

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. (RPF 1596, *in camera*). Professor Town's model is not a structural merger simulation model, but rather a descriptive analysis of the correlation between prices and a hospital or system's share that cannot distinguish what factors drive the observed correlation. (RX-71(A) at 000074-000076, *in camera*). This type of model has been criticized in academic literature, particularly when direct evidence is available. (RX-71(A) at 000074-000076, *in camera*). {

.} (RPF 1596, *in camera*). Moreover, peer-reviewed merger simulation methodologies based on logit demand models similar to that used by Professor Town have been shown to be wildly inaccurate when compared against evidence of actual merger effects. (RX-71(A) at 000076, *in camera*).

In addition, Professor Town's model has not been accepted in any other hospital merger cases. (RPF 1583). In addition, the multinomial logit functional form that Professor Town uses has been criticized in economic literature for generating restrictive substitution patterns. (RPF 1584). There are no peer-reviewed studies that Professor Town, or Ms. Guerin-Calvert, are aware of that validate the accuracy of the price predictions Professor Town's merger simulation model generates. (RPF 1585; RX-71(A) at 000076, *in camera*).

467. Other scholars' analysis of the Willingness-to-Pay merger simulation model has shown it to make accurate and conservative estimates of the impact of hospital mergers. (PX01850 at 063-064 (¶ 97) (Town Rebuttal Report), *in camera*).

Response to Finding No. 467:

Only variants of the basic model Professor Town uses to estimate the predicted price effects in this case have been introduced in peer-reviewed economics literature. (RX-71(A) at 000076, *in camera*). The implication that the model has therefore been peer-reviewed and validated for use in analyzing specific hospital mergers is misleading, and incorrect. (RX-71(A) at 000076, *in camera*). There are no peer-reviewed articles that validate the model's predictions against the outcomes of actual mergers and therefore no way to judge the accuracy of the model's predictions. (RPF 1585; RX-71(A) at 000076, *in camera*). Only one working paper purports to validate the model but that paper has not been published in a peer-reviewed journal. (RX-71(A) at 000076, *in camera*).

In addition, 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. (RPF 1596, *in*

camera). Professor Town's model is not a structural merger simulation model, but rather a descriptive analysis of the correlation between prices and a hospital or system's share that cannot distinguish what factors drive the observed correlation. (RX-71(A) at 000074-000076, *in camera*). This type of model has been criticized in academic literature, particularly when direct evidence is available. (RX-71(A) at 000074-000076, *in camera*). Moreover, peer-reviewed merger simulation methodologies based on logit demand models similar to that used by Professor Town have been shown to be wildly inaccurate when compared against evidence of actual merger effects. (RX-71(A) at 000076, *in camera*).

Professor Town's merger simulation results are *inconsistent* with the actual post-joinder rates observed in *this* case. {

.} (RPF 1384-1384, *in camera*). {

}

(RPF 1385, *in camera*, 1876, *in camera*). In the first year of the new contract between

{

.} (RPF 1399, *in camera*).

4. ProMedica's Ownership of Paramount May Further Enhance ProMedica's Incentive to Seek Post-Acquisition Rate Increases

468. Some of the business decisions made on behalf of Paramount or ProMedica hospitals may have an impact on the other, and if a business decision was to have such an impact, an evaluation of that impact may be performed. (Joint Stipulations of Law and Fact, JX00002A ¶ 14).

Response to Finding No. 468:

Respondent has no specific response.

469. Paramount's margin goes toward the ProMedica Health System bottom line. (Wachsman, Tr. 5178-5181, *in camera*; Randolph, Tr. 7071).

Response to Finding No. 469:

The proposed finding is an incomplete statement of the record. Mr. Randolph testified that Paramount's margin is "retained within the insurance corporation . . . ." (Randolph, Tr. 7071; PX01910 (Randolph, IHT at 73-74)). In fact, Paramount's profits are retained within the ProMedica system in order to further Paramount's business objectives. (RPF 620). Moreover, Paramount's target operating margin varies between 1 and 3 percent, based on various economic conditions and expectations, and this year it is just over 1 percent. (Randolph, Tr. 6903). Paramount's operating margin is so small because its main purpose is to try to deliver cost-effective products to employers and others in the community. (Randolph, Tr. 6903-6904). This goes back to Paramount's roots, when it was formed, in part, to pass along savings to customers that it was able to obtain from providers. (Randolph, Tr. 6904).

470. Paramount pays the lowest reimbursement rates to ProMedica's hospitals, relative to the rates that third-party health plans pay to ProMedica's hospitals. (Randolph, Tr. 7071; Wachsman, Tr. 5178-5181, *in camera*). Paramount gets better rates from ProMedica than another health plan that was primarily aligned with ProMedica and had identical network composition would get. (Randolph, Tr. 7071-7072).

Response to Finding No. 470:

The proposed finding mischaracterizes the record. Mr. Randolph testified that there is a "significant expectation[]" that Paramount would get the best price from ProMedica, relative to third party MCOs. (Randolph, Tr. 6971). Nevertheless, negotiations between Paramount and the ProMedica hospitals are "contentious." (Randolph, Tr. 6971).

471. ProMedica's ownership of Paramount may increase ProMedica's incentive to bargain more aggressively with health plans for higher rates. (PX02067 at 007-008 (¶ 24) (Radzialowski, Decl.), *in camera*; PX01917 at 013 (Radzialowski, Dep. at 49), *in*

camera; PX02148 at 056-057 (¶ 99) (Town Expert Report), *in camera*); PX02073 at 004 (¶18) (McGinty, Decl.), *in camera*).

Response to Finding No. 471:

The proposed finding of fact is contradicted by the record. ProMedica does not have an incentive to "bargain more aggressively" with MCOs for higher rates, because members of those MCOs would not likely switch to Paramount even if the MCO was unable to come to an agreement with ProMedica. (RPF 1423-1426, 1427, in *camera*, 1428-1430). Major MCOs have testified that if they were unable to reach an agreement with ProMedica to have the ProMedica hospitals in their networks, their members would switch to those other MCOs that continued to offer broad networks. (RPF 1424, 1426, 1427, *in camera*). ProMedica experiences no net benefit if MCO members switch to competing health plans other than Paramount. (RPF 1425).

472. If ProMedica raised reimbursement rates to third-party health plans, these health plans' insurance products would become more expensive and, thus, less attractive to employers relative to Paramount's products. (PX01914 at 018 (Pirc, IHT at 62-63), *in camera*; PX02067 at 007-008 (¶ 24) (Radzialowski, Decl.), *in camera*; PX02073 at 004-005 (¶ 18) (McGinty, Decl.), *in camera*). As a result, such a rate increase would benefit ProMedica not only by increasing revenues at its hospitals (because of the higher rates) but also by attracting more customers to Paramount's insurance products. (PX01914 at 018 (Pirc, IHT at 63), *in camera*; PX02067 at 007-008 (¶ 24) (Radzialowski, Decl.), *in camera*; PX02073 at 004-005 (¶18) (McGinty, Decl.), *in camera*; *see also* Randolph, Tr. 7109-7110).

Response to Finding No. 472:

The proposed finding of fact is contradicted by the record. To begin, if ProMedica raised reimbursement rates to third party health plans, those health plans could incentivize members to use lower-cost hospital providers. (RPF 1272). Such "steerage" can produce lower costs for health plans, as well as lower out-of-pocket costs for plan members. (RPF 1273). In fact, both health plans and employers in Lucas County already engage in steering members and employees toward particular hospital networks, and {

} (RPF 1279-1315, 1292, *in camera*).

It is not likely that employers would switch to Paramount if ProMedica raised reimbursement rates. Major MCOs have testified that if they were unable to reach an agreement with ProMedica to have the ProMedica hospitals in their networks, their members would switch to those other MCOs that continued to offer broad networks. (RPF 1424, 1426, 1427, *in camera*). ProMedica experiences no net benefit if MCO members switch to competing health plans other than Paramount. (RPF 1425).

Regardless, ProMedica intends to {

} (RPF 1351, *in camera*).

473. If a third-party health plan were unable to offer a network that included ProMedica, Paramount would benefit because its network would become more attractive relative to the other health plan's network. (PX02067 at 007-008 (¶ 24) (Radzialowski, Decl.), *in camera*; PX01917 at 026 (Radzialowski, Dep. at 98-99); *see* PX01914 at 018 (Pirc, IHT at 63), *in camera*; PX02073 at 004-005 (¶18) (McGinty, Decl.), *in camera*).

<u>Response to Finding No. 473:</u>

The proposed finding of fact is contradicted by the record. (RPF 1423-1426, 1427, in *camera*, 1428-1430). Major MCOs have testified that if they were unable to reach an agreement with ProMedica to have the ProMedica hospitals in their networks, their members would switch to other MCOs that continued to offer broad networks. (RPF 1424, 1426, 1427, *in camera*). Paramount, on the other hand, has the smallest hospital network in Lucas County. (RPF 315). ProMedica experiences no net benefit if MCO members switch to competing health plans other than Paramount. (RPF 1425).

474. ProMedica's ownership of Paramount makes a health plan's failure to contract with ProMedica more costly for the health plan because walking away from ProMedica would cause the health plan to become less attractive to current and potential members, relative to other health plans including Paramount that include ProMedica in its network. (PX02148 at 056-057 (¶ 99) (Town Expert Report), *in camera*; PX02067 at 007-008 (¶ 24) (Radzialowski, Decl.), *in camera*; *see* PX01914 at 018 (Pirc, IHT at 63), *in camera*).

Response to Finding No. 474:

The proposed finding of fact is contradicted by the record. If a MCO was unable to come to an agreement with ProMedica, it likely would not benefit Paramount. Major MCOs have testified that if they were unable to reach an agreement with ProMedica to have the ProMedica hospitals in their networks, their members would switch to those other MCOs that continued to offer broad networks. (RPF 1424, 1426, 1427, *in camera*). Paramount, on the other hand, has the smallest hospital network in Lucas County. (RPF 315). ProMedica experiences no net benefit if MCO members switch to competing health plans other than Paramount. (RPF 1425).

475. The cost to ProMedica of failing to reach an agreement with a health plan is diminished by the increased revenue Paramount will receive from patients switching from that health plan to Paramount as a result of ProMedica being out of that health plan's network. (PX02148 at 056-057 (¶ 99) (Town Expert Report), *in camera*; PX02067 at 007-008 (¶ 24) (Radzialowski, Decl.), *in camera*; *see* PX01914 at 018 (Pirc, IHT at 63), *in camera*).

Response to Finding No. 475:

The proposed finding of fact is contradicted by the record. (RPF 1423-1426, 1427, *in camera*, 1428-1430). Major MCOs have testified that if they were unable to reach an agreement with ProMedica to have the ProMedica hospitals in their networks, their members would switch to other MCOs that continued to offer broad networks. (RPF 1424, 1426, 1427, *in camera*). Paramount, on the other hand, has the smallest hospital network in Lucas County. (RPF 315). ProMedica experiences no net benefit if MCO members switch to competing health plans other than Paramount. (RPF 1425).

476. Adding St. Luke's to ProMedica and, thus, to Paramount's network increases the attractiveness of Paramount's products to customers in Lucas County. (Randolph, Tr.

7007-7008, 7061-7062; PX01914 at 018 (Pirc, IHT at 64), *in camera*; PX02067 at 007-008 (¶ 24) (Radzialowski, Decl.), *in camera*). For example, since St. Luke's joined Paramount, two employers – the City of Maumee Schools and Anthony Wayne Schools – switched to Paramount from other health plans. (Randolph, Tr. 7007-7010).

Response to Finding No. 476:

The proposed finding mischaracterizes the record. Mr. Randolph testified that although St. Luke's addition to Paramount's network increased the attractiveness of Paramount's products to specific employers in Lucas County, a primary reason Paramount was able to gain the City of Maumee Schools and Anthony Wayne Schools as clients was due to Paramount's position as the lower cost option as compared to the schools' previous MCO. (Randolph, Tr. 7007-7008, 7010).

477. ProMedica's acquisition of St. Luke's makes failing to contract with ProMedica even more costly to third-party health plans and less costly to ProMedica, because walking away from ProMedica creates a much wider disparity than before the Acquisition: the third-party health plan's network becomes significantly less attractive *without* both ProMedica and St. Luke's, while Paramount's network becomes significantly more attractive *with* both ProMedica and St. Luke's. (PX02148 at 056-057 (¶ 99) (Town Expert Report), *in camera*; PX02067 at 007-008 (¶ 24) (Radzialowski, Decl.), *in camera*; *see* PX01914 at 018 (Pirc, IHT at 64-65), *in camera*).

Response to Finding No. 477:

The proposed finding mischaracterizes the record. Even after the joinder, Paramount's hospital provider network is still the smallest in Lucas County, because the Mercy Hospitals are not in-network. (RPF 314, 315). Therefore, even if a third party MCO was unable to come to an agreement with ProMedica to keep the ProMedica hospitals in-network, its members would likely not switch to Paramount, because Paramount still has a narrower network than other MCOs in Lucas County. (RPF 314, 1424, 1426, 1427, *in camera*). ProMedica experiences no net benefit if MCO members switch to competing health plans other than Paramount. (RPF 1425).

Furthermore, should a third party health plan fail to contract with ProMedica, they could still successfully market a narrower network, just as many health plans offered narrow networks

in the past in Lucas County, and just as Paramount continues to market a narrow network. (RPF 709-729, 779-799). Indeed, {

} (RPF 1251, *in camera*).

C. Market Dynamics Will Not Constrain ProMedica's Price Increases

1. Mercy's Presence in the Relevant Markets Will Not Constrain ProMedica's Exercise of Increased Market Power Resulting From the Acquisition

478. Despite the geographic proximity of Mercy's three Toledo-area hospitals and ProMedica's three legacy Toledo-area hospitals, and the relative similarity of their service offerings, ProMedica maintained a substantial advantage in terms of its Lucas County market share prior to the Acquisition. (PX02148 at 063 (¶ 114) (Town Expert Report), *in camera*).

Response to Finding No. 478:

The proposed finding is inaccurate. Professor Town's market shares for inpatient general acute care services are flawed not only because he uses less than one year's worth of data, (PX02148 at 143, *in camera*) ("Based on hospital discharges with commercial insurance from July 2009 through March 2010"), but also because he limits his "market" to only those general acute care inpatient services (identified as "diagnostic related groups" or "DRGs") that both ProMedica and St. Luke's provided to at least three commercially-insured patients (RPF 1491), thereby eliminating from his "market" (and his share calculations) many services that ProMedica, Mercy, and UTMC offer and provide. (RPF 1489-1493, 1504, 1510, *in camera*). Professor Town also excluded overlapping St. Luke's and ProMedica DRGs for which St. Luke's and ProMedica compete with hospitals outside of Lucas County (RPF 1494-1495), and DRGs with a case weight index, which reflects complexity of care, greater than two. (RPF 1496). Professor Town included, however, some DRGs with case weights higher than four, which captures some services that could be classified as tertiary or quaternary medical services.

(RPF 1500). His separate inpatient OB services product market is similarly based on less than one year's worth of data and 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. (RPF 1501).

Moreover, Professor Town's market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

When market shares are measured using billed charges, rather than patient days, to reflect the fact that many DRGs and service lines cost more, require longer stays and, hence, generate higher revenues, St. Luke's has only a {   } percent share of the general acute care inpatient services market, inclusive of inpatient OB services, for Lucas County. (RX-71(A)-000036-000037, *in camera*). {   } combined have a higher share than ProMedica in Lucas County. (RX-71(A) at 000036-000037, *in camera*). Looking only at inpatient OB services, St. Luke's share is only { } percent based on billed charges in Lucas County. (RX-71(A) at 000036-000037, *in camera*). For all {

} of all hospitals in Lucas County based on billed charges. (RX-71(A)-000036-000037, *in camera*).

Finally, the proposed finding is misleading because it overlooks the fact that St. Luke's only treats about ten commercially insured patients per day, only one of which is an expectant mother. (RFP 1147; PX02137 at 055, *in camera*).

a. Market Share Analysis Demonstrates that Mercy's Presence Has Not And Will Not Constrain ProMedica

479. Prior to the Acquisition, ProMedica's market share for inpatient GAC services was 63 percent larger than that of Mercy. For inpatient obstetrics services, ProMedica's share was 266 percent larger than Mercy's. (PX02148 at 063 (¶ 114) (Town Expert Report), *in camera*; PX02148 at 143 (Town Expert Report, Ex. 6), *in camera*).

Response to Finding No. 479:

The proposed finding is inaccurate and misleading. Professor Town's market shares for inpatient general acute care services are flawed not only because he uses less than one year's worth of data, (PX02148 at 143, *in camera*) ("Based on hospital discharges with commercial insurance from July 2009 through March 2010"), but also because he limits his "market" to only those general acute care inpatient services (identified as "diagnostic related groups" or "DRGs") that both ProMedica and St. Luke's provided to at least three commercially-insured patients (RPF 1491), thereby eliminating from his "market" (and his share calculations) many services that ProMedica, Mercy, and UTMC offer and provide. (RPF 1489-1493, 1504, 1510, *in camera*). Professor Town also excluded overlapping St. Luke's and ProMedica DRGs for which St. Luke's and ProMedica compete with hospitals outside of Lucas County (RPF 1494-1495), and DRGs with a case weight index, which reflects complexity of care, greater than two. (RPF 1496). Professor Town included, however, some DRGs with case weights higher than four, which captures some services that could be classified as tertiary or quaternary medical services. (RPF 1500). His separate inpatient OB services product market, Professor Town is similarly based on less than one year's worth of data and 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. (RPF 1501).

Moreover, Professor Town's market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34

percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

When market shares are measured using billed charges, rather than patient days, to reflect the fact that many DRGs and service lines cost more, require longer stays and, hence, generate higher revenues, St. Luke's has only a { } percent share of the general acute care inpatient services market, inclusive of inpatient OB services, for Lucas County. (RX-71(A)-000036-000037, *in camera*). { } combined have a higher share than ProMedica in Lucas County. (RX-71(A) at 000036-000037, *in camera*). Looking only at inpatient OB services, St. Luke's share is only { } percent based on billed charges in Lucas County. (RX-71(A) at 000036-000037, *in camera*). For all {

} of all hospitals in Lucas County based on billed charges. (RX-71(A)-000036-000037, *in camera*).

Finally, the proposed finding is misleading because it overlooks the fact that St. Luke's only treats about ten commercially insured patients per day, only one of which is an expectant mother. (RFP 1147; PX02137 at 055, *in camera*).

480. The difference in shares between ProMedica and Mercy prior to the Acquisition demonstrates that consumers do not view the hospital systems as interchangeable. (PX02148 at 063 (¶ 114) (Town Expert Report), *in camera*).

Response to Finding No. 480:

The proposed finding is inaccurate and misleading. Not only did Professor Town testify that "Mercy is ProMedica's closest substitute." (RPF 1116), but he also admitted that a payor could substitute ProMedica for Mercy in its network and been able to market its product. (Town, Tr. 4057). {

} (RPF 1110, *in camera*). 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. (RPF 1111). {

}

(RPF 1112, *in camera*). Finally, a draw area analysis shows that ProMedica hospitals draw from almost exactly the same zip codes as their Mercy counter-parts. (RPF 1117).

481. ProMedica's market share is significantly higher than Mercy's, even without St. Luke's. (Oostra, Tr. 5973 (referring to 2006 data reflected in PX00270)).

Response to Finding No. 481:

This proposed response is misleading because it does not accurately reflect Mr. Oostra's testimony nor the document to which he is referring. Mr. Oostra testified that the document PX00270 stated that in *2006* – *prior* to ProMedica being in MMO's network and *prior* to Mercy being in Anthem's network – ProMedica's market shares in four distinct service lines were higher than Mercy's. (Oostra, Tr.5970-5973; RPF 714). He also testified that he did not know what ProMedica's market share was *today* for these four service lines. (Oostra, Tr. 5970-5973). The document clearly states the market share numbers are from 2006 for four service lines. (PX00270 at 026). Finally, the proposed finding is misleading because it overlooks the fact that St. Luke's only treats about ten commercially insured patients per day, only one of which is an expectant mother. (RFP 1147; PX02137 at 055, *in camera*).

482. ProMedica's CEO, Randall Oostra, admitted that prior to the Acquisition, Mercy was not a geographical "mirror image" to ProMedica, since St. Anne no longer offers obstetrics services. (Oostra, Tr. 5973; *see also* Sheridan, Tr. 6675; *see generally* Radzialowski, Tr. 640; Sandusky, Tr. 1307-1308; Answer at ¶ 15).

Response to Finding No. 482:

This proposed finding mischaracterizes Mr. Oostra's testimony. Mr. Oostra testified that for *women's services* St. Anne's is not a mirror image to Flower Hospital – not that Mercy as a whole for all product lines is not a mirror image to ProMedica. (Oostra, Tr. 5972-5973). Moreover, Mr. Oostra said nothing regarding whether Mercy was a *geographical* mirror image to ProMedica. (Oostra, Tr. 5972-5973).

This proposed finding mischaracterizes Ms. Sheridan's testimony. Ms. Sheridan testified that she was unaware that St. Anne's did not offer obstetric services. (Sheridan, Tr. 6675). She said nothing regarding whether Mercy was a *geographical* mirror image to ProMedica or whether ProMedica as a whole was a mirror image to Mercy. (Sheridan, Tr. 6675).

This proposed finding mischaracterizes Mr. Radzialowski's testimony. Mr. Radzialowski testified only that St. Anne's is missing obstetrics. (Radzialowski, Tr. 640). He makes no comparison to ProMedica. (Radzialowski, Tr. 640).

This proposed finding mischaracterizes Ms. Sandusky's testimony. Ms. Sandusky testified that St. Anne's does not offer obstetric services. (Sandusky, Tr. 1308). Moreover, she went on to testify that Mercy St. Vincent and The Toledo Hospital are "all tertiary care providers." (Sandusky, Tr. 1308).

483. In southwestern Lucas County, the combined market share of ProMedica and St. Luke's in both inpatient GAC services and inpatient obstetrics services is much larger than Mercy's corresponding share. (PX02148 at 043-044, 156-159, 161 (¶¶ 82-83, Ex. 10, Ex.11) (Town Expert Report), *in camera*; PX02290 at 002-003 (Mercy Business Development Committee Meeting Minutes, Mar. 9, 2010), *in camera*).

Response to Finding No. 483:

The proposed finding is inaccurate and misleading. Professor Town's market shares for inpatient general acute care services are flawed not only because he uses less than one year's worth of data, (PX02148 at 143, in camera) ("Based on hospital discharges with commercial insurance from July 2009 through March 2010"), but also because he 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. (RPF 1501). His separate inpatient OB services product market, Professor Town is similarly based on less than one year worth of data and 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. (RPF 1501).

Moreover, Professor Town's market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

Furthermore, southwest Lucas County is not the relevant geographic market and focusing on market share in this area distorts St. Luke's competitive significance. (*See, e.g.*, RPF 1036-1049). As Complaint Counsel and their economic expert agree, the relevant geographic market is all of Lucas County, and hospitals compete for patients across that market. (RPF 1028-1030).

Finally, the proposed finding is misleading because it overlooks the fact that St. Luke's only treats about ten commercially insured patients per day, only one of which is an expectant mother. (RFP 1147; PX02137 at 055, *in camera*).

484. The Acquisition has further increased the disparity between ProMedica's and Mercy's market shares in both relevant markets. (PX02148 at 064-065 (¶ 116-117) (Town Expert Report), *in camera*). ProMedica's post-Acquisition market share in inpatient GAC services is roughly twice as large as Mercy's. (PX02148 at 064-065 (¶ 116) (Town Expert Report), *in camera*; PX02148 at 143 (Town Expert Report, Ex. 6), *in camera*). ProMedica's post-Acquisition market share in inpatient obstetrics services is more than

four times greater than Mercy's. (PX02148 at 064-065 (¶¶ 116-117) (Town Expert Report), *in camera*).

Response to Finding No. 484:

The proposed finding is inaccurate and misleading. Professor Town's market shares for inpatient general acute care services are flawed not only because he uses less than one year's worth of data, (PX02148 at 143, *in camera*) ("Based on hospital discharges with commercial insurance from July 2009 through March 2010"), but also because he 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. (RPF 1501). His separate inpatient OB services product market, Professor Town is similarly based on less than one year's worth of data and 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. (PX02148 at 143, *in camera*; RPF 1501).

Moreover, Professor Town's market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

Finally, the proposed finding is misleading because it overlooks the fact that St. Luke's only treats about ten commercially insured patients per day. (RFP 1147; PX02137 at 055, *in camera*).

485. Prior to the Acquisition, Mercy's presence in the market did not limit ProMedica's ability to charge the highest rates, by far, in Lucas County. ProMedica's case-mix-adjusted (*i.e.*,

apples-to-apples) prices were { } percent higher than Mercy's. (Town, Tr. 3794-3795, *in camera*; PX02148 at 037, 062-063 (¶¶ 68, 111-113) (Town Expert Report), *in camera*; *see also* PX02148 at 145 (Town Expert Report, Ex. 7), *in camera*).

Response to Finding No. 485:

The proposed finding is inaccurate and misleading. First, the first sentence of this proposed finding is not a fact, but an improper legal argument. The first sentence of this proposed finding also violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record. Second, Professor Town's case-mix-adjusted price estimations do not indicate the reason for the difference in prices across hospitals in Lucas County, and Professor Town agrees that the presence of price differences alone are not sufficient to determine the exercise of market power. (RPF 1515, in camera). In addition, {

.} (RPF 1350, 1527, *in camera*). However, Professor Town's case-mix-adjusted price calculations result in Mercy's prices being higher. (RPF 1527). {

}. (RPF 1528, *in camera*) {

.} (RPF 1528, *in camera*). prices.

Moreover, PX01016 at 009 shows that rates follow costs. (PX01016 at 009, *in camera*). For example, {

.} (PX01016 at 009, *in camera*).

486. There is no evidence suggesting that the price disparities between ProMedica and Mercy are due to differences in costs of care or quality of care. (Town, Tr. 3795, *in camera*; PX02148 at 037-038 (¶¶ 68-69) (Town Expert Report), *in camera*).

Response to Finding No. 486:

The proposed finding is inaccurate. PX01016 at 009 shows that rates follow costs. (PX01016 at 009, *in camera*). For example, {

.} (PX01016 at 009, *in camera*). PX01030 at 019 also shows that {

.} (PX01030 at 019, *in camera*). Moreover, Professor Town agreed that prices for a hospital may differ across MCOs for a number of reason such as cost or quality. (RPF 1523). In addition, {

.} (RPF 1402, *in camera*).

487. ProMedica's rates would reasonably be expected to be much lower and closer to Mercy's if Mercy served as a very close substitute to ProMedica prior to the Acquisition and constrained it accordingly. (PX02148 at 037-038 (¶¶ 68-69) (Town Expert Report), *in camera*).

Response to Finding No. 487:

The proposed finding is inaccurate. Professor Town's case-mix-adjusted price estimations do not indicate the reason for the difference in prices across hospitals in Lucas County, and Professor Town agrees that the presence of price differences alone are not sufficient to determine the exercise of market power. (RPF 1515, in camera). In addition, {

} (RPF 1350, 1527, *in camera*). However, Professor Town's case-mix-adjusted price calculations result in Mercy's prices being higher. (RPF 1527). {

}. (RPF 1528, *in camera*) {

.} (RPF 1528, *in camera*). prices. Professor Town agreed that prices for a hospital may differ across MCOs for a number of reason such as cost or quality. (RPF 1523).

Moreover, PX01016 at 009 shows that rates follow costs. (PX01016 at 009, *in camera*). For example, {

.} (PX01016 at 009, *in camera*). PX01016 at 009 also shows that looking at hospitals at a disaggregated level, {

} (PX01016 at 009, *in camera*). For example, {

.} (PX01016 at 009, *in camera*). {

} (RPF 1402, *in camera*).

Finally, not only did Professor Town testify that "Mercy is ProMedica's closest substitute." (RPF 1116), but he also admitted that a payor could substitute ProMedica for Mercy in its network and market its product. (Town, Tr. 4057). {

} (RPF 1110, *in camera*). The history of MCO networks 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. (RPF 1111). {

.} (RPF 1112, *in camera*).

b. Mercy Cannot Constrain Post-Acquisition ProMedica In Southwest Lucas County

488. The Acquisition has given ProMedica a significant locational advantage over Mercy because Mercy offers no direct counterpart to St. Luke's in southwest Lucas County. (PX02148 at 064-065 (¶ 116) (Town Expert Report), *in camera*); (Sheridan, Tr. 6698).

Response to Finding No. 488:

The proposed finding is misleading, because the geographic market alleged by Complaint Counsel in their Complaint is Lucas County, not "southwest Lucas County." (Complaint ¶ 16). In addition, the proposed finding mischaracterizes the record and is contradicted by the record. The record shows that hospital location is not an important factor in Toledo, where all hospitals are within 25 minutes of each other and where the overall drive time to reach hospitals is short. (RPF 442, 1210). Instead, 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. (RPF 1484). In fact, a drive time analysis 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. (RPF 1212). This analysis shows that a large number and proportion of patients are not choosing the hospital located closest to them. (RPF 1217). Moreover, {

.} (RPF 1251, *in camera*).

489. Greg Radzialowski, Senior Network Manager of Aetna, testified that Mercy is unable to cover the southwest portion of Lucas County, and that the location of St. Luke's significantly increases ProMedica's leverage with Aetna. (Radzialowski, Tr. 713-714).

Response to Finding No. 489:

The proposed finding is misleading, because the geographic market alleged by Complaint Counsel in their Complaint is Lucas County, not "southwest Lucas County." (Complaint ¶ 16). In addition, the proposed finding is contradicted by the record. 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. (RPF 441). Furthermore, the location of a hospital is not a high magnitude factor for consumers in Toledo, where all hospitals are within 25 minutes

of each other. (RPF 442). Consequently, 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. (RPF 1484). In fact, a drive time analysis 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. (RPF 1212). This analysis shows that a large number and proportion of patients are not choosing the hospital located closest to them. (RPF 1217). In fact, 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. (RPF 1480). 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. (RPF 1481). Moreover, {

} (RPF 1251, *in camera*).

490. Don Pirc, Vice President of Network Management of MMO, testified that a network without St. Luke's would leave a fairly sizable geographic hole in MMO's network. (Pirc, Tr. 2195).

Response to Finding No. 490:

The proposed finding is contradicted by the record. Mr. Pirc clarified that when he referred to a hole in MMO's network if they were without St. Luke's, he meant that "people would forced to travel and they don't want to travel." (Pirc, Tr. 2195). This is clearly contradicted by the record. In fact, a drive time analysis 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. (RPF 1212). This analysis shows that a large number and proportion of patients are not choosing the hospital

located closest to them. (RPF 1217). In fact, 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. (RPF 1480). 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. (RPF 1481).

491. Gina Sheridan, an executive of United HealthCare, testified that St. Luke's location serves a great need in Lucas County. (Sheridan, Tr. 6672-6673).

Response to Finding No. 491:

The proposed finding is contradicted by the record, which shows that hospital location is not an important factor in Toledo, where all hospitals are within 25 minutes of each other and where the overall drive time to reach hospitals is short. (RPF 442, 1210). Instead, 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. (RPF 1484).

492. Jim Pugliese, Regional Vice President of Contracting and Provider Relations for Anthem, testified that the area around St. Luke's is an important customer base for Anthem. (Pugliese, Tr. at 1442-1443).

Response to Finding No. 492:

To the extent that this finding implies that the location of St. Luke's is important to Anthem's customer base, it is misleading, as well as contradicted by the record. To begin, hospital participation is not a primary consideration for customers when choosing their MCO because customers tend not to use hospitals very frequently. (RPF 441). For example, typically only about 6 percent of the commercially-insured go to a hospital in any given year. (RPF 441). Furthermore, hospital location is not a high magnitude factor for selecting an MCO in Toledo where all hospitals are within 25 minutes of each other. (RPF 442, 1218). The overall drive

time to reach hospitals in Toledo is short, and the incremental drive time between them is minimal. (RPF 1210). Furthermore, a 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. (RPF 1212). This analysis shows that a large number and proportion of patients are not choosing the hospital located closest to them. (RPF 1217). In fact, 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. (RPF 1480). 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. (RPF 1481).

493. Further, Mercy currently attracts relatively few patients from the { }. (PX02290 at 002-003 (Mercy Business Development Committee Meeting Minutes, Mar. 9, 2010), *in camera*}).

Response to Finding No. 493:

The proposed finding is misleading, because the geographic market alleged by the FTC in their Complaint is Lucas County, not "southwest Lucas County." (Complaint ¶ 16). In addition, the proposed finding is an incomplete statement of the record. Mr. Shook testified that Mercy's inpatient market share in the southwest quadrant of Lucas County is between {

.} (Shook, Tr. 981, 1012-1013, *in camera*). Notably, St. Luke's market share in the southwest quadrant of Lucas County, where St. Luke's is located, is only approximately 40 percent. (Shook, Tr. 1012, *in camera*; PX02290 at 002-003, *in camera*). In other words, more patients are driving past the hospital closest to them (St. Luke's) in order to get treatment at a hospital that is not as close. (Shook, Tr. 1040).

494. The facts surrounding { } do not support Respondent's assertion that Mercy will be better able to constrain ProMedica in the future. {

} (PX02288, *in camera;* Shook, Tr. 971-972, *in camera*).

Response to Finding No. 494:

The proposed finding mischaracterizes the record. Mercy can and does constrain ProMedica because there is excess capacity in the Toledo market. (RPF 659-673). Mercy itself has the capacity to accommodate an additional ten patients per day at its Toledo-area hospitals. (RPF 663). Similarly, St. Charles and St. Vincent have the capacity to accommodate an additional expectant mother each day. (RPF 664).

495. Mercy has no current plans in its {Southwest Strategy to build an inpatient facility, or to offer obstetrics or other inpatient general acute care services that require an overnight stay.} (PX02288, *in camera*; Shook, Tr. 982-986, *in camera*).

Response to Finding No. 495:

The proposed finding is misleading. Mercy can and does constrain ProMedica without building an inpatient facility because there is excess capacity in the Toledo market. (RPF 659-673). Mercy itself has the capacity to accommodate an additional ten patients per day at its Toledo-area hospitals, the same number of commercially insured patients that St. Luke's treats in a day. (RPF 663, 1147). Similarly, St. Charles and St. Vincent have the capacity to accommodate an additional expectant mother each day. (RPF 664). By comparison, St. Luke's performs deliveries for about one commercially insured mother per day. (RX-71(A) at 000201).

496. Mercy's President, Scott Shook, testified that Mercy has not achieved its { .} (Shook, Tr. 1019, *in camera*). Despite Mercy's efforts to {

} (Shook, Tr. 988, *in camera*).

Response to Finding No. 496:

The proposed finding is an incomplete statement of the record. Mr. Shook testified that { } in southwest Lucas County. (Shook, Tr. 1019, *in camera*; RPF 1179, *in camera*). { } (RPF 1179, *in camera*). For example, { } (RPF 1180, *in camera*).

Furthermore, the proposed finding is misleading, because the geographic market alleged by Complaint Counsel in their Complaint is Lucas County, not "southwest Lucas County." (Complaint ¶ 16). In Lucas County, { }. (RPF 169, *in camera*).

c. Econometric Analysis Demonstrates Mercy is Less Preferred Than ProMedica

497. Willingness-to-pay ("WTP") is a peer-reviewed econometric methodology for quantifying hospital bargaining leverage with health plans. (Town, Tr. 3798-3799, *in camera*). Willingness-to-pay is the health plan's willingness to pay for the hospital to be in its network of providers. (Town, Tr. 3799, *in camera*). Willingness-to-pay is measured in utils. (Town, Tr. 3799-3800, *in camera*).

Response to Finding No. 497:

Professor Town's model has not been accepted in any other hospital merger cases. (RPF 1583). In addition, the multinomial logit functional form that Professor Town uses has been criticized in economic literature for generating restrictive substitution patterns. (RPF 1584). There are no peer-reviewed studies that Professor Town, or Ms. Guerin-Calvert, are aware of that validate the accuracy of the price predictions Professor Town's merger simulation model generates. (RPF 1585; RX-71(A) at 000076, *in camera*). Only variants of the basic

model Professor Town uses to estimate the predicted price effects in this case have been introduced in peer-reviewed economics literature. (RX-71(A) at 000076, *in camera*). The implication that the model has therefore been peer-reviewed and validated for use in analyzing specific hospital mergers is misleading, and incorrect. (RX-71(A) at 000076, *in camera*). There are no peer-reviewed articles that validate the model's predictions against the outcomes of actual mergers and therefore no way to judge the accuracy of the model's predictions. (RPF 1585; RX-71(A) at 000076, *in camera*). Only one working paper purports to validate the model but that paper has not been published in a peer-reviewed journal. (RX-71(A) at 000076, *in camera*).

Moreover, Professor Town's model is not a structural merger simulation model, but rather a descriptive analysis of the correlation between prices and a hospital or system's share that cannot distinguish what factors drive the observed correlation. (RX-71(A) at 000074-000076, *in camera*). This type of model has been criticized in academic literature, particularly when direct evidence is available. (RX-71(A) at 000074-000076, *in camera*)

498. Willingness-to-pay analysis shows that, prior to the Acquisition, commercially-insured patients placed { } percent more value on having in-network access to ProMedica than on having in-network access to Mercy. (PX02148 at 063 (¶ 118) (Town Expert Report), *in camera*; PX02148 at 165 (Town Expert Report, Ex. 13), *in camera*) (ProMedica's WTP is 8235.6 and Mercy's WTP is 6727.89). That is, prior to the Acquisition, ProMedica had { } percent more bargaining leverage than Mercy. (Town, Tr. 3802, *in camera*).

Response to Finding No. 498:

Professor Town's bargaining framework on which he bases his model does not reflect the overall reality and the richness of how bargaining takes place in Lucas County. (RPF 1097). It fails to account for key elements that take place in setting prices such as size and exclusivity of the network, inclusion of most favored nations clauses and cost structure of the hospital. (RPF 1097; Guerin-Calvert, Tr. 7458-7460). Variation in willingness-to-pay is likely to be due, at least in part, to many factors other than increased bargaining power related to mergers. (RX-

71(A) at 000073). Professor Town also 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. (RPF 1553).

In addition, Professor 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 that could affect that choice. (RPF 1552). Professor Town's merger simulation model also 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. (RPF 1566). Professor Town, however, admits that "the realized choice is almost, by definition, going to be different" than choice he calculates. (RPF 1567).

499. As a result of the Acquisition, consumers value in-network access to ProMedica nearly twice as much as they value in-network access to Mercy. (PX02148 at 165 (Town Expert Report, Ex. 13), *in camera*) (ProMedica and St. Luke's post-Acquisition WTP is 12,346.19 and Mercy's WTP is 6727.89)).

Response to Finding No. 499:

Professor Town's bargaining framework on which he bases his model does not reflect the overall reality and the richness of how bargaining takes place in Lucas County. (RPF 1097). It fails to account for key elements that take place in setting prices such as size and exclusivity of the network, inclusion of most favored nations clauses and cost structure of the hospital. (RPF 1097; Guerin-Calvert, Tr. 7458-7460). Variation in willingness-to-pay is likely to be due, at least in part, to many factors other than increased bargaining power related to mergers. (RX-71(A) at 000073). Professor Town also 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. (RPF 1553).

In addition, Professor 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 that could affect that choice. (RPF 1552). Professor Town's merger simulation model also 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. (RPF 1566). Professor Town, however, admits that "the realized choice is almost, by definition, going to be different" than choice he calculates. (RPF 1567).

500. ProMedica's acquisition of St. Luke's increases the value to health plans of contracting with ProMedica. (Town, Tr. 3802-3803, *in camera*; PX02148 at 165 (Town Expert Report, Ex. 13), *in camera*).

Response to Finding No. 500:

This proposed finding is based on Professor Town's willingness-to-pay calculation. This calculation is unreliable for several reasons. First, he includes OB patients in the data, but excludes newborns. (RPF 1550). Professor 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." (RPF 1550). Second, he includes data from hospitals located outside of Lucas County, and therefore outside the relevant geographic market. (RPF 1565). Third, Professor Town's merger simulation model does not allow one to independently or directly observe a patient's second choice of hospitals if his or her first choice becomes unavailable or more expensive. (RPF 1566). Professor Town simply estimates the probability that a given patient would choose a certain hospital if St. Luke's were not available. (Town, Tr. 4243). But, Professor Town admits that the choice a consumer makes "is almost, by definition, going to be different" from the choice that he estimates. (RPF 1567). Fourth, although Professor Town

acknowledges that one must appropriately control for the intrinsic value associated with a hospital, he does not. (RPF 1568-1569).

Moreover, his willingness-to-pay is based on a bargaining model characterizing negotiations between hospital systems and commercial payors to set prices. (RX-71(A) at 000072, *in camera*). However, Professor Town's bargaining model is too simplistic to accurately represent the bargaining dynamics in Lucas County because it ignores elements such as the history a provider and MCO have that can affect bargaining. (*See* RPF 1097-1104).

Furthermore, this proposed finding ignores evidence that St. Luke's was not as important as Complaint Counsel claim. MCOs testified that St. Luke's was not a "must have" and they only needed at least one network hospital that can offer tertiary services. (RPF 1149, 341, 388, 1119, *in camera*). Moreover, MCOs have paid lower rates to St. Luke's over the years than they have other hospitals in Lucas County, indicating that St. Luke's is less valuable. (RPF 1154). Hospital competitors do not regard St. Luke's as an essential provider of inpatient services, with {

} (RPF 1151-1152, *in camera*). Professor Town even agreed that St. Luke's was not a must have hospital. (RPF 1148).

501. Post-Acquisition, ProMedica's willingness-to-pay increases dramatically; it is { } greater than Mercy's willingness-to-pay. (Town, Tr. 3803, *in camera*); PX02148 at 165 (Town Expert Report, Ex. 13), *in camera*). Professor Town's willingness-to-pay analysis was strongly corroborated by the testimonial and documentary evidence in this matter. (Town, Tr. 3803-3804, *in camera*). Thus, the Acquisition has rendered Mercy a significantly more distant substitute for ProMedica in the eyes of health plans and their members. (Town, Tr. 3802-3804, *in camera*; PX02148 at 064-065 (¶¶ 116-117) (Town Expert Report), *in camera*).

Response to Finding No. 501:

Professor Town's "willingness-to-pay" calculation is unreliable for several reasons. First, he includes OB patients in the data, but excludes newborns. (RPF 1550). Professor 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." (RPF 1550). Second, he includes data from hospitals located outside of Lucas County, and therefore outside the relevant geographic market. (RPF 1565). Third, Professor Town's merger simulation model does not allow one to independently or directly observe a patient's second choice of hospitals if his or her first choice becomes unavailable or more expensive. (RPF 1566). Professor Town simply estimates the probability that a given patient would choose a certain hospital if St. Luke's were not available. (Town, Tr. 4243). But, Professor Town admits that the choice a consumer makes "is almost, by definition, going to be different" from the choice that he estimates. (RPF 1567). Fourth, although Professor Town acknowledges that one must appropriately control for the intrinsic value associated with a hospital, he does not. (RPF 1568-1569).

Moreover, his willingness-to-pay is based on a bargaining model characterizing negotiations between hospital systems and commercial payors to set prices. (RX-71(A) at 000072, *in camera*). However, Professor Town's bargaining model is too simplistic to accurately represent the bargaining dynamics in Lucas County because it ignores elements such as the history a provider and MCO have that can affect bargaining. *See* (RPF 1097-1104).

In addition, the proposed finding violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record to support their statement that "Professor Town's willingness-to-pay analysis was strongly corroborated by the testimonial and documentary evidence in this matter." The citation to Professor Town's testimony contains no specific corroborating testimony or documents.

Looking at testimonial and documentary evidence actually undermines Professor Town's willingness-to-pay analysis. {

.} (RPF 1110, *in camera*). 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. (RPF 1111). On the other hand, MCOs testified that St. Luke's was not a "must have" and they only needed at least one network hospital that can offer tertiary services. (RPF 1149, 341, 388, 1119, *in camera*). Moreover, MCOs have paid lower rates to St. Luke's over the years than they have other hospitals in Lucas County, indicating that St. Luke's is less valuable. (RPF 1154). Hospital competitors do not regard St. Luke's as an essential provider of inpatient services, with {

.} (RPF 1151-1152, *in camera*).

Professor Town even agreed that St. Luke's was not a must have hospital. (RPF 1148).

502. Mercy did not provide a sufficiently strong competitive constraint to prevent ProMedica from exercising its market power before the Acquisition. (PX02148 at 066 (¶ 119) (Town Expert Report), *in camera*). Because the Acquisition has made ProMedica more dominant and has made Mercy less competitive against ProMedica, there is no reason to believe that Mercy will be able to constrain ProMedica's post-Acquisition exercise of enhanced market power. (PX02148 at 066 (¶ 119) (Town Expert Report), *in camera*).

Response to Finding No. 502:

The first sentence of this proposed finding is based on Professor Town's market shares, case-mix adjusted prices and willingness-to-pay calculations, all of which are flawed.

Professor Town's "willingness-to-pay" calculation is unreliable for several reasons. First, he includes OB patients in the data, but excludes newborns. (RPF 1550). Professor 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." (RPF 1550). Second, he includes data from hospitals located outside of Lucas County, and therefore outside the relevant geographic market. (RPF 1565). Third, Professor Town's merger simulation model does not allow one to independently or directly observe a patient's second choice of hospitals if his or her first choice becomes unavailable or more expensive. (RPF 1566). Professor Town simply estimates the probability that a given patient would choose a certain hospital if St. Luke's were not available. (Town, Tr. 4243). But, Professor Town admits that the choice a consumer makes "is almost, by definition, going to be different" from the choice that he estimates. (RPF 1567). Fourth, although Professor Town acknowledges that one must appropriately control for the intrinsic value associated with a hospital, he does not. (RPF 1568-1569).

Moreover, his willingness-to-pay is based on a bargaining model characterizing negotiations between hospital systems and commercial payors to set prices. (RX-71(A) at 000072, *in camera*). However, Professor Town's bargaining model is too simplistic to accurately represent the bargaining dynamics in Lucas County because it ignores elements such as the history a provider and MCO have that can affect bargaining. *See* (RPF 1097-1104).

Professor Town's market shares for inpatient general acute care services are flawed because he limits his "market" to only those general acute care inpatient services (identified as "diagnostic related groups" or "DRGs") that both ProMedica and St. Luke's provided to at least three commercially-insured patients (RPF 1491), thereby eliminating from his "market" (and his share calculations) many services that ProMedica, Mercy, and UTMC offer and provide. (RPF 1489-1493, 1504, 1510, *in camera*). Professor Town also excluded overlapping St. Luke's and ProMedica DRGs for which St. Luke's and ProMedica compete with hospitals outside of Lucas County (RPF 1494-1495), and DRGs with a case weight index, which reflects complexity of

care, greater than two. (RPF 1496). {

.} (RX-71(A) at 000015-000018, *in camera*). Professor Town included, however, some DRGs with case weights higher than four, which captures some services that could be classified as tertiary or quaternary medical services. (RPF 1500).

Professor Town's case-mix adjusted prices do not indicate the reason for the difference in prices across hospitals in Lucas County, and Professor Town agrees that the presence of price differences alone are not sufficient to determine the exercise of market power. (RPF 1515). No theoretical or empirical basis exists on which to draw inferences of market power from a comparison of price levels across hospitals. (RX-71(A) at 000069, *in camera*). Professor 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. (RPF 1520). These case-mix-adjusted prices also do not take into consideration the complexity of the bargaining process. (RPF 1521).

Moreover, Mercy was and is a competitive constraint against ProMedica because it is ProMedica's closest substitute – as described by Professor Town. (RPF 1116).

D. Health Plans Cannot Constrain ProMedica's Price Increases

1. A Hospital Network Consisting of Mercy and UTMC is Not a Viable Substitute for One Including ProMedica

a. Market Share Analysis Confirms That A Network of Mercy and UTMC is Less Preferred Than A Network That Includes ProMedica

503. ProMedica's post-Acquisition market share is significantly higher than the combined market share of Mercy and UTMC in Lucas County. (Town, Tr. 3804-3805; PX02148 at

069-070 (¶ 125) (Town Expert Report), *in camera*). A Mercy and UTMC network is not a viable or close substitute for a ProMedica-St. Luke's network, as evidenced by relative market shares, and patient draw by zip codes, which indicate each hospital's relative desirability among patients. (PX02148 at 069-071 (¶¶ 125-126) (Town Expert Report), *in camera*).

Response to Finding No. 503:

Professor Town's market shares for inpatient general acute care services are flawed because he limits his "market" to only those general acute care inpatient services (identified as "diagnostic related groups" or "DRGs") that both ProMedica and St. Luke's provided to at least three commercially-insured patients (RPF 1491), thereby eliminating from his "market" (and his share calculations) many services that ProMedica, Mercy, and UTMC offer and provide. (RPF 1489-1493, 1504, 1510, *in camera*). Professor Town also excluded overlapping St. Luke's and ProMedica DRGs for which St. Luke's and ProMedica compete with hospitals outside of Lucas County (RPF 1494-1495), and DRGs with a case weight index, which reflects complexity of care, greater than two. (RPF 1496). {

.} (RX-71(A) at 000015-000018, *in camera*). Professor Town included, however, some DRGs with case weights higher than four, which captures some services that could be classified as tertiary or quaternary medical services. (RPF 1500).

When market shares are measured using billed charges, rather than patient days, to reflect the fact that many DRGs and service lines cost more, require longer stays and, hence, generate higher revenues, St. Luke's has only a { } percent share of the general acute care inpatient services market, inclusive of inpatient OB services, for Lucas County. (RX-71(A) at 000036-000037, *in camera*). { } combined have a higher share than ProMedica in

Lucas County. (RX-71(A) at 000036-000037, *in camera*). Looking only at inpatient OB services, St. Luke's share is only { } percent based on billed charges in Lucas County. (RX-71(A) at 000036-000037, *in camera*). For all {

} of all hospitals in Lucas County based on billed charges. (RX-71(A)-000036-000037, *in camera*).

{

.} (RPF 1250). Even Complaint Counsel's economic expert admitted that MCOs have not marketed such a network. (Town, Tr. 4311). Moreover, actual market experience has shown that MCOs can and have swapped Mercy for ProMedica successfully. (RPF 359, 1111-1112, 1249, 1250-1251, *in camera*). And {

} (RPF 1119, *in camera*). In addition, Mr. Shook testified that a { } (Shook, Tr. 1132, *in camera*).

Finally, 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. (RPF 1134). The greatest diversion is not between {

} (RPF 1138, *in camera*). A draw area analysis shows that ProMedica hospitals draw from almost exactly the same zip codes as their Mercy counter-parts. (RPF 1117). On the other hand, St. Luke's has significantly less overlap with ProMedica hospitals' draw areas. (RPF 1118).

504. Post-Acquisition, the combined market share of Mercy and UTMC is 42 percent for general acute-care services, significantly less than the 58 percent share for ProMedica and St. Luke's. (Town, Tr. 3804-3805, *in camera*); (PX02150 (Market Share Chart)).

<u>Response to Finding No. 504:</u>

Professor Town's market shares for inpatient general acute care services are flawed because he limits his "market" to only those general acute care inpatient services (identified as "diagnostic related groups" or "DRGs") that both ProMedica and St. Luke's provided to at least three commercially-insured patients (RPF 1491), thereby eliminating from his "market" (and his share calculations) many services that ProMedica, Mercy, and UTMC offer and provide. (RPF 1489-1493, 1504, 1510, *in camera*). Professor Town also excluded overlapping St. Luke's and ProMedica DRGs for which St. Luke's and ProMedica compete with hospitals outside of Lucas County (RPF 1494-1495), and DRGs with a case weight index, which reflects complexity of care, greater than two. (RPF 1496). {

.} (RX-71(A) at 000015-000018, *in camera*). Professor Town included, however, some DRGs with case weights higher than four, which captures some services that could be classified as tertiary or quaternary medical services. (RPF 1500).

When market shares are measured using billed charges, rather than patient days, to reflect the fact that many DRGs and service lines cost more, require longer stays and, hence, generate higher revenues, St. Luke's has only a { } percent share of the general acute care inpatient services market, inclusive of inpatient OB services, for Lucas County. (RX-71(A) at 000036-000037, *in camera*). { } combined have a higher share than ProMedica in Lucas County. (RX-71(A) at 000036-000037, *in camera*). Looking only at inpatient OB services, St. Luke's share is only { } percent based on billed charges in Lucas County. (RX-71(A) at 000036-000037, *in camera*). For all {

} of all hospitals in Lucas County based on billed charges. (RX-71(A)-000036-000037, *in camera*).

505. In St. Luke's core service area, a network consisting of Mercy and UTMC would not be viable for residents. (Town, Tr. 3761-3762, *in camera*). Mercy and UTMC have very low market shares in St. Luke's core service area. (Town, Tr. 3761-3762).

Response to Finding No. 505:

Professor Town's market shares for inpatient general acute care services are flawed because he limits his "market" to only those general acute care inpatient services (identified as "diagnostic related groups" or "DRGs") that both ProMedica and St. Luke's provided to at least three commercially-insured patients (RPF 1491), thereby eliminating from his "market" (and his share calculations) many services that ProMedica, Mercy, and UTMC offer and provide. (RPF 1489-1493, 1504, 1510, *in camera*). Professor Town also excluded overlapping St. Luke's and ProMedica DRGs for which St. Luke's and ProMedica compete with hospitals outside of Lucas County (RPF 1494-1495), and DRGs with a case weight index, which reflects complexity of care, greater than two. (RPF 1496). {

} (RX-71(A) at 000015-000018, *in camera*). Professor Town included, however, some DRGs with case weights higher than four, which captures some services that could be classified as tertiary or quaternary medical services. (RPF 1500).

Furthermore, St. Luke's core service area is not the relevant geographic market, and focusing on market share in this area distorts St. Luke's competitive significance. (RPF 1036-1049). As Complaint Counsel and their economic expert agree, the relevant geographic market is all of Lucas County, and hospitals compete for patients across that market. (RPF 1028-1030).

Finally, St. Luke's concluded from analyzing patient data that UTMC gained the most patients out of all competing hospitals when St. Luke's did not participate in Paramount's and Anthem's networks, which contradicts the proposed finding's implication that UTMC cannot serve as a viable hospital alternative for residents living in St. Luke's core service area. (RX-2162 at 000001).

506. In St. Luke's core service area, the combined market share for Mercy and UTMC is about 25 percent for general acute-care services, significantly less than the 72 percent share for ProMedica and St. Luke's. (Town, Tr. 3805, *in camera;* PX02148 at 143 (Town Expert Report, Ex. 6), *in camera*).

Response to Finding No. 506:

Professor Town's market shares for inpatient general acute care services are flawed because he limits his "market" to only those general acute care inpatient services (identified as "diagnostic related groups" or "DRGs") that both ProMedica and St. Luke's provided to at least three commercially-insured patients (RPF 1491), thereby eliminating from his "market" (and his share calculations) many services that ProMedica, Mercy, and UTMC offer and provide. (RPF 1489-1493, 1504, 1510, *in camera*). Professor Town also excluded overlapping St. Luke's and ProMedica DRGs for which St. Luke's and ProMedica compete with hospitals outside of Lucas County (RPF 1494-1495), and DRGs with a case weight index, which reflects complexity of care, greater than two. (RPF 1496). {

} (RX-71(A) at 000015-000018, *in camera*). Professor Town included, however, some DRGs with case weights higher than four, which captures some services that could be classified as tertiary or quaternary medical services. (RPF 1500).

Furthermore, St. Luke's core service area is not the relevant geographic market, and focusing on market share in this area distorts St. Luke's competitive significance. (RPF 1036-1049). As Complaint Counsel and their economic expert agree, the relevant geographic market is all of Lucas County, and hospitals compete for patients across that market. (RPF 1028-1030).

507. In particular, with respect to obstetrics services, a network comprised of Mercy and UTMC would not be nearly as attractive as a network comprised of ProMedica and St. Luke's because Mercy's St. Anne, located proximally to ProMedica's Flower Hospital, and UTMC, located proximally to St. Luke's, do not offer obstetrics services. (PX02148 at 069-070 (¶ 125) (Town Expert Report), *in camera*).

Response to Finding No. 507:

Professor Town's separate inpatient OB services product market is based on less than one year's worth of data (PX02148 at 143, *in camera*) ("Based on hospital discharges with commercial insurance from July 2009 through March 2010"), and 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. (RPF 1501).

Moreover, Professor Town's market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

Furthermore, proximate location has been shown to be irrelevant to patients because a 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. (RPF 1210). 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. (RFP 1212). 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. (RPF 1213). For Professor Town's inpatient OB patients, 37 percent have a hospital located closer to them than St. Luke's. (RPF 1216). This analysis shows that a large number and proportion of patients are not choosing the hospital located closest to them. (RFP 1217). 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. (RPF 1218).

Finally, inpatient obstetrical services patients choose hospitals based on many other factors besides location. (RPF 43-46). This is evidenced by Professor Town's own conclusion that the vast majority of expectant mothers in St. Luke's core service area travel to hospitals outside of St. Luke's core service area. (RPF 243).

508. Because UTMC and Mercy St. Anne do not offer obstetrics services, the asymmetry between ProMedica and the post-Acquisition walk-away network of Mercy and UTMC is heightened. Post-Acquisition, ProMedica's share is three times greater in obstetrics services than Mercy and UTMC. (Town, Tr. 3806-3807, *in camera*).

Response to Finding No. 508:

The first sentence of this proposed finding violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record. Further, Professor Town's separate inpatient OB services product market is flawed, because it is based on less than one year's worth of data (PX02148 at 143, *in camera*) ("Based on hospital discharges with commercial insurance from July 2009 through March 2010"), and 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. (RPF 1501).

Moreover, Professor Town's market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

This proposed findings also overlooks the fact that MMO successfully used Mercy as its sole provider of high-risk inpatient OB services prior to 2008, despite Mercy's relatively lower number of OB admissions, showing that MCOs do not need ProMedica to provide high level OB services. (RPF 714, 719-724, 1022).

b. Respondent Admits That A Hospital Network of Mercy and UTMC Has Not Been Offered by Health Plans

509. Respondent's expert, Ms. Guerin-Calvert, admits that if a health plan could not reach an agreement with ProMedica today, the health plan would have to offer an unprecedented network comprised of Mercy and UTMC. (Guerin-Calvert, Tr. 7896-7897).

Response to Finding No. 509:

Respondent has no specific response.

510. No health plan in at least the last 10 years has ever offered a network comprised of only UTMC and Mercy. (JX00002A at ¶ 9, Respondent's Reply to RFA at ¶ 14; PX02148 at 062-063 (¶ 112) (Town Expert Report), *in camera*).

Response to Finding No. 510:

Respondent has no specific response.

511. Respondent's expert, Ms. Guerin-Calvert, testified that in the past 20 years, there has never been a network comprised of only Mercy and UTMC. (Guerin-Calvert, Tr. 7895).

Response to Finding No. 511:

Respondent has no specific response.

512. In fact, Jack Randolph, who has been President of Paramount since 1992, is unaware of any health plan ever marketing a network consisting only of Mercy and UTMC. (Randolph, Tr. 7065). Health plans have had many different permutations of hospital providers in their networks in Lucas County, but have not marketed a network of Mercy and UTMC alone. (Randolph, Tr. 7069-70; *see also* Guerin-Calvert Tr. at 7893-7896).

Response to Finding No. 512:

Respondent has no specific response.

513. Ron Wachsman, Senior Vice President for Managed Care, Reimbursement, and Revenue Cycle Management of ProMedica, testified that no health plan doing business in Lucas County has ever offered a network consisting of only the Mercy hospitals and UTMC, or a network of only Mercy or only UTMC. (Wachsman, Tr. 5196-5197, *in camera*; PX01927 at 019 (Wachsman, Dep. at 69), *in camera*).

Response to Finding No. 513:

Respondent has no specific response.

c. Health Plan Testimony Confirms That a Hospital Network of Mercy and UTMC Would Not Be A Viable Substitute For One Including ProMedica

514. Aetna is not aware of any health plan that has offered a network of just Mercy and UTMC. (Radzialowski, Tr. 672).

Response to Finding No. 514:

Complaint Counsel's proposed finding is inaccurate and misleading. Aetna's lack of awareness says nothing about the viability of such a network.

515. Aetna has never considered offering a network comprised of Mercy and UTMC only. (Radzialowski, Tr. 672; *see also* 715-716, *in camera*).

Response to Finding No. 515:

Complaint Counsel's proposed finding is inaccurate and misleading. Aetna's strategy in Lucas County was to offer a broad provider network to compete with the limited networks offered by other major MCOs. In this circumstance, there was no reason for Aetna to consider a network comprised of Mercy and UTMC. (RPF 801-802).

516. Aetna has no future plans to offer such a network of Mercy and UTMC only. (Radzialowski, Tr. 672; *see also* 715-716, *in camera*). {

} (Radzialowski, Tr. 716, *in camera*).

Response to Finding No. 516:

Complaint Counsel's proposed finding is inaccurate and misleading. None of the references to trial testimony support this future-oriented proposed finding. All of the references in Mr. Radzialowski's testimony speak to past behavior.

517. An Aetna executive testified that prior to the Acquisition, marketing a network consisting of St. Luke's, Mercy, and UTMC would have been feasible. (PX02067 at 006 (¶ 21) (Radzialowski, Decl.), *in camera*). However, post-Acquisition, marketing a network that excludes ProMedica would be "significantly detrimental to Aetna's business." (PX01917 at 020 (Radzialowski, Dep. at 76), *in camera*).

Response to Finding No. 517:

Complaint Counsel's proposed finding is inaccurate and misleading. {

} (RPF 1250, *in camera*). No MCO has ever attempted to { } (RPF 1250, *in camera*). Lucas County, however, has a long history of successful limited networks. (RPF 709-717, 719-722, 725-728, 779-781).

518. Anthem has never marketed a health plan product with a hospital network that consisted solely of Mercy and UTMC to Lucas County employers. (Pugliese, Tr. 1477, *in camera*). No such network has ever been marketed because "[t]here wasn't a demand for that type of network." (Pugliese, Tr. 1477-1478, *in camera*).

Response to Finding No. 518:

Complaint Counsel's Proposed Finding is inaccurate and misleading. Anthem's long-time strategy was to promote a limited network anchored on the ProMedica hospitals, which it offered in direct competition with MMO's Mercy-focused network. (RPF 719-720, 725-728). In

these circumstances, there was never any reason for Anthem to market such a network. Mr. Pugliese's comments about demand for such a network are not based upon any market research studies. Anthem testified it has not surveyed member preferences or utilization patterns. (RPF 1261-1263).

519. A network consisting of Mercy and UTMC would not be commercially viable for Anthem because it "is not representative of what our customers have been asking for." (Pugliese, Tr. 1478, *in camera*).

Response to Finding No. 519:

Complaint Counsel's proposed finding is misleading and inaccurate. Mr. Pugliese's comments about demand for such a network are not based upon any market research studies. Anthem testified it has not surveyed member preferences or utilization patterns. (RPF 1261-1263).

520. Even if Anthem could offer a Mercy-UTMC network at a lower price, the network would not be competitive. (Pugliese, Tr. 1577-1578 ("We wouldn't be more competitive. We would be lacking in network, so price might be better, but the network would not.")).

Response to Finding No. 520:

Complaint Counsel's proposed finding is speculative. Mr. Pugliese's comments about such a network are not based upon any market research studies. Anthem testified it has not surveyed member preferences or utilization patterns. (RPF 1261-1263).

521. An MMO executive testified that MMO could not offer a viable health plan network in Lucas County that consisted only of UTMC and Mercy. (Pirc, Tr. 2262, *in camera*).

Response to Finding No. 521:

Complaint Counsel's proposed finding is speculative. Mr. Pirc expressly stated that MMO has { } such a network. (Pirc, Tr. 2262, *in camera*). He has no data upon which to base the assessment cited in the proposed finding.

522. MMO's members in southwest Lucas County would have to travel too far to receive care if MMO's network consisted of only Mercy and UTMC. (Pirc, Tr. 2262, *in camera*).

Response to Finding No. 522:

Complaint Counsel's proposed finding is speculative. Mr. Pirc expressly stated that MMO has { } such a network. (Pirc, Tr. 2262, *in camera*). He has no data upon which to base the assessment cited in the proposed finding. MMO expressly testified that it has not conducted any studies of members' willingness to travel. (RPF 1264-1265). MMO also has not studied member utilization in southwest Lucas County. (RPF 1266). Distance is not a determinant factor for patients in Lucas County. (RPF 218-243, 1210-1218). Moreover, UTMC is only about 6 miles away from St. Luke's. (RPF 1140).

523. Marketing a network without ProMedica post-Acquisition, even at lower reimbursement rates, would be unmarketable and result in a loss of membership for MMO. (Pirc, Tr. 2313, *in camera*).

Response to Finding No. 523:

Complaint Counsel's proposed finding is speculative. { } (RPF 1250, *in camera*). Mr. Pirc expressly stated that MMO has { } such a network. (Pirc, Tr. 2262, *in camera*). In fact, no MCO has ever attempted to { } (RPF 1250, *in camera*). Lucas County, however, has a long history of successful limited networks. (RPF 709-717, 719-722, 725-728, 779-781).

524. Post-Acquisition, MMO could not offer a PPO product in Lucas County that did not include ProMedica's hospitals. (Pirc, Tr. 2261-2262, *in camera*).

Response to Finding No. 524:

Complaint Counsel's proposed finding is speculative. Respondent refers to its response to Complaint Counsel's proposed finding 523, which it incorporates here by reference.

525. United has never marketed a network consisting solely of UTMC and Mercy. (Sheridan, Tr. 6694; PX01939 at 031 (Sheridan, Dep. at 119), *in camera*).

Response to Finding No. 525:

Complaint Counsel's proposed finding is inaccurate and misleading. United's past experience says nothing about the viability of such a network.

526. An United executive testified that marketing a network without ProMedica post-Acquisition makes it much more difficult to serve its members. (PX01902 at 018 (Sheridan, IHT at 63), *in camera*).

Response to Finding No. 526:

Complaint Counsel's finding is misleading and inaccurate. United testified that {

}. (RPF 365, *in camera*) United also has long experience anchoring its network with the Mercy hospitals instead of ProMedica. (RPF 359, 363-364). Its Mercy-anchored network competed successfully for many years. (RPF 363-364}.

527. United added ProMedica to its network in the fall of 2010. (Sheridan, Tr. 6621). United was under significant internal pressure to bring ProMedica into United's network. (Sheridan, Tr. 6693, *in camera*). Having a "skinnied-down" narrow network in Lucas County was not attractive enough for United to grow its membership, even at a lower price. (Sheridan, Tr. 6692-93, *in camera*). In fact, if ProMedica didn't rejoin the United network, { }. (Sheridan, Tr. 6693, *in camera*).

Response to Finding No. 527:

Complaint Counsel's proposed finding is misleading and inaccurate. Ms. Sheridan did not know the price of competitors' network offerings and testified only that it was her understanding that United's network was offered at a price point that was "{ } than some of United health plan competitors' networks." (Sheridan, Tr. 6692, *in camera*). Ms. Sheridan did not identify these competitors or what the composition of these networks were. Narrow networks are less expensive than broad networks. (RPF 562-563). Ms. Sheridan's observation on pricing relative to only some, unspecified competitors says nothing about the competitiveness of the United plan from a pricing perspective.

528. A network comprised solely of Mercy and UTMC could not be viably marketed by FrontPath; as it would account for less than { } of their current Lucas County utilization. (Sandusky, Tr. 1351, *in camera*)

<u>Response to Finding No. 528:</u>

Complaint Counsel's proposed finding is speculative and misleading. FrontPath has always marketed broad networks in Lucas County. (RPF 342). FrontPath thus has no data upon which to base this assessment.

529. ProMedica is a significant provider for FrontPath. (Sandusky, Tr. 1324). If ProMedica was not in FrontPath's network, it would significantly affect FrontPath's book of business. (Sandusky, Tr. 1324).

<u>Response to Finding No. 529:</u>

Respondent has no specific response.

530. Humana testified that it cannot create a viable hospital network in Lucas County that consists only of Mercy and UTMC. (McGinty, Tr. 1201; PX02073 at 004 (¶ 15) (McGinty, Decl.), *in camera*).

<u>Response to Finding No. 530:</u>

Complaint Counsel's proposed finding is speculative and misleading. The proposed finding relates to Humana's Medicare Advantage product, which is not part of the relevant product market. (McGinty, Tr. 1201, 1208). Furthermore, on commercial products, Humana's strategy in Lucas County has been to offer a broad provider network to compete with the limited networks offered by other major MCOs. (McGinty, Tr. 1194). It thus has no data relating to the viability of a narrow network.

531. Humana's Medicare Advantage product originally included only Mercy but was "not successful." (McGinty, Tr. 1199-1200, 1261). Humana did not consider adding UTMC to the Mercy-only network because adding a high-cost hospital with questionable quality would destroy the network's value proposition by increasing premiums for members. (McGinty, Tr. 1201).

<u>Response to Finding No. 531:</u>

Complaint Counsel's proposed finding is misleading and inaccurate. Medicare Advantage is Humana's government insurance product and not within the relevant product market. (McGinty, Tr. 1218 ("Q: Does the Medicare Advantage product replace Medicare coverage? A: That is what it does"). In addition, Humana only tried the Mercy-only Medicare Advantage network for less than two months. (McGinty, Tr. 1200).

532. Ultimately, a network comprised of Mercy and UTMC would not allow Humana to be competitive versus other health plans. (McGinty, Tr. 1201).

Response to Finding No. 532:

Complaint Counsel's proposed finding is misleading and inaccurate. The proposed finding relates to Humana's Medicare Advantage product, which is not part of the relevant product network. (McGinty, Tr. 1201, 1218).

533. Humana subsequently added St. Luke's to the Medicare Advantage network and increased its membership. (McGinty, Tr. 1200-1201). When Humana switched to a ProMedica/St. Luke's network, it gained over 4,000 Medicare Advantage members over when Humana offered a Mercy/St. Luke's network. (McGinty, Tr. 1203-1204).

Response to Finding No. 533:

Complaint Counsel's proposed finding is misleading and inaccurate. The proposed finding relates to Humana's Medicare Advantage product, which is not part of the relevant product network. (McGinty, Tr. 1201, 1218).

d. Employer Testimony Confirms That a Hospital Network of Mercy and UTMC Would Not Be a Viable Substitute For One Including ProMedica

534. A provider network consisting of only Mercy and UTMC is unacceptable to employers. (Neal, Tr. at 2112-2113; Buehrer, Tr. 3091).

Response to Finding No. 534:

The proposed finding is inaccurate and misleading. Complaint Counsel misrepresent the testimony of the only two employers whose opinions are cited in support of this broad claim.

Each of these two employers offered additional testimony that contradicts and undermines the proposed finding.

Ms. Neal's opinions about the provider network preferences of Lucas County employees lack any foundation. Chrysler has conducted no studies on the willingness of its employees to travel for healthcare services in Lucas County within at least the past five years, and has conducted no disruption analyses examining the impact of the closure of St. Luke's within the last ten years. (Neal, Tr. 2155, 2157). She has no personal knowledge of the area: she lives in Michigan and has never visited any of the Lucas County hospitals. (Neal, Tr. 2127-2128, 2151). She relies upon third-party consultants for healthcare contracting in Lucas County and lacks knowledge of basic facts of the Lucas County healthcare marketplace. (Neal, Tr. 2092, 2127 (acknowledging no knowledge of joinder prior to being contacted by Complaint Counsel), 2148 (showing no knowledge of significant MCO competitors operating in Lucas County market), 2151-2152 (showing no knowledge of services provided by Lucas County hospitals). Although her objection to a Mercy-UTMC network was supposedly rooted in the "availability of hospitals in the communities where [employees] live," Ms. Neal did not know the proportion of Chrysler employees receiving services at each Lucas County hospital. (Neal, Tr. 2113, 2151). Specifically, with respect to St. Luke's, Ms. Neal lacked any knowledge of the hospital's location with respect to Lucas County residents in general and Chrysler's insureds in particular. (Neal, Tr. 2155). This lack of personal knowledge fatally undermines Ms. Neal's credibility. Her testimony thus provides no support for the proposed finding.

Like Ms. Neal, Mr. Buehrer's testimony offers no support for Complaint Counsel's proposed finding. Mr. Buehrer confirmed he has conducted no studies of his employees' health insurance utilization. (Buehrer, Tr. 3088). He is unaware of how much of his employees'

healthcare costs derive from general acute-care inpatient services. (Buehrer, Tr. 3088-3089). He also lacks any knowledge as to where his employees actually receive hospital services. (Buehrer, Tr. 3089). Although he lives in Lucas County, Mr. Buehrer, like Ms. Neal, lacks even basic knowledge about the local healthcare market. (Buehrer, Tr. 3058). Despite the fact that his sister serves on the board of St. Luke's, he first learned of the joinder when Complaint Counsel contacted him. (Buehrer, Tr. 3060, 3080). Mr. Buehrer does not personally track employee healthcare data, uses a broker to negotiate health plan coverage, and lacks any knowledge of the network composition for any competing MCOs. (Buehrer, Tr. 3088-3089). Any geographic basis for Mr. Buehrer's opinion is also suspect. For fully two-thirds of his employees (several of whom live outside Lucas County in locations as far away as northeastern Ohio near the Pennsylvania border), St. Luke's was not the closest hospital. (Buehrer, Tr. 3083-3084). His testimony makes it clear that Mr. Buehrer, whose family has lived in the Maumee area for over 40 years and has close ties to the community, is personally very fond of St. Luke's hospital. (Buehrer, Tr. 3058-3060, 3096 (indicating that his sister sits on St. Luke's Board and his brother is a member of the Maumee City Council). However, such fondness provides no basis for his opinion as to his employees healthcare preferences. Mr. Buehrer's lack of any personal knowledge regarding his employees' healthcare usage and preferences fatally undermines his credibility and, as a result, his testimony also provides no support for the proposed finding.

535. A Chrysler representative testified that a network consisting solely of Mercy and UTMC would be "very detrimental to [Chrysler's Lucas County] employees." (Neal, Tr. 2112-2113)

Response to Finding No. 535:

The proposed finding is inaccurate and misleading. Respondent refers to its response to Complaint Counsel's proposed finding 534 which it incorporates here by reference.

536. Mr. Buehrer, President of the Buehrer Group Architectural and Engineering Inc., testified that network consisting of Mercy, UTMC, and St. Luke's acceptable only "because St. Luke's was included." (Buehrer, Tr. 3091).

Response to Finding No. 536:

The proposed finding is inaccurate and misleading. Respondent refers to its response to Complaint Counsel's proposed finding 534 which it incorporates here by reference.

e. Economic and Econometric Analysis Demonstrates that a Network of Mercy and UTMC Would not be a Viable Substitute For One Including ProMedica

537. The walk-away network that managed care organizations can turn to post-Acquisition when negotiating with ProMedica is the Mercy and UTMC combination; for residents of southwest Lucas County, a network comprised of Mercy and UTMC is much less attractive. (Town, Tr. 3806, *in camera*); PX02148 at 067-068 (¶ 126) (Town Expert Report), *in camera*).

Response to Finding No. 537:

Southwest Lucas County is not the relevant geographic market. (RPF 1036-1049). As Complaint Counsel and their economic expert agree, the relevant geographic market is all of Lucas County, and hospitals compete for patients across that market. (RPF 1028-1030).

{

} (RPF 1250, *in camera*).

Even Complaint Counsel's economic expert admitted that MCOs have not tried to market such a network. (Town, Tr. 4311). Moreover, actual market experience has shown that MCOs can and have swapped Mercy for ProMedica successfully. (RPF 359, 1111-1112, 1249-1251). In addition, Mr. Shook testified that a { } (Shook, Tr. 1132, *in camera*). Finally, the proposed finding is misleading because it overlooks the fact that St. Luke's only treats about ten commercially insured patients per day, and Mercy and UTMC have significant excess capacity to treat additional patients. (RFP 662-664, 1147, 1316-1319; PX02137 at 055, *in camera*).

538. Professor Town's willingness-to-pay analysis demonstrates that a network of ProMedica and St. Luke's is significantly more valuable than a network of Mercy and UTMC. (Town, Tr. 3808, *in camera*; PX02148 at 066, 164-165 (¶ 118, Ex. 13) (Town Expert Report), *in camera*. This suggests that ProMedica's bargaining leverage is heightened because the value of the walk-away network is significantly less than the post-Acquisition bargaining leverage of St. Luke's. (Town, Tr. 3808-9, *in camera*); (PX02148 at 066-068, 071-072 (¶¶119-122, 127) (Town Expert Report), *in camera*).

Response to Finding No. 538:

Professor Town's "willingness-to-pay" calculation is unreliable for several reasons. First, he includes OB patients in the data, but excludes newborns. (RPF 1550). Professor 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." (RPF 1550). Second, he includes data from hospitals located outside of Lucas County, and, therefore, outside the relevant geographic market. (RPF 1565). Third, Professor Town's merger simulation model does not allow one to independently or directly observe a patient's second choice of hospitals if his or her first choice becomes unavailable or more expensive. (RPF 1566). Professor Town simply estimates the probability that a given patient would choose a certain hospital if St. Luke's were not available. (Town, Tr. 4243). But, Professor Town admits that the choice a consumer makes "is almost, by definition, going to be different" from the choice that he estimates. (RPF 1567). Fourth, although Professor Town acknowledges that one must appropriately control for the intrinsic value associated with a hospital, he does not. (RPF 1568-1569).

Moreover, his willingness-to-pay is based on a bargaining model characterizing negotiations between hospital systems and commercial payors to set prices. (RX-71(A) at 000072, *in camera*). However, Professor Town's bargaining model is too simplistic to accurately represent the bargaining dynamics in Lucas County because it ignores elements such

as the history a provider and MCO have that can affect bargaining. (RPF 1104, *see also* RPF 1097-1103).

In addition, {

.} (RPF 1250, *in camera*). Even Complaint Counsel's economic expert admitted that MCOs have not tried to market such a network. (Town, Tr. 4311). Moreover, actual market experience has shown that MCOs can and have swapped Mercy for ProMedica successfully. (RPF 359, 1111-1112, 1249-1251). In addition, Mr. Shook testified that a { .} (Shook, Tr. 1132, *in camera*).

This proposed finding also ignores the possibility of lower or discounted rates in exchange for a narrow network. (RPF 561-562, 730-732, *in camera*). In Lucas County, { } received discounted rates from ProMedica and Mercy, respectively, because their exclusive relationships prior to 2008 offered the hospitals the promise of a greater volume of each MCO's members. (RPF 730-732, *in camera*, 1253).

Finally, the proposed finding is misleading because it overlooks the fact that St. Luke's only treats about ten commercially insured patients per day, and Mercy and UTMC have significant excess capacity to treat additional patients. (RFP 662-664, 1147, 1316-1319; PX02137 at 055, *in camera*).

2. Health Plans Cannot Defeat ProMedica's Price Increases By Steering Members to Less Expensive Hospitals

539. Health plans currently place greater emphasis on open-access networks than they did prior to 2008. (Radzialowski, Tr. 615, 657-658; PX02148 at 064 (¶¶ 121) (Town Expert Report), *in camera*; PX02067 at 004-005 (¶ 15) (Radzialowski, Decl.), *in camera*). For example, an Anthem executive testified that it added Mercy in 2008 and St. Luke's in 2009 in response to member preferences for access to all Lucas County hospitals. (Pugliese, Tr. 1544-1545); (Radzialowski, Tr. 657-658); (PX02072 at 003-004 (¶ 13) (Firmstone, Decl.), in camera); *see also* (PX02067 at 004-005 (¶ 15) (Radzialowski, Decl.).

Response to Finding No. 539:

Complaint Counsel improperly cite the Declaration (PX02072) of a witness who was not deposed and who did not testify.

Furthermore, Complaint Counsel misrepresent witness testimony and ignore additional testimony and evidence that undermines the proposed finding. For example, Complaint Counsel cite testimony from Mr. Radzialowski that describes a general view of trends in Aetna's national business. (Radzialowski, Tr. 615). Aetna offered a broad network in Lucas County since at least 2006 and, thus, it is inaccurate to state that Aetna now places a greater emphasis on open networks now. (RPF 390).

The history of networks in Lucas County demonstrates frequent reconfigurations as MCOs compete with one another. (RPF 709-717). Some MCOs adopt an open network strategy and others opt for a limited network strategy; some MCOs shift back and forth between these options. Anthem, for example, operated a broad network in the early 2000s before shifting to counter MMO's limited network offering. (RPF 709, 712). It later shifted back to broad access. (RPF 714-715). Preferences for different network configurations fluctuate for different reasons, but a driving factor is price and limited networks offer MCOs the opportunity to provide a full range of health services at a lower cost to members. (RPF 566-567).

540. Members prefer broader networks. (Radzialowski, Tr. 657; Sandusky, Tr. 1287-1288; Pugliese, Tr. 1449; PX01939 at 020 (Sheridan, Dep. at 74), *in camera*; PX01944 (Pirc, Dep. at 76).

Response to Finding No. 540:

Complaint Counsel misrepresent witness testimony. Mr. Radzialowski was asked whether Aetna members care about broad access to hospitals, but he responded by describing the actions of other MCOs in Lucas County. (Radzialowski, Tr. 657). Aetna itself offered a broad network for years while competitors focused on limited networks, but this competitive difference

never translated to any business advantage for Aetna, as one would have expected if members truly were driven by a strong preference for open networks. (RPF 800-803). As Mr. Radzialowski and others have testified, price is a more important factor than breadth of network. (Radzialowski, Tr. 742; RPF 435).

Ms. Sandusky also did not testify to member preferences. (Sandusky, Tr. 1287-1288). She stated that it was FrontPath's strategy to offer a broad network and she indicated that this approach separated it from other MCOs in Lucas County. (Sandusky, Tr. 1287-1288). Nevertheless, she also testified that FrontPath gained no competitive benefit by offering a broad network. (RPF 807-808). Members did not shift to FrontPath because of its broad network.

Market evidence from Lucas County demonstrates that a very large segment of the population prefers limited networks: Paramount has offered a narrow network for more than a decade and yet is one of the largest MCOs in Lucas County. (RPF 780-781).

Finally, all MCO testimony about members' supposed preferences lacks foundation because none has conducted any study to determine patient preferences. (RFP 1261-1271).

541. Lucas County employers testified that their employees prefer health plan networks that include broad access to hospitals. (Lortz, Tr. 1700-1701, 1706; Caumartin, Tr. 1859-1861, 1864; Neal, Tr. 2102-2106, 2113; Buehrer, Tr. 3074, 3078).

Response to Finding No. 541:

To the extent that Complaint Counsel's proposed finding relies upon the testimony of Ms. Neal and Mr. Buehrer, Respondent refers to its response to CCPF 534, which it incorporates here by reference.

Complaint Counsel further misrepresents the status of Mr. Caumartin. Mr. Caumartin is not a "Lucas County employer." Mr. Caumartin is the retired former Superintendent of Bowling Green Schools. (Caumartin, Tr. 1833). He also served as the head of the Wood County Schools Health Consortium. (Caumartin, Tr. 1833). Wood County is not in the relevant geographic

market identified by Complaint Counsel. Mr. Caumartin's testimony as to the preference of Wood County employers therefore has no relevance in this matter. Even if Mr. Caumartin's testimony were relevant, it does not support Complaint Counsel's proposed finding. Mr. Caumartin testified that employees realized a limited network met their needs equally well as a broad network. (Caumartin, Tr. 1859-1860).

Complaint Counsel also misrepresents the testimony of Mr. Lortz. Mr. Lortz merely testified that, in his opinion, employees wanted access to their personal physician, which is not the same as saying that employees desire having all Lucas County hospitals in their provider network. (Lortz, 1700-1701). Physician networks are separate from hospital provider networks. Lucas County physicians maintain privileges at multiple Lucas County hospitals. (RPF 674-693). With respect to actual hospital services, Mr. Lortz testified that the UAW has conducted no studies regarding member preferences for hospital services and any testimony relating to employee preferences for broad networks thus lacks any foundation. (Lortz, 1738).

542. Patients are resistant to changing hospitals, or losing access to hospitals in a health plan network. (Sheridan, Tr. 6680).

Response to Finding No. 542:

Complaint Counsel cite to no study or analysis that supports this anecdotal, opinion testimony.

543. Patients do not like health plans steering them to particular hospitals. (Radzialowski, Tr. 657-658; Pugliese, Tr. 1465, 1544-1545; PX01917 at 018 (Radzialowski, Dep. at 68), *in camera*).

Response to Finding No. 543:

Complaint Counsel cite to testimony (PX01917) that lacks any foundation, is speculative and based upon leading questions. Furthermore, Complaint Counsel blatantly misrepresent Mr. Radzialowski's testimony. When asked whether Aetna had any information about how members

respond to steering mechanisms, {

} (PX01917 (Radzialowski, Dep. at 68), *in camera*). Lack of data undermines Complaint Counsel's proposed finding, as no MCO has conducted any study of member preferences. (RPF 1261-1265, 1266, *in camera*, 1267, *1268, in* camera, 1269-1271).

544. In-network steering is defined as charging different prices to patients for accessing in-network hospitals based on the price the health plan pays to the hospital for its members' inpatient care. (Town, Tr. 3810, *in camera*).

Response to Finding No. 544:

Many mechanisms are available to encourage MCO plan members to select preferred providers. Not all such mechanisms are based on financial incentives. (RPF 1272).

545. Implementation of a steering mechanism would be costly to health plans because it would devalue the health plan's product. (Town, Tr. 3810, *in camera*).

Response to Finding No. 545:

Complaint Counsel cite to no MCO testimony to support this assertion. MCOs, in fact, testified that steerage programs can produce lower costs for the MCO. (RPF 1273).

546. It is not practical to steer members to lower cost providers because members prefer full access to their health plan's network and find steering mechanisms inconvenient and difficult to understand. (PX02148 at 067-069 (¶¶ 122-123) (Town Expert Report), *in camera*).

Response to Finding No. 546:

Complaint Counsel's proposed finding ignores testimony and evidence from Lucas County that MCOs and some of Lucas County's largest employers are *already* engaging in steerage programs. (RPF 1272-1273, 1274-1284, *in camera*, 1285, 1286-1290, *in camera*, 1292-1293, *in camera*, 1294-1305, 1306, *in camera*, 1307-1315). Complaint Counsel's assertions about member preferences fail for all of the reasons discussed in the responses to CCPF 534, 540, and 541. In addition, Complaint Counsel's expert conducted no consumer preference surveys to provide any foundation for this proposed finding. (Town, Tr. 4253).

547. There are significant differences in prices across the hospital systems in Lucas County, and if steering were an effective tool by which health plans could shift patients to lower cost hospitals and manage costs, a strong incentive to use this tool existed prior to the Acquisition. (Town, Tr. 3811, *in camera*).

Response to Finding No. 547:

Complaint Counsel cite to no evidence supporting their assertion that there are significant differences in the prices between the two hospital systems in Lucas County. Testimony at trial suggested the difference between rates at ProMedica and Mercy hospitals were minimal. For example, Aetna testified that the difference between its rates for Mercy and ProMedica was only { }. (RPF 1350, *in camera*).

Complaint Counsel further ignore relevant facts in evidence that undermine the proposed finding. Until very recently, most major MCOs offered limited provider networks, which led to reduced premium rates as a result of volume discounting. (RPF 562-563, 709-717, 730-732, *in camera*). MCOs were already engaging in a form of steering by contracting with a smaller network of hospitals to obtain reduced rates. There was less need to engage in additional steering *within* these limited networks.

548. The absence of any widespread in-network steering in Lucas County prior to the Acquisition, shows that this was not an effective tool for health plans, or undesirable insofar as it devalued the health plans' product. (Town, Tr. 3811, *in camera*).

Response to Finding No. 548:

Respondent refers to its response to CCPF 547, which it incorporates here by reference. In addition, Complaint Counsel ignores evidence in the record that demonstrates steering is in use by major Lucas County employers and has been an effective tool to encourage members to select the lower-cost healthcare options. (RPF 1272-1273, 1274-1284, *in camera*, 1285, 1286-1290, *in camera*, 1292-1293, *in camera*, 1294-1305, 1306, *in camera*, 1307-1315).

549. Even if in-network steering were implemented, it would be unlikely to defeat a price increase. (Town, Tr. 3813, *in camera*; PX01850 at 027-030 (¶¶ 39-43) (Town Rebuttal

Report), *in camera*). This is because unlike hospital markets, in most markets consumers directly face prices. (Town, Tr. 3813-3814, *in camera*) Mergers of close competitors in markets where consumers do not face prices still raise competitive concerns. (Town, Tr. 3813-3814, *in camera*; PX01850 at 014 (¶19) (Town Rebuttal Report), *in camera*).

Response to Finding No. 549:

Complaint Counsel's proposed finding is speculative, inaccurate and misleading. Complaint Counsel misrepresent the nature on in-network steering. The purpose of hard steering is to provide financial incentives that encourage members to seek care at preferred facilities. (RPF 1272). Hard steering thus does allow consumers to face pricing.

550. It would be even more difficult for health plans to steer Lucas County residents to hospitals outside of Lucas County, such as Fulton County Health Center or Wood County Hospital, even if these hospitals have available capacity, in an effort to resist a price increase. (PX02148 at 028-029 (¶ 50) (Town Expert Report), *in camera*).

Response to Finding No. 550:

Complaint Counsel's proposed finding is speculative, inaccurate and misleading. Steering mechanisms merely need to direct members to competing hospitals in order to be effective. (RPF 1272). Competing hospitals exist within Lucas County. To the extent that hospitals in Fulton County and Wood County compete with Lucas County hospitals, patients will already be utilizing these facilities and implementing a steering program will not be difficult.

551. Health plans have testified that Wood County Hospital and Fulton County Health Center are insignificant competitors to the Lucas County hospitals, and thus, not viable alternatives for Lucas County members. (Pirc, Tr. 2183, 2191- 2193; Radzialowski, Tr. 648-651; Sandusky, Tr. 1315; Pugliese, Tr. 1451; Sheridan, Tr. 6691 (*in camera*), 6682).

Response to Finding No. 551:

The testimony cited by Complaint Counsel does not support the proposed finding. No MCO witness testified as to whether hospitals outside Lucas County were viable alternatives for Lucas County members. In fact, numerous MCO witnesses have testified that they include these hospitals in their Lucas County-based provider networks. (RPF 291; Radzialowski, Tr. 648).

Testimony cited by Complaint Counsel focused on whether the MCO witness believed Lucas County patients would travel to hospitals outside Lucas County. The value of such testimony, to the extent it even supports the proposed finding, is suspect. No MCO has conducted studies of member travel patterns or preferences. (RPF 1261-1265, 1266, *in camera*, 1267, *1268, in* camera, 1269-1271).

552. Indeed, Jack Randolph, CEO of Paramount, testified that a network marketed to Lucas County members that consisted of only non-Lucas County hospitals would be "absurd" and not a viable or marketable option. (Randolph, Tr. 7064).

Response to Finding No. 552:

Respondent has no specific response.

553. Wood County Hospital and Fulton County Health Center executives have testified that they do not compete with Lucas County hospitals. (Korducki, Tr. 515-516; (Beck, Tr. 388-390).

Response to Finding No. 553:

Complaint Counsel ignore contradictory testimony from the same witnesses. Wood County Hospital places advertisements on local television and in the *Toledo Blade* and the *Sentinel Tribune*. (Korducki, Tr. 513). This advertising reaches Lucas County residents. (Korducki, Tr. 514). Wood County Hospital also advertises on billboards throughout the area. (Korducki, Tr. 513).

Both Fulton County Health Center and Wood County Hospital are aware that Lucas County hospitals advertise in the *Toledo Blade* and on radio and television stations that reach Fulton and Wood Counties. (Beck, Tr. 437-438; Korducki, Tr. 565). St. Luke's has advertised on billboards in Wood County. (Korducki, 565).

554. Respondent's argument that steering is easy because health plans have demonstrated the ability to exclude Mercy or ProMedica in past network configurations fails to consider the change in value to health plans in comprising an alternative, or walk-away network without St. Luke's. (Town, Tr. 3822-3823, *in camera*).

Response to Finding No. 554:

Complaint Counsel's proposed finding misrepresents witness testimony. Professor Town's cited testimony relates to in-network vs. out-of-network steering. He does not discuss a walk-away network that lacks St. Luke's. (Town, Tr. 3822-3823, *in camera*).

555. Notably, in the past 10-15 years, no health plan network has excluded both ProMedica and St. Luke's. (Town, Tr. 3824, *in camera*; Guerin-Calvert, Tr. 7893-7897).

Response to Finding No. 555:

The lack of this option in the past owes to the existing network configurations in Lucas County and history of market developments and it provides no evidence as to the future marketability of such a network configuration. (RPF 1251, *in* camera, 1598, 1602).

556. MMO does not steer its members to use certain hospitals within MMO's network based on the reimbursement rates that MMO pays. (Pirc, Tr. 2213-2214; PX01944 at 019 (Pirc, Dep. at 72), *in camera*). MMO has no plans to implement a program to steer members to certain in-network providers using financial incentives. (Pirc, Tr. 2214; PX01944 at 022 (Pirc, Dep. at 82), *in camera*)). MMO has never implemented a tiered hospital network and has no plans to do so in the future. (Pirc, Tr. 2216).

Response to Finding No. 556:

Complaint Counsel provide an incomplete account of MMO testimony. MMO's representative testified that it had no plans to launch a steerage program "in the near future," but he also acknowledged that { } in steerage programs. (Pirc, Tr. 2214; RPF 1274, *in camera*). Moreover, the {

} continues to grow {

} (RPF 1278, *in camera*, 1293, *in camera*).

557. MMO does not tier hospitals in its network based on the quality of care that the hospitals deliver to MMO's members. (PX01944 at 019 (Pirc, Dep. at 72), *in camera*; Pirc, Tr. 2214).

Response to Finding No. 557:

The proposed finding is misleading. MMO testified that quality measures were currently still "too nebulous." (Pirc, Tr. 2214).

558. Apart from the health insurance products offered to { } employees, none of MMO's products in Lucas County provide financial incentives for MMO's members to seek care at certain hospitals over others. (Pirc, Tr. 2213-2214; PX01944 at 019 (Pirc, Dep. at 73), *in camera*). Mr. Pirc is unaware of any requests from self-insured customers in Lucas County that MMO create tiered networks which provide different levels of insurance coverage to members, depending on the hospital the members choose for inpatient care. (Pirc, Tr. 2215; PX01944 at 019 (Pirc, Dep. at 72-73), *in camera*).

Response to Finding No. 558:

Complaint Counsel misrepresents Mr. Pirc's testimony. Mr. Pirc testified that {

} (Pirc, Tr. 2307, *in camera*).

Furthermore, Complaint Counsel's attempt to dismiss the importance of the {

} is misleading. { } is one of the largest employers in Lucas County and its tiering program, thus, affects thousands of insureds. (RPF 1297-1298).

559. MMO's marketing department has indicated that the market would not welcome such a steering program, because of the general preference among members for broad access to providers. (PX01944 at 022 (Pirc, Dep. at 82-83), *in camera*)).

Response to Finding No. 559:

Complaint Counsel blatantly misrepresent witness testimony. { } directly contradicted this statement at trial when he {

}. (Pirc, Tr. 2307, *in camera*).

560. Six to seven years ago, MMO implemented a {
} (Pirc, Tr. 2215-2216); PX01944 at 022 (Pirc, Dep. at 83), *in camera*). However, the { } who were not

placed in { }, causing MMO to end it. (Pirc, Tr. 2215-2216; PX01944 at 022 (Pirc, Dep. at 83, *in camera*)). This was the last time MMO attempted any steering program aimed at all its members. (PX01944 at 022 (Pirc, Dep. at 84), *in camera*).

Response to Finding No. 560:

The testimony cited by Complaint Counsel refers to activities outside the Lucas County market and is, thus, not relevant to the present litigation. Even if it were relevant, the proposed finding ignores the fact that this experience dates back seven years. The healthcare industry has seen tremendous change within the intervening years and remains in flux. {

} (RPF 1293, *in camera*)

561. Hospital systems with bargaining leverage, including { }, take steps to protect themselves from steering programs. (Pirc, Tr. 2259, *in camera*; PX01944 at 022 (Pirc, Dep. at 84, *in camera*)). { } has negotiated anti-steering language into its MMO contracts for its Lucas County hospitals, including { }. (PX01944 at 022-023 (Pirc, Dep. at 84-87), *in camera*; PX02533 at 017-018 (Anti-Steering Provision in MMO/ ProMedica Contract), *in camera*). This language prohibits MMO from implementing tiered networks that place { } in anything but the most favored tier. (Pirc, Tr. 2259-2260, *in camera*; PX01944 at 022-023 (Pirc, Dep. at 85-86), *in camera*)). Prior to the acquisition, MMO's contract with St. Luke's Hospital did not have such language. (Pirc, Tr. 2260, *in camera*). { } was able to obtain anti-steering provisions in its contract with MMO prior to { } (*See e.g.*, PX02533 at 017-018 (Anti-Steering Provision in MMO/ ProMedica Contract effective Jan. 1, 2008, *in camera*); *see generally* (PX01944 at 023 (Pirc, Dep. at 87), *in camera*).

Response to Finding No. 561:

All parties to every hospital-MCO negotiation have bargaining leverage, which by definition refers to the characteristics that differentiate the parties, whether real or perceived. (RPF 1320-1330). All parties attempt to use such differentiating characteristics to their advantage in negotiations. (RPF 1320-1330).

MMO and ProMedica's contracts, both for the legacy ProMedica hospitals and St. Luke's, were {

}. (RPF 1334, *in camera*, 1383, *in camera*).

At the time each contract was accepted by MMO, MMO { } to any provisions relating to steering because it {

}. (Pirc, Tr. 2307, *in camera*). If MMO's evaluation of these clauses changes in the future, it is free to request an off-cycle renegotiation of its contracts with ProMedica. (RPF 1066). Alternatively, at its next contract renewal, this provision could be one of those that enter into the mix of its negotiations and trade-offs with ProMedica. (RPF 1084-1085, 1089).

Regardless of the language in its existing contracts relating to tiering or "hard steerage," MMO and other MCOs retain the ability to engage in so-called "soft steering," which provides information to members to encourage use of low cost alternatives. (RPF 1272, 1277, *in camera*).

562. MMO's contracts with Mercy and UTMC do not contain { }. (Pirc, Tr. 2260, *in camera*); PX01944 at 023 (Pirc, Dep. at 87-88), *in camera*).

Response to Finding No. 562:

The presence or absence of such provisions in the Mercy and UTMC contracts is unrelated to any issues of bargaining leverage. These clauses do not exist because, for no reason identified in the record, the hospitals in question did not ask to include them. (PX01944 (Pirc, Dep. at 87-88), *in camera*). No conclusion can thus be drawn from the presence or absence of these clauses in other hospital contracts.

563. { } has negotiated anti-transparency language into its MMO contracts with { } that prohibits MMO from disclosing to its members the rates it pays to these hospitals and thus allowing its members to price shop for services. (Pirc, Tr. 2247-2248, *in camera*; *see also* PX01944 at 022, 024 (Pirc, Dep. at 82, 91)). MMO's contracts with Mercy and UTMC do not prevent MMO from sharing rate information with its members. (Pirc, Tr. 2249, *in camera*).

Response to Finding No. 563:

So-called anti-transparency provisions {

}. (RPF 1276-1277, *in camera*). There is also no prohibition on providing hospital cost information to physicians and {

} (RPF 1277, *in camera*). Finally, {

},

testimony from other MCOs indicates that rate data is always confidential for all hospitals. (Sandusky, Tr. 1303).

564. Anthem has never used steering – in the sense of affirmative financial incentives – to entice members to use particular, low-cost hospitals. (Pugliese, Tr. 1465; PX01942 at 003 (Pugliese, Dep. at 8), *in camera*).

Response to Finding No. 564:

Complaint Counsel ignore relevant facts in evidence that add important context to the proposed finding. Until very recently, most major MCOs operating in Lucas County, including Anthem, offered limited provider networks, which led to reduced premium rates as a result of volume discounting. (RPF 562-563, 709-717, 730-732, *in camera*). MCOs were already engaging in a form of steering by contracting with a smaller network of hospitals to obtain reduced rates. There was, thus, less need to engage in additional steering *within* these limited networks.

565. Anthem's customers do not want to be told by Anthem where to go for healthcare – "that's become clear in terms of the benefit designs. They've been asking for broad-access PPO networks, and part of that is the ability to choose their doctor and their hospital." (Pugliese, Tr. 1465).

Response to Finding No. 565:

Complaint Counsel cite unsubstantiated opinion testimony for this proposed finding. Mr. Pugliese's subsequent testimony confirmed that Anthem has not conducted any studies relating to member preferences. (RPF 1261-1262).

566. Mr. Pugliese is not aware of any attempts by employers in Lucas County to steer their employees to lower-cost hospitals or any plans by Anthem to implement such a steering plan for Lucas County employers. (PX01942 at 003 (Pugliese, Dep. at 8-9), *in camera*).

Response to Finding No. 566:

{ } unfamiliarity with the Lucas County market does nothing to diminish the fact that { } (RPF 1272-1273, 1274-1284, *in camera*, 1285, 1286-1290, *in camera*, 1292-1293, *in camera*, 1294-1305, 1306, *in camera*, 1307-1315).

567. Higher-priced providers have displayed resistance to hard steerage. Such resistance arises as part of contract discussions. Higher-priced hospitals resist affirmative steering because they may lose business. (Pugliese, Tr. 1466).

Response to Finding No. 567:

Mr. Pugliese's testimony does not relate specifically to Lucas County. Mr. Pugliese offered no other testimony indicating this was his experience in Lucas County.

568. If Anthem tried to implement a steering program in Lucas County, Mr. Pugliese expects that hospitals would resist. (PX01942 at 032 (Pugliese, Dep. at 122-124), *in camera*).

Response to Finding No. 568:

Complaint Counsel's proposed finding relies on testimony that lacks a foundation and is speculative. Mr. Pugliese testified that Anthem has never in the past attempted to use a steering program and he thus has no basis for knowing how hospitals would react. (Pugliese, Tr. 1465).

569. Larger hospitals in Lucas County would have a better ability to resist Anthem's implementation of a steering program. (PX01942 at 032 (Pugliese, Dep. at 122-124), *in camera*).

Response to Finding No. 569:

Complaint Counsel's proposed finding relies on testimony that lacks a foundation and is speculative. Mr. Pugliese testified that Anthem has never in the past attempted to use a steering program and he thus has no basis for knowing how hospitals would react. (Pugliese, Tr. 1465).

570. Although Anthem provides online tools allowing members to access quality and cost information about hospitals, it does not provide economic incentives for members to use any particular hospitals, and its online tools have not resulted in any shifts in the hospitals its members utilize. (PX01919 at 004 (Pugliese, Dep. at 12-13)).

Response to Finding No. 570:

Complaint Counsel misrepresent witness testimony and exclude significant information. Mr. Pugliese testified that such tools exist but that they had only been available for six months. (PX01919 at 004 (Pugliese, Dep. at 12-13)).

571. An Aetna executive testified that "[s]teering is providing incentives to patients or physicians to pursue healthcare with specific providers." (Radzialowski, Tr. 723). Hard steerage is providing financial incentives to a member to go to a particular provider. Soft steerage is providing information to members and physicians to try to change where care is provided. (Radzialowski, Tr. 723-724).

Response to Finding No. 571:

Respondent has no specific response.

572. Aetna only uses soft steerage such as transparency measures in Lucas County. (Radzialowski, Tr. 723-724). Aetna testified that "soft steering" efforts have not been effective at steering members to low-cost hospitals because informational and transparency measures "don't have teeth, they haven't had [an] impact[.]" (Radzialowski, Tr. 724); (PX01938 at 004 (Radzialowski, Dep. at 12), *in camera*).

Response to Finding No. 572:

The inability of Aetna to craft a successful soft steerage program in the past does not suggest that Aetna's programs will continue to experience the same fate in the future or that other MCOs will not succeed at doing so either. {

.} (RPF 1293, *in camera*).

573. In January 2011, Aetna started a pilot hard-steering program to 100 or fewer Aetna employees in Toledo. (Radzialowski, Tr. 724-725). In the pilot, hospitals are "tiered" into low-cost (*i.e.*, lower rates) "first tier" hospitals, which provide a more financially-advantageous benefit for members, and high-cost (i.e., higher rates) "second tier" hospitals, which require members to pay a higher copay. (Radzialowski, Tr. 725).

Response to Finding No. 573:

Respondent has no specific response.

574. There are no results yet showing whether the program successfully steers members to lower-cost hospitals, but Aetna has received "a good number of complaints from the members not liking to have steerage imposed on them[.]" (Radzialowski, Tr. 725-726).

Response to Finding No. 574:

Respondent has no specific response.

575. Hospitals also dislike Aetna's pilot program. "The hospitals complained, too, because they got letters identifying which tier they were in, and the hospitals did not like being identified publicly as being a high-cost or low-cost hospital, so we got complaints from the hospitals as well." (Radzialowski, Tr. 726). "There's quite a number of hospitals that have expressed their concern about being put in tier two and wanting to be in tier one." (PX01938 at 004 (Radzialowski, Dep. at 11), *in camera*)).

Response to Finding No. 575:

Respondent has no specific response.

576. ProMedica, for one, complained that TTH and Flower were not in tier one. (PX01938 at 004 (Radzialowski, Dep. at 11), *in camera*). Today, none of Aetna's contracts in northern Ohio prevent steerage, but now in response to the pilot program a number of hospitals are proposing contract language to restrict steerage. (Radzialowski, Tr. 727).

Response to Finding No. 576:

Complaint Counsel misrepresent Mr. Radzialowski's testimony in this compound finding. Mr. Radzialowski's trial testimony does not provide any link between the complaints mentioned in his deposition and the efforts by some hospitals in unspecified areas of northern Ohio to add new language to their contracts. Mr. Radzialowski did not identify any Lucas County hospitals as those that were proposing new contractual language to prevent steering.

(Radzialowski, Tr. 727). His commentary can thus not be tied to the relevant market. In addition, he specified that "nothing has come of [these efforts] yet." (Radzialowski, Tr. 727).

577. An Aetna executive testified that it is probable that hospital systems like ProMedica, with substantial bargaining leverage, can reject a health plan's attempt to negotiate terms that would steer patients to low-cost providers. (PX01917 at 017-018 (Radzialowski, Dep. at 65-68), *in camera*).

Response to Finding No. 577:

Complaint Counsel blatantly misrepresent Mr. Radzialowski's testimony. When asked about whether a hospital system with substantial leverage would be able to avoid having a steering mechanism implemented in its contract, Mr. Radzialowski testified that {

}. When asked whether the same might happen for { }, he testified that {

} (PX01917 (Radzialowski, Dep. at 65-68), *in camera*).

578. United does not have any steering mechanisms in place. (PX01939 at 006, 029 (Sheridan, Dep. at 21, 112-113), *in camera*).

Response to Finding No. 578:

The lack of a current program does not prevent any MCO from implementing such programs quickly in the future. {

.} (RPF 1293, *in camera*).

579. A United executive testified that she was not aware of any United programs with tiered benefits. (PX01939 at 007 (Sheridan, Dep. at 23), *in camera*).

Response to Finding No. 579:

The lack of a current program does not prevent any MCO from implementing such programs quickly in the future. {

.} (RPF 1293, *in camera*).

580. Humana does not have any plans in Lucas County or Ohio that have incentives to use one in-network provider over another in-network provider (*i.e.* tiered network). (McGinty, Tr. 1184-1185).

Response to Finding No. 580:

The lack of a current program does not prevent any MCO from implementing such programs quickly in the future. {

} (RPF 1293, *in camera*).

581. Since at least 2003, Humana has never offered a tiered network in Lucas County. (McGinty, Tr. 1184-1185).

Response to Finding No. 581:

Market dynamics in Lucas County have changed dramatically over the course of the past decade. (RPF 709-717). The incentives to create tiered networks in the past were very different while the major MCOs were offering limited networks. Mr. McGinty testified that Humana's strategy at the time was to offer broad networks to compete with the limited networks. (McGinty, 1194-1195).

582. Other than employers that are healthcare providers, Ms. Sandusky testified she is not aware of any FrontPath member using a benefit structure that steers members to hospitals based on the cost of that hospital to the FrontPath member. (Sandusky, Tr. 1328).

Response to Finding No. 582:

There is ample evidence of such steerage in Lucas County and Complaint Counsel overlooks testimony that corrects Ms. Sandusky's oversight. FrontPath has been {

}. (RPF 1279-1284, *in camera*, 1285-1288, *in camera*). Lucas County Government, the eighth largest employer in the county, adopted an innovative steerage program that relies on the employer's benefit design to encourage employees to select lower cost healthcare alternatives. (RPF 1285). As part of this program, Lucas County Government absorbed a greater share of the premium for health plans that steered employees to

lower cost options. FrontPath was { } in the Lucas County Government's menu of plan options. (RPF 1286, *in camera*). { }. (RPF 1287-1288, *in camera*).

583. This is because there are provisions in FrontPath's agreements with providers that prevent the use of steering. (Sandusky, Tr. 1328-1329).

Response to Finding No. 583:

FrontPath's experience merely demonstrates that steerage can be accomplished by MCO customers even when an individual MCOs contract contains provisions that supposedly prevent such outcomes.

584. Professor Town testified that he is aware of only two of approximately 10,000 Lucas County employers that have steering or tiered networks. Both of these employers are in the health care related business. (Town, Tr. 4461). It is fairly common for hospital employers to provide a higher level of coverage for care at their own hospitals. (Randolph, Tr. 7006-7007). This is similar to an employee discount in other types of industries. (Randolph, Tr. 7006-7007).

Response to Finding No. 584:

The fact that hospitals are among the leaders in using steering programs does not diminish the importance of such programs. On the contrary, in Toledo, it testifies to the scope and impact of these programs. { }. (RX-261 at 000004, *in camera*). Lucas County Government, the eighth largest employer in the county, also engages in a steering program as described in the response to CCPF 582. (RPF 1285). { } (RPF 1293, *in camera*).

585. Ronald Wachsman, Senior Vice President for Managed Care, Reimbursement, and Revenue Cycle Management of ProMedica, testified that one of ProMedica's goals in managed care contracting is to ensure that health plans will not steer members to other in-

network providers or establish networks that exclude ProMedica. (PX01945 at 013 (Wachsman, Dep. at 43), *in camera*; Wachsman, Tr. 4874).

Response to Finding No. 585:

Hospital contract negotiations are a complex process with trade-offs on both sides. (RPF 1063, 1070, 1081, 1084-1085, 1089). ProMedica was only able to obtain its preferred language in some contracts because {

}. (Pirc, Tr. 2307, *in camera*). If this view changes in the future, ProMedica will either fail to obtain agreement to such language or will be obliged to make other concessions in order to achieve this objective.

586. ProMedica claims to accept price transparency, but only to the extent it will not steer significant business away from ProMedica hospitals. (Wachsman, Tr. 4880-4881).

Response to Finding No. 586:

The proposed finding mischaracterizes Mr. Wachsman's testimony. {

} (PX01945 (Wachsman, Dep. at 43), *in camera*).

587. ProMedica will discourage any strategies to steer patients away from ProMedica facilities to the extent that it can. (PX01945 at 013 (Wachsman, Dep. at 43), *in camera*).

Response to Finding No. 587:

Complaint Counsel mischaracterize { } testimony. {

} (PX01945 (Wachsman, Dep. at 43), *in camera*). ProMedica's ability to negotiate anti-discrimination clauses with MCOs depends upon the value the MCOs place upon avoiding such language. {

} (Pirc, 2307, *in camera*).

588. ProMedica has anti-steering provisions in its contracts with { } and { }, the two { } payers in Lucas County besides ProMedica's own health plan, Paramount. (Wachsman, Tr. 5162-5163, *in camera*). ProMedica has also negotiated a contract with { } for St. Luke's that includes an anti-steering provision. (Wachsman, Tr. 5165-5166, *in camera*).

Response to Finding No. 588:

ProMedica's ability to negotiate anti-discrimination clauses with MCOs depends upon the value the MCOs place upon avoiding such language. {

.} (Pirc, 2307, *in camera*).

589. The anti-steering provisions keep health plans from steering members away from ProMedica hospitals to other in-network hospitals because of prices or for any other reason. (Wachsman, Tr. 5163-5164, *in camera*).

Response to Finding No. 589:

As discussed above in the responses to CCPF 582 and 583, which are incorporated here by reference, the presence of such language in a contract does not prevent steering from occurring.

590. ProMedica also contractually restricts in-network steering by employers. (Wachsman, Tr. 5244-5246, *in camera*).

Response to Finding No. 590:

Complaint Counsel blatantly misrepresent { } testimony. {

} indicated in his response that hospitals can provide incentives for their *own* employees to stay within the hospital's systems. (Wachsman, Tr. 5244-5246, *in camera*). This is the { } to which Complaint Counsel refer in their proposed finding. (Wachsman, Tr. 5244-5246, *in camera*).

591. In his testimony at trial, Ronald Wachsman acknowledged that the reason health plans would want to steer patients is to incentivize the use of lower-priced service providers. (Wachsman, Tr. 5163-5164, *in camera*).

Response to Finding No. 591:

Respondent has no specific response.

592. Ronald Wachsman was not aware, however, of a significant Lucas County health plan ever contracting with fewer than all of ProMedica's Lucas County hospitals. (Wachsman, Tr. 5173, *in camera*).

Response to Finding No. 592:

MCOs testified that they have never sought to contract with fewer than all of the ProMedica hospitals. (Sheridan, Tr. 6685; Sandusky, Tr. 1325). Nor have any MCOs testified that ProMedica ever told them that ProMedica would not { } all system hospitals. (RPF 1420, *in camera*).

E. Physicians Cannot Constrain ProMedica's Price Increases

1. A High Degree of Overlap in Physicians' Admitting Privileges Has Not and Will Not Constrain ProMedica's Exercise of Increased Market Power Resulting From the Acquisition

593. Admitting privileges across hospitals is a misleading measure of physician preferences or a physician's actual admission patterns. (PX01850 at 011-012 (¶ 14) (Town Rebuttal Report), *in camera*). Market shares are a much better measure of physician (and patient) preferences and admission patterns. (PX01850 at 011-012 (¶ 14) (Town Rebuttal Report), *in camera*). Physician steering and admitting privileges will not constrain ProMedica's post-Acquisition bargaining power. (Town, Tr. 3818, *in camera*).

Response to Finding No. 593:

Complaint Counsel's reliance on statements derived from Professor Town's report provides no support for the conclusions Complaint Counsel draw from Professor Town's testimony. Complaint Counsel suggest that admitting privileges are a misleading measure of actual physician preference and admitting patterns; they then suggest that because of this "fact," physician steering cannot constrain any potential post-joinder supracompetitive pricing by ProMedica. Physician admitting privileges — and in particular the fact that most physicians actively maintain privileges at multiple Lucas County hospitals — do provide an important view

of admission patterns and physician or patient preferences. Respondent's expert analyzed the admission patterns of Lucas County physicians and demonstrated that holding multiple privileges { } (RPF 694-697, *in camera*, 698, 699-700, *in camera*, 701, 702, *in camera*, 703, 704-708, *in camera*).

More important, physicians in Lucas County already maintain privileges at multiple hospitals; they already regularly admit patients to all hospitals where they have privileges, and through these admissions they exercise significant control over hospital revenues. Therefore, {

} (RPF 1204-1206, 1207-1209, *in camera*).

594. It is not uncommon for physicians to maintain admitting privileges at hospitals where they rarely admit patients. *See* PX02056 at 001 (¶ 3) (Korducki, Decl.) ("WCH has a total of approximately 180 physicians on its staff. However, many of these physicians visit WCH only three to four times per year."); Andreshak, Tr. 1751-1752, 1756-1757; *cf.* PX01850 at 011-012 (¶ 14) (Town Rebuttal Report), *in camera*).

Response to Finding No. 594:

Complaint Counsel cite Mr. Korducki's Declaration relating to Wood County Hospital, which Complaint Counsel have determined to be outside the relevant geographic area.

Complaint Counsel also cite Dr. Andreshak's testimony in support of this proposed finding. However, Dr. Andreshak's testimony confirms that for hospitals within Lucas County, he admits a significant number of patients and performs related surgeries at St. Vincent's, The Toledo Hospital, and St. Luke's. (Andreshak, Tr. 1756-1757).

Complaint Counsel misunderstand the important role of multiple privileges. {

} (RPF 1204-1206, 1207-1209, *in camera*).

595. Dr. Bazeley testified that although he has admitting privileges at both St. Luke's and Flower, he has not admitted a patient to Flower in the last seven years. (PX01932 at 022 (Bazeley, Dep. at 81), *in camera*).

Response to Finding No. 595:

Respondent has no specific response.

596. Dr. Gbur testified that although he has admitting privileges at St. Vincent, St. Anne, St. Charles, Bay Park, Flower and St. Luke's, he admits 60-70 percent of his patients to St. Luke's. (Gbur, Tr. 3105-3106).

Response to Finding No. 596:

Respondent has no specific response.

597. Dr. Marlowe testified that approximately 90 percent of his patients deliver at St. Luke's, although he maintains privileges at St. Luke's, TTH, and St. Vincent's. (Marlowe, Tr. 2397, 2399).

Response to Finding No. 597:

Respondent has no specific response.

598. Dr. Read maintains privileges at TTH, St. Vincent, and St. Luke's, but 60% of her patients deliver at St. Luke's. (Read, Tr. 5268, 5291).

Response to Finding No. 598:

Respondent has no specific response.

599. Respondent's analysis of physician admitting privileges ignores the role of patient preferences in hospital choice and the role that distance plays in the value patients place on having access to different hospitals. (Town, Tr. 3818, *in camera*).

Response to Finding No. 599:

Complaint Counsel's proposed finding is inaccurate and misleading. Many factors influence a patient's preferred choice of hospital. (RPF 43-51, 52-56, *in camera*). Key factors, however, are whether the patient's doctor has privileges at a given hospital and whether the patient's insurance covers care at that hospital. (RPF 43). Complaint Counsel misunderstand that patient preferences are actually central to the physician privilege analysis. If an MCO were

unable to reach an agreement with ProMedica post-joinder and opted to drop ProMedica from its network, patients whose doctors lacked privileges at multiple hospitals would be forced either to seek care from another doctor or pay higher out-of-pocket charges. (RPF 682-683). The key benefit for patients whose doctors practice at multiple hospitals is that they are able to maintain the relationship with their preferred physician and obtain care with that doctor at another hospital. (RPF 682-683). {

} (RPF 1207-1209, *in camera*).

Distance is not an important factor in patient choice of hospitals in Lucas County. (RPF 218-243, 1210-1218). Patients in Lucas County regularly choose hospitals that are not the closest facility. (RPF 1217).

600. Physicians maintain privileges at multiple hospitals to accommodate patient preferences for inpatient care. (Andreshak, Tr. 1751-1755; Marlowe, Tr. 2428-2429; Read, Tr. 5271, 5284; Shook, Tr. 940-941; Pugliese, Tr. 1467; *cf.* Gbur, Tr. 3105-3106).

Response to Finding No. 600:

Complaint Counsel's proposed finding is inaccurate and misleading. Physicians do maintain privileges at multiple hospitals to respond to patient preferences. (RPF 680). Particularly in Lucas County, with its history of limited networks, {

} (Guerin-Calvert, Tr. 7356, *in camera*). Physicians also obtain privileges at multiple hospitals for many other 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. (RPF 679).

601. Patient preference plays a major role in where a patient is ultimately admitted. (Marlowe, Tr. 2457; Read Tr. 5290-5291; *cf.* PX01932 at 023 (Bazeley, Dep. at 085)).

Response to Finding No. 601:

The proposed finding is misleading. Where a patient decides to receive hospital care is influenced by many factors, including especially whether a given hospital is covered by the patient's insurance. (RPF 43).

602. Obstetrics patients often preselect an obstetrician based on where the doctor maintains admitting privileges. ((Marlowe, Tr. 2456-2457; Read, Tr. 5284).

Response to Finding No. 602:

Complaint Counsel mischaracterize the witness testimony cited in support of this proposed finding. Dr. Marlowe testified that employees of Mercy, UTMC, and ProMedica are steered by their health insurance plans to use their own hospital systems. (Marlowe, Tr. 2456-2457). These patients are driven by their insurance plan to select a particular hospital. (Marlowe, Tr. 2456). His testimony is consistent with the view expressed by Respondent that patients care foremost about which hospitals are covered by their insurance and whether their doctors practice at those hospitals. (RPF 43). If for some reason any of these patients had a change in circumstances that resulted in a change in the hospitals covered by their insurance, they would still benefit from having a doctor who practiced at multiple hospitals, and they could continue to receive care from the same physician at the new hospital. Dr. Read testified to the fact that she has privileges at multiple hospitals, which allows her patients to select the hospital where they will receive care. (Read, Tr. 5284).

603. When UTMC's employed physicians decide which hospital they should admit a patient to, one of the main factors they consider is the patient's preference and geographically where the patient is being referred from. (Gold, Tr. 205).

Response to Finding No. 603:

Complaint Counsel's proposed finding is inaccurate and misleading. Many factors influence a patient's preferred choice of hospital. (RPF 43-51, 52-56, *in camera*). The key factors, however, are whether the patient's doctor has privileges at a given hospital and whether the patient's insurance covers care at that hospital. (RPF 43).

604. Patient preferences are important to both health plans and hospitals' marketability. Hospitals routinely perform consumer-preference and patient-satisfaction surveys, demonstrating that they too are invested in patient preferences. (PX01607 at 001-003 (SLH Presentation: 2008 Market Report St. Luke's Board Executive Committee); PX00602 at 029-038 (PHS Presentation: Market Position Growth Strategies); PX02532 at 001-002 (Mercy Health Partners Brand Attribute Market Fit Study – 08031), *in camera*; PX02534 at 001-007 (Mercy Health Partners Hospital Marketing Study St. Vincent Mercy Children's Market Area Nov., 2007), *in camera*; PX00593 at 001-012(Great Lakes Marketing Presentation: Regional Hospital Research, Central Region)).

Response to Finding No. 604:

Respondent has no specific response.

605. Health plan testimony demonstrates that patients' preferences for hospitals play a key role in health plans' marketing efforts. (Radzialowski, Tr. 588-589; Pirc, Tr. 2167-2168). Notably, an Aetna executive testified that he has never reviewed or considered overlapping physician admitting privileges in Lucas County. (Radzialowski, Tr. 721).

Response to Finding No. 605:

Complaint Counsel misrepresent MCO testimony regarding patient preferences. For example, MMO has not even performed any patient preference studies or surveys. (RPF 1264-1265, 1266, *in camera*). A similar story unfolds with Aetna; it too, has not performed any studies of patient preferences within the last five years. (RPF 1269-1271). Other MCOs recognize the importance of physician privileges and testified that they did consider such issues in evaluating their own networks. (RPF 356).

606. Hospitals in Lucas County are differentiated by location and other characteristics, and, therefore, patients face costs associated with hospital switching independent of the physicians' cost of shifting their patients. (PX01850 at 011-016 (¶¶ 14-23) (Town Rebuttal Report), *in camera*).

Response to Finding No. 606:

Complaint Counsel's proposed finding is inaccurate and misleading. The Mercy and ProMedica hospitals are closest substitutes, as even Complaint Counsel's expert agrees. (RPF 1114, 1116). Like The Toledo Hospital and Mercy St. Vincent, UTMC provides tertiary services as well as more advanced procedures. (RPF 178, 180). St. Luke's offers no services that cannot be obtained at other Lucas County hospitals. (RPF 1149). Patients do not face any significant costs for switching in terms of the range and quality of services offered among these hospitals. Multiple local witness, including Lucas County physicians, also testified that travel in Toledo is fast and easy. (Sandusky, Tr. 1282-1283; Andreshak, Tr. 1813, 1824-1825; Gbur, Tr. 3115-3116; Read, Tr. 5272; Marlowe, Tr. 2403; RPF 442). Expert analysis confirmed the minimal drive time to and between the Lucas County hospitals. (RPF 218-243, 1210-1218). All hospitals in Lucas County are located within close proximity to one another. The locations of the ProMedica and Mercy hospitals line up with one another and UTMC is a only few miles down the road from St. Luke's. (RPF 144, 152, 160, 161, 166, 1140).

607. The fact that many physicians in Lucas County had admitting privileges at both ProMedica and St. Luke's before the Acquisition supports the conclusion that these firms directly competed with one another before the Acquisition. (PX01850 at 011-016 (¶¶ 14-23) (Town Rebuttal Report), *in camera*); *see* (PX02136 at 043 (¶ 42) (Guerin-Calvert Supp. Decl.), *in camera*)).

Response to Finding No. 607:

The overlap of physicians between ProMedica, Mercy, and St. Luke's shows that ProMedica and St. Luke's were not closest substitutes. Twice as many physicians with privileges at ProMedica admit to the Mercy hospitals as admit to St. Luke's. (RPF 701). The overlap between St. Luke's is far more significant between St. Luke's and { }. (RPF 708, *in camera*).

608. This is because, in addition to competing for inclusion in health plan networks, ProMedica and St. Luke's competed prior to the Acquisition to attract patients based on variables such as quality and patient satisfaction while also competing to convince

physicians to refer to their hospitals rather than a competitor's hospital. (Response to RFA at ¶ 20; *cf.* PX01850 at 011-012 (¶ 14) (Town Rebuttal Report), *in camera*).

Response to Finding No. 608:

Complaint Counsel cite evidence which fails to support the proposed finding. Nothing in these materials supports the view that ProMedica and St. Luke's are each other's closest competitors. Respondent acknowledged in its Response to Complaint Counsel's Request for Admissions that, subject to the general objections contained therein, clinical quality, amenities, cost, location, visibility, physician location and patient experience are some of the many dimensions upon which hospitals seek to attract patients and payors. (RX-1860 at 000010-000011). Nothing in these materials speaks to competition for physician referrals.

609. Examination of physician privileges and the share of those privileges across hospitals to measure competitive overlap reveals that ProMedica is St. Luke's closest competitor, and that St. Luke's is a close competitor to ProMedica. (Town, Tr. 3821-3822, *in camera*).

Response to Finding No. 609:

The overlap of physicians between ProMedica, Mercy, and St. Luke's shows that ProMedica and St. Luke's were not closest substitutes. Twice as many physicians with privileges at ProMedica admit to the Mercy hospitals as admit to St. Luke's. (RPF 701). The overlap between St. Luke's is far more significant between St. Luke's and { }. (RPF 708, *in camera*).

610. St. Luke's has more overlapping physicians with ProMedica than with other systems, by a large margin. (Rupley, Tr. 1999-2000, *in camera*)

Response to Finding No. 610:

Complaint Counsel misrepresent Mr. Rupley's testimony, which was carefully qualified at trial. (Rupley, Tr. 2000, *in camera* ({

})(emphasis added)). Regardless of what Mr. Rupley believed may have been correct when questioned about his hand-written notes from a meeting that occurred

nearly two years ago, careful expert analysis of the actual physician data reveals that Complaint Counsel's characterization is inaccurate. (RPF 694-697, *in camera*, 698, 699-700, *in camera*, 701, 702, *in camera*, 703, 704-708, *in camera*).

611. The high degree of overlap in physician admitting privileges prior to the Acquisition did not constrain ProMedica from charging the highest prices in Lucas County and some of the highest in the state. (PX01850 at 11 (Town Rebuttal Report) (¶18); *see generally* (PX00153 (Oostra (ProMedica) Jan. 2009 e-mail)).

Response to Finding No. 611:

ProMedica's rates prior to the joinder are not at issue in this litigation. As Professor Town acknowledged, higher reimbursement rates, in and of themselves, are not anticompetitive. (RPF 1332). The rates received by ProMedica, as with all the hospitals in Lucas County, were the result of the historical evolution of the market within Lucas County, the quality and complexity of services provided by ProMedica's hospitals, and complex, multifaceted negotiations with MCOs. (RPF 11, 1104, 1334, *in camera*, 1341, *in camera*, 1342, 1349, *in camera*). Even if some outside observers considered ProMedica's rates comparatively high, they were nonetheless *competitive*: every MCO confirmed that its pre-joinder negotiations with ProMedica were { }. (1334, *in camera*, 1341, *in camera*, 1342, 1349, *in camera*).

2. Physician Steering Has Not and Will Not Constrain ProMedica's Exercise of Increased Market Power Resulting From the Acquisition

a. Physician Steering Is Not Feasible Because of Physician Preferences and Employment by Hospitals

612. Physicians would prefer to limit the hospitals to which they admit patients. There are costs involved for a physician who has patients admitted to multiple hospitals, including making rounds and maintaining call coverage at the hospitals; in addition to physician travel time. (PX01850 at 9 (¶15) (Town Rebuttal Report), *in camera*; Marlowe, Tr. 2401-2403).

Response to Finding No. 612:

The proposed finding is misleading. Most physicians have privileges at multiple hospitals in Lucas County. (RPF 674). Most physicians already maintain privileges at multiple hospitals by their own choice. There is no need to *increase* the number of hospitals where these physicians already practice: physicians do not need to have privileges at *every* Lucas County hospital in order to be able to provide their patients the option of obtaining services at a hospital that does not charge supracompetitive rates.

The so-called "costs" of maintaining privileges at multiple hospitals are not as significant as Complaint Counsel suggest and can be minimized as trial testimony plainly revealed. First, hospitals already have different levels of privileges with different duties required of the physician. (Korducki, Tr. 489-491). The hospital's active medical staff have the greatest responsibilities toward the hospital, but even these duties have been reduced. (Korducki, Tr. 490-491; Marlowe, 2401 (indicating that the trend toward employed physicians has eliminated on-call duties at some hospitals). Hospitals also have associate staff privileges, which have no medical staff organizational responsibilities. (Korducki, Tr. 490). They even extend courtesy privileges to doctors who admit a smaller number of patients each year. (Andreshak, Tr. 1752-1753, 1810; Korducki, Tr. 490-491). These physicians face no administrative responsibilities toward the hospital. (Korducki, Tr. 490). It is not necessary for physicians to have the highest level of staff privileges in order to provide their patients the option of obtaining services at a hospital that does not charge supracompetitive rates.

Multiple local witness, including Lucas County physicians, testified that travel in Toledo is fast and easy. (Sandusky, Tr. 1282-1283; Andreshak, Tr. 1813, 1824-1825; Gbur, Tr. 3115-3116; Read, Tr. 5272; Marlowe, Tr. 2403; RPF 442). Expert analysis confirmed the minimal drive time to and between the Lucas County hospitals. (RPF 218-243, 1210-1218). All hospitals

in Lucas County are located within close proximity to one another. The locations of the ProMedica and Mercy hospitals line up with one another and UTMC is a only few miles down the road from St. Luke's. (RPF 144, 152, 160, 161, 166, 1140). Physicians do not need to maintain privileges at every one of these hospitals; maintaining privileges at the closest competing hospital achieves the desired effect.

613. Physician employment further limits health plans' ability to steer patients. (Town, Tr. 3819-3820, *in camera*); PX01850 at 012-013 (¶ 16) (Town Rebuttal Report), *in camera*).

Response to Finding No. 613:

The proposed finding is inaccurate and misleading. Complaint Counsel ignore trial testimony and documents in evidence that disprove the proposed finding. (RPF 686-693; RX-1908 at 000005, *in camera*).

614. Physicians employed by a hospital system generally admit to that hospital system. (Marlowe, Tr. 2393-2394; Beck, Tr. 400; Korducki, Tr. 497-498; *see generally* Shook, Tr. at 1057). For example, Dr. Riordan, a ProMedica physician, testified that he would not be able to admit patients to either UTMC or Mercy hospitals due to exclusive contracting arrangements. (PX01949 at 015, 027 (Riordan, Dep. at 50, 98)).

Response to Finding No. 614:

The proposed finding is misleading. The testimony cited by counsel (PX01949) lacks foundation. In addition, Complaint Counsel misrepresent Dr. Riordan's testimony. There is nothing in Dr. Riordan's testimony that suggests that his employment with ProMedica prohibits him from admitting patients to other hospitals. In fact, his testimony revealed that as a ProMedica physician he held privileges and treated patients at UTMC. (PX01949 (Riordan, Dep. at 98)). His testimony indicated that he dropped his privileges at Mercy when a new cardiac group was hired there. (PX01949 (Riordan, Dep. at 98)). His testimony does not provide any support for the view that Mercy's employed physicians were prohibited from admitting

patients to other hospitals. No employed physician is prohibited from admitting patients to other hospitals. (RPF 686-693; RX-1908 at 000005, *in camera*).

615. Indeed, ProMedica is the largest employer of physicians in Lucas County, with over 250 employed physicians. (Joint Stipulations of Law and Fact, JX00002A ¶ 26; Wachsman, Tr. 5156; Pugliese, Tr. 1440).

Response to Finding No. 615:

Respondent has no specific response.

616. Similarly, UTMC's employed physicians generally admit their medical-surgical adult inpatients to UTMC, except for obstetrical services, which UTMC does not offer. (Gold, Tr. 204-205).

Response to Finding No. 616:

Complaint Counsel misrepresent Dr. Gold's testimony. Dr. Gold testified that the hospital to which UTMC's physicians would admit their patients depended on their specialties. (Gold, Tr. 204). He "hoped" that most physicians admitted their medical-surgical adult inpatients to UTMC. (Gold, Tr. 204).

617. An Anthem executive testified that employed physicians are expected to admit patients to the hospital system that employs the physician. (Pugliese, Tr. 1468). It is not likely that employed physicians would steer patients away from the hospital system that employs them. (Pugliese, Tr. 1469).

Response to Finding No. 617:

The proposed finding is misleading. Complaint Counsel misrepresent Mr. Pugliese's testimony. Mr. Pugliese actually expressly testified that Anthem is not aware of what the contracts of physicians employed by Lucas County hospitals require with respect to referrals. (Pugliese, Tr. 1572). Furthermore, Anthem has conducted no studies of the referral and admitting patterns of either employed or independent physicians within Lucas County. (Pugliese, Tr. 1572). Anthem admitted that physicians employed by Lucas County hospitals, including

ProMedica, maintain privileges at multiple hospitals, which allows patients to have more influence over where they receive hospital care. (RPF 685).

b. Physician Steering Is Not Feasible Because Physicians Are Not Aware of Rates Charged By Hospitals To Health Plans

618. Physicians are not sensitive to the rates hospitals charge health plans. (Town, Tr. 3819, *in camera*). There is no evidence on the record that non-employed, independent physicians steer patients to specific hospitals because of the rates charged to health plans.

Response to Finding No. 618:

The proposed finding is misleading. Physicians do not need to be aware of the specific rates that hospitals charge to MCOs in order to be able to provide their patients the option of obtaining services at a hospital that does not charge supracompetitive rates. MCOs can {

;} to achieve the goal of directing care to lower-cost facilities. (RPF 1277, *in camera*). Physicians *are* sensitive to the costs borne by their patients and *do* seek to ensure that patients can receive care at facilities, such as in-network hospitals, that will minimize their out-of-pocket costs. (RPF 465, 682).

619. While it is clear that a patient's physician plays a role in the patient's admission decision, physician testimony unanimously demonstrates that physicians do not admit patients to hospitals based on the cost to the patients' health plans. (Marlowe, Tr. 2417; Read, Tr. 5293; Andreshak, Tr. 1782-1783; PX01932 at 033 (Bazeley, Dep. at 127), *in camera*; PX01948 at 044-045 (Peron, Dep. at 166-167, 169-170), *in camera*).

Response to Finding No. 619:

The proposed finding is misleading. The physicians cited contradict Complaint Counsel's proposed finding, sometimes within the very same sentence. Trial testimony clearly demonstrates that physicians are keenly aware of the cost of care and that their admitting decisions are influenced by consideration of the cost to their patients and their patients' insurance coverage. For example, Dr. Andreshak described how his office examines the out-of-pocket costs faced by patients, and because he had privileges at multiple hospitals, he was able to direct

his patients to facilities where those costs would be lower. (Andreshak, 1805-1806). Dr. Andreshak specifically expanded his practice to other hospitals to be able to treat patients whose insurance did not cover every hospital. (Andreshak, Tr. 1807). Dr. Marlowe emphasized that he admits patients based on their insurance coverage. (Marlowe, Tr. 2417). Dr. Read also expressly testified that she takes into account the patient's cost for treatment at different hospitals. (Read, Tr. 5293). Finally, Dr. Gbur, whom Complaint Counsel omit from their "unanimous" list, testified that admission decisions were heavily "insurance-driven" and based on what coverage his patients have. (Gbur, Tr. 3105, 3107).

620. Physicians are not aware of the rates that hospitals charge health plans. (Gold, Tr. 206-207; Pirc, Tr. 2379, *in camera*; Pugliese, Tr. 1467-1468; Sandusky, Tr. 1325).

Response to Finding No. 620:

The proposed finding is misleading. Respondent refers to its response to CCPF 618, which it incorporates here by reference. In addition, the MCO testimony cited does nothing to alter physician testimony stating that they routinely make admitting decisions based upon patient insurance and out-of-pocket costs. The only hospital representative cited testified that regardless of whether they knew what the MCOs paid the hospital, physicians were "very cognizant" of a patient's insurance coverage. (Gold, Tr. 206).

621. Not one physician who testified at trial had ever seen a contract between a hospital and a health plan. (Andreshak, Tr. 1782; Gbur, Tr. 3109; Marlowe, Tr. 2417; Read, Tr. 5293).

Response to Finding No. 621:

Complaint Counsel's proposed finding is inaccurate and misleading. Respondent refers to its responses to CCPF 618 and 619, which it incorporates here by reference.

622. Dr. Gold is not aware of any instance in which a physician employed by UTMC admitted a patient to a hospital specifically based on the amount that the hospital was reimbursed by a health plan. (Gold, Tr. 206-207). UTMC physicians do not see the contracts between hospitals and health plans. (Gold, Tr. 206-207).

Response to Finding No. 622:

Complaint Counsel's proposed finding is inaccurate and misleading. Respondent refers to its responses to CCPF 618 and 619, which it incorporates here by reference.

623. Mr. Beck, of Fulton County Health Center ("FCHC"), testified that physicians do not admit patients to FCHC based on how much a procedure would cost a health plan or employer. (Beck, Tr. 403).

Response to Finding No. 623:

Complaint Counsel's proposed finding is inaccurate and misleading.

With respect to costs for health plans, Respondent refers to its responses to CCPF 618 and 619, which it incorporates here by reference.

With respect to costs for employers, Mr. Beck offered no such testimony. The ALJ sustained Respondent's objection that Complaint Counsel was leading the witness and the proposed finding violates the ALJ's Order on Post-Trial Briefs in this respect. (Beck, Tr. 403). No rephrased question was ever asked and no response is on record from Mr. Beck. (Beck, Tr. 403).

624. Physicians in Lucas County do not have access to contracts between MMO and Lucas County hospitals. (Pirc, Tr. 2378-2379, *in camera*). Physicians in Lucas County do not see the specific negotiated rates between MMO and Lucas County hospitals. (Pirc, Tr. 2379, *in camera*).

Response to Finding No. 624:

Complaint Counsel's proposed finding is inaccurate and misleading. Respondent refers to its response to CCPF 620, which it incorporates by reference.

625. Physicians in Anthem's network are not party to the contracts that Anthem negotiates with hospitals in Lucas County. (Pugliese, Tr. 1467-1468). As such, Mr. Pugliese is not aware of any means by which physicians can routinely access the reimbursement rates negotiated between health plans and hospitals in Lucas County. (Pugliese, Tr. 1468).

Response to Finding No. 625:

Complaint Counsel's proposed finding is inaccurate and misleading. Respondent refers to its responses to CCPF 620, which it incorporates by reference. Mr. Pugliese's lack of knowledge offers no insight as to what doctors in Lucas County know or do not know.

626. Mr. Pugliese has never seen an effort by physicians to steer or affirmatively encourage patients away from higher-priced hospitals to lower-priced hospitals. (Pugliese, Tr. 1468). He would be surprised if that began to happen in the future because "there would be no motivation for that at this point." (Pugliese, Tr. 1468).

Response to Finding No. 626:

Complaint Counsel's proposed finding is inaccurate and misleading. Until very recently, most major MCOs operating in Lucas County, including Anthem, offered limited provider networks, which led to reduced premium rates as a result of volume discounting. (RPF 562-563, 709-717, 730-732, *in camera*). MCOs were thus themselves already engaging in a form of steering by contracting with a smaller network of hospitals to obtain reduced rates.

627. Physicians are not aware of the rates FrontPath has negotiated with the Lucas County hospitals. (Sandusky, Tr. 1325).

Response to Finding No. 627:

Respondent refers to its responses to CCPF 620, which it incorporates by reference.

628. Even if physicians knew the rates that hospitals charge health plans in Lucas County, physicians recommend a hospital to a patient based on the needs of that patient, not the cost to the employer or health plans. (Marlowe, Tr. 2405; *see generally* Read, Tr. 5268; PX01932 at 032 (Bazeley, Dep. at 127), *in camera*). There is no evidence that any physician has ever admitted a patient to one in-network hospital instead of an alternate in-network hospital on account of the price to the health plan or employer. (Guerin-Calvert, Tr. 7911). Hospital prices do not affect physician behavior because physicians simply do not have the financial "skin in the game." (PX01850 at 013-014 (¶ 17) (Town Rebuttal Report), *in camera*).

Response to Finding No. 628:

Complaint Counsel's proposed finding is inaccurate and misleading.

With respect to the second sentence of Complaint Counsel's proposed finding, Respondent refers to its response to CCPF 626, which it incorporates by reference.

Prices *do* affect physician behavior because they are very mindful of the costs faced by their patients, as described at length in the response to CCPF 619. (RPF 465). A physician who requires patients to receive treatment at an out-of-network hospital or at a hospital where the physician does not maintain privileges risks losing the patient to another physician. Testimony demonstrates that physicians are attuned to these concerns and have specifically adjusted their business and admitting practices to accommodate patients' insurance needs. (Andreshak, Tr. 1807).

XII. LUCAS COUNTY EMPLOYERS AND RESIDENTS WILL BE HARMED BY THE ACQUISITION

A. Local Employers and Physicians are Concerned About the Competitive Harm From the Acquisition

1. Employers Believe that Hospital Competition is Beneficial

629. Local employers recognize that competition among hospitals is beneficial and important to employees and community members. A former local school superintendent testified, "[Hospital] competition is good. And I think having the option for ... employees to select which [hospital] they want to go to is ... a plus for the community and certainly for the employer and employees." (Caumartin, Tr. 1865). Another local employer expressed concern about the Acquisition by noting that "when you eliminate a player ... you reduce your competitive market forces." (Buehrer, Tr. 3077).

Response to Finding No. 629:

Complaint Counsel's proposed finding lacks any foundation. Mr. Caumartin, whose testimony is cited by Complaint Counsel, does not live or work in Lucas County. (Caumartin, Tr. 1833-1835). The organization he led before retiring operates entirely within Wood County, which Complaint Counsel has identified as being outside the relevant market. (Caumartin, Tr. 1835). Complaint Counsel has argued that patients in Wood County do not seek care at Lucas County hospitals and thus Mr. Caumartin's statements regarding hospital competition are without merit or foundation.

Mr. Buehrer likewise lacks any foundation for the cited testimony. He knows nothing about the local healthcare market or how hospital contracting or even MCO competition operates. (Buehrer, Tr. 3089-3090, 3093). He does not handle his company's healthcare benefits directly himself, but rather works through a broker. (Buehrer, Tr. 3089). He has never engaged in negotiations with hospitals or MCOs and does not have any personal knowledge of any aspect of hospital competition. (Buehrer, Tr. 3089). His company does not even track any aspect of its healthcare utilization, whether that be where his employees' obtain care or the relative expenditures for general acute-care inpatient services relative to any other medical service. (Buehrer, Tr. 3087-3089). He has no basis to comment upon the impact of the joinder upon hospital competition in Lucas County and his testimony is unfounded opinion.

2. Employers are Concerned that the Acquisition Will Lead to Higher Hospital Rates, Forcing Employers to Reduce Health Insurance Coverage or Other Employee Benefits

630. Even prior to ProMedica's acquisition of St. Luke's, Chrysler perceived ProMedica as the dominant healthcare provider in Lucas County. (Neal, Tr. 2111). Chrysler believes that the Acquisition gives ProMedica "very strong leverage when it comes to negotiating reimbursement rates with the healthcare plans" that Chrysler contracts with. (Neal, Tr. 2111).

Response to Finding No. 630:

Complaint Counsel's proposed foundation lacks any foundation. Ms. Neal had no knowledge of the Lucas County market and her opinions are unfounded. She testified that she had never visited any Lucas County hospitals. (Neal, Tr. 2151). She does not negotiate directly with either the Lucas County hospitals or the MCOs. (Neal, Tr. 2144). She works through a consultant and could not even identify all the MCOs that compete in Lucas County or which hospitals were in their networks. (Neal, Tr. 2092, 2148, 2150). She could not specify which services ProMedica or any of the Lucas County hospitals offered. (Neal, Tr. 2151-2152). She did not know how many of her employees utilized ProMedica hospitals or any of the hospitals in

Lucas County. (Neal, Tr. 2151). She did not know what proportion of her employees' healthcare expenditures derived from general acute-care inpatient services as opposed to any other healthcare service. (Neal, Tr. 2147). In fact, her company, a large national corporation with substantial resources, has not conducted any studies of the Lucas County marketplace. (Neal, Tr. 2132, 2155). Ms. Neal does not monitor the Toledo market and did not even know about the joinder until Complaint Counsel contacted her. (Neal, Tr. 2126-2127).

Complaint Counsel also mischaracterize Ms. Neal's testimony. She did not describe ProMedica as the dominant healthcare provider in Toledo, but spoke only of the fact that ProMedica that the hospital represented the largest portion of the company's "hospital spend". (Neal, Tr. 2111). In fact, ProMedica's allegedly "dominant" 43.8 percent share of Chrysler's expenditure was comparable to Mercy's 35 percent share. (Neal, Tr. 2147).

631. St. Luke's is an important and significant hospital for many Lucas County employees, particularly those living in southwest Lucas County. (Buehrer, Tr. 3069 (one-third of company's employees live in close proximity to St. Luke's, making St. Luke's the most convenient hospital for them)).

Response to Finding No. 631:

Complaint Counsel's proposed finding lacks any foundation. None of the Lucas County employers who testified, including Mr. Buehrer, had conducted any studies that indicated which hospitals their employees utilized or whether they were willing to travel elsewhere to receive general acute care inpatient services. (Neal, Tr. 2155; Lortz, Tr. 1738; Buehrer, Tr. 3088). Expert study of patient travel patterns, however, has demonstrated that patients in Lucas County, including those in "southwest Lucas County" regularly do travel to hospitals that are not the ones closest to their homes. (RPF 218-243; 1210-1218). Travel within Lucas County is rapid and easy and distances between hospitals are minimal. (RPF 221, 1210).

Mr. Buehrer expressly testified that he had not analyzed or even examined his employees' healthcare utilization or what portion of their healthcare expenditures even derived from general inpatient acute care services. (Buehrer, Tr. 3088-3089). He could not identify which hospitals any of his twenty-four employees used, though he surmised that at least five of the six employees that lived outside Lucas County did not use Lucas County hospitals at all. (Buehrer, Tr. 3084). For the eight employees that Mr. Buehrer identified as living closer to St. Luke's than other hospitals, Mr. Buehrer conceded that UTMC was also proximately located to these employees. (Buehrer, Tr. 3069).

632. Local employers testified that they are concerned that the Acquisition will lead to higher rates at St. Luke's and ProMedica's other Lucas County hospitals, resulting in higher healthcare costs for employers and their employees. (Caumartin, Tr. 1862 ("the major concern" is "that costs could go up"); Neal, Tr. 2111 (Chrysler's inpatient spend on ProMedica will be a "very large number for one hospital to have")).

Response to Finding No. 632:

Complaint Counsel's proposed finding lacks any foundation. Complaint Counsel rely upon the testimony of Mr. Caumartin, but Mr. Caumartin does not live or work in Lucas County. (Caumartin, Tr. 1833-1835). The organization he led before retiring operates entirely within Wood County, which Complaint Counsel has identified as being outside the relevant market. (Caumartin, Tr. 1835). Complaint Counsel has argued that patients in Wood County do not seek care at Lucas County hospitals, and thus Mr. Caumartin's statements regarding rates at Lucas County hospitals are without merit or foundation.

Complaint Counsel also relies upon Ms. Neal, but Ms. Neal's testimony also lacks any foundation. As described in Respondent's response to CCPF 630, which Respondent incorporates by reference, Ms. Neal has no knowledge of hospital-MCO negotiations or how hospital rates are set. She conceded that many factors, including the demographic composition of workforce and many healthcare services other than general acute-care inpatient services

contributed to her company's overall healthcare costs. (Neal, Tr. 2141-2143). She did not know and had not studied the proportion of Chrysler's healthcare costs that could be attributed to general acute-care inpatient services. (Neal, Tr. 2147). General acute-care inpatient services are only a very small portion of overall costs because so few persons, only 6% of all commercially insured patients, actually require these services during any given year. (RPF 441).

633. Increased healthcare costs force some employers to eliminate services or covered procedures from their employees' benefit plans or reduce other employee healthcare benefits. (Buehrer, Tr. 3072 (rising cost of health insurance led employer to eliminate the vision plan it offered to its employees), 3065-3066 (continuing rise in healthcare costs led to elimination of coverage for employees' working spouses who could receive health insurance from their own employer); Caumartin, Tr. 1837; Lortz, Tr. 1713; Pugliese, Tr. 1559-1560 (when healthcare costs increase, one of the options that employers select is to "change their [plan's] benefit design."); Town, Tr. 3604; PX02148 at 011-013 (¶ 18) (Town Expert Report), *in camera*).

Response to Finding No. 633:

Complaint Counsel's proposed finding is inaccurate and misleading. Complaint Counsel also rely upon the testimony of Mr. Caumartin. For all the reasons explained in Respondent's response to CCPF 629, this testimony does not pertain to the relevant market and lacks the foundation necessary to support Complaint Counsel's proposed finding

Complaint Counsel's proposed finding misleadingly implies that hospital rate increases are the sole or even most important source of increases to healthcare premiums. For the reasons discussed by Respondent below in its response to CCPF 654, healthcare costs increase for many reasons unrelated to increases in the cost of general acute-care inpatient services.

Further, Complaint Counsel's proposed finding misrepresents witness testimony. Mr. Buehrer testifies that his company discontinued a recently added vision insurance program in response to an insurance rate increase, but Mr. Buehrer further testified that the increase in his rates was not due to any increase in the cost of general acute-care inpatient services but instead to an increase in healthcare utilization by his employees. (Buehrer, Tr. 3085-3086).

3. Employers Would Be Concerned if the Acquisition Leads Health Plans to Offer a Narrower Network

634. Employers want a health plan that offers a network with broad provider access so that employees and their family members can use their preferred physician or hospital. (Caumartin, Tr. 1861; Lortz, Tr. 1700-1704; Buehrer, Tr. 3068, 3074; Neal, Tr. 2105-2107; PX02148 at 011 (¶ 17) (Town Expert Report), *in camera*).

Response to Finding No. 634:

Complaint Counsel rely upon the testimony of Mr. Caumartin. For all the reasons explained in Respondent's response to CCPF 629, this testimony does not pertain to the relevant market and lacks the foundation necessary to support Complaint Counsel's proposed finding. Complaint Counsel further rely on testimony that is unintelligible. Mr. Caumartin's response of "um-hum" is neither clearly affirmative or negative and should be disregarded. (Caumartin, 1861).

For the Lucas County employers referenced by Complaint Counsel, Respondent has demonstrated in its prior responses that none of these employers has the foundation to discuss patient preferences. No employer identified has conducted any studies of its employees hospital utilization or preferences. (Neal, Tr. 2151, 2155; Buehrer, Tr. 3088; Lortz, Tr. 1738). None even knows which hospitals their employees currently use. (Neal, 2151; Buehrer, 3089).

Even if the employers were qualified to offer opinions on their employees, their actual actions contradict Complaint Counsel's proposed findings. Mr. Buehrer testified that his company had maintained a contract with MMO for the past thirteen years. (Buehrer, Tr. 3086). During the vast majority of that time, MMO only offered a narrow network of providers. (RPF 709-717). Mr. Buehrer testified that MMO's narrow network was acceptable to him and his employees. (Buehrer, Tr. 3091-3092).

Narrow networks are preferable to many employers because they offer a full complement of healthcare services at a lower cost than broad networks. (RPF 566-567).

635. Health plans recognize that Lucas County employers prefer having access to a broad provider network. (Radzialowski, Tr. 657; Sandusky, Tr. 1304-1305; Pugliese, Tr. 1449; Pirc, Tr. 2281; Sheridan, Tr. 6680-6681; Town, Tr. 3617-3618, 3628; PX02148 at 013 (¶ 20) (Town Expert Report), *in camera*).

Response to Finding No. 635:

Complaint Counsel's proposed finding lacks any foundation. The MCO witnesses cannot properly testify as to the opinions of employers; such testimony is hearsay. Furthermore, none of the MCO witnesses has conducted any studies or surveys of employer or member preferences. (RPF 1261-1265, 1266, *in camera*, 1267, 1268, *in camera*, 1269-1271). In addition, the proposed finding is contradicted by ten years of contracting history in Lucas County, when the most successful MCOs successfully offered narrow networks. (RPF 709-717). Even today, one of the top three MCOs in Lucas County continues to offer a narrow network. (RPF 779-781). The key benefit to narrow networks is price; broad networks are more expensive. (RPF 566-567) Price is a primary consideration for employers in the selection of competing health plans. (RPF 435; Randolph, Tr. 6935-6936)

636. Offering a network with fewer provider choices often proves disruptive to employees, who may no longer have access to their preferred provider. (Caumartin, Tr. 1847, 1864; Neal, Tr. 2107; Pugliese, Tr. 1667, *in camera*; PX02148 at 067 (¶ 121) (Town Expert Report), *in camera*).

Response to Finding No. 636:

Complaint Counsel rely upon the testimony of Mr. Caumartin. For all the reasons explained in Respondent's response to CCPF 629, this testimony does not pertain to the relevant market and lacks the foundation necessary to support Complaint Counsel's proposed finding.

Complaint Counsel's proposed finding is also vague to the extent that it refers to "providers" without specifying hospital providers, which are the subject of this litigation.

Complaint Counsel's proposed finding is also speculative. Ms. Neal did not testify to any experience with actually having a hospital leave its network. She imagined the possible

employee response, but this opinion was not based on personal knowledge. (Neal, Tr. 2107). She also addressed her concerns about continuity of care when she acknowledged that the doctors used by Chrysler's employees in Lucas County generally maintain privileges at multiple Lucas County hospitals. (Neal, Tr. 2152-2153). Expert analysis has shown that physicians with privileges at multiple hospitals can and do admit patients to the various hospitals where they maintain privileges. (RPF 694-697, *in camera*, 699-700, *in camera*, 701, 702, *in camera*, 703, 704-708, *in camera*). Having multiple privileges allows a physician to avoid any disruption to the care of patients when hospitals cease to participate in the MCO network. (RPF 683). Mr. Pugliese's testimony incorrectly suggest that patients would cease to have access to a hospital that was non-participating, but this neglects the role of multiple insurance coverages and the fact that patients may always go to out-of-network hospitals, as Anthem experienced with the Mercy hospitals. (RPF 744, 745, *in camera*; Read, Tr. 5287).

637. Employees would be concerned if their health plan's network no longer included ProMedica's hospitals, including St. Luke's. (Buehrer, Tr. 3068 ("It's always been a requirement for a [health insurance] plan we would fund that St. Luke's Hospital be a part of the plan."), 3079 ("those that live in Maumee would now have to go to a hospital that's further away for their services [if St. Luke's were no longer in the network]"); Caumartin, Tr. 1864 (not having ProMedica's hospitals in-network would cause "turmoil" for many employees); Neal, Tr. 2155).

Response to Finding No. 637:

Complaint Counsel's proposed finding is inaccurate and lacks foundation. No employee testified at trial. The employers may not properly testify on behalf of their employees; such testimony is hearsay. Furthermore, Complaint Counsel misrepresent employer testimony. Mr. Buehrer, whose sister sits on the board of St. Luke's, actually testified, "*For me personally*, it's always been a requirement..." to have St. Luke's. (Buehrer, Tr. 3060, 3068 (emphasis added)). Mr. Buehrer explained that he wanted St. Luke's because he has had "ties to the community for many years, and St. Luke's Hospital has always been a good member of our community, and

their foundation sponsors a lot of good projects over the years in our community. And so as a business owner, there is not a lot I can do to help out good partners for our community, but one is to see that we do business with those partners that are strong community stewards and citizens." (Buehrer, Tr. 3068-3069). Mr. Buehrer's personal preferences and affection for St. Luke's say nothing about employee preferences. Mr. Buehrer expressly testified that he is unaware what hospitals his employees use and he has never studies employee healthcare utilization. (Buehrer, Tr. 3089).

Complaint Counsel further rely upon the testimony of Mr. Caumartin. For all the reasons explained in Respondent's response to CCPF 629, this testimony does not pertain to the relevant market and lacks the foundation necessary to support Complaint Counsel's proposed finding. In addition, Mr. Caumartin's testimony does not support the proposed finding. Mr. Caumartin testified that employees quickly adjusted to the change of hospital in their network. (Caumartin, Tr. 1859-1860). The change was "not the end of the world" because Mercy was equally as good as ProMedica. (Caumartin, Tr. 1859-1860).

Finally, Complaint Counsel rely on Ms. Neal. For the reasons described by Respondent in its response to CCPF 630, which Respondent incorporates by reference, Ms. Neal lacks any foundation to discuss her employee preferences. Chrysler has not conducted any studies of employee preferences. (Neal, Tr. 2155). She was not aware of what hospitals were utilized by Chrysler employees or what services each hospital provides. (Neal, Tr. 2151, 2154-2155). Moreover, in the testimony cited by Complaint Counsel, Ms. Neal indicated that Chrysler employees were directed to certain hospitals by their physicians. (Neal, Tr. 2155-2156). She also acknowledged that the physicians Chrysler's employees use maintain privileges in multiple

networks. (Neal, Tr. 2152-2153). Because of this, Chrysler's employees could continue to be cared for by the same physicians without disruption. (RPF 683).

638. A provider network consisting of only Mercy and UTMC is unacceptable to employers. (Neal, Tr. 2112-2113 (network consisting solely of Mercy and UTMC would be "very detrimental to [Chrysler's Lucas County] employees"); Buehrer, Tr. 3091 (network consisting of Mercy, UTMC, and St. Luke's acceptable only "because St. Luke's was included")).

Response to Finding No. 638:

Complaint Counsel's proposed finding lacks any foundation. For the reasons described by Respondent in its response to CCPF 630, which Respondent incorporates by reference, Ms. Neal lacks any foundation to discuss how Chrysler's employees would react to a network comprised of Mercy and UTMC.

For the reasons described by Respondent in its response to CCPF 631, which Respondent incorporates by reference, Mr. Buehrer lacks any foundation to discuss how his employees would react to a network comprised of Mercy and UTMC. For the reasons described by Respondent in its response to CCPF 637, which Respondent incorporates by reference, Mr. Buehrer's personal preference for St. Luke's has no bearing on his employees' views, which Mr. Buehrer has not examined and does not know. Mr. Buehrer confirmed that his employees could not receive all the benefits they required from St. Luke's and therefore, St. Luke's is not an essential component of the plan network for his employees. (Buehrer, Tr. 3092).

4. Physicians are Concerned about the Potential and Actual Elimination of Services at St. Luke's Post-Acquisition

639. A local cardiologist is concerned that the Acquisition will result in the elimination or transfer of services at St. Luke's. In particular, Dr. Gbur is concerned that St. Luke's open heart program will be moved to a less-preferred and less-convenient ProMedica facility. (Gbur, Tr. 3112-3113). If St. Luke's no longer provides an open heart program, Dr. Gbur is concerned that it will affect his ability to perform cardiac interventions at St. Luke's. Specifically, if Dr. Gbur's cardiac patients suffer a heart attack, some will have to add "another 10 to 15 minutes to their transit time" since they will have to travel to a hospital other than St. Luke's for open heart services. (Gbur, Tr. 3112-3113).

Response to Finding No. 639:

Complaint Counsel's proposed finding is inaccurate and misleading. Dr. Gbur's concern about the elimination or transfer of services is not specific to the joinder. He acknowledged during testimony that St. Luke's cardiovascular service line was not profitable prior to the joinder and St. Luke's was considering eliminating this service. (Gbur, Tr. 3125). He is unable to perform his work without cardiovascular surgery services at St. Luke's. (Gbur, Tr. 3126). Dr. Gbur was so concerned about this possibility that he had a clause written into his office lease with St. Luke's that would allow him to get out of the lease if St. Luke's eliminated this service line. (Gbur, Tr. 3125).

Complaint Counsel's proposed finding is also inaccurate with respect to its characterization of ProMedica facilities as less preferred and less convenient. The cited testimony makes no reference to ProMedica at all and says nothing about preference or convenience.

Finally, Dr. Gbur's testimony about the impact on patients if St. Luke's relocates its open-heart program is not credible. Dr. Gbur stated he was worried by the addition of up to 15 minutes of transit time for these patients. (Gbur, Tr. 3112-3113). Yet Dr. Gbur also testified that he was able to drive to Mercy in as little as 15 minutes. (Gbur, Tr. 3116). Expert testimony suggests that even this figure may err on the high end, since the largest additional drive time experienced by St. Luke's patients diverted to other hospitals was a maximum of 17 minutes. (RPF 242). And half of all St. Luke's patients diverting to another hospital *reduced* their travel time. (RPF 239). None of this expert analysis takes into account that the patients who are the focus of Dr. Gbur's concern would likely be traveling by ambulance, which can be expected to travel somewhat more rapidly, and also this analysis focuses on the *maximum* additional drive

time. Dr. Gbur testified that UTMC, a mere 6 miles away, performs the same interventional cardiology services. (Gbur, Tr. 3116-3117). Patients who could no longer receive these services at St. Luke's would still be able to receive them at UTMC and the travel time will not be as high as Complaint Counsel's proposed finding suggests.

Complaint Counsel's proposed finding is also misleading as to the scope of the concern. Dr. Gbur testified that he performs between five and ten procedures each week across all three Lucas County hospitals where he practices. (Gbur, Tr. 3119). He also testified that approximately sixty to seventy percent of his work is at St. Luke's. (Gbur, Tr. 3105-3106). This results in approximately three to six procedures per week at St. Luke's. Only about sixty percent of these patients, however, are actually admitted as inpatients, which further reduces the number of concerned patients to between two and four patients. (Gbur, Tr. 3118-3119). As already noted, analysis of St. Luke's inpatient admissions revealed that approximately half of all patients diverted to another hospital would actually reduce their travel time. (RPF 239). This fact further reduces the number of concerned patients to about 1 to 2 patients who *may* have a longer transit time, if ambulances and the proximity of equivalent services at UTMC are disregarded. (RPF 239).

640. Before ProMedica ceased providing inpatient rehabilitation services at St. Luke's, St. Luke's patients "raved" about its excellent, high-quality services. (Andreshak, Tr. 1796-1797). An orthopedic surgeon stated that his patients "improved better [at St. Luke's] than if they would have gone to a nursing home rehab facility." (Andreshak, Tr. 1797).

Response to Finding No. 640:

Complaint Counsel's proposed finding is inaccurate and misleading. Dr. Andreshak improperly discusses the views of his patients, which is hearsay and should be disregarded. Dr. Andreshak testified that Lucas County patients have many options for receiving rehabilitation services. (Andreshak, Tr. 1821). Dr. Andreshak believes the hospitals offering these services

are quality facilities. (Andreshak, Tr. 1819-1820). Dr. Andreshak was unable to explain how many patients actually made use of St. Luke's rehabilitation facility. (Andreshak, 1821). In fact, the program { } and St. Luke's CEO testified that it would have had to { } in any effort to remain independent. (RPF 1964, *in camera*). Dr. Andreshak acknowledged that the space formerly used by the rehabilitation center was converted into a med-surg unit after the joinder that increased St. Luke's ability to care for patients receiving surgery at the hospital. (Andreshak, Tr. 1821-1822). { }. (RPF 2230, *in camera*).

641. The post-Acquisition closure of St. Luke's inpatient rehabilitation center upset rehabilitation patients, especially patients from Maumee and Bowling Green. (Andreshak, Tr. 1798). Dr. Andreshak's inpatient rehabilitation patients were "upset," and the "most disgruntled patients" were from Maumee and Bowling Green. (Andreshak, Tr. 1798). The Maumee patients "really were the ones who suffered and didn't feel that they were able to go someplace adequately." (Andreshak, Tr. 1798). Bowling Green patients "loved the ... [patient rehabilitation center] at St. Luke's since Bowling Green only has nursing home type rehab facilities." (Andreshak, Tr. 1798).

Response to Finding No. 641:

Complaint Counsel's proposed finding is inaccurate and misleading. Dr. Andreshak improperly discusses the views of his patients, which is hearsay and should be disregarded. Complaint Counsel's proposed finding contradicts its own position on the relevant geographic market. Complaint Counsel has argued that facilities in Bowling Green, located in Wood County, do not compete with Lucas County providers. { }. (RPF 2230, *in camera*). Prior to the joinder, St. Luke's rehabilitation program { } and St.

Luke's CEO testified that it would have had to { } in any effort to remain independent. (RPF 1964, *in camera*).

642. The post-Acquisition closure of St. Luke's inpatient rehabilitation center resulted in fewer, less convenient options for rehabilitation patients. (Andreshak, Tr. 1797). Following the closure of St. Luke's inpatient rehabilitation center post-Acquisition, the two main Lucas County rehabilitation centers that remain are at Flower Hospital and St. Charles Hospital; both are inconvenient for Maumee and Bowling Green patients due to distance and travel time. (Andreshak, Tr. 1766, 1768, 1797, 1823-1824).

Response to Finding No. 642:

Complaint Counsel's proposed finding is inaccurate and misleading. Respondent refers to its response to CCPF 641, which it incorporates here by reference.

B. Self-insured Employers' Healthcare Costs Will Increase Directly and Immediately as a Result of the Acquisition

643. Unlike fully-insured employers who pay fixed monthly premiums to health plans, self-insured employers directly pay the full cost of their employees' healthcare claims to healthcare providers. (Neal, Tr. 2097 ("As a self-insured company, any increases in the cost of healthcare is a direct impact on our bottom line."); Caumartin, Tr. 1836-1837; Radzialowski, Tr. 622, 625-626; Town, Tr. 3612-3613; PX02148 at 011-013 (¶ 18) (Town Expert Report), *in camera*).

Response to Finding No. 643:

The proposed finding is an incomplete statement of the record. Employers do not negotiate directly with hospital providers; they rely on health insurance companies to do so. (RPF 459). Self-insured employers gain access to the provider network and discounted prices that health insurance companies negotiate with healthcare providers. (RPF 432). For self-insured products, the employer typically funds an account that the insurer draws upon to pay healthcare expenses. (RPF 430).

644. Thus, when hospital reimbursement rates increase, self-insured employers immediately bear the full burden of these higher costs. (Sandusky, Tr. 1296; McGinty, Tr. 1243-1244; Radzialowski, Tr. 625-626, 840-841, *in camera*; Town, Tr. 3612-3613; PX02148 at 011-013 (¶ 18) (Town Expert Report), *in camera*; Radzialowski, Tr. 840-841, *in camera* ("Local employers ... [whose] members receive services at St. Luke's, especially the self-insured employers, would feel a direct impact from unexpected [rate] increases.")).

Response to Finding No. 644:

The proposed finding is misleading. Many variables affect an employer's total healthcare expenses, including: the number of employees and family members covered under an employer's plan, the benefit design offering and product type, the demographic mix of an employer's covered members (e.g. age, sex, health status), the amount of prescription drug usage by an employer's insured employees, as well as other factors. (Neal, Tr. 2140-2142).

A self-insured employer's total medical expenses consist of inpatient care, outpatient care, physician care, prescription drugs, physical rehabilitation, skilled nursing facilities, and many other healthcare-related expenses. (Neal, Tr. 2121-2123). Only 25 percent of provider medical claims are for inpatient hospital services. (RPF 427). Therefore, if a hospital was able to negotiate an increase in its reimbursement rates, that increase would only affect approximately a quarter of the self-insured employer's medical claims costs.

Furthermore, self-insured employers have several options in response to a rate increase. First, they could increase their salaried employees' health insurance deductibles, coinsurance, copays, cost share, and/or their premiums. (Neal, Tr. 2115). Note, however, that employers cannot pass through an increase in rates immediately to their United Auto Workers (UAW) union employees due to the UAW's collective bargaining agreements with employers. (RPF 453-458). These agreements, which are typically three years in duration, state that out-of-pocket healthcare costs for union members cannot change absent an additional or subsequent agreement between the employer and the UAW. (RPF 453-458). Therefore, 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. (RPF 453-458).

Alternatively, the employer could absorb the increase, without passing anything along to employees. (RPF 451-452).

645. ProMedica and St. Luke's executives agree that when hospital reimbursement rates increase, self-insured employers immediately and directly must pay these higher costs. Respondent admitted that "if the reimbursement rate Paramount pays to hospitals changes, that change is ultimately passed on to the self-insured customer because self-insured customers pay their own claims. ... [A]ny reimbursement rate change affects self-insured customers on the effective date of the new contract between Paramount and a hospital." (Response to RFA at ¶ 35).

Response to Finding No. 645:

The first sentence of the proposed finding violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record.

646. St. Luke's CEO, Daniel Wakeman, testified that if St. Luke's rates increased post-Acquisition (as has already occurred for some health plan members), and self-insured employers' "volume stayed the same, they would pay higher costs per unit." (Wakeman, Tr. 2687, *in camera*).

Response to Finding No. 646:

The proposed finding is misleading. Many variables affect an employer's total healthcare expenses, including: the number of employees and family members covered under an employer's plan, the benefit design offering and product type, the demographic mix of an employer's covered members (e.g. age, sex, health status), the amount of prescription drug usage by an employer's insured employees, as well as other factors. (Neal, Tr. 2140-2142).

A self-insured employer's total medical expenses consist of inpatient care, outpatient care, physician care, prescription drugs, physical rehabilitation, skilled nursing facilities, and many other healthcare-related expenses. (Neal, Tr. 2121-2123). Only 25 percent of provider medical claims are for inpatient hospital services. (RPF 427). Therefore, if a hospital was able to negotiate an increase in its reimbursement rates, that increase would only affect approximately a quarter of the self-insured employer's medical claims costs.

Furthermore, self-insured employers have several options in response to a rate increase. First, they could increase their salaried employees' health insurance deductibles, coinsurance, copays, cost share, and/or their premiums. (Neal, Tr. 2115). Note, however, that employers cannot pass through an increase in rates immediately to their United Auto Workers (UAW) union employees due to the UAW's collective bargaining agreements with employers. (RPF 453-458). These agreements, which are typically three years in duration, state that out-of-pocket healthcare costs for union members cannot change absent an additional or subsequent agreement between the employer and the UAW. (RPF 453-458). Therefore, 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. (RPF 453-458).

Alternatively, the employer could absorb the increase, without passing anything along to employees. (RPF 451-452).

647. ProMedica's CEO, Randall Oostra, testified that if a Lucas County hospital or hospital system increases its rates to commercial health plans, those increased costs are "passed on straightforward" to self-insured employers. (Oostra, Tr. 6144).

Response to Finding No. 647:

The proposed finding is misleading. Many variables affect an employer's total healthcare expenses, including: the number of employees and family members covered under an employer's plan, the benefit design offering and product type, the demographic mix of an employer's covered members (e.g. age, sex, health status), the amount of prescription drug usage by an employer's insured employees, as well as other factors. (Neal, Tr. 2140-2142).

A self-insured employer's total medical expenses consist of inpatient care, outpatient care, physician care, prescription drugs, physical rehabilitation, skilled nursing facilities, and many other healthcare-related expenses. (Neal, Tr. 2121-2123). Only 25 percent of provider

medical claims are for inpatient hospital services. (RPF 427). Therefore, if a hospital was able to negotiate an increase in its reimbursement rates, that increase would only affect approximately a quarter of the self-insured employer's medical claims costs.

Furthermore, self-insured employers have several options in response to a rate increase. First, they could increase their salaried employees' health insurance deductibles, coinsurance, copays, cost share, and/or their premiums. (Neal, Tr. 2115). Note, however, that employers cannot pass through an increase in rates immediately to their United Auto Workers (UAW) union employees due to the UAW's collective bargaining agreements with employers. (RPF 453-458). These agreements, which are typically three years in duration, state that out-of-pocket healthcare costs for union members cannot change absent an additional or subsequent agreement between the employer and the UAW. (RPF 453-458). Therefore, 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. (RPF 453-458).

Alternatively, the employer could absorb the increase, without passing anything along to employees. (RPF 451-452).

648. In Lucas County, approximately 70 percent of the commercially insured business is self-insured. (Town, Tr. 3613-3614; PX02148 at 011-013 (¶ 18) (Town Expert Report), *in camera*).

Response to Finding No. 648:

The proposed finding is inaccurate. Approximately 50 percent of Paramount's commercially insured membership are fully-insured, and about 50 percent are self-insured. (RPF 307). Anthem's self-insured product comprises approximately 55 percent of its commercial business in Lucas County. (RPF 287). Approximately 60 percent of MMO's commercial business is self-insured; the remaining 40 percent is for fully insured products. (RPF 265).

Approximately two-thirds of Aetna's commercially insured members are self-insured. (RPF 381). { .} (RPF 407, *in camera*).

C. Fully-insured Employers' Premiums Will Increase as a Direct Result of the Acquisition

649. Under a fully-insured plan, an employer pays a premium to a health plan and the health plan absorbs all of the costs for the medical care that the employees receive. (Buehrer, Tr. 3063, 3086). Thus, the health plan bears the risk that the employees' medical expenses will exceed the amount collected from premiums. (Pugliese, Tr. 1430-1431; PX02148 at 011-013 (¶ 18) (Town Expert Report), *in camera*).

Response to Finding No. 649:

Respondent has no specific response.

650. When a health plan incurs a rate increase from a hospital, it will pass down the increased costs to employers in the form of higher premiums. (Radzialowski, Tr. 625-626, 779; PX01938 at 030 (Radzialowski, Dep. at 114), *in camera* ("With the fully insured, I can't see any circumstance where we would not automatically pass that on through the premium increase."); Pugliese, Tr. 1558, 1560; PX01942 at 025 (Pugliese, Dep. at 94), *in camera*; McGinty, Tr. 1210-1211, 1242-1243; Pirc, Tr. 2174; PX01944 at 020 (Pirc, Dep. at 76), *in camera*; Sheridan, Tr. 6701-6702, *in camera*; Town, Tr. 3614; PX02148 at 011-013 (¶ 18) (Town Expert Report), *in camera*).

Response to Finding No. 650:

The proposed finding is misleading. To begin, only 25 percent of provider medical claims are for inpatient hospital services. (RPF 426-427). Therefore, if a hospital was able to negotiate an increase in its reimbursement rates, that increase would only affect approximately a quarter of the total medical claims costs.

Furthermore, healthcare premiums are affected by a variety of factors in addition to healthcare costs, such as the employer's benefit design, size, and age of workforce, among other things. (RPF 424). For fully-insured products, the premium remains the same for the entire term of the contract, even if a provider's reimbursement rate changes during the course of the contract. (RPF 447). Therefore, a health plan cannot pass down a hospital rate increase to

employers in the form of higher premiums until a policy renewal, and fully-insured employers may have a contract with a MCO whose duration is anywhere from one to three years. (RPF 444-445).

Also, MCOs will sometimes increase premiums in anticipation of a rate increase. (RPF 450). However, if that anticipated rate increase does not occur, Aetna, at least, does not make any adjustments to the premiums it calculated to reduce the cost of the premium. (RPF 450). Similarly, MCOs do not always pass through *decreases* in reimbursement rates to members in the form of lower premiums. (RPF 449). In other words, premiums are affected by many variables, and are not directly tied to healthcare costs.

651. Jack Randolph, the President of Paramount, a health plan owned by ProMedica, also acknowledged that when Paramount has to pay increased reimbursement rates to providers, at some point, it has to pass on those increased costs to its customers. (Randolph, Tr. 7108-7109).

Response to Finding No. 651:

The proposed finding is misleading. Because inpatient hospital services only comprise 25 percent of provider medical claims, an increase in hospital reimbursement rates only affects 25 percent of the total medical claims costs that health plans, like Paramount, ultimately insure. (RPF 427).

652. St. Luke's CEO acknowledged that if St. Luke's rates increased to health plans, he believed that the health plans "would have then passed those rates off to the employers and the community." (Wakeman, Tr. 2687, *in camera*).

Response to Finding No. 652:

The proposed finding misstates the record. Mr. Wakeman testified that that was his assumption in the fall of 2009 when he drafted an email, PX01125, to board members. (Wakeman, Tr. 2687, *in camera*). In fact, health plans cannot pass down a hospital rate increase to employers in the form of higher premiums until a policy renewal, and fully-insured employers

may have a contract with a MCO whose duration is anywhere from one to three years. (RPF 444-445). Furthermore, if the rates are eventually passed through to employers, those 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. (RPF 452).

D. Employees' Premiums and Out-of-Pocket Costs Will Increase as a Direct Result of the Acquisition

653. Employers cite healthcare costs as one of their largest expenses. (Caumartin, Tr. 1846-1847 (health insurance is a "very significant" expense); Buehrer, Tr. 3073 (health insurance is the "second highest expense behind payroll"); Neal, Tr. 2118 (Healthcare is "the largest fixed cost for [Chrysler's] bargaining unit employees when we negotiate a collective bargaining agreement with the UAW."); Lortz, Tr. 1707-1708 ("healthcare is one of the big pieces" in collective bargaining)).

Response to Finding No. 653:

Complaint Counsel's proposed finding is misleading. Complaint Counsel rely upon the testimony of Mr. Caumartin. For all the reasons explained in Respondent's response to CCPF 629, this testimony does not pertain to the relevant market and lacks the foundation necessary to support Complaint Counsel's proposed finding.

654. When healthcare costs rise due to hospital rate increases, employers generally must increase employees' premiums, co-payments, deductibles, and out-of-pocket costs. (Neal, Tr. 2114 (Chrysler passes the cost of increased healthcare prices "through to our employees in the form of premium sharing or increased cost sharing"), 2115, 2117, 2158; Caumartin, Tr. 1837; Buehrer, Tr. 3072; Town, Tr. 3614; PX02148 at 011-013 (¶ 18) (Town Expert Report), *in camera*).

Response to Finding No. 654:

Complaint Counsel's proposed finding is inaccurate and misleading. Complaint Counsel rely upon the testimony of Mr. Caumartin. For all the reasons explained in Respondent's response to CCPF 629, this testimony does not pertain to the relevant market and lacks the foundation necessary to support Complaint Counsel's proposed finding.

Complaint Counsel's proposed finding also misleadingly implies that hospital rate increases are the sole or even most important source of increases to healthcare premiums. As MCOs and employers acknowledged at trial, healthcare premiums are influenced by many factors, including MCO administrative costs, the costs of healthcare services other than general acute-care inpatient services, and the demographic composition of the group of employees being insured. (RPF 653-657). Errors by MCOs also drive some premium increases, although MCOs do not publicize these or even correct them. (RPF 450). Employees of large national employers like Chrysler, who insure with large MCOs for facilities in multiple geographic locations, may see an increase in their premiums due to cost increases in those other geographic locations. (RPF 657).

The utilization of services by employees within the insured group is a critical factor. Mr. Buehrer, whom Complaint Counsel rely upon, testified that his own company's insurance premium had gone up not because of any hospital rate increases, but because of the increased utilization of medical services by his employees. (Buehrer, Tr. 3085-3086). The items that impact premiums are the services people use everyday like physician services and prescription drug services. (Randolph, Tr. 6935-6936). Only 6 percent of all commercially insured patients use any general acute-care inpatient services in a given year. (RPF 441).

Finally, employers are not obliged to pass along premium increases. They have many options and for many reasons may choose not to pass along whatever increases they do receive. (RPF 451-452). Union contracts often limit the ability to pass along increases. (RPF 454-455).

655. As E. Dean Beck, Fulton County Health Center's CEO, testified, if healthcare costs go up, "[o]bviously, the premiums [that people pay] go up." (Beck, Tr. 441).

Response to Finding No. 655:

Complaint Counsel's proposed finding is misleading. Mr. Beck did not limit his testimony to *general acute-care inpatient services*. He spoke of all healthcare costs. (Beck, Tr. 444-445 ("Any place that insurance is used, that would impact it"). As Respondent noted in response to CCPF 654, "healthcare costs" comprise many different factors, and general acute-care inpatient services are but one small portion of the total. (RPF 653-657). Mr. Beck agreed that premiums increase even when there is no increase in the cost of general acute-care inpatient services. (Beck, Tr. 445).

656. Health plans also recognize that employers have to pass on any increased healthcare costs. (Pugliese, Tr. 1559-1560; Radzialowski, Tr. 782; PX01938 at 030 (Radzialowski, Dep. at 116), *in camera* (If an employer chose not to pass on healthcare cost increases to employees, it "would have to make the money up somewhere else to keep financially viable.")).

Response to Finding No. 656:

Complaint Counsel misrepresent the witness testimony. Mr. Pugliese's cited testimony contradicts Complaint Counsel's proposed finding. He testified that employers have many options and that they may choose not to pass along a premium increase. (Pugliese, Tr. 1559-1560). Likewise, Mr. Radzialowski acknowledged at trial that employers may choose to absorb the cost of a premium increase. (Radzialowski, Tr. 782). Other MCO witnesses also agreed that employers could opt not to pass along a premium increase. (McGinty, Tr. 1245).

657. When costs for employee health insurance coverage increase for employers with union members, these employers try to pass on those added costs to union members by reducing service levels or by increasing the amount the union members must pay. (Lortz, Tr. 1707, 1711-1713).

Response to Finding No. 657:

Complaint Counsel's proposed finding is misleading. In addition, the value of any testimony from Mr. Lortz' testimony is limited due to his bias against ProMedica. ProMedica and Mr. Lortz's union have been involved in a long-running dispute over unionization at

ProMedica's hospitals. (Lortz, Tr. 1726-1730). Mr. Lortz's boss publicly announced the union's intention to boycott ProMedica hospitals. (Lortz, Tr. 1727) Mr. Lortz has close ties to Mercy and first heard of the joinder from Mercy. After hearing about the joinder, Mr. Lortz contacted the Ohio Attorney General's office to express concerns about the joinder. (Lortz, Tr. 1715-1713).

Complaint Counsel's proposed finding is misleading because it ignores the fact that the UAW contracts Mr. Lortz described are multi-year contracts and that for the duration of these contracts no change in healthcare costs are possible. (RPF 454-455).

Further, for the reasons discussed by Respondent in its response to CCPF 654, which it incorporates here by reference, Complaint Counsel's proposed finding is misleading because it equates "healthcare costs" with "general acute care inpatient service rate increases." The increases discussed by Complaint counsel may have many causes beyond general acute-care inpatient services, and general acute-care inpatient services are only a small component of total healthcare costs. (RPF 427, 441, 653-657). Premiums may increase even when general acute-care inpatient services do not change. (Beck, Tr. 445).

658. When healthcare costs increase for self-insured employers with unionized employees, such as Chrysler, employers must offset these higher costs through reduced wages or other trade-offs. (Neal, Tr. 2118).

Response to Finding No. 658:

Complaint Counsel's proposed finding is misleading because it ignores the fact that the UAW contracts Mr. Lortz described are multi-year contracts and that for the duration of theses contracts no change in healthcare costs are possible. (RPF 454-455).

Further, for the reasons discussed by Respondent in its response to CCPF 654, which it incorporates here by reference, Complaint Counsel's proposed finding is misleading because it equates "healthcare costs" with "general acute care inpatient service rate increases." The

increases discussed by Complaint counsel may have many causes beyond general acute-care inpatient services, and general acute-care inpatient services are only a small component of total healthcare costs. (RPF 427, 441, 653-657). Premiums may increase even when general acute-care inpatient services do not change. (Beck, Tr. 445).

659. When healthcare costs rise due to hospital rate increases, employers may be forced to reduce wages, lay off employees, or discontinue offering health insurance to their employees. (Town, Tr. 3614).

Response to Finding No. 659:

Complaint Counsel's proposed finding is misleading and inaccurate. No Lucas County employer identified layoffs or eliminating healthcare benefits as a response to an increase in general acute-care inpatient services.

Complaint Counsel's proposed finding also misleadingly implies that hospital rate increases are the sole or even most important source of increases to healthcare premiums. For the reasons discussed by Respondent in its response to CCPF 654, healthcare costs may increase for many reasons unrelated to increases in the cost of general acute-care inpatient services.

660. In some cases, higher healthcare costs may lead employees to delay or forego routine physical check-ups or certain medical treatment. (Caumartin, Tr. 1838; Town, Tr. 3614-3615). Hugh Caumartin, a former local school superintendent, is concerned that higher healthcare rates will lead employees to "pull back on getting the medical services they need" or not take their family members to get check-ups. (Caumartin, Tr. 1838). He believes that employees might not "use the benefits that are available to them because of the added cost." (Caumartin, Tr. 1838).

Response to Finding No. 660:

Complaint Counsel's proposed finding is inaccurate and misleading. Complaint Counsel rely upon the testimony of Mr. Caumartin. For all the reasons explained in Respondent's response to CCPF 629, this testimony does not pertain to the relevant market and lacks the foundation necessary to support Complaint Counsel's proposed finding. Mr. Caumartin further has no foundation for this speculative testimony. Cost increases have occurred in the past, but

Mr. Caumartin was unable to link his "worries" about this speculative harm to any actual employee experience. (Caumartin, Tr. 1838).

661. Higher healthcare costs have additional negative consequences for employees and the local community. (Caumartin, Tr. 1837-1838). As Hugh Caumartin, a former local school superintendent testified, when hospital rates increase to a school system "somebody's got to pay the ticket" and sometimes "taxpayers pick up the additional" cost. (Caumartin, Tr. 1837). Other times, a school system must divert funding from its educational program to pay for healthcare. (Caumartin, Tr. 1838).

Response to Finding No. 661:

Complaint Counsel's proposed finding is inaccurate and misleading. Complaint Counsel rely upon the testimony of Mr. Caumartin. For all the reasons explained in Respondent's response to CCPF 629, this testimony does not pertain to the relevant market and lacks the foundation necessary to support Complaint Counsel's proposed finding.

Complaint Counsel's proposed finding also misleadingly implies that hospital rate increases are the sole or even most important source of increases to healthcare premiums. For the reasons discussed by Respondent I its response to CCPF 654, healthcare costs may increase for many reasons unrelated to increases in the cost of general acute-care inpatient services.

XIII. THE ACQUISITION WILL ELIMINATE BENEFICIAL NON-PRICE COMPETITION AND RESULT IN LOWER QUALITY OF CARE AND SERVICE LEVELS

662. Hospitals compete on the basis of clinical quality, amenities, and patient experience. (Joint Stipulations of Law and Fact, JX00002A ¶ 11; Response to RFA at ¶20; PX02148 at 084-085 (¶ 155) (Town Expert Report), *in camera*). Many such non-price elements of competition will likely be negatively affected by the Acquisition. (Town, Tr. 3605-3606, 3630-3631, 3634-3635).

Response to Finding No. 662:

The joinder will not adversely impact non-price elements of competition in the Toledo area. For example, St. Luke's will receive quality-related benefits from joining the ProMedica system, such as access to technologies it did not have such as eICU and smart pump. (RPF

2245-2253). Further, the joinder provides St. Luke's with much needed capital that allows it to remain open as a community hospital. (RPF 2113). In addition, St. Luke's patients will benefit from additional amenities that St. Luke's was unable to afford on its own, such as new private rooms and upgraded technology. (RPF 2114).

A. Pre-Acquisition Competition Between ProMedica and St. Luke's Resulted in Improved Hospital Quality and Service Offerings

663. The Acquisition eliminates important non-price competition between ProMedica and St. Luke's. Reduced competition can lead to lower quality compared to markets with higher levels of competition. (PX01942 at 026 (Pugliese, Dep. at 98), *in camera*; Town, Tr. 3634-3635).

Response to Finding No. 663:

The first sentence of the proposed finding is not a fact, but an improper legal argument. In addition, the first sentence of the proposed finding violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record.

664. As an independent hospital, St. Luke's challenged other hospital systems "to keep costs down" and "to keep service levels up." (PX01170 at 020 (St. Luke's presentation about controlling health care cost); Wakeman, Tr. 2540-2541; Rupley, Tr. 1935-1936; *see also* PX01144 at 003 (Rupley planning session notes, Jan. 2007) ("SLH – gives choice, customer service, quality, etc.")).

Response to Finding No. 664:

Respondent has no specific response.

665. Health plan executives have testified that non-price dimensions, such as clinical quality, are an important factor they consider when negotiating for a hospital's inclusion in the health plan's network. (Radzialowski, Tr. 655; Sheridan, Tr. 6622; Pugliese, Tr. 1455; McGinty, Tr. 1173; PX01944 at 006 (Pirc, Dep. at 18-19)).

Response to Finding No. 665:

MCOs were unwilling to increase St. Luke's rates in recognition of its allegedly superior costs and service levels. (RPF 1456-1460). Moreover, MCOs bluntly informed St. Luke's

during negotiations { } (PX01583 at 001, *in camera*; Wakeman, Tr. 2973-2974, *in camera*).

666. Health plans continually monitor the quality of the hospitals in their networks. (Radzialowski, Tr. 600, 632).

Response to Finding No. 666:

However, the rates that MCOs pay to St. Luke's were not tied to St. Luke's quality measures. (RPF 1457). In addition, MMO testified that the healthcare industry does not know how to measure quality. (RPF 1437).

667. Health plan customers want quality information for hospitals in their networks to help make informed decisions. (Pugliese, Tr. 1449). Anthem Care Comparison is an online tool that provides Anthem's members with cost and quality rankings for selected hospital services. (PX01919 at 004 (Pugliese, Dep. at 12)).

Response to Finding No. 667:

Respondent has no specific response.

668. Respondent's executives and expert confirm that competition between hospitals benefits the local community through better customer service, higher quality care, better access for patients and improved facilities. (Oostra, Tr. 6039; Guerin-Calvert, Tr. at 7792; Waschsman, Tr. 5116-5118; PX01905 at 033 (Wachsman, IHT at 127), *in camera*).

Response to Finding No. 668:

Respondent has no specific response.

B. St. Luke's Quality Was Superior to ProMedica's

669. Prior to the Acquisition, St. Luke's ranked as the highest quality, lowest cost hospital in the Toledo market. (PX01018 at 012 (Options for St. Luke's), *in camera*; PX01072 at 001 (St. Luke's Key Messages); Rupley, Tr. 1920, 1924-1925; Wakeman, Tr. 2482-2483, 2494).

Response to Finding No. 669:

Prior to the joinder, St. Luke's touted itself as the highest quality, lowest cost hospital in the Toledo market; however, data, documents, and testimony reveal that all Lucas County hospitals are quality institutions. (RPF 1446). Further, more recent quality metrics ranked St.

Luke's lower than the legacy ProMedica hospitals for quality. (RPF 1466 (CMS reporting data through fourth quarter of 2010)). In addition, MCOs were unwilling to increase St. Luke's rates in recognition of its allegedly superior quality. (RPF 1456-1460).

670. Delivering high-quality service and achieving high patient satisfaction are important parts of St. Luke's mission. (Wakeman, Tr. 2493). According to Barbara Machin, former Chairman of St. Luke's board, "Our motto has always been 'Patients First Always.' Quality and patient service and patient care has been our mantra." (PX01907 at 016 (Machin, IHT at 54), *in camera*).

Response to Finding No. 670:

Respondent has no specific response.

671. Despite St. Luke's rapid growth in patient volume in 2010, patient satisfaction and quality were unaffected and remained at very high levels. (Wakeman, Tr. 2495-2497; Black, Tr. 5685, 5690).

Response to Finding No. 671:

Contrary to Complaint Counsel's assertions, during the first three quarters of 2010, {

.} (RPF 1462, *in camera)*. Although he was initially surprised by these scores, {

.} (RPF 1464, *in camera*). At the same time, ProMedica hospitals {

} (RPF 1463, *in camera*).

672. In fact, several quality measures improved, such as myocardial infarction (i.e., heart attack) care, emergency and obstetrics satisfaction levels, and door-to-artery time for cardiac intervention. (Wakeman, Tr. 2496-2497, 3042-3043).

Response to Finding No. 672:

Nonetheless, American College of Cardiology (ACC) data through the third quarter of 2010 ranked TTH higher than St. Luke's for cardiology services. (RPF 1465). Further, TTH outperformed St. Luke's with regard to heart services on two outcome-validated measures issued by the Society of Thoracic Surgeons and the ACC. (RPF 1468).

673. St. Luke's achievements in clinical quality exceed those of The Toledo Hospital ("TTH") and Flower, its closest competitors in the ProMedica system for inpatient hospital services. ProMedica's flagship hospital, TTH, ranked *last* in the Toledo market and below the state average for quality. (Rupley, Tr. 1984-1985, *in camera*, 1991-1993, *in camera* (TTH showed a "dismal performance"); PX01016 at 006 (St. Luke's Board Meeting Affiliation Update, Dec. 2009), *in camera*; PX01172 (St. Luke's e-mail, Kathy Connell, Corp. Comm'ns Director, to Scott Rupley, Aug. 28, 2009), *in camera* ("[I]n the Commonwealth scoring on quality, SLH was the best, just a hair shy of the top 10% nationally, with Toledo Hospital dead last and well below the state average."); PX01030 at 018-019 (St. Luke's Affiliation Analysis Update, Oct. 2009), *in camera*). Flower ranked sixth in Lucas County for overall quality. (Rupley, Tr. 2002; PX01172 at 008, *in camera*; PX01030 at 018 (St. Luke's Affiliation Analysis Update, Oct. 2009), *in camera*).

Response to Finding No. 673:

The proposed finding is misleading and inaccurate because Complaint Counsel focuses on outdated quality scores to support its assertion that St. Luke's quality surpassed that of ProMedica's hospitals. (PX01172, *in camera* (August, 2009); PX01030, *in camera* (Oct. 2009); PX01016, *in camera* (Dec. 2009)). However, recent quality measures show ProMedica's legacy hospitals outperforming St. Luke's. During the first three quarters of 2010, {

.} (RPF 1462, *in camera).*

Although he was initially surprised by these scores, {

} (RPF 1464, *in camera*). At the same time, ProMedica hospitals {

.} (RPF 1463, *in camera*). In addition, more recent quality metrics ranked St. Luke's lower than the legacy ProMedica hospitals for quality. (RPF 1466 (CMS reporting data through fourth quarter of 2010)). In terms of cardiac services, American College of Cardiology (ACC) data through the third quarter of 2010 ranked TTH higher than St. Luke's for cardiology services. (RPF 1465). Further, TTH outperformed St. Luke's with regard to heart services on two outcome-validated measures, issued by the Society of Thoracic Surgeons and the ACC. (RPF 1468). For critical care, ProMedica ranks in the top decile under the APACHE

measurements. (RPF 1472). For pneumonia care, data through the fourth quarter of 2010 ranked St. Luke's behind ProMedica's legacy hospitals. (PX01930 (Reiter, Dep. at 157)). Finally, ProMedica received 32 awards from HealthGrades for clinical quality, including 18 or 19 at The Toledo Hospital alone. (Oostra, Tr. 5775).

674. ProMedica has admitted that St. Luke's is a high quality hospital. (Answer at ¶ 33; Oostra, Tr. 6027-6028; PX01913 at 032 (Hammerling, IHT at 119), *in camera* (St. Luke's has a "good reputation historically" for quality and patient care); PX01903 at 033 (Hanley, IHT at 123), *in camera* ("I think St. Luke's has strong quality of care [.]"); PX01949 at 018 (Riordan Dep. at 64-65)).

Response to Finding No. 674:

ProMedica believes that all of its hospitals, including St. Luke's, have comparable quality. (RPF 1449). Further, MCOs also consider all Lucas County hospitals to be quality institutions. (RPF 1451-1453).

675. ProMedica documents reflect patients' awareness that St. Luke's was a high-quality hospital, often scoring better than ProMedica in quality rankings. (PX00399 at 024 (ProMedica Central Region, Great Lakes Marketing Presentation), *in camera*; PX00272 (Commonwealth Fund 2007 scores); PX01138 at 001 (Quality Scoring from hospitalbenchmark.com)).

Response to Finding No. 675:

ProMedica believes that all of its hospitals, including St. Luke's, have comparable quality. (RPF 1449). Other documents exist that contradict Complaint Counsel's assertion and reflect that some patients {

} (RPF 1454, *in camera*). In addition, the same document {

.} (RPF 1455, *in camera*).

676. ProMedica also has admitted that St. Luke's scored higher than TTH and Flower in patient satisfaction scores. (PX01904 at 035 (Steele, IHT at 131), *in camera*).

Response to Finding No. 676:

Subsequent to the testimony cited above, {

}.

(RPF 1462, *in camera*).

677. Navigant, the healthcare consulting firm that ProMedica hired to analyze the Acquisition with St. Luke's, found St. Luke's to have high quality levels based on respected third-party quality rating organizations. (PX01946 at 008 (Nolan, Dep. at 24)).

Response to Finding No. 677:

Navigant based its conclusion on CMS scores that were several years old. (PX01946 (Nolan, Dep. at 24)). More recent quality measures show ProMedica's legacy hospitals outperforming St. Luke's. During the first three quarters of 2010, {

.} (RPF 1462, *in camera)*. Although he was initially surprised by these scores, {

} (RPF 1464, *in camera*). At the same time, ProMedica hospitals {

.} (RPF 1463, *in camera*). In addition, more recent CMS quality metrics ranked St. Luke's lower than the legacy ProMedica hospitals for quality. (RPF 1466 (CMS reporting data through fourth quarter of 2010)).

678. The data used by Navigant showed that St. Luke's scored higher than TTH on several cardiac service quality measures including Overall Heart Attack, Overall Heart Failure, and Heart Failure Mortality Rate. (Nolan, Tr. 6339-6343, *in camera*; PX01221 at 068 (Navigant clinical integration presentation, Sept. 23, 2010), *in camera*).

Response to Finding No. 678:

The proposed finding is inaccurate and misleading. Complaint Counsel misstates the evidence. For example, PX01221 reflects that TTH outperformed St. Luke's according to mortality rates, while handling more complicated cases, as reflected by a higher case mix index. (PX01221 at 072-073, *in camera*). Additionally, American College of Cardiology (ACC) data

through the third quarter of 2010 ranked TTH higher than St. Luke's for cardiology services. (RPF 1465). Further, TTH outperformed St. Luke's with regard to heart services on two outcome-validated measures, issued by the Society of Thoracic Surgeons and the ACC. (RPF 1468). Navigant determined in its study that {

} (RPF 1474-1477, *in camera*). Further, TTH's mortality rate was half the rate of St. Luke's. (PX01221 at 068, *in camera*).

679. Health plans have testified that St. Luke's is an important part of their Lucas County provider networks because it provides high-quality services. (Sandusky, Tr. 1312-1313; McGinty, Tr. 1190-1191; Pugliese, Tr. 1443-1445; Pirc, Tr. 2195-2196; PX02280 at 001-013 (MMO document on St. Luke's quality)).

Response to Finding No. 679:

MCOs were unwilling to increase St. Luke's rates in recognition of its allegedly superior quality. (RPF 1456-1460). Further, Anthem and Paramount have successfully marketed networks without St. Luke's in the past. (RPF 725-728, 779-797).

680. Both Mercy and UTMC view St. Luke's as a high-quality competitor. (Shook, Tr. 1032, 1123, *in camera*; Gold, Tr. 225).

Response to Finding No. 680:

Lucas County residents and physicians perceive the quality of care at Lucas County hospitals to be comparable with one another. (RPF 1447-1448).

681. St. Luke's "is regularly recognized by third-party quality ratings organizations that rank St. Luke's within the top 10% of hospitals nationally, based on outcomes, cost and patient satisfaction." (PX00390 at 001 (ProMedica News Release May 26, 2010); *see also* PX01073 at 001 (St. Luke's Press Release Healthgrades.com)).

Response to Finding No. 681:

There are varying degrees of reliability for quality metrics. (RPF 1432). The least reliable group of sources include for-profit organizations that base their scores on coding-based indicators and studies with poor validity, such as HealthGrades and Thompson Reuters. (RPF 1436).

682. Third-party quality ranking organizations also regularly praise St. Luke's for its value, *i.e.*, its combination of high quality and low costs. (Rupley, Tr. 1933-1934; PX02300 at 001 (Leap Frog recognized St. Luke's as one of only 13 hospitals across the nation to be rated "Highest Value"); PX01170 at 013-014 (Data Advantaged named St. Luke's "one of the Top 100 Best Kept Secrets in the United States.")).

Response to Finding No. 682:

There are varying degrees of reliability for quality metrics. (RPF 1432). Less reliable quality sources include non-profit organizations such as LeapFrog. (RPF 1435).

C. ProMedica Cannot Be Expected to Improve St. Luke's Quality

683. St. Luke's prides itself on providing benefit to the community through its high quality of care and patient satisfaction. (Wakeman, Tr. 2493; Rupley, Tr. 1920, 1924-1925; PX01933 at 017 (Oppenlander, Dep. at 60), *in camera*).

Response to Finding No. 683:

Respondent has no specific response.

684. In an internal analysis of potential acquisition options, St. Luke's noted that its "well maintained" facilities, "strong clinical quality outcomes," "strong patient/employee satisfaction and loyalty," and "positive working relationships with affiliated physicians" were all important points of leverage "to secure the best offer" for St. Luke's from several possible affiliation partners. (PX01018 at 018 (Options for St. Luke's), *in camera*).

Response to Finding No. 684:

Respondent has no specific response.

685. Prior to the Acquisition, St. Luke's management and Board of Directors were concerned about the poor quality outcomes and measures at ProMedica's hospitals. (Wakeman, Tr. 2675-2676, *in camera*; Black, Tr. 5720; PX01932 at 019 (Bazeley, Dep. at 69), *in camera*).

Response to Finding No. 685:

Complaint Counsel base their argument on testimony discussing outdated data from 2008 and 2009. (Wakeman, Tr. 2675, *in camera*).

686. In fact, St. Luke's feared that the Acquisition by ProMedica would lower St. Luke's quality. (Wakeman, Tr. 2674-3676, *in camera*; Rupley, Tr. 2011, *in camera*; Black, Tr. 5720, *in camera*; PX01130 at 002 (Notes from Due Diligence Meetings, Aug. 26, 2009), *in camera* ("Some of ProMedica's quality outcomes/measures are not very good. Would not want them to bring poor quality to St. Luke's."); *see* PX01016 at 023 (St. Luke's Affiliation Update Dec. 2009), *in camera*).

Response to Finding No. 686:

Again, Complaint Counsel cite outdated data. (Wakeman, Tr. 3002, *in camera* ({

})). More recent data reflects ProMedica scoring better than St. Luke's according to CMS. (RPF 1465-1466). Further, Mr. Wakeman testified that {

} (Wakeman, Tr. 2996-2997, *in camera*).

687. Prior to the Acquisition, ProMedica needed to improve the clinical quality and patient satisfaction at its Lucas County hospitals. (PX00153 at 001 (Oostra (ProMedica) Jan. 2009 e-mail re: ProMedica's "subpar quality scores"); PX01930 at 034 (Reiter, Dep. at 127); PX01904 at 034 (Steele, IHT at 129), *in camera* (TTH struggled to be patient-centered)).

Response to Finding No. 687:

Complaint Counsel's support for their argument is dated and the document they cite is from 2009, reflecting 2008 data. (PX00153 dated Jan. 2009). Further, regarding PX00153, Mr. Oostra testified that {

} (Oostra, Tr. 5933-5934, *in camera*). Recent data shows that ProMedica did improve its quality because fourth quarter CMS data ranked Bay Park, Flower, and TTH above St. Luke's.

(RPF 1466). Further, Dr. Reiter testified that regarding patient satisfaction scores, "in 2010 we've seen significant improvement in three ProMedica hospitals, which is Bay Park, Flower, and Toledo in the Toledo area." (PX01930 (Reiter, Dep. at 127)). For pneumonia care, Dr. Reiter testified that data through the fourth quarter of 2010 ranked St. Luke's behind ProMedica's legacy hospitals. (PX01930 (Reiter, Dep. at 157)).

688. Mr. Oostra told Mr. Wakeman that ProMedica needed to improve its quality. (Oostra, Tr. 5998-5999). Mr. Wakeman then informed the St. Luke's Board of Directors that ProMedica "acknowledges they need to improve" quality measures. (PX01030 at 018 (St. Luke's Oct. 2009 Affiliation Analysis Update), *in camera*; *see also* PX01920 at 025 (Wakeman, Dep. at 92-93), *in camera*).

Response to Finding No. 688:

Again, Complaint Counsel's support is dated and does not reflect recent improvements at ProMedica regarding quality. (RPF 1466-1467). Complaint Counsel also misstates Mr. Oostra's testimony. Mr. Oostra testified that "any [health] executive in this country ... will say they need to improve their quality." (Oostra, Tr. 5998-5999). Further, Mr. Wakeman testified that {

} (Wakeman, Tr. 2996-2997, *in camera*).

689. Following the Acquisition, executives at ProMedica admit their approach to quality is not keeping pace and "needed to catch up." (PX00527 at 001 (2011 ProMedica executives' emails); Oostra, Tr. 6015-6019). They have described their quality program as involving "too much discussion, process, pages/documents, reporting structures, committees, charts, [and] meetings." (PX00527 at 001 (2011 ProMedica executives' emails); Oostra, Tr. 6024-6025).

Response to Finding No. 689:

The proposed finding is misleading. At the same time, however, ProMedica's quality program is more robust and comprehensive than St. Luke's. (RPF 2241-2244). Further, recent

data shows that ProMedica did improve its quality, and fourth quarter CMS data ranked Bay Park, Flower, and TTH above St. Luke's. (RPF 1466). Further, Dr. Reiter testified that regarding patient satisfaction scores, "in 2010 we've seen significant improvement in three ProMedica hospitals, which is Bay Park, Flower, and Toledo in the Toledo area." (PX01930 (Reiter, Dep. at 127)). ProMedica tracks and compares the quality performance of each of its business units, and creates quality report cards to measure quality outcomes. (RPF 2243-2244).

690. Employees at ProMedica find the system's quality program to be confusing. ProMedica's Chief Medical Officer noted that "audiences after hearing quality presentations leave meetings glassy eyed and very confused" and that few employees "can fully explain the PHS approach to quality much less feel compelled to follow." (PX00527 at 001 (2011 ProMedica executives' emails); Oostra, Tr. 6025-6026).

Response to Finding No. 690:

The proposed finding is misleading. Mr. Oostra explained that Dr. Reiter was very "academic" and ProMedica needed to operationalize in the future. (Oostra, Tr. 6025). Mr. Oostra also explained that ProMedica eliminated the quality committee so that quality would be discussed directly at the board meetings because it was an important agenda item. (Oostra, Tr. 6026). Nevertheless, recent data shows that ProMedica did improve its quality, and fourth quarter CMS data ranked Bay Park, Flower, and TTH above St. Luke's. (RPF 1466). Further, Dr. Reiter testified that regarding patient satisfaction scores, "in 2010 we've seen significant improvement in three ProMedica hospitals, which is Bay Park, Flower, and Toledo in the Toledo area." (PX01930 (Reiter, Dep. at 127)).

691. Anthem has a quality scoring program that provides financial bonuses to hospitals that perform well on quality measures. (Pugliese, Tr. 1446-1447). None of ProMedica's Lucas County hospitals met the criteria needed to receive a quality bonus in 2010. (Pugliese, Tr. 1447-1448; Oostra, Tr. 6000-6003; PX02453 at 001 (Oct. 2010 email between ProMedica and Anthem)). In fact, TTH scored in the bottom 6th percentile of all hospitals reviewed by Anthem. (PX02453 at 001).

Response to Finding No. 691:

The proposed finding is misleading, because the bonus at issue refers to the 2009 scorecard year, which was distributed in 2010. ProMedica did not receive a quality bonus from Anthem for the 2009 year. (PX02453 at002 (referring to the 2009 scorecard)). Moreover, Anthem does not even offer "pay for performance" bonuses to St. Luke's. (RPF 1459).

692. Prior to the acquisition, St. Luke's had been named a "highest value hospital" by Leapfrog. No ProMedica hospitals had ever received that recognition since 2006. (Sandusky, Tr. 1310-1311).

Response to Finding No. 692:

There are varying degrees of reliability for quality metrics. (RPF 1432). Less reliable quality sources include non-profit organizations such as LeapFrog. (RPF 1435).

D. Physicians Prefer St. Luke's Quality of Care Over ProMedica's

693. Independent physicians testified that St. Luke's is a high quality facility with good quality of care and a patient-centered approach. (Read, Tr. 5294; Andreshak, Tr. 1786-1787, 1790-1791; Marlowe, Tr. 2417-2418; Gbur, Tr. 3110).

Response to Finding No. 693:

Physicians in Lucas County perceive quality to be comparable among TTH, St. Vincent, and St. Luke's. (RPF 1448).

694. A hospital's clinical staff is very crucial and important in the care of a patient. The clinical staff assists patients through the admission process, work in the operating rooms, and care for patients while they are recovering. (Andreshak, Tr. 1783-1784). A hospital's clinical staff is very important for reliability. Clinical staff, especially nurses, asses the patients and report changes to the patient's doctor. (Andreshak, Tr. 1785-1786).

Response to Finding No. 694:

Respondent has no specific response.

695. Independent physicians have found St. Luke's to have good quality clinical staff and nurses, who take pride in their work and are very involved in the care of their patients. (Andreshak, Tr. 1786; *see* Marlowe, Tr. 2409-2410). In contrast, physicians and their patients find ProMedica's Toledo Hospital to be "a lot more impersonal," with a nursing staff that patients feel do not listen to them, and are unresponsive to patient needs. (Andreshak, Tr. 1787-1788; *see also* Marlowe Tr. 2449-2450 (TTH is more "hustle and

bustle" than St. Luke's; since St. Luke's obtained access to Paramount, many of his Paramount patients have switch their birthing location from TTH to St. Luke's)).

Response to Finding No. 695:

Dr. Andreshak testified that St. Luke's has had the same quality before and after the joinder with ProMedica. (Andreshak, Tr. 1786). He also testified that ProMedica has "very well trained people . . . good caring nurses." Further, physicians in Lucas County perceive quality to be comparable among TTH, St. Vincent, and St. Luke's. (RPF 1448).

696. Continuity of care is important for patient satisfaction at a hospital. Patients prefer to have the same nurses throughout their hospital stay. This allows the nurses to develop a rapport with the patients. (Andreshak, Tr. 1784-1785; Marlowe, Tr. 2409-2410, *see* Read, Tr. 5295). Physicians have found the continuity of care of the clinical staff at St. Luke's Hospital to be excellent with the same nurses attending a patient throughout their stay. (Marlowe, Tr. 2409-2410; Andreshak, Tr. 1787, Read Tr. 5294-5295). At ProMedica's hospitals however, Dr. Andreshak testified that he would never have the same nurse due to the high turnover rates and nurses transferring between different floors. (Andreshak, Tr. 1787-1788).

Response to Finding No. 696:

Respondent has no specific response.

697. Doctors rely on a hospital's administration and nonclinical staff for scheduling. (Andreshak, Tr. 1790). It is important for a patient who is in pain and suffering to have surgery sooner rather than later. (Andreshak, Tr. 1791-1792, 1794).

Response to Finding No. 697:

Respondent has no specific response.

698. Dr. Andreshak testified that St. Luke's staff was very good about trying to make openings available for scheduling surgeries, even when they were completely booked. (Andreshak, Tr. 1790-1792). On the other hand, Dr. Andreshak had trouble scheduling surgeries at TTH. He often found that they had no scheduled surgery times available, and they were not willing to work with him to try and find a time. (Andreshak, Tr. 1793-1794).

Response to Finding No. 698:

Respondent has no specific response.

699. Block scheduling is preferable for surgeons because it allows them to do multiple surgeries in the same day at the same hospital. (Andreshak, Tr. 1792-1793). Prior to the

Acquisition, Dr. Andreshak had block days at St. Luke's. (Andreshak, Tr. 1793). At TTH, he could not get full block days, and the half-block days he could sometimes get were inefficient due to backed up surgeries. (Andreshak, Tr. 1793-1794).

Response to Finding No. 699:

Respondent has no specific response.

700. The quality of a hospital's facilities or equipment can impact patients' treatment. Surgeons require a lot of technical equipment to perform surgeries and the quality of the equipment is crucial. Dr. Andreshak found St. Luke's to have all of the specialized equipment he needed. If St. Luke's did not have something he needed, St. Luke's would try to get it for him as long as it was not outside their normal budget. (Andreshak, Tr. 1790). Dr. Gbur found the cardiac facilities at St. Luke's to be the same level of quality as those at TTH and St. Vincent's. (Gbur, Tr. 3108) Luke's inpatient rehabilitation center was high quality. Dr. Andreshak and his patients felt that they got excellent care and improved better than if they had gone to a nursing home rehab facility. (Andreshak, Tr. 1796-1797).

Response to Finding No. 700:

Respondent has no specific response.

701. St. Luke's provides all of its inpatient obstetric ("OB") services in an LDPR (labor, delivery, post-partum and recovery) setting. Patients receive all of their care in the same room from the time they are admitted to the hospital until they are discharged. (Read, Tr. 5280; Marlowe, Tr. 2407). Many patients prefer this setting because the patient is able to remain in the same room, and will not have a roommate. (Read, Tr. 5292). Remaining in the same room also means that patients will have the same nursing staff throughout their stay. (Marlowe, Tr. 2409-2410).

Response to Finding No. 701:

The joinder will not change St. Luke's inpatient obstetrical rooms, but will enable St. Luke's to increase its percentage of private rooms. (RPF 2114).

702. By contrast, The Toledo Hospital's OB ward does not have all private rooms, and patients are moved to a different room in another wing of the hospital for post-partum and recovery. (Marlowe, Tr. 2409-2410; Read, Tr. 5280).

Response to Finding No. 702:

There are no differences in quality between LDR and LDRP settings. (Read, Tr. 5281).

XIV. NEW ENTRY AND EXPANSION WILL NOT COUNTERACT OR DETER THE ANTICOMPETITIVE EFFECTS OF THE ACQUISITION

A. Entry or Expansion Will Not Be Timely, Likely, or Sufficient

1. Entry Will Not Be Timely

703. It would take significantly longer than the two-year timeframe prescribed by the *Merger Guidelines* to plan, obtain zoning, licensing, and regulatory permits, and construct a new hospital in Lucas County. ProMedica's CEO Randall Oostra testified that building even a small hospital the size of Bay Park – which has approximately 80 staffed beds and is far smaller than St. Luke's – would be a "several-year project." (PX01906 at 024 (Oostra, IHT at 92-93), *in camera*).

Response to Finding No. 703:

Respondent has no specific response.

704. ProMedica's CEO testified that Wildwood Medical Center, ProMedica's new 36-bed orthopedic and spine hospital, took one or two years to plan and 18 months to construct. (Oostra, Tr. 5779-5782).

Response to Finding No. 704:

Respondent has no specific response.

705. Scott Rupley, St. Luke's' Marketing and Planning Director, testified that it would take "at least two to three years" to plan and open a new hospital. (PX01937 at 042 (Rupley, Dep. at 160), *in camera*).

Response to Finding No. 705:

Mr. Rupely first testified that he did not know how long it would take to open a new hospital. When pressed and following an objection by Mr. Rupely's counsel, Mr. Rupely guessed two to three years. (PX01937 (Rupely, Dep. at 160)).

706. Mercy's Vice President for Business Development and Advocacy, Scott Shook, testified that it took Mercy about four and a half years to develop St. Anne, a hospital with approximately 74 beds, from the "very beginning of planning to the opening" of the hospital. (Shook, Tr. 962). Construction alone took approximately 20 months. (Shook, Tr. 962).

Response to Finding No. 706:

Respondent has no specific response.

707. Mr. Shook noted that hospitals are "highly regulated" and there are significant licensing and regulatory requirements entailed in opening a new hospital. (Shook, Tr. 963).

Response to Finding No. 707:

Ohio does not have certificate of need ("CON") requirements for building a new hospital.

(RPF 1156).

708. Constructing a new obstetrics unit and encouraging a sufficient number of obstetricians to utilize and support it would take a substantial amount of time as well. Mercy's Scott Shook testified that it would be very challenging to encourage obstetricians to utilize a new unit since most obstetricians tend to deliver at the hospital that employs them, and it is difficult to recruit new obstetricians. (PX02068 at 005 (¶¶ 20, 21) (Shook, Decl.), *in camera*).

Response to Finding No. 708:

Respondent has no specific response.

2. Entry Is Not Likely to Occur

a. It is Unlikely That Any Firms Will Open a New Hospital in Lucas County

709. The *Merger Guidelines* explain that for entry to be considered likely, it must be a profitable endeavor, in light of the associated costs and risks. (PX02214 at 032 (§ 9.2) (*Merger Guidelines*)). Constructing a new hospital requires an extraordinarily large, up-front capital investment, and the pay-off is risky and deferred into the future, which makes it highly unlikely that a new hospital competitor will enter the Lucas County hospital market. (PX02148 at 091 (¶ 167) (Town Expert Report), *in camera*).

Response to Finding No. 709:

The first sentence of the proposed finding is not a fact, but improper legal argument. It is unlikely that any firms will open a new hospital in Lucas County in the future because there is already excess inpatient bed capacity. (RPF 1231-1235). One competitor hospital noted that {

}

(RPF 1152, *in camera*). 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. (RPF 1229). For example, a competitor hospital has determined that {

}. (RPF 1169, *in camera*). This competitor believes that {

} (RPF 1164, *in camera*, 1165, 1166-1167, *in camera*).

Rather than building new inpatient facilities, competitor hospitals in Toledo are responding to the joinder by {

}. (RPF 1169-1173, *in camera*, 1175, *in camera*, 1189, 1190-1203).

710. It would cost a substantial amount of money to construct even a basic 35-bed general acute-care hospital in Lucas County. Scott Shook of Mercy testified that it would require at least $55 million in up-front, initial capital to build this type of basic general-acute care hospital. (PX02068 at 006-007 (¶¶ 25, 26) (Shook, Decl.), *in camera*). By comparison, Mercy spent $75 million on the building and equipment costs to construct 74-bed St. Anne in 2002, even though much of the equipment did not have to be purchased because Riverside Hospital's equipment was transferred to St. Anne. (Shook, Tr. 900, 960-962). Mercy spent an additional $2.6 to 3 million to purchase the land for St. Anne. (Shook, Tr. 961). Today, it would cost even more to build a hospital comparable to St. Anne. (Shook, Tr. 962).

Response to Finding No. 710:

Respondent has no specific response.

711. ProMedica's CEO Randall Oostra testified that it would cost $350 million or more in today's market to build a hospital with 300 licensed beds similar to St. Luke's. (PX01906 at 023 (Oostra, IHT at 86), *in camera*; *see* PX01937 at 041 (Rupley, Dep. at 157), *in camera* (to build a new, competitive hospital in Lucas County would cost $100 million)).

Response to Finding No. 711:

Respondent has no specific response.

712. ProMedica admits that building a new hospital, even assuming the entity already owns the land upon which the hospital will be built, could cost millions of dollars. (Response to RFA at ¶ 19). In particular, ProMedica admits that building a new Lucas County hospital with 300 or more licensed beds would cost millions of dollars, even for an entity

that already owns the land upon which to build a hospital. (Joint Stipulations of Law and Fact, JX00002A ¶ 10).

Response to Finding No. 712:

Respondent has no specific response.

713. It is generally understood that it costs approximately $1 million per bed for a new inpatient hospital. (Oostra, Tr. 5899, *in camera*; Nolan, Tr. 6261). In addition, ProMedica's CEO testified that costs have "gone up dramatically" and "continue to go up." (Oostra, Tr. 5899-5900, *in camera*).

Response to Finding No. 713:

Respondent has no specific response.

714. Charles Kanthak, St. Luke's' Facilities Services Director, estimated that to build a new hospital identical to St. Luke's in northwest Ohio in 2009 would cost $165 million "on the cheap" and over $200 million to "do it right." (PX01257 at 001 (Oct. 2009 email describing St. Luke's' buildings and departments and estimating how much it would cost to build a "replacement" St. Luke's in 2009)).

Response to Finding No. 714:

Respondent has no specific response.

715. Although ProMedica purchased land in southwest Lucas County around 2000, ProMedica's CEO, Randall Oostra, testified that ProMedica does not have any current plans to build a hospital on that land, better known as the Arrowhead property. (Oostra, Tr. 5897-5898, 5901-5902, *in camera*). After ten years, ProMedica has not constructed any new buildings on Arrowhead. (Oostra, Tr. 5900, *in camera*).

Response to Finding No. 715:

Respondent has no specific response.

716. Although ProMedica anticipated developing Arrowhead, it had difficulty obtaining debt financing so it froze its capital and "pulled the project back." (Oostra, Tr. 5900-5901). Even up through 2009, one year before ProMedica decided to acquire St. Luke's, plans for developing Arrowhead did not even pass ProMedica's Finance Committee's initial screening process due to "limited capital and higher priorities." (Response to IROG at ¶ 10).

Response to Finding No. 716:

Respondent has no specific response.

717. ProMedica admitted that its 2010-2012 Strategic Plan does not contemplate or even mention the construction of a new general acute care hospital on ProMedica's Arrowhead property. (Joint Stipulations of Law and Fact, JX00002A ¶ 49).

Response to Finding No. 717:

ProMedica admitted that construction on the Arrowhead land "did not appear" on its 2010-2012 Strategic Plan. (JX00002A ¶ 49). However, the Arrowhead expansion did appear on ProMedica's 2009-2011 Strategic Plan. (PX00324 at007, *in camera*).

718. Access to necessary capital is a significant barrier to entry for the vast majority of potential entrants to Lucas County. (PX02148 at 091 (¶ 167) (Town Expert Report), *in camera*).

Response to Finding No. 718:

Respondent has no specific response.

719. Current economic conditions make it particularly challenging to obtain the necessary capital to undertake significant hospital expansions or to construct a new hospital in Lucas County. ProMedica's CEO, Randall Oostra, testified that hospital systems across the country, including ProMedica, have had difficulty obtaining debt financing and have had to pull back on capital projects. (Oostra, Tr. 5900-5901, *in camera*).

Response to Finding No. 719:

Respondent has no specific response.

720. David Dewey, St. Luke's VP of Business Development, testified that "it would be more difficult to get [] capital" and establish a new hospital in today's economic environment. (PX01909 at 045 (Dewey, IHT at 174), *in camera*).

Response to Finding No. 720:

Respondent has no specific response.

721. A 2009 presentation created by St. Luke's senior executives and presented to St. Luke's Board explains how the tight capital markets have made new hospital construction or expansion in Toledo highly unlikely: "ProMedica and Mercy do not want to build in the [southwest] area due to lack of capital access. Also, both have taken on large amounts of debt due to recent major construction projects. [UTMC does] not want to build either." (PX01018 at 006, *in camera*) (St. Luke's presentation: Options for St. Luke's).

Response to Finding No. 721:

The proposed finding is inaccurate and misleading. During internal deliberations in the fall of 2009 about which affiliation partner to select, St. Luke's believed that an affiliation with *either* ProMedica or Mercy would lead to the other building a new hospital facility near St. Luke's. (PX01030 at 021, *in camera*). Regardless, there is already excess inpatient bed capacity in Lucas County. (RPF 1231-1235). One competitor hospital noted that {

} (RPF 1152, *in camera*). 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. (RPF 1229). For example, a competitor hospital has determined that {

}. (RPF 1169, *in camera*). This competitor believes that {

} (RPF 1164, *in camera*, 1165, 1166-1167, *in camera*). Rather than building new inpatient facilities, competitor hospitals in Toledo are responding to the joinder by

{

}. (RPF 1169-1173, *in camera*, 1175, *in camera*, 1189, 1190-1203).

722. In his May 2009 planning notes, Scott Rupley, St. Luke's Marketing and Planning Director, declared, "Nobody is going to be able to build anything for awhile. Can't borrow money." (PX01120 at 002 (Scott Rupley notes from Apr. 25 Planning Summit Follow-Up with Nolan)).

Response to Finding No. 722:

The proposed finding is inaccurate and misleading. During internal deliberations in the fall of 2009 about which affiliation partner to select, St. Luke's believed that an affiliation with

either ProMedica or Mercy would lead to the other building a new hospital facility near St. Luke's. (PX01030 at 021, *in camera*).

723. Ronald Wachsman, ProMedica's Senior Vice President of Managed Care, Reimbursement, and Revenue Cycle Management, testified that "[i]n a healthcare system, a high percentage of the costs are fixed costs." (Wachsman, Tr. 5127). These high fixed costs make it financially challenging to operate and maintain a hospital.

Response to Finding No. 723:

The second sentence of the proposed finding is not a fact, but an improper argument, and violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record.

724. The fact that Lucas County already has ample general acute-care inpatient beds to fulfill the needs of the community makes entry or expansion even more unlikely. ProMedica's economic expert, Margaret Guerin-Calvert, testified that "the Toledo market as a whole has excess capacity." (Guerin-Calvert, Tr. 7766).

Response to Finding No. 724:

Respondent has no specific response.

725. St. Luke's David Dewey testified that "there is enough [hospital service] capacity" in "northwest Ohio as a whole." (PX01909 at 045-046 (Dewey, IHT at 176-177), *in camera*).

Response to Finding No. 725:

Respondent has no specific response.

726. Mercy's Scott Shook testified that there is an "excess" of inpatient beds among hospitals in the Toledo area. (Shook, Tr. 1040-1041).

Response to Finding No. 726:

Respondent has no specific response.

727. Lucas County's population currently is flat or declining, making it economically unattractive to add more hospital beds. ProMedica's CEO, Randall Oostra, testified that the metropolitan Toledo market is "declining at about 0.2 percent per year in total." (Oostra, Tr. 6275). Mr. Oostra stated that the number of people being admitted to a hospital in the metropolitan area has been "flat to actually slightly declining over the past years" and he "expect[s] that decline to continue into the future." (Oostra, Tr. 6287).

Response to Finding No. 727:

The first sentence of the proposed finding violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record.

728. Navigant Consulting's Managing Director, Kevin Nolan, testified to this same fact and included it in Navigant Consulting's executive summary of its January 2011 clinical integration strategy final report to ProMedica. (Nolan, Tr. 6371, *in camera*; PX02386 at 007, *in camera* (Navigant Presentation).

Response to Finding No. 728:

Respondent has no specific response.

729. St. Luke's CEO, Dan Wakeman, testified that "the general metropolitan Toledo area has seen a population decline in the last ten years." (PX01911 at 015 (Wakeman, IHT at 54), *in camera*).

Response to Finding No. 729:

Respondent has no specific response.

730. ProMedica's documents also project a flat or declining population for Lucas County. ProMedica's 2010 Environmental Assessment states that "Overall demographics indicate little or no growth for [the] next five years." (PX00159 at 005, *in camera* (ProMedica 2010 Environmental Assessment)). One of the key assumptions in ProMedica's Strategic Plan for 2009 through 2011 is "flat demographics overall." (PX00324 at 005, *in camera* (Overview of PHS Strategic Plan 2009-2011 presentation).

Response to Finding No. 730:

Respondent has no specific response.

731. Scott Shook agreed that the greater Toledo area's "total population is declining -- stagnant to declining," aging, and not forecast to grow. (Shook, Tr. 1040).

Response to Finding No. 731:

Respondent has no specific response.

b. It is Unlikely That Any Firms Will Open a New Obstetrics Unit in Lucas County

732. Obstetrics is a very costly service for a hospital to provide. (Shook, Tr. 956).

Response to Finding No. 732:

Respondent has no specific response.

733. A potential entrant into the Lucas County obstetrics services market would face significant costs and risks associated with constructing and operating a new obstetrics unit, thus making it highly unlikely that such entry or expansion will occur. Mercy's Scott Shook testified that it would be very expensive for a hospital without an obstetrics unit to add one, even if it already had existing space available to build an obstetrics unit. (Shook, Tr. 957).

Response to Finding No. 733:

Respondent has no specific response.

734. Mr. Shook estimated that establishing a new, financially viable labor-and-delivery unit inside a hospital's existing space would cost at least $10 to $12.6 million. (PX02068 at 005 (¶ 20) (Shook, Decl.), *in camera*).

Response to Finding No. 734:

Respondent has no specific response.

735. Dr. Jeffrey Gold, Chancellor and Executive Vice President for Biosciences and Health Affairs for the University of Toledo, with management responsibilities for UTMC, testified that if a hospital wanted to manage high-risk births, it would be necessary to build both an obstetrics unit and a neonatal intensive care unit ("NICU"), as well as ensure that there is sufficient call coverage and emergency department capacity, at a cost of tens of millions of dollars. (Gold, Tr. 222; PX02064 at 003 (¶ 10) (Gold, Decl.)).

Response to Finding No. 735:

It requires less resources for a hospital to offer low-risk obstetrics services, like St. Luke's, compared to offering a full-service obstetrics program capable of treating high-risk patients. (Gold, Tr. 336-337).

736. Determining how many deliveries a hospital must perform per year to break even financially is "dependent upon the hospital and its cost structure and whether or not they have inpatient obstetricians and for how many hours coverage per day, et cetera, so there's varying factors that would go into that." (Shook, Tr. 1047).

Response to Finding No. 736:

Respondent has no specific response.

737. Licensing restrictions limit how and where an obstetrics unit can be situated within a hospital in Lucas County. Obstetrics units must be separated from other sections of the hospital to limit the spread of infections to or from newborns. (Shook, Tr. 956).

Response to Finding No. 737:

Respondent has no specific response.

738. In addition to high construction costs, obstetrics units have "high fixed costs" of operation and are expensive to maintain. (Shook, Tr. 956).

Response to Finding No. 738:

Respondent has no specific response.

739. Mr. Shook testified that Toledo-area hospitals with a Level II or Level III perinatal referral center are required by law to have an in-house obstetrician and an in-house anesthesiologist to provide continuous obstetrical coverage, which are two "extremely expensive" resources, especially when comparing the "cost on a per-case basis versus what are the payments." (Shook, Tr. 956-957).

Response to Finding No. 739:

Respondent has no specific response.

740. Mr. Shook also noted that since no one knows when a baby will arrive, a "cadre of nurses" must be available at all times in an obstetrics unit to assist with deliveries. (Shook, Tr. 956).

Response to Finding No. 740:

Respondent has no specific response.

741. Obstetrics services typically do not generate sufficient revenue to cover their costs, making it economically undesirable to expand or build an obstetrics unit. (Shook, Tr. 1141). Mr. Shook of Mercy stated that it is extremely challenging to maintain a financially viable obstetrics unit. (Shook, Tr. 1046).

Response to Finding No. 741:

Respondent has no specific response.

742. Mr. Shook testified that it is common for a hospital to lose money on its obstetrics services. (Shook, Tr. 1141). Mr. Shook noted that this is particularly true for "normal vaginal deliveries, [in which hospitals] get paid very little in relationship to the cost." (Shook, Tr. 957).

Response to Finding No. 742:

Respondent has no specific response.

743. David Dewey, St. Luke's Vice President of Business Development, testified that St. Luke's obstetrics unit "does not financially cover its costs." (PX01909 at 062 (Dewey, IHT at 243), *in camera*).

Response to Finding No. 743:

Respondent has no specific response.

744. Mr. Shook affirmed that "[o]bstetrics is often a money-loser for hospitals because payments tend to be low, but expenses are high." (PX02068 at 004 (¶ 19) (Shook, Decl.), *in camera*).

Response to Finding No. 744:

Respondent has no specific response.

745. UTMC's Dr. Gold also testified that it is difficult to operate a profitable labor-and-delivery unit. (PX02064 at 003 (¶ 10) (Gold, Decl.)).

Response to Finding No. 745:

Respondent has no specific response.

746. The decline in the overall birthrate over the last decade in Lucas County makes entry or expansion into obstetrics particularly unappealing. St. Luke's David Dewey, testified that "[t]he overall OB business in northwest Ohio is going down." (PX01909 at 044 (Dewey, IHT at 171), *in camera*).

Response to Finding No. 746:

Respondent has no specific response.

747. The Project Director of ProMedica's Regional Perinatal Center Program sent an email in September 2010 that provided the statistics for total deliveries in Lucas County, noting that deliveries decreased from 2000 through 2009 and explained that this downward trend has continued through June 2010. (PX01107 at 001) (ProMedica email with subject line "2010 mo delivery count – Lucas Co").

Response to Finding No. 747:

Respondent has no specific response.

748. Mercy's Scott Shook testified that "[t]here has been in Lucas County a decrease in the number of deliveries over the years ... regardless of facility." (Shook, Tr. 958).

Response to Finding No. 748:

Respondent has no specific response.

749. Scott Shook stated that Mercy discontinued obstetrics services at St. Anne around 2007 or 2008 because St. Anne experienced a "significant decrease" in the volume of its deliveries. (Shook, Tr. 958).

Response to Finding No. 749:

Respondent has no specific response.

750. Navigant Consulting's Managing Director, Kevin Nolan, testified that the metropolitan Toledo market's "obstetric population, women 18 to 44, is declining." (Nolan, Tr. 6275, *in camera*). Mr. Nolan also testified that the number of women of child-bearing age in the Toledo metropolitan area is "projected to decline over the next five to ten years consistently" meaning "less babies being born" and contracted obstetrics volume. (Nolan, Tr. 6304-6305, *in camera*).

Response to Finding No. 750:

Respondent has no specific response.

3. Entry Will Not Be Sufficient to Deter or Counteract the Harm that Will Result From the Acquisition

751. Under the *Merger Guidelines*, for entry or expansion to be sufficient, it must replace at least the scale and strength of one of the merging firms in order to replace the lost competition from the merger or acquisition. (PX02214 at 032 (§ 9.3) (*Merger Guidelines*)).

Response to Finding No. 751:

The proposed finding is not a fact, but an improper legal argument.

752. Here, any entry that does occur will not be sufficient under the *Merger Guidelines,* for many of the same reasons that entry is unlikely in the first place. Due to the time and significant expense it takes to become established in the market and earn a sufficient return on investment, an entrant would have a difficult time competing successfully in the market and replacing the competition eliminated from the Acquisition. (PX02148 at 091 (¶ 167) (Town Expert Report), *in camera*).

Response to Finding No. 752:

The first sentence of the proposed finding is not a fact, but an improper legal argument and violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record.

753. Establishing a new hospital, let alone obtaining sufficient market share to earn a sufficient return on investment, is challenging. David Dewey, St. Luke's' Vice President of Business Development, testified that if another hospital entered Lucas County, it "would have to establish its own market share. It would have to hire its own staff, get its own medical staff support," all of which he stated would be difficult because of the tight capital markets. (PX01909 at 045 (Dewey, IHT at 174), *in camera*).

Response to Finding No. 753:

The first sentence of the proposed finding is not a fact, but an improper legal argument and violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record. The proposed finding is also misleading because Mr. Dewey testified that he did not know how feasibly or not a new hospital could "establish its own market share," "hire its own staff," and "get its own medical staff support." Mr. Dewey nowhere stated that this would be "challenging." (PX01909 (Dewey, IHT at 174), *in camera*).

754. A new entrant also would have a difficult time establishing an obstetrics unit that would sufficiently replace the competition eliminated by the Acquisition. Mercy's Vice President, Scott Shook, stated that "[t]oday, it would take a substantial monetary commitment to construct a birthing center and hire a sufficient number of obstetricians to generate enough deliveries to break even." (PX02068 at 005 (¶ 23) (Shook, Decl.), *in camera*).

Response to Finding No. 754:

Respondent has no specific response.

755. Mr. Shook also testified: "One of the most significant difficulties with creating a financially viable obstetrics unit is the ability to encourage obstetricians to utilize the new unit." (PX02068 at 005 (¶ 21) (Shook, Decl.), *in camera*).

Response to Finding No. 755:

Respondent has no specific response.

756. Mr. Shook noted that, in Lucas County, "many obstetricians are employed by ProMedica, which instructs its obstetricians to direct expectant mothers to use ProMedica hospitals," making it difficult for another hospital to gain market share. (PX02068 at 004 (¶ 19) (Shook, Decl.), *in camera*). Therefore, any new obstetrics entry is highly unlikely to be sufficient to restore the competition eliminated by the Acquisition.

Response to Finding No. 756:

The joinder does not eliminate competition for high-risk obstetrics services because there have always been only two providers of high-risk obstetrics services – Mercy and ProMedica. (RPF 1022). Moreover, Mr. Shook testified that the Toledo area has more than enough obstetricians to meet the community's needs. (Shook, Tr. 1046).

B. Out-of-Market Firms are Reluctant to Enter the Toledo Market

757. In 2009, St. Luke's executives communicated to the St. Luke's Board that hospital systems outside of Toledo "have shown reluctance of entering" the Toledo market. (PX01016 at 024, *in camera* (St. Luke's Hospital Board Meeting Affiliation Update presentation, Dec. 15, 2009)).

Response to Finding No. 757:

Respondent has no specific response.

C. No Planned Entry or Expansion is Contemplated by Out-of-Market Firms

758. Hospitals outside of Lucas County have no plans to build a new hospital in Lucas County. Stanley Korducki, Wood County Hospital's ("WCH") CEO, testified that WCH has no current plans to build a new hospital because WCH has "enough capacity to serve [its] people" and there is no need to invest resources in a new hospital. (Korducki, Tr. 526).

Response to Finding No. 758:

Respondent has no specific response.

759. Mr. Korducki testified that WCH is not planning on adding any inpatient services. (Korducki, Tr. 519).

Response to Finding No. 759:

Respondent has no specific response.

760. Mr. Korducki noted that WCH has no plans to expand the hospital in response to ProMedica's acquisition of St. Luke's because WCH is focused on taking care of its own community's needs. (Korducki, Tr. 525-526).

Response to Finding No. 760:

The proposed finding is misleading because WCH completed a 100,000 square expansion, 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 in February 2010. (RPF 206). The expansion also enabled WCH to convert all of its patient rooms to private rooms (RPF 207). Moreover, this expansion is part of a larger renovation project that WCH estimates will cost $42 million and take at least four years to complete. (RFP 208).

761. Fulton County Health Center's ("FCHC") CEO, E. Dean Beck, similarly testified that FCHC has no plans to expand by building a new hospital in Lucas County because "[t]here are a sufficient number of hospitals in Lucas County." (Beck, Tr. 410).

Response to Finding No. 761:

Respondent has no specific response.

762. Mr. Beck stated that FCHC does the best job it can to service Fulton County patients and meet their needs and expectations. (Beck, Tr. 410).

Response to Finding No. 762:

Respondent has no specific response.

763. Mr. Beck explained that FCHC has never changed its service offerings to competitively respond to any of the Lucas County hospitals because FCHC does not "try and compete with them." (Beck, Tr. 410).

Response to Finding No. 763:

Respondent has no specific response.

764. Mr. Beck stated that FCHC has no plans to increase its number of inpatient beds and does not plan to do so in response to ProMedica's acquisition of St. Luke's. (Beck, Tr. 409). In fact, as a critical access hospital, FCHC is limited by law to 25 inpatient beds, and FCHC already has the maximum allowable beds by law. (Beck, Tr. 409).

Response to Finding No. 764:

Respondent has no specific response.

765. David Dewey, St. Luke's Vice President of Business Development, testified that he was unaware of any potential hospital entry or expansion in Lucas County. (PX01909 at 040 (Dewey, IHT at 156), *in camera*).

Response to Finding No. 765:

Respondent has no specific response.

766. Scott Rupley, St. Luke's Marketing and Planning Director, also testified that he was unaware of any hospital or hospital system outside of Lucas County attempting to establish a hospital in Lucas County. (PX01937 at 041 (Rupley, Dep. at 155), *in camera*).

Response to Finding No. 766:

Respondent has no specific response.

D. No Planned Expansion is Contemplated by Existing Lucas County Hospitals

767. Neither Mercy nor UTMC has plans to construct a new hospital in Lucas County. Around 2004 or 2005, Mercy purchased land in Monclova, in southwest Lucas County, and considered building a "small, 34-bed general medical-surgical facility" in a 50-50 joint venture with physicians. The hospital would have provided limited general medical/surgical care, but would not have offered services such as an intensive care unit. (Shook, Tr. 963-965).

Response to Finding No. 767:

In furtherance of this plan, Mercy had architectural line drawings completed for the potential facility and also sought and received zoning approval for the project. (RPF 1161-1162). Regardless, during internal deliberations in the fall of 2009 about which affiliation partner to select, St. Luke's believed that an affiliation with *either* ProMedica or Mercy would lead to the other building a new hospital facility near St. Luke's. (PX01030 at 021, *in camera*). ProMedica also believes that Mercy will move forward with its plans to build a new hospital in Monclova. (RPF 1174).

768. Scott Shook, Mercy's Vice President, testified that Mercy has "scrapped" its plans to construct a hospital on its Monclova property. (Shook, Tr. 964). One primary reason Mercy will not build a hospital in Monclova is because the new healthcare reform laws

preclude physicians from having a new ownership interest in a hospital. In addition, there has been a "significant decline in the hospital population over the last two decades," and Mercy does not believe that it would be "a good business decision to invest in that very high-cost fixed asset." (Shook, Tr. 966-967). As a result, Mercy has no current plans to construct a new inpatient hospital in the greater Toledo area. (Shook, Tr. 968).

Response to Finding No. 768:

During internal deliberations in the fall of 2009 about which affiliation partner to select, St. Luke's believed that an affiliation with *either* ProMedica or Mercy would lead to the other building a new hospital facility near St. Luke's. (PX01030 at 021, *in camera*). ProMedica also believes that Mercy will move forward with its plans to build a new hospital in Monclova. (RPF 1174). In any event, Mercy also believed that {

} (RPF 1164, *in camera*). Mercy also recognized that {

}

(RPF 1167, *in camera*).

769. Even if ProMedica's acquisition of St. Luke's is blessed, Mercy would not competitively respond by building a new inpatient hospital in the greater Toledo area. (Shook, Tr. 968).

Response to Finding No. 769:

That is because {

} (RPF 1169, *in camera*).

However, Mercy does have a {

} (RPF 1175, *in camera*). Mercy {

} (RPF 1177, *in camera*). In pursuance of this plan, Mercy is currently {

} (RPF 1178-1179, *in camera*).

Regardless, during internal deliberations in the fall of 2009 about which affiliation partner to select, St. Luke's believed that an affiliation with *either* ProMedica or Mercy would lead to the other building a new hospital facility near St. Luke's. (PX01030 at 021, *in camera*). ProMedica also believes that Mercy will move forward with its plans to build a new hospital in Monclova. (RPF 1174).

770. Similarly, UTMC's Dr. Jeffrey Gold testified that UTMC does not have any current plans to build a new hospital in or near Lucas County. (Gold, Tr. 223).

Response to Finding No. 770:

UTMC recently competed a number of renovations, expanded its facilities, and engaged in outreach activity, which is a means of entry or expansion and offers a competitive constraint against ProMedica. (RPF 1190). For example, UTMC has outreach clinics located in Lucas County and outside Lucas County in Perrysburg. (RPF 1191-1193). UTMC hopes that patients that visit its outreach clinics will seek inpatient care from UTMC in the future. (RPF 1196). UTMC's board recently approved a $25 million expenditure for private room conversion, implementation of electronic medical records, improvement of outpatient care, and construction of a cancer center. (RPF 1197).

771. Dr. Gold also testified that UTMC has no current plans to increase capacity for general acute-care inpatient services, not even in response to ProMedica's acquisition of St. Luke's. (Gold, Tr. 223-224).

Response to Finding No. 771:

UTMC's board recently approved a $25 million expenditure for private room conversion, implementation of electronic medical records, improvement of outpatient care, and construction of a cancer center. (RPF 1197). In addition, UTMC recently 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. (RPF 1200). Prior to that, UTMC had completed inpatient and outpatient modernization that renovated spaces for heart and vascular services and renovated space for outpatient orthopedics, at a cost of about $5.8 million. (RPF 1202).

772. Mercy has no plans to expand, and UTMC has no plans to offer, obstetrics services in Lucas County, even if rates for obstetrics services rose by a significant amount as a result of the Acquisition. Mercy's Scott Shook testified that it is "highly unlikely" that Mercy will reinstitute obstetrics services at St. Anne because Mercy is "using the space. Currently, [Mercy has] relocated some other services to the obstetrical area." (Shook, Tr. 958-959).

Response to Finding No. 772:

Respondent has no specific response.

773. Even if Mercy wanted to reconfigure beds at its Lucas County hospitals for obstetrical use, Mr. Shook testified that it would "take some effort to open them up." (Shook, Tr. 1042-1043). Mr. Shook explained that Mercy does not let "space sit idly by" and the space is not "just sitting there being mothballed." (Shook, Tr. 1042-1043).

Response to Finding No. 773:

Respondent has no specific response.

774. Increasing the number of obstetrics beds also would require additional nurses and other employees to staff the beds. (Shook, Tr. 1042-1043). Therefore, Mr. Shook testified that it is unlikely that Mercy will expand obstetrics services in Lucas County at any point in the near future. (Shook, Tr. 959).

Response to Finding No. 774:

Respondent has no specific response.

775. Mercy has no plans to build a new obstetrics unit from scratch in the near future. (Shook, Tr. 960).

Response to Finding No. 775:

Respondent has no specific response.

776. Even if prices for obstetrics services rose by some small but significant amount, it would not induce Mercy to offer any new obstetrics services in Lucas County. (Shook, Tr. 960).

Response to Finding No. 776:

Respondent has no specific response.

777. UTMC has never offered inpatient obstetrics services and has no current plans to do so. (Gold, Tr. 220). Neither the University of Toledo nor UTMC has even held any meetings about nor budgeted any money toward offering obstetrics services at its hospital. (Gold, Tr. 220-221).

Response to Finding No. 777:

[illegible]ing low-risk obstetrics would require far less resources than a full-service obstetrics pro[illegible]m capab[illegible] of treating high-risk patients. (Gold, Tr. 336-337).

778. [illegible]old also testified that "it is highly unlikely that UTMC will build a new [illegible]elivery unit in the greater Toledo area in the next few years, if ever" even if [illegible] obs[illegible]etrics services increased by "10 to 15 percent." (PX02064 at 003 (¶ 10) [illegible]).

[illegible]se to [illegible] No. 778:

[illegible]ng low-risk obstetrics would require far less resources than a full-service obstetrics p[illegible]m capable of treating high-risk patients. (Gold, Tr. 336-337).

XV. THE ACQUISITION PRODUCES NO CREDIBLE MERGER-SPECIFIC EFFICIENCIES TO REBUT THE PRESUMPTION OF COMPETITIVE HARM

779. The *Horizontal Merger Guidelines* ("*Merger Guidelines*") provide a framework within which to assess the efficiencies that Respondent alleges may result from the Acquisition. (PX02214 at 032-034 (§ 10) (Merger Guidelines)). The *Merger Guidelines* place the burden on Respondent to substantiate their efficiency claims. (PX02214 at 032-034 (§ 10) (*Merger Guidelines*)). With a very strong presumption of competitive harm and voluminous evidence strengthening the presumption, this Acquisition would have to result in extraordinary efficiencies to offset the competitive harm. (*See* Complaint Counsel's Proposed Conclusions of Law Section XX.H.2).

Response to Finding No. 779:

The proposed finding is not a fact, but an improper legal argument.

780. The efficiencies alleged by Respondent here fall far short. The alleged efficiencies are not actual cognizable efficiencies, are not merger-specific, or are speculative and unsubstantiated. (Dagen, Tr. 3247; PX02147 at 007-008 (¶ 17) (Dagen Expert Report)). Some of the alleged savings stem from increasing the prices that consumers pay, while others fail to take into account a negative impact on quality of care and patient convenience. All of the asserted efficiency claims appear to have been developed for the purposes of litigation.

Response to Finding No. 780:

The proposed finding is not a fact, but an improper legal argument. The proposed finding also violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record.

A. Respondent Has Not Come Close to Meeting its Burden of Substantiating its Own Efficiency Claims

781. The *Merger Guidelines* put the burden on "*the merging firms* to substantiate efficiency claims." (PX02214 at 032-034 (§ 10) (*Merger Guidelines*) (emphasis added)).

Response to Finding No. 781:

The proposed finding is not a fact, but an improper legal argument.

782. A key fact witness that Respondent relies upon to substantiate its efficiencies claims, Gary Akenberger, never testified live in this court. Mr. Akenberger, ProMedica's Senior Vice President of Finance, submitted an affidavit that discussed Respondent's alleged efficiencies. (PX02104 (Akenberger, Decl.), *in camera*; PX02105 (Exhibits to Akenberger, Decl.), *in camera*).

Response to Finding No. 782:

Respondent has no specific response.

783. During his deposition, Mr. Akenberger described himself as the lead individual responsible for the financial analysis, substantiation, and verification of Respondent's alleged efficiencies. (PX01931 at 025, 026 (Akenberger, Dep. at 93, 100), *in camera*). He stated that he reviewed every individual efficiency claim. (PX01931 at 028 (Akenberger, Dep. at 105), *in camera*). Kathleen Hanley, ProMedica's CFO, testified in court that Mr. Akenberger was one of the key employees familiar with the specifics and details of ProMedica's efficiencies analysis. (Hanley, Tr. 4729, *in camera*).

Response to Finding No. 783:

Mr. Akenberger testified that, to the extent an efficiency required financial substantiation, he was responsible for the financial analysis and that either he or members of his staff reviewed the documentation to make sure it was appropriate. (PX01931 (Akenberger, Dep. at 93, 100)).

784. Neither of Respondent's expert witnesses conducted any analyses or offered any opinions on whether Respondent's alleged efficiencies are cognizable under the *Merger Guidelines*. Ms. Guerin-Calvert testified that she has not conducted an efficiencies analysis. (Guerin-Calvert, Tr. 7580; PX01925 at 013 (Guerin-Calvert, Dep. at 42)).

Response to Finding No. 784:

Respondent has no specific response.

785. Mr. Den Uyl testified that he did not analyze Respondent's claimed efficiencies to determine whether they are cognizable under the *Merger Guidelines*. (Den Uyl, Tr. 6515). For instance, Mr. Den Uyl did not analyze whether Respondent's alleged efficiencies are merger-specific, and he has no expert opinion on the issue. (Den Uyl, Tr. 6515). Mr. Den Uyl testified that he would be qualified to conduct an efficiencies analysis in this case – if he were asked to do so – because he has conducted such analyses in numerous other cases, including cases involving hospital mergers. (Den Uyl, Tr. 6515-6516). However, he was not even asked to conduct such an analysis in this case. (Den Uyl, Tr. 6516).

Response to Finding No. 785:

Respondent has no specific response.

786. Gabriel Dagen, Complaint Counsel's expert, is the only expert witness in this case who conducted an analysis of the efficiencies alleged by Respondent. Mr. Dagen is the only expert witness in this case who presented an expert opinion on whether Respondent's alleged efficiencies are cognizable under the *Merger Guidelines*. (*See* Dagen, Tr. 3245, *in camera*). For example, Mr. Dagen is the only expert witness in this case who analyzed each of the alleged efficiencies to determine whether they are merger-specific. (*See* Dagen, Tr. 3245, *in camera*).

Response to Finding No. 786:

Respondent has no specific response.

B. The Asserted Efficiencies Are Not Credible

787. The May 6, 2010 "Efficiencies Analysis of the Proposed Joinder of ProMedica Health System and OhioCare Health System" ("Compass Lexecon Report") is a summary of the efficiencies analysis that was prepared by ProMedica management and the economic consulting firm Compass Lexecon. (PX00020 at 001-039 (Compass Lexecon Report), *in*

camera; PX02104 at 002 (¶ 5) (Akenberger, Decl.), *in camera*; PX01906 at 075 (Oostra, IHT at 293), *in camera*).

Response to Finding No. 787:

The May 6, 2010 Compass Lexecon Report is not the most recent summary of ProMedica's and St. Luke's efficiencies analysis. Mr. Akenberger's December 23, 2010 declaration is a more recent summary of efficiencies. (PX02104, *in camera*).

788. The proposed efficiencies contained in the Compass Lexecon Report represent an "initial plan." (Oostra, Tr. 6148 ("first plan"); PX01906 at 074 (Oostra, IHT at 291), *in camera* ("initial plan")). Mr. Oostra, ProMedica's CEO, testified that the efficiencies contained in the report were "preliminary" and he felt that "if we don't find those efficiencies, we will find other efficiencies." (Oostra, Tr. 6145, 6148; PX01906 at 075 (Oostra, IHT at 294), *in camera*).

Response to Finding No. 788:

Mr. Oostra testified that while the efficiencies identified in the Compass Lexecon Report were preliminary, ProMedica has since had more time to look at the opportunities, and, in that time, ProMedica added to that list of opportunities and confirmed whether the numbers in the report were the right numbers. (Oostra, Tr. 6145-6146; *see also* PX02104 at 002-003, *in camera* (testimony from Mr. Akenberger stating {

})). Mr. Oostra also confirmed that ProMedica has in fact been able to identify additional efficiencies outside of the Compass Lexecon Report. (Oostra, Tr. 6148-6149).

789. ProMedica's CFO, Kathleen Hanley, testified that the conclusions in the Compass Lexecon Report were "estimates," and based on a "gut feeling" that the Acquisition would generate savings. (Hanley, Tr. 4728, *in camera*; PX01903 at 054 (Hanley, IHT at 206-207), *in camera*).

Response to Finding No. 789:

Ms. Hanley testified that ProMedica's further analysis affirmed {

} (Hanley, Tr. 4728, *in camera*).

790. The Compass Lexecon Report itself contains the following caveat: "estimates . . . are preliminary and subject to further analysis, revision, and substantiation." (PX00020 at 003 (Compass Lexecon Report), *in camera*). The report's executive summary states that the annual efficiencies opportunities contained in the report "may" be accomplished. (PX00020 at 004 (Compass Lexecon Report), *in camera*).

Response to Finding No. 790:

Mr. Oostra testified that while the efficiencies identified in the Compass Lexecon Report were preliminary, ProMedica has since had more time to look at the opportunities, and, in that time, ProMedica added to that list of opportunities and confirmed whether the numbers in the report were the right numbers. (Oostra, Tr. 6145-6146; *see also* PX02104 at 002-003, *in camera* (testimony from Mr. Akenberger stating {

.})).

791. Mr. Dagen testified that, with the exception of some "minor changes" contained in the affidavit of Gary Akenberger, Respondent never presented any significant additional analysis, revision, or substantiation of its efficiency claims that was above and beyond what was contained in the Compass Lexecon Report. (Dagen, Tr. 3248, *in camera*).

Response to Finding No. 791:

Mr. Dagen's conclusion is not supported by even a cursory comparison of the Compass Lexecon Report and Mr. Akenberger's affidavit. For example, Exhibit 2 to Mr. Akenberger's affidavit presents a line by line comparison of the revisions to the Compass Lexecon numbers. Twenty-three of the thirty-seven service line integration and cost savings opportunities underwent revisions in Mr. Akenberger's affidavit. (RX-114 at 000062-000068, *in camera*).

792. Key St. Luke's personnel who would be best-positioned to assess the likelihood of achieving efficiencies at St. Luke's had little or no input into the efficiencies analysis. Douglas Deacon, St. Luke's Vice President of Professional Services, had not even seen the Compass Lexecon Report before his investigational hearing in September 2010.

(PX01908 at 050 (Deacon, IHT at 191-192), *in camera*). His involvement with the development of the analysis was "nil," even though he believed that such an analysis was "something [he] should be involved with." (PX01908 at 050-051 (Deacon, IHT at 193-194), *in camera*).

Response to Finding No. 792:

The first sentence of this proposed finding is an improper legal argument and violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record. Furthermore, ProMedica continued to verify and refine the efficiencies analysis presented in the Compass Lexecon report that was shown to Mr. Deacon at his investigational hearing in September 2010. (PX02014 at 002-003, *in camera*). In completing the analysis, ProMedica {

} (PX02014 at 002-003, *in camera*).

793. Eric Perron, St. Luke's Computer Information Systems Director, testified that neither he nor his staff was involved in quantifying the information technology-related savings that Respondent alleges St. Luke's may experience as a result of the Acquisition. (PX01928 at 038 (Perron, Dep. at 145), *in camera*). When presented during his deposition with the portion of the Compass Lexecon Report containing Respondent's alleged EMR savings for St. Luke's, Mr. Perron indicated that he had never seen the document and was unaware of the alleged savings. (PX01928 at 040 (Perron, Dep. at 150-151), *in camera*).

Response to Finding No. 793:

Although Mr. Perron had not reviewed the Compass Lexecon report, Mr. Perron reviewed {

} (PX01928 (Perron, Dep. at 152-153), *in camera*; PX02104 at 017-018, *in camera*).

794. Dennis Wagner, St. Luke's Interim Treasurer at the time of the Acquisition, had never before seen the Compass Lexecon Report when he was presented with a copy during his investigational hearing in September 2010. (PX01915 at 040 (Wagner, IHT at 156), *in camera*). Mr. Wagner testified that the report's alleged savings for supply chain efficiencies involved "no[] or very little analysis." (PX01915 at 052 (Wagner, IHT at

204), *in camera*). He said of the speech-and-hearing services efficiency claim: "I don't believe this claim." (PX01915 at 045 (Wagner, IHT at 173), *in camera*).

Response to Finding No. 794:

ProMedica continued to verify and refine the efficiencies analysis presented in the Compass Lexecon report that was shown to Mr. Wagner at his investigational hearing in September 2010. (PX02014 at 002-003, *in camera*). In completing the analysis, ProMedica

{

}

(PX02014 at 002-003, *in camera*). Mr. Wagner was not asked to verify the updated speech-and hearing services efficiency claim and did not review the updated support for this claim.

795. In January 2011, Navigant Consulting completed a study titled "Clinical Integration Strategy" that outlined clinical service consolidation recommendations for ProMedica. (PX00396 ("Clinical Integration Strategy" Executive Summary), *in camera*; PX00479 ("Clinical Integration Strategy" Final Report), *in camera*). Notably, the study primarily addresses relocating existing ProMedica services to existing ProMedica facilities, without explaining what role, if any, the Acquisition plays in facilitating such consolidations. (PX00396 at 008-010 ("Clinical Integration Strategy" Executive Summary), *in camera*). Kevin Nolan, the lead consultant on the project, testified that most of Navigant's recommendations have little to no impact on St. Luke's services. (PX01946 at 019-021 (Nolan, Dep. at 67-75)).

Response to Finding No. 795:

Mr. Nolan did not testify that most of Navigant's recommendations would have little to no impact on St. Luke's services. Mr. Nolan actually testified that Navigant recommended continuing "to grow and develop the cardiovascular program at St. Luke's" and "develop[ing] a women's center of excellence at St. Luke's, so it was really expanding the women's, and the OB-GYN program at St. Luke's." (PX01946 (Nolan, Dep. at 68-69)).

1. Revenue Enhancements Are Not Cognizable Efficiencies

796. The numerous claimed revenue enhancement opportunities are not true efficiencies because they merely shift revenue among the participants in the market and, in effect, do

nothing more than increase ProMedica's bottom-line. (PX02147 at 077-081 (¶¶ 148-159) (Dagen Expert Report)).

Response to Finding No. 796:

The proposed finding is not a fact, but an improper legal argument.

797. Mr. Akenberger, ProMedica's Senior Vice President of Finance, testified that "[an] efficiency relates to expense savings, both capital and operating[,]" and that a price increase is not an efficiency. (PX01931 at 034 (Akenberger, Dep. at 130), *in camera; see also* Dagen, Tr. 3288, *in camera* ("a price increase would be a revenue enhancement, [but] that's not an efficiency")).

Response to Finding No. 797:

Respondent has no specific response.

798. To be credited, an efficiency must reduce costs, increase output, or improve quality. (Dagen, Tr. 3287-3288, *in camera*; PX02147 at 077 (¶ 149) (Dagen Expert Report)). Respondent's claimed revenue enhancements have none of these consumer-benefitting effects. (Dagen, Tr. 3288-3289, *in camera*; PX00020 at 029-033 (description of revenue enhancement efficiencies in Compass Lexecon Report), *in camera*).

Response to Finding No. 798:

The proposed finding is not a fact, but an improper legal argument.

799. For example, revenue enhancements that Respondent alleges will result from improving St. Luke's coding and charge capture practices have no impact on the quality or quantity of clinical services that St. Luke's provides to patients. (Hanley, Tr. 4733-4735, *in camera*; PX00020 at 030 (Compass Lexecon Report), *in camera*). These practices will merely increase the amount that is paid to St. Luke's by patients (or their insurers) for the same quantity and quality of services. (Hanley, Tr. 4733-4735, *in camera*).

Response to Finding No. 799:

Respondent has no specific response.

2. Respondent's Alleged Capital Cost Avoidance Opportunities Are Not Cognizable Efficiencies

800. The bulk of the claimed efficiencies from the Acquisition are avoided capital costs. (PX00020 at 006-007 (Compass Lexecon Report summary of efficiencies), *in camera*; PX02104 at 003-004 (chart summarizing alleged efficiencies in Mr. Akenberger's affidavit), *in camera*).

Response to Finding No. 800:

Respondent has no specific response.

801. In general, capital cost avoidance claims are not cognizable efficiencies. (Town, Tr. 3928-3929 ("removing an expenditure that would create value [is not] an efficiency"); PX02148 at 094 (¶ 172) (Town Expert Report), *in camera*). Firms invest in their businesses to better compete and thus enhance consumer welfare, and if these competition-driven investments are "avoided," consumers generally are left worse off. (PX02148 at 094 (¶ 172) (Town Expert Report), *in camera*).

Response to Finding No. 801:

The proposed finding is not a fact, but an improper legal argument.

802. Even if cognizable in theory, several of Respondent's largest capital cost avoidance claims are speculative at best because, in reality, ProMedica had no plans to invest the capital that it claims it would have spent absent the Acquisition. (PX02147 at 048-049 (¶¶ 89-91) (Dagen Expert Report)).

Response to Finding No. 802:

ProMedica identified {

} (PX02104 at 016, *in camera*; RX-114 at 251, *in camera*). ProMedica temporarily postponed its {

} (PX02104 at 016, *in camera*). ProMedica {

} (PX02104 at 016, *in camera*). In addition,

{

}

(PX02105 at 201-203, *in camera*; PX02104 at 017, *in camera*; RX-114 at 271-274, *in camera*).

a. Construction of a Hospital at Arrowhead

803. Respondent alleges that, as a result of the Acquisition, it may be able to avoid spending $90 - 100 million on constructing and equipping a new hospital at its "Arrowhead" property (located less than three miles from St. Luke's). (PX00020 at 035 (Compass Lexecon Report), *in camera*; (PX02104 at 016 (¶ 30) (Akenberger, Decl.), *in camera*).

Response to Finding No. 803:

Respondent has no specific response.

804. Ms. Hanley, ProMedica's CFO, explained that ProMedica acquired St. Luke's "instead of investing millions of dollars in a competing facility." (PX01903 at 063 (Hanley, IHT at 243-244), *in camera*).

Response to Finding No. 804:

Respondent has no specific response.

805. There is little evidence in the record that ProMedica actually intended to build the Arrowhead hospital absent the Acquisition. (Dagen, Tr. 3279-3280, *in camera* (no strategic plans, capital budgeting documents, or permits for constructing a hospital at Arrowhead); PX02147 at 046-049 (¶¶ 85-89) (Dagen Expert Report); PX02148 at 094-095 (¶¶ 172-173) (Town Expert Report), *in camera*).

Response to Finding No. 805:

ProMedica identified {

} (PX02104 at 016, *in camera*; RX-114 at 251, *in camera*).

ProMedica temporarily postponed its {

} (PX02104 at 016, *in camera*). ProMedica {

} (PX02104 at 016, *in camera*).

806. The only support for the cost of constructing a new hospital at Arrowhead is a single-page document premised on how much ProMedica spent to build Bay Park Hospital earlier in the decade. (PX02105 at 200 (Exhibit to Akenberger, Decl.), *in camera*). Mr. Akenberger testified that he had never seen this document in the ordinary course, and only became aware of it while preparing Respondent's efficiency claims. (PX01931 at 038 (Akenberger, Dep. at 147), *in camera*). Other than this one-page document, Mr. Akenberger, current Senior Vice President of Finance and a financial executive at ProMedica for most of the last decade, has never seen any financial analysis of constructing a hospital at Arrowhead. (PX01931 at 038 (Akenberger, Dep. at 145-146), *in camera*; PX01912 at 004-005 (Akenberger, IHT at 9-11), *in camera*).

Response to Finding No. 806:

The proposed finding is inaccurate. ProMedica anticipated a need for inpatient beds in the southwest suburbs of Toledo because the area was growing and ProMedica wanted to serve it with a clinically integrated system. (Hanley, Tr. 4539). In furtherance of these plans, ProMedica prepared site plans and capital projections. (Hanley, Tr. 4540). {

}

(RX-31 (Akenberger, Dep. at 150-151, *in camera*)). Complaint Counsel has also not introduced any evidence that it is inappropriate to base calculations for a {

} (PX02104 at 016-017, *in camera*). Because {

} (PX02104 at 016-017, *in camera*).

807. ProMedica has owned the Arrowhead land for a decade. (PX01906 at 022 (Oostra, IHT at 82), *in camera*). The 2010-2012 Strategic Plan, the most recent such plan to be created prior to ProMedica's merger negotiations with St. Luke's, does not even mention constructing a new hospital at Arrowhead. (Joint Stipulations of Law and Fact, JX00002A ¶ 49; Hanley, Tr. 4720-4721, *in camera*; PX00006 (ProMedica Hospitals' 2010-2012 Strategic Goals and Objectives), *in camera*; PX00007 (ProMedica 2010-2012 Strategic Goals and Objectives), *in camera*). Mr. Akenberger testified that he has never seen a ProMedica Board-approved capital budget that contemplates constructing a hospital at the Arrowhead property. (PX01931 at 039 (Akenberger, Dep. at 150-151), *in camera*).

Response to Finding No. 807:

The proposed finding is misleading because Mr. Akenberger testified that {

}

(RX-31 (Akenberger, Dep. at 150-151, *in camera*)).

808. Mr. Akenberger admitted that, even without the Acquisition, it is "possible" that ProMedica would have not gone ahead with constructing a hospital at Arrowhead. (PX01931 at 039 (Akenberger, Dep. at 152), *in camera*).

Response to Finding No. 808:

Mr. Akenberger also testified that ProMedica intended {

} absent the joinder with St. Luke's. (PX01931 (Akenberger, Dep. at 152), *in camera*).

b. Construction of a Bed Tower at Flower Hospital

809. Respondent also alleges that the Acquisition may enable it to avoid spending $25 to 30 million to construct a second bed tower at Flower Hospital. (PX00020 at 036 (Compass Lexecon Report), *in camera*; PX02104 at 17 (¶ 31) (Akenberger, Decl.), *in camera*). Even if this were a cognizable efficiency in theory, there is no credible evidence that ProMedica had plans to construct a new bed tower at Flower Hospital absent the Acquisition.

Response to Finding No. 809:

Complaint Counsel's final statement violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record.

810. ProMedica's most recent pre-Acquisition Strategic Plans did not evidence an intention to construct a second bed tower at Flower Hospital. (Joint Stipulations of Law and Fact, JX00002A ¶ 48 ("The construction of a new bed tower at Flower Hospital did not appear on ProMedica's 2010-2012 Strategic Plan."); PX00006 (ProMedica Hospitals' 2010-2012 Strategic Goals and Objectives), *in camera*; PX00007 (ProMedica 2010-2012 Strategic Goals and Objectives), *in camera*). At no time in the two to three years leading up to the Acquisition did ProMedica generate any plans relating to constructing a new bed tower at Flower Hospital. (Hanley, Tr. 4542-4543).

Response to Finding No. 810:

Ms. Hanley testified there was no allocation of funds for constructing a second bed tower at Flower. (Hanley, Tr. 4543). ProMedica's engineering team did, however, {

} (PX02104 at 017, *in camera*; RX-114 at 271-274, *in camera*).

811. The construction of a new bed tower at Flower Hospital has not appeared on any capital budget approved by the ProMedica Board since January 1, 2007. (Joint Stipulations of Law and Fact, JX00002A ¶ 47). Ms. Hanley testified that the Flower Hospital bed tower project "did not end up ... at the top of the list from a capital allocation standpoint." (Hanley, Tr. 4541-4542). She also stated that ProMedica's plans for financing the project were "premature until . . . we prioritize [and] authorize [the project,]" and said that such

plans had not yet reached the ProMedica Board level. (PX01903 at 064 (Hanley, IHT at 248-249), *in camera*).

Response to Finding No. 811:

Respondent has no specific response.

812. Furthermore, any alleged savings from the Flower Hospital capital cost avoidance claim are not merger-specific because ProMedica's decision of whether or not to construct a new bed tower at Flower Hospital is not logically connected to its acquisition of St. Luke's. (Dagen, Tr. 3281-3282, *in camera* ("[decision of] whether or not a bed tower is going to be built at Flower Hospital is [] a unilateral decision at Flower"); PX02147 at 049 (¶¶ 90-91) (Dagen Expert Report)).

Response to Finding No. 812:

ProMedica's decision not to construct a new bed tower at Flower is connected to its acquisition of St. Luke's because {

} (PX01931 (Akenberger, Dep. at 162-163), *in camera*). {

} (PX01931 (Akenberger, Dep. at 162-163), *in camera*). The joinder can also potentially impact the number of available {

} (PX01931 (Akenberger, Dep. at 163), *in camera*).

813. Respondent alleges that the acquisition of St. Luke's enables ProMedica to avoid building the bed tower because St. Luke's facilities have unused capacity that can be utilized by ProMedica. (PX01931 at 042 (Akenberger, Dep. at 162-163), *in camera*). The proposed bed tower would add 136 beds to Flower Hospital, of which 92 would be classified as either psychiatric or skilled nursing facility beds. (PX01931 at 041 (Akenberger, Dep. at 158-160), *in camera*). However, St. Luke's has zero skilled nursing facility or psychiatric beds. (PX01931 at 042 (Akenberger, Dep. at 161-162, 164), *in camera*).

Response to Finding No. 813:

ProMedica's decision not to construct a new bed tower at Flower is connected to its acquisition of St. Luke's because {

} (PX01931

(Akenberger, Dep. at 162-163), *in camera*). {

} (PX01931 (Akenberger, Dep. at 162-163), *in camera*). The joinder potentially also

can impact the number of available {

} (PX01931 (Akenberger, Dep. at

163), *in camera*).

814. Further, the inpatient beds that St. Luke's does have were nearly at full capacity leading up to the Acquisition. (PX00170 at 001, 006 (Mr. Wakeman's Aug. 2010 Memo to St. Luke's Board stating "inpatient capacity is limited" and "our concern is . . . lack of beds"); PX01360 at 001 (Wakeman email concerning June 2010 utilization review), *in camera* ("we're pretty tight,"); PX01292 at 003 (Sept. 2009 St. Luke's Board meeting minutes), *in camera*, ("hospital is close to capacity with inpatients")).

Response to Finding No. 814:

St. Luke's had plenty of licensed beds in the facility at the time of the joinder. (PX01360 at 001, *in camera* ({ })). St. Luke's was only at "capacity" because it had converted patient rooms into offices and conference spaces in the early 2000s, when their volume dropped significantly and stayed there for a long period of time, and it did not have the capital to convert these administrative spaces back to patient rooms. (Johnston, Tr. 5364-5366).

815. Mr. Akenberger admitted it was "possible" that ProMedica may still construct a bed tower at Flower Hospital even now that it has acquired St. Luke's. (PX01931 at 042 (Akenberger, Dep. at 163-164), *in camera*).

Response to Finding No. 815:

The proposed finding is inaccurate and misleading. Mr. Akenberger, when asked if it was "possible" that ProMedica may still {

} (PX01931 (Akenberger, Dep. at 163-164), *in camera*).

c. Implementation of EMR and IT at Standalone St. Luke's

816. Respondent alleges that the Acquisition may save St. Luke's somewhere in the range of $7.6 to 15.7 million in costs relating to implementation of an Electronic Medical Records ("EMR") system and related information technology ("IT") upgrades. (PX00020 at 038 (Compass Lexecon Report), *in camera*; PX02104 at 017-018 (¶ 32) (Akenberger, Decl.), *in camera*). Mr. Dagen noted that the "large range" in possible savings demonstrates that Respondent has not "vetted this [efficiency claim] in great detail." (Dagen, Tr. 3283, *in camera*).

Response to Finding No. 816:

The range in potential savings is a result of the fact that the parties {

} (PX02104 at 018, *in camera*). The fact that the parties have not yet made this decision does not mean that the ultimate range is somehow inaccurate.

817. As the basis for these alleged savings, the Compass Lexecon Report asserts that St. Luke's would have spent $16 to 24 million to implement EMR and related IT applications as a standalone hospital. (PX00020 at 038 (Compass Lexecon Report), *in camera*). However, Respondent has presented no documents or analysis to substantiate the St. Luke's standalone EMR costs that are contained in the Compass Lexecon Report. (PX01931 at 043, 045 (Akenberger, Dep. at 167-173), *in camera*, (Mr. Akenberger could not identify any substantiation in his affidavit or its exhibits)).

Response to Finding No. 817:

The proposed finding is inaccurate. Mr. Akenberger attached Exhibits 14 through 22 and Exhibit 52 to his affidavit to support ProMedica's estimate that it would cost St. Luke's {

} (PX02104 at 018, *in camera*; RX-114 at 105-143, 279-280, *in camera*).

818. St. Luke's Chairman, James Black, believes that St. Luke's standalone costs for implementing IT related to healthcare reform would be between $12 million and $14 million. (Black, Tr. 5701-5702).

Response to Finding No. 818:

Respondent has no specific response.

819. Respondent's alleged post-Acquisition EMR and IT savings appear to be significantly overstated for other reasons, as well. In calculating how much ProMedica will spend to implement EMR at St. Luke's after the Acquisition, Respondent failed to account for over $1 million in annual maintenance costs. (Dagen, Tr. 3283-3285, *in camera*; PX02147 at 051-054 (¶¶ 95-98) (Dagen Expert Report)). Once these are properly considered, the difference in cost of implementing EMR and related IT at St. Luke's as a standalone and doing so as a part of ProMedica is significantly smaller than Respondent claims. (PX02147 at 051-054 (¶¶ 95-98) (Dagen Expert Report)).

Response to Finding No. 819:

Mr. Dagen improperly bases his conclusion on figures other than those that ProMedica actually used in its efficiency calculation. ProMedica estimated that St. Luke's would have spent between { } to implement EMR on a standalone basis and an additional { } to upgrade its existing IT applications. (RX-114 at 60, *in camera*). Mr. Dagen's conclusion that St. Luke's estimates included annual maintenance costs was not based on an analysis of these numbers. Accordingly, Mr. Dagen's conclusion that ProMedica did not make an apples-to-apples comparison of numbers that both included annual maintenance costs – and that these numbers need to be accounted for – is unfounded. (Dagen, Tr. 3283-3285, *in camera*; PX02147 at 051-054).

820. It is unclear when ProMedica will begin to implement the EMR and IT systems at St. Luke's, as well as how the timeline for implementation will compare to the timeline that a standalone St. Luke's would have pursued. (PX01931 at 044-045 (Akenberger, Dep. at 172-174), *in camera*; PX01912 at 068 (Akenberger, IHT at 262-263), *in camera*; PX01928 at 037 (Perron, Dep. at 139), *in camera* (ProMedica will start EMR implementation at St. Luke's in { })). As a result, it is unclear from the evidence whether ProMedica will implement the EMR systems at St. Luke's in time to take advantage of all federal financial incentives. (PX01928 at 037 (Perron, Dep. at 139), *in camera* ("unsure" whether ProMedica will implement EMR at St. Luke's in time to obtain all federal funds); *see* PX01912 at 068 (Akenberger, IHT at 262-263), *in camera*).

Response to Finding No. 820:

ProMedica intends to install EMR systems at St. Luke's in time to receive ARRA legislation incentives. (RPF 2156, *in camera*, 2160).

821. In contrast, a standalone St. Luke's fully expected to start implementing EMR in time to qualify for all federal funds. (PX01933 at 038-039 (Oppenlander, Dep. at 144-148), *in camera*; PX01928 at 021, 023, 030 (Perron, Dep. at 75-76, 84-85, 113), *in camera*; PX01908 at 055 (Deacon, IHT at 213), *in camera*; PX01281 at 012 ("Finance Pillar Challenge" Presentation); PX01496 at 003 (EMR vendor bid from Dec. 2009 includes ARRA payment schedule); PX01503 at 001, *in camera* (EMR vendor bid in June 2010 indicates that a standalone St. Luke's was "capable of qualifying for meaningful use incentives")).

Response to Finding No. 821:

At the time of the joinder, St. Luke's did not have sufficient IT staff to comply with the "meaningful use" requirements. (RPF 1727). St. Luke's was also not certain whether it would { .} (RPF 1732, *in camera*). Furthermore, St. Luke's was unable to comply with the statutory requirements in any financially prudent manner. (RPF 1737, 1733).

822. To the extent St. Luke's misses targets to receive federal funds due to ProMedica's slower EMR implementation schedule, the Acquisition will delay EMR's benefits to patients and increase total costs. (PX02147 at 053 (¶ 98) (Dagen Expert Report)).

Response to Finding No. 822:

The proposed finding is misleading. ProMedica intends to install EMR systems at St. Luke's in time to receive ARRA legislation incentives. (RPF 2156, *in camera*, 2160).

3. Alleged Efficiencies May Decrease Quality and Access and Increase Costs to Patients

823. ProMedica intends to reduce St. Luke's staffing levels to the levels of Flower Hospital. (PX00020 at 015 (Compass Lexecon Report), *in camera*). This runs contrary to the conclusions of St. Luke's executives in March 2010 that it was important to "maintain current staff levels to help ensure high quality and Press Ganey [patient satisfaction] scores." (PX01047 at 001 (Board Leadership Steering Committee Meeting 3/15/10 Proposed Topics)).

Response to Finding No. 823:

ProMedica anticipated that {

} (PX02104 at 007-008, *in camera*).

824. Testimony by St. Luke's and ProMedica executives also suggests that cutting staff at St. Luke's could reduce quality of care, but that this fact was not considered when calculating the alleged savings from this alleged efficiency. (PX01909 at 048-049 (Dewey, IHT at 188-189), *in camera* (stating that St. Luke's is "a pretty lean organization" and that cutting staff "would be impacting [] service [and] quality"); PX01912 at 052 (Akenberger, IHT at 199), *in camera* ("quality factor was not captured [in the analysis]")). There has been no analysis put forth showing that St. Luke's was overstaffed prior to the Acquisition, and no analysis of whether reducing St. Luke's staffing can be done without impacting quality of care. (Dagen, Tr. 3272-3273, *in camera*).

Response to Finding No. 824:

The proposed finding is misleading. Mr. Akenberger specifically stated in his affidavit when discussing the efficiency related to { } that { } (PX02104 at 007-008, *in camera*).

825. Given that ProMedica generally has higher reimbursement rates across its various service lines than does St. Luke's, it is likely that any efficiency claim that is predicated on closing a service line at St. Luke's and moving it to a ProMedica facility will result in a price increase to health plans, employers, and patients. (Dagen, Tr. 3255-3256, *in camera* ("if you move a service from a lower priced facility to a higher priced facility, and you do the same number of cases . . . patients and payers are going to be paying higher prices for that service")).

Response to Finding No. 825:

Complaint Counsel's statement that ProMedica generally has higher reimbursement rates across its various service lines violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record.

826. Respondent alleges $1.3 million in savings from consolidating inpatient rehabilitation services at Flower Hospital. (PX00020 at 011 (Compass Lexecon Report), *in camera*; PX02104 at 005-006 (¶ 9) (Akenberger, Decl.), *in camera*). This involves closing St. Luke's inpatient rehabilitation center and shifting its patients to Flower Hospital. (PX02104 at 005-006 (¶ 9) (Akenberger, Decl.), *in camera*). After the consolidation, patients who previously chose St. Luke's inpatient rehabilitation center due to its convenience – or other factors, such as its quality of care – no longer have that option. (Nolan, Tr. 6351, *in camera*; Andreshak, Tr. 1796-1797 (St. Luke's inpatient rehabilitation center had "excellent" quality of care); Dagen, Tr. 3256-3257, *in camera*).

Response to Finding No. 826:

Complaint Counsel explicitly approved the consolidation of {

} (RPF 2230, *in camera*). Furthermore, Dr. Andreshak did not testify that the consolidation resulted in "less convenient" options for patients. (Andreshak, Tr. 1797-1799).

827. Dr. Thomas Andreshak, an independent physician in Toledo, testified that St. Luke's inpatient rehabilitation center provided high quality care before it was closed as a result of the Acquisition. (Andreshak, Tr. 1797-1799). His patients – in particular, those who live in Maumee and Bowling Green – are inconvenienced by having to go to Flower Hospital instead of St. Luke's for these services. (Andreshak, Tr. 1797-1799).

Response to Finding No. 827:

Complaint Counsel explicitly approved the consolidation of {

} (RPF 2230, *in camera*). Furthermore, Dr. Andreshak did not testify that the consolidation resulted in "less convenient" options for patients. (Andreshak, Tr. 1797-1799).

828. Revenue from patients who would have gone to St. Luke's inpatient rehabilitation center but must now go to more expensive Flower Hospital will generate $1 million in additional revenue for Flower Hospital compared to what these patients would have paid for the same services at St. Luke's. (PX00905 at 001 (spreadsheet containing calculations of various efficiencies), *in camera*; Dagen, Tr. 3257-3262, *in camera*). This revenue increase is due to the higher reimbursement that ProMedica receives for inpatient rehabilitation services, meaning that the patients who must switch from St. Luke's inpatient rehabilitation center to Flower Hospital's center will incur a price increase as a direct result of the consolidation. (Dagen, Tr. 3257-3262, *in camera*; PX02147 at 054-056 (¶¶ 100-103) (Dagen Expert Report)). As ProMedica's Mr. Akenberger testified, a price increase is not an efficiency. (PX01931 at 034 (Akenberger, Dep. at 130), *in camera*).

Response to Finding No. 828:

Respondent has no specific response.

829. In his affidavit, Mr. Akenberger revised the savings that ProMedica claims may result from the inpatient rehabilitation consolidation from the original $1.3 million down to $193,000. (PX02104 at 003 (Akenberger, Decl.), *in camera*). Despite the decrease in the claimed savings, the $1 million price increase to patients will still be carried out. (PX02147 at 055-056 (¶¶ 100-103) (Dagen Expert Report)). Furthermore, while the savings are alleged to be $193,000 per year, the cost of the consolidation (*i.e.*, the cost of achieving the alleged savings) is at least { }. (Nolan, Tr. 6367, *in camera*; PX00479 at 015 ("Clinical Integration Strategy" Final Report), *in camera*).

Response to Finding No. 829:

The estimated {

} (Nolan, Tr. 6367, *in camera*;

PX00479 at 015, *in camera*). The parties would recognize { } in efficiencies from

consolidating {

} (PX02104 at 005-006, *in camera*).

830. Respondent alleges $2.7 million in savings from consolidating heart and vascular services at TTH. (PX02104 at 006-007 (¶ 10) (Akenberger, Decl.), *in camera*; PX02105 at 051 (Exhibits to Akenberger, Decl.), *in camera*). This involves eliminating St. Luke's open heart surgery program. (PX01931 at 034 (Akenberger, Dep. at 131), *in camera*). Patients who previously went to St. Luke's for open heart procedures will have to go to TTH, instead. (PX01931 at 034 (Akenberger, Dep. at 131), *in camera*). As a result, some patients who require immediate open heart procedures will experience a longer ambulance ride on their way to TTH instead of St. Luke's. (Nolan, Tr. 6331-6333, *in camera*). Also, patients who arrive at St. Luke's – or who are already there for another procedure – and then require an open heart procedure will have to be transferred to TTH, instead of receiving that care onsite at St. Luke's. (Nolan, Tr. 6330-6331, 6333-6334, *in camera*; Hanley, Tr. 4743, 4745-4746, *in camera*).

Response to Finding No. 830:

Mr. Nolan testified only that patients coming from a location that is closer to St. Luke's than TTH will have a longer drive on their way to TTH. (Nolan, Tr. 6332, *in camera*). (*See also* Nolan, Tr. 6342, *in camera* (stating that { } has one of the lowest heart attack mortality rates while { } mortality rates are { })).

831. Dr. Gbur, an independent physician who performs interventional cardiology procedures at St. Luke's, testified that the elimination of open heart services at St. Luke's could add 10 to 15 minutes of additional transit time for patients who experience a heart attack and must go to a hospital with open heart capabilities for treatment. (Gbur, Tr. 3112-3113).

Response to Finding No. 831:

Respondent has no specific response.

832. Unlike the inpatient rehabilitation consolidation, Respondent did not disclose how shifting St. Luke's heart and vascular volume to Flower Hospital would impact the revenues earned on those procedures. (PX2105 at 051 (Exhibits to Akenberger, Decl.).

However, given that ProMedica's reimbursement for services is on average higher than St. Luke's, a price increase resulting from this consolidation may exceed any actual cost savings generated by it. (PX02147 at 060-061 (¶ 111) (Dagen Expert Report)).

Response to Finding No. 832:

Mr. Dagen does not cite any document for his conclusion that ProMedica's reimbursement for services is on average higher than St. Luke's. (PX02147 at 060 n.194).

833. Neither the Compass Lexecon Report, Mr. Akenberger's affidavit, nor Navigant's "Clinical Integration Strategy" report discuss in any detail how patient quality of care or convenience will be impacted by consolidating rehabilitation, heart, vascular, and psychiatry services. (PX00020 (Compass Lexecon Report), *in camera*; PX02104 (Akenberger, Decl.), *in camera*; PX00479 ("Clinical Integration Strategy" Final Report), *in camera*; Dagen, Tr. 3257, *in camera* (did not see any analysis by ProMedica of the impact of clinical consolidations on patient convenience)).

Response to Finding No. 833:

{ } has one of the lowest heart attack mortality rates while { } mortality rates are { .} (Nolan, Tr. 6342, *in camera*).

C. The Asserted Efficiencies Are Speculative

834. The *Merger Guidelines* state that "[e]fficiency claims will not be considered if they are vague, speculative, or otherwise cannot be verified by reasonable means." (PX02214 at 032-034 (§ 10) (*Merger Guidelines*)).

Response to Finding No. 834:

The proposed finding is not a fact, but an improper legal argument.

835. Virtually all of the claimed efficiencies in the Compass Lexecon Report contain the caveat that they "may" be accomplished by the Acquisition. (PX00020 (Compass Lexecon Report), *in camera*).

Response to Finding No. 835:

Respondent has no specific response.

836. Mr. Akenberger's affidavit acknowledges that ProMedica's verification of the savings identified in the Compass Lexecon Report "is still a work in progress." (PX02104 at 003 (¶ 7) (Akenberger, Decl.), *in camera*).

Response to Finding No. 836:

Respondent has no specific response.

837. The Compass Lexecon Report alleged that the Acquisition may generate $77,000 in savings relating to speech and hearing services purchased by St. Luke's. (PX00020 at 018 (Compass Lexecon Report), *in camera*). An St. Luke's executive expressed doubt about the savings during his investigational hearing. (PX01915 at 045 (Wagner, IHT at 173), *in camera*). Subsequently, in Mr. Akenberger's affidavit, the alleged savings were reduced to $4,000. (PX02104 at 009 (¶ 15) (Akenberger, Decl.), *in camera*).

Response to Finding No. 837:

ProMedica continued to verify and refine the efficiencies analysis presented in the Compass Lexecon report that was shown to Mr. Wagner at his investigational hearing in September 2010. (PX02104 at 002-003, *in camera*). In completing the analysis, ProMedica

{

.}

(PX02104 at 002-003, *in camera*).

838. The Compass Lexecon Report alleged approximately $10 million in capital cost avoidances that subsequently were removed entirely from the list of claimed efficiencies in Mr. Akenberger's affidavit, because ProMedica either decided to go forward with the projects or to abandon the projects for reasons unrelated to the Acquisition. (PX02104 at 003 (¶ 7) (Akenberger, Decl.), *in camera*; PX00020 (Compass Lexecon Report) at 39)).

Response to Finding No. 838:

ProMedica continued to verify and refine the efficiencies analysis presented in the Compass Lexecon report. (PX02104 at 002-003, *in camera*).

839. The Compass Lexecon Report asserts that the Acquisition may generate savings from consolidating Oncology, Orthopedics, Women's, Neuro/Stroke, Cancer and Pulmonary services at either a ProMedica or St. Luke's facility. (PX00020 at 013 (Compass Lexecon Report), *in camera*). Mr. Akenberger confirmed that the potential savings from these clinical consolidation are still "not yet quantified." (PX02104 at 006-007 (¶ 10) (Akenberger, Decl.), *in camera*).

Response to Finding No. 839:

ProMedica did not include these clinical consolidations in any estimates precisely because they were not quantified. (PX02104 at 006-007, *in camera*).

840. The Compass Lexecon Report states that ProMedica may realize approximately $1.4 million in savings from lowering St. Luke's physician coverage costs in General Surgery, Obstetrics, and Interventional Services to a median benchmark rate. (PX00020 at 023 (Compass Lexecon Report), *in camera*). Mr. Dagen concluded that these claims are unsubstantiated because, in calculating the savings, Respondent assumed that St. Luke's could lower its physician coverage costs to the benchmark median rate without considering why St. Luke's rates are higher in the first place. (PX02147 at 068-069 (¶¶ 127-128) (Dagen Expert Report)).

Response to Finding No. 840:

Respondent has no specific response.

841. Indeed, ProMedica executives involved in the efficiencies analysis testified that the St. Luke's and ProMedica physician coverage contracts likely require different duties and, therefore, are not "apples to apples" comparisons. (PX01904 at 048 (Steele, IHT at 182-183, *in camera*); PX01912 at 057 (Akenberger, IHT at 219-220), *in camera*).

Response to Finding No. 841:

Respondent has no specific response.

842. The alleged annual cost savings in Navigant's "Clinical Integration Strategy" report were "still being refined" by ProMedica as late as December 2010. (PX00506 at 001 (Dec. 2010 email from Andy Hoehn), *in camera*). Between December 2010 and January 2011 (when Navigant produced the final version of its report), the alleged savings decreased from approximately $7 million to $3.4 million. (PX00476 at 011 (Dec. 2010 draft of "Clinical Integration Strategy" report), *in camera*; PX02386 at 014 (Jan. 2011 final version of "Clinical Integration Strategy" report), *in camera*). Further, the $74.4 million cost of implementing Navigant's "Clinical Integration Strategy" recommendations will exceed the projected $3.4 million in annual savings for many years into the future. (Nolan, Tr. 6354-6355, *in camera*; Hanley, Tr. 4747-4749; *in camera*; PX00479 at 014 ("Clinical Integration Strategy" Final Report), *in camera*).

Response to Finding No. 842:

Respondent has no specific response.

843. Mr. Dagen concluded that many of the other efficiency claims also are unsubstantiated or speculative because the back-up materials submitted by Respondent lacked details necessary to verify the underlying data and methodologies used in the calculations of savings. These claims include, among others: lowering St. Luke's costs for insurance, clinical engineering, marketing, and legal services, transferring St. Luke's pathology lab testing services to TTH, consolidating offsite ancillary services, consolidating pension and investment advisory needs, and eliminating interventional services contracts at St. Luke's. (PX02147 at 061-077 (¶¶ 112-147) (Dagen Expert Report)).

Response to Finding No. 843:

Mr. Akenberger attached substantiation for these claims as exhibits to his declaration. (PX02104 at 012 {{ }), at 010 { }), at 012 { }), at 012 { }), at 008-009 { }), *in camera*; RX-114 at 000170-000173 { }, at 000144-000148 { }, at 000166-000167 { }, at 000168-000169 { }, at 00094-000104 { }, *in camera*).

D. **The Proposed Efficiencies Are Not Merger-Specific**

844. The *Merger Guidelines* "credit only those efficiencies likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects. These are termed merger-specific efficiencies." (PX02214 at 032-033 (§ 10) (*Merger Guidelines*)).

Response to Finding No. 844:

The proposed finding is not a fact, but an improper legal argument.

1. **St. Luke's Could Have Accomplished the Efficiencies with An Alternative Purchaser**

845. In 2009, UTMC executives expressed to St. Luke's executives an interest in pursuing an affiliation with St. Luke's. (Joint Stipulations of Law and Fact, JX00002A ¶ 51)

Response to Finding No. 845:

The proposed finding is not a fact, but an improper legal argument.

846. Mr. Dagen concluded that a significant number of the efficiencies claimed by Respondent could be achieved through an affiliation between St. Luke's and UTMC. (PX02147 at 083 (¶ 163) (Dagen Expert Report)). Mr. Den Uyl, Respondent's expert witness, did not conduct any analysis of whether efficiencies alleged to result from the Acquisition could have been attained through a St. Luke's merger with UTMC. (Den Uyl, Tr. 6527).

Response to Finding No. 846:

The proposed finding is misleading. 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).

847. Respondent has admitted that a "St. Luke's affiliation with any potential partner, including UTMC, would have brought certain benefits to patients in the metropolitan Toledo area" and "may have led to certain efficiencies." (Response to RFA at ¶¶ 11-12).

Response to Finding No. 847:

UTMC's and St. Luke's discussions did not reach the due diligence stage, where any potential efficiencies could have been identified and quantified. (Gold, Tr. 322-323).

848. Dr. Jeffrey Gold, UTMC Dean, testified that a UTMC-St. Luke's affiliation would make possible "enhancing and improving the level of healthcare services provided to the community." (Gold, Tr. 247). Dr. Gold also testified that a UTMC-St. Luke's affiliation could generate efficiencies in "back-of-the-house functions" such as "finance, information technology, human resources services, and many others," as well as promote "consolidation of clinical services." (Gold, Tr. 245-246).

Response to Finding No. 848:

UTMC and St. Luke's discussions did not reach the due diligence stage, where any potential efficiencies could have been identified and quantified. (Gold, Tr. 322-323).

849. An ordinary course UTMC document laying out the "Business Case" for an affiliation with St. Luke's listed categories of potential savings; many of the UTMC/St. Luke's potential savings are similar to the savings Respondent asserts may result from the Acquisition, including: purchasing, finance, accounting, marketing, information technology, clinical information services, human relations, auditing, legal, ancillary services (*e.g.*, imaging and laboratory), supply purchasing, and professional liability, among others. (PX02206 at 003-004) ("UTMC-OCHS Business Case")).

Response to Finding No. 849:

UTMC and St. Luke's discussions did not reach the due diligence stage, where any potential efficiencies could have been identified and quantified. (Gold, Tr. 322-323).

850. A 2009 St. Luke's Board presentation described various clinical consolidation opportunities that could result from a UTMC affiliation. (PX01035 at 009 (St. Luke's 2009 "Affiliation Analysis Update"), *in camera*; PX00020 at 013 (description of clinical consolidation efficiency in Compass Lexecon Report), *in camera*).

Response to Finding No. 850:

UTMC and St. Luke's discussions did not reach the due diligence stage, where any potential efficiencies could have been identified and quantified. (Gold, Tr. 322-323).

851. In early 2009, St. Luke's CEO, Dan Wakeman, sent an email to St. Luke's CFO at the time, David Oppenlander, that stated: "UTMC has a big McKesson agreement . . . [i]f we were to move down that pathway, that would be [an] inexpensive way to get into one of the big 6 [Health Information Management] systems." (PX01317 at 001; *cf.* PX00020 at 038 (description of EMR efficiency in Compass Lexecon Report), *in camera*).

Response to Finding No. 851:

UTMC and St. Luke's discussions did not reach the due diligence stage, where any potential efficiencies could have been identified and quantified. (Gold, Tr. 322-323).

852. Mr. Wakeman noted that "[t]he community and organizational benefits of [a] partnership [with UTMC] are endless" and that "[i]n terms of reduction of expense, a closer relationship with [UTMC] would provide just as much value as the two systems [Mercy and ProMedica]." PX01406 at 001 (Jul. 2009 Wakeman (St. Luke's) e-mail to Dr. Gold (UTMC)); PX01407 at 001 (Oct. 2009 Wakeman (St. Luke's) e-mail to Dr. Gold (UTMC)); PX01920 at 039 (Wakeman, Dep. at 148-149), *in camera*).

Response to Finding No. 852:

UTMC and St. Luke's discussions did not reach the due diligence stage, where any potential efficiencies could have been identified and quantified. (Gold, Tr. 322-323).

853. St. Luke's also considered affiliating with Mercy. (Wakeman, Tr. 2558). Scott Shook, Vice President of Business Development and Advocacy at Mercy, testified that a merger between Mercy and St. Luke's could produce many efficiencies, {

}. (Shook, Tr. 1003, *in camera*). Mr. Shook also believed that an St. Luke's-Mercy merger could generate {

}. (Shook, Tr. 1003-1004, *in camera*).

Response to Finding No. 853:

The proposed finding is misleading. {

.}

(Shook, Tr. 1107, *in camera*).

854. According to an analysis conducted by third party consultants, the potential benefits of an St. Luke's-Mercy affiliation included: {

}.

(Shook, Tr. 1104-1105, *in camera*; PX02307 at 006 (Aug. 21, 2009 Health Care Future presentation titled "Evaluating a Fully Integrated Relationship"), *in camera*).

Response to Finding No. 854:

Respondent has no specific response.

2. St. Luke's or ProMedica Could Have Unilaterally Accomplished the Efficiencies

855. Respondent asserts that the Acquisition may generate $4.5 million in savings from eliminating a family practice residency program and replacing it with a regular physician's practice. (PX00020 at 016 (Compass Lexecon Report), *in camera*). Ms. Hanley, ProMedica's CFO, testified that ProMedica will close a family practice residency program housed at a ProMedica (not a St. Luke's) facility after the Acquisition. (Hanley, Tr. 4730, *in camera*). She admitted that ProMedica on its own, separate and apart from the Acquisition, could have consolidated its two family practice residency programs. (Hanley, Tr. 4730-4731, *in camera*). As a result, this efficiency is not merger-specific. (PX02147 at 065-066 (¶¶ 120-121) (Dagen Expert Report)).

Response to Finding No. 855:

Upon further analysis, ProMedica concluded it would save approximately {

} (PX02104 at 008, *in camera*).

856. Respondent asserts that ProMedica will experience savings from consolidating inpatient psychiatry programs at Flower Hospital. (PX2104 at 006 (¶ 10) (Akenberger, Decl.), *in camera*). This alleged efficiency is not merger-specific, however, because it appears that the consolidation could have been accomplished without the Acquisition. (Dagen, Tr. 3264, *in camera*; PX02147 at 058-059 (¶¶ 107-109) (Dagen Expert Report)). In particular, the inpatient psychiatry consolidation involves shifting patients from the TTH's inpatient psychiatry department to Flower Hospital. (PX2104 at 006 (¶ 10) (Akenberger, Decl.), *in camera*). Notably, St. Luke's does not provide inpatient psychiatry services, thus this alleged efficiency does not involve shifting any inpatient psychiatry patients between St. Luke's and Flower Hospital. (PX01931 at 042 (Akenberger, Dep. at 161-162), *in camera*; Nolan, Tr. 6328-6329, *in camera*).

Response to Finding No. 856:

Mr. Akenberger testified that ProMedica could not consolidate its {

} (PX02104 at 006, *in camera*). ProMedica expects that, with the joinder, however, {

}

(PX02104 at 006, *in camera*). Mr. Akenberger never testified that the capacity at Flower would increase due to patients shifting to St. Luke's for psychiatric services; thus, Mr. Dagen's conclusion is unfounded. (PX02104 at 006, *in camera*).

857. Respondent claims that St. Luke's will save approximately $1 million on its purchase of supplies as a result of the Acquisition. (PX00020 at 025 (Compass Lexecon Report), *in camera*). These savings were calculated by estimating how much St. Luke's would spend on its supplies if it were to join a group purchasing organization that ProMedica is already a member of. (Dagen, Tr. 3273-3274; PX02147 at 071-072 (¶¶ 132-133) (Dagen Expert Report)). However, any such savings are not merger-specific because St. Luke's could join the group purchasing organization as a standalone hospital. (Dagen, Tr. 3273-3274, *in camera*; PX02147 at 071-072 (¶¶ 132-133) (Dagen Expert Report)).

Response to Finding No. 857:

St. Luke's cannot { } because it, as an individual hospital, it { } than ProMedica. (PX02104 at 011, *in camera*).

858. Respondent asserts that St. Luke's and ProMedica may generate approximately $467,000 in additional revenue from increasing patient referrals between ProMedica and St. Luke's. (PX00020 at 032-033 (Compass Lexecon Report), *in camera*). Mr. Dagen concluded St. Luke's and ProMedica each could have unilaterally increased cross-referrals of patients without the Acquisition in place. (PX02147 at 078-081 (¶¶ 151-155, 159) (Dagen Expert Report)).

Response to Finding No. 858:

Respondent has no specific response.

859. The *Merger Guidelines* state that "parties may believe that they can reduce costs by adopting each other's 'best practices' or by modernizing outdated equipment. But, in many cases, these efficiencies can be achieved without the proposed merger." (PX02292 at 054-055 (*Commentary on the Merger Guidelines*)). That is the case here.

Response to Finding No. 859:

The proposed finding is not a fact, but an improper legal argument.

860. ProMedica intends to reduce St. Luke's staffing levels to reflect ProMedica's practices at Flower Hospital. (PX00020 at 015 (Compass Lexecon Report), *in camera*). This alleged efficiency could be accomplished without the Acquisition because there is nothing proprietary about ProMedica's "best practices" with respect to proper staffing levels, meaning that St. Luke's could have cut staff on its own if it believed doing so was appropriate and would not negatively impact quality of care. (PX02147 at 062 (¶ 114) (Dagen Expert Report)).

Response to Finding No. 860:

Respondent has no specific response.

861. Respondent asserts approximately $2 million of revenue enhancement as a result of implementing new coding and charge capture practices at St. Luke's. (PX00020 at 030 (Compass Lexecon Report), *in camera*). Mr. Dagen concluded that this alleged efficiency is not merger-specific because St. Luke's could have improved its coding and charge capture best practices on its own. (PX02147 at 078-079 (¶¶ 150-154) (Dagen Expert Report)).

Response to Finding No. 861:

Respondent has no specific response.

862. Ron Wachsman, ProMedica's Vice President of Managed Care and Reimbursement, testified that the coding and charge capture revenue enhancements are "best practices." (Wachsman, Tr. 5230-5231, *in camera*). The information technology platforms that ProMedica uses to maximize its revenue collections are available through a third party vendor. (Wachsman, Tr. 5230-5231, *in camera*). As a result, Mr. Wachsman acknowledged that St. Luke's may have been able to achieve the $2 million in revenue enhancements on its own. (Wachsman, Tr. 5230, *in camera*).

Response to Finding No. 862:

Respondent has no specific response.

863. Ms. Hanley, ProMedica's CFO, described these coding and charge capture practices as "very common revenue cycle approaches and techniques that you can go to any seminar and . . . gain information about." (Hanley, Tr. 4735, *in camera*).

Response to Finding No. 863:

Respondent has no specific response.

864. Dennis Wagner, St. Luke's Finance Director, testified about the coding and charge capture efficiency claim: "I would not think there was that much opportunity, because I believe our routines are proper and correct right now." (PX01915 at 054 (Wagner, IHT at 209), *in camera*). In fact, Navigant Consulting already conducted a coding and documentation study for St. Luke's in 2009. (PX01946 at 007 (Nolan, Dep. at 18-19)).

Response to Finding No. 864:

Complaint Counsel has not cited any evidence that the information that Navigant Consulting provided St. Luke's was similar to or more efficient than the best practices that ProMedica employs.

865. Respondent asserts as an efficiency the revenue enhancement that St. Luke's will experience as a result of becoming an in-network provider in the Paramount provider network. (PX00020 at 031 (Compass Lexecon Report), *in camera*). However, this alleged efficiency could have been accomplished without the Acquisition if Paramount had simply chosen to contract with St. Luke's. (Dagen, Tr. 3289-3290, *in camera*; PX02147 at 080-081 (¶ 158) (Dagen Expert Report)).

Response to Finding No. 865:

The proposed finding is inaccurate and misleading. Prior to the joinder, St. Luke's had proposed rates to Paramount that it found unacceptable. (Randolph, Tr. 7084) ("Well, for Paramount, to the extent we could add St. Luke's at a cost-effective rate that did not impede our ability to be cost-effective, then yes, it was important. We never got to that point because they never did, so, therefore, the issue of it being important to anyone else is kind of a moot point.").

866. St. Luke's executives expressed interest in participating in Paramount's provider network prior to the Acquisition. (Wakeman, Tr. 2584-2585; PX01911 at 035 (Wakeman, IHT at 134-135), *in camera* ("we'd really like to get back in")). Mr. Wachsman testified that it was ProMedica's reluctance that prevented St. Luke's from being a part of the Paramount provider network prior to the Acquisition. (PX01905 at 052 (Wachsman, IHT at 203), *in camera*). In particular, ProMedica did not add St. Luke's to Paramount's network prior to the Acquisition due to concerns about the patient volume that ProMedica's hospitals would lose to St. Luke's. (Wachsman, Tr. 5193, *in camera*).

Response to Finding No. 866:

The proposed finding is inaccurate and misleading. Prior to the joinder, St. Luke's had proposed rates to Paramount that it found unacceptable. (Randolph, Tr. 7084) ("Well, for

Paramount, to the extent we could add St. Luke's at a cost-effective rate that did not impede our ability to be cost-effective, then yes, it was important. We never got to that point because they never did, so, therefore, the issue of it being important to anyone else is kind of a moot point.").

867. Mr. Wakeman testified in court that St. Luke's might have been able to gain access to Paramount's provider network through an affiliation with UTMC, as well. (Wakeman, Tr. 2692, *in camera*; PX01030 at 002 (Affiliation Analysis Update), *in camera*).

Response to Finding No. 867:

The proposed finding is misleading. On April 10, 2009, Paramount informed UTMC that it would not add St. Luke's to its provider network because {

}

(PX00224 at 002, *in camera*).

E. The Proposed Efficiencies Appear Designed for Litigation

868. Projections of efficiencies may be viewed with skepticism, particularly if they are generated outside of the usual business planning process. (PX02214 at 032-034 (§ 10) (*Merger Guidelines*)).

Response to Finding No. 868:

The proposed finding is not a fact, but an improper legal argument.

869. By late 2009, St. Luke's leadership was aware that a transaction with ProMedica would generate an antitrust review. (PX01030 at 017 (St. Luke's 2009 "Affiliation Analysis Update" to the St. Luke's Board, containing HHI calculations), *in camera*).

Response to Finding No. 869:

The proposed finding is misleading because St. Luke's calculated HHIs for affiliations with Mercy and UTMC as well. (PX01030 at 017, *in camera*).

870. Even before Complaint Counsel's investigation began, ProMedica had budgeted hundreds of thousands of dollars for the anticipated antitrust review, which it expected would last at least several months. (PX00077 at 001 (ProMedica "High Level Timeline"); PX01918 at 024 (Oostra, Dep. at 86-87), *in camera*).

Response to Finding No. 870:

Respondent has no specific response.

871. A January 2010 document planning for the Acquisition includes references to "[e]fficiency [e]xperts" and "[e]fficiency expert reports" under the column "Antitrust Review." (PX00077 at 001 (ProMedica "High Level Timeline")).

Response to Finding No. 871:

Respondent has no specific response.

872. ProMedica executives testified that the decision to hire Compass Lexecon was motivated, in part, by the need to present an efficiencies analysis of the Acquisition during FTC review. (Oostra, Tr. 6150; PX01906 at 072-073 (Oostra, IHT at 284-285), *in camera*; PX01903 at 058 (Hanley, IHT at 225), *in camera*). ProMedica hired Compass Lexecon, in particular, because it had extensive experience in dealing with the FTC. (Oostra, Tr. 6150-6151; (PX00077 at 001 (ProMedica "High Level Timeline")).

Response to Finding No. 872:

ProMedica also hired Compass Lexecon to determine whether it could achieve enough savings at St. Luke's so that a joinder would not impact ProMedica's other hospitals. (Oostra, Tr. 6150). It was important to ProMedica that the efficiencies were accurate and that ProMedica could achieve them. (Oostra, Tr. 6150).

873. The Compass Lexecon Report includes a summary of the underlying process used to generate and document the asserted efficiencies. The report's summary states that the process was "supervised by antitrust counsel" and that "Compass Lexecon's role . . . was to provide antitrust guidance." (PX00020 at 003 (Compass Lexecon Report), *in camera*). The May 6, 2010 Compass Lexecon Report was completed only weeks before ProMedica signed the Joinder Agreement to acquire St. Luke's. (Oostra, Tr. 6147).

Response to Finding No. 873:

{

} (Hanley, Tr. 4647-4648, 4652, *in camera*).

874. After ProMedica received "[u]nfavorable responses from Compass Lex[e]con" because it had not "accomplished enough in savings," ProMedica concluded that it would "need to be more aggressive with a timeline of the first 3-5 years" because the "FTC discounts [the] value of [efficiencies] each year the farther out you go." (PX01136 at 001 (ProMedica "Joinder Efficiencies Opportunities"), *in camera*).

Response to Finding No. 874:

Complaint Counsel neither showed this document to any witnesses nor asked any witnesses any questions about the context of this document.

875. Navigant's "Clinical Integration Strategy" report was finalized in January 2011, four months after the Acquisition had been consummated. (PX00479 ("Clinical Integration Strategy" Final Report), *in camera*). Kevin Nolan, the lead consultant on the project, testified that work product generated for the purposes of this report was reviewed by Respondent's antitrust counsel. (Nolan, Tr. 6324, *in camera*).

Response to Finding No. 875:

The proposed finding is misleading. Mr. Nolan testified that Respondent's antitrust counsel's review of Navigant's work product changed neither its conclusions or recommendations as a result of the attorney review. (Nolan, Tr. 6397).

F. The Claimed Efficiencies Do Not Outweigh the Anticompetitive Harm Resulting From the Acquisition

876. Dr. Town concurred with Mr. Dagen's analysis of ProMedica's alleged efficiencies, and concluded that the alleged benefits of the Acquisition would not outweigh the significant competitive harm that would result from the Acquisition. (Town, Tr. 3607 ("any merger-specific efficiencies are going to be insufficient to outweigh the rather large impact on prices that this acquisition will lead to"); PX02148 at 093-094 (¶ 171) (Town Expert Report), *in camera*).

Response to Finding No. 876:

The proposed finding is not a fact, but an improper legal argument.

G. Healthcare Reform Measures Do Not Justify the Acquisition

877. Ongoing healthcare reform provides incentives for providers to form Accountable Care Organizations ("ACO"). (PX01449 at 014-015 (Nov. 2009 "Reform Readiness Assessment" by Kaufman Hall)).

Response to Finding No. 877:

Respondent has no specific response.

878. Another component of healthcare reform is the installation of Electronic Medical Records ("EMR" or "EHR") systems at hospitals. (Den Uyl, Tr. 6452-6453, *in camera*). Under the American Recovery and Reinvestment Act of 2009, hospitals receive financial incentives for meeting certain "meaningful use" targets for EMR implementation.

(PX01281 at 010-012 ("Financial Pillar Challenge" presentation); PX01928 at 014 (Perron, Dep. at 47-48), *in camera*).

Response to Finding No. 878:

Respondent has no specific response.

879. Because St. Luke's was, prior to the Acquisition, a low-cost and high-quality provider, it was well-positioned to take advantage of pending healthcare reform. (PX01072 at 001 ("Key Messages from St. Luke' Hospital"); Wakeman, Tr. 2620-2621).

Response to Finding No. 879:

The proposed finding is inaccurate and misleading. Mr. Wakeman verified that St. Luke's quality scores { } (RPF 1462-1464, *in camera*). As of March 2011, St. Luke's was the lowest performing hospital of ProMedica's Toledo-area hospitals according to CMS scores. (RPF 1467). Moreover, 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).

880. Furthermore, St. Luke's was in a financial position to implement an EMR system and appeared motivated prior to the Acquisition to do so in time to receive federal subsidies. (PX02147 at 015 (¶ 29) (Dagen Expert Report); PX01933 at 039 (Oppenlander, Dep. at 147-148), *in camera;* PX01908 at 055 (Deacon, IHT at 213), *in camera*).

Response to Finding No. 880:

At the time of the joinder, St. Luke's did not have sufficient IT staff to comply with the "meaningful use" requirements. (RPF 1727). St. Luke's was also not certain whether it would { } (RPF 1732, *in camera*). 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*)). Furthermore, St. Luke's was unable to comply with the statutory requirements in any financially prudent manner. (RPF 1737, 1733).

1. ACO Requirements Have Not Yet Been Finalized

881. Providers in an ACO agree to be accountable for quality, cost, and overall care in exchange for a share of the savings achieved. (PX01449 at 014-015 (Nov. 2009 "Reform Readiness Assessment" by Kaufman Hall)). Savings achieved by an ACO can be shared via contractual relationships, joint ventures, and other methods besides mergers, joinders, or acquisitions. (PX01920 at 030 (Wakeman, Dep. at 111), *in camera*; PX01449 at 020-022 (Nov. 2009 "Reform Readiness Assessment" by Kaufman Hall)). Indeed, it is likely that, absent this Acquisition, an independent St. Luke's would, if invited, participate both in ProMedica's and Mercy's ACOs. (PX01920 at 030 (Wakeman, Dep. at 111-112), *in camera*).

Response to Finding No. 881:

The proposed finding is inaccurate and misleading. The documents that Complaint Counsel cites for its first two statements do not support those statements. Mr. Wakeman testified that it was speculative to suggest that { } and further speculation to guess as to whether { } (PX01920 (Wakeman, Dep. at 113-114), *in camera*).

882. Healthcare reform remains in flux, and the nature and form of ACOs remain undetermined. St. Luke's CEO, Mr. Wakeman, noted: "I think we know there's going to be ACOs. Exactly what they're going to look like and who's going to be in them and how they're going to perform has yet to be defined." (PX01920 at 031 (Wakeman, Dep. at 114), *in camera*). Mr. Wakeman also testified that "because [ACOs] haven't been finalized, we don't know what the final rules are at this point." (Wakeman, Tr. 2621; PX01920 at 030-031 (Wakeman, Dep. at 111-114), *in camera* ("[i]t's all speculation")).

Response to Finding No. 882:

Respondent has no specific response.

883. Randy Oostra, CEO of ProMedica, testified that ACO regulations are "still in draft form" and, as a result, no one is certain what ACOs will look like until the rules are finalized.

(Oostra, Tr. 6154). Further, he indicated that ProMedica may not pursue an ACO model at all due to its complexity. (Oostra, Tr. 6154-6155).

Response to Finding No. 883:

Respondent has no specific response.

884. As a result of the ACO rules not yet being clearly defined, St. Luke's CEO has not studied them in depth. (PX01920 at 031 (Wakeman, Dep. at 114), *in camera*). Further, as of yet there has not been any indication that a hospital must be a part of a health system in order to participate in its ACO. (Wakeman, Tr. 2623-2624).

Response to Finding No. 884:

Respondent has no specific response.

2. Independent St. Luke's Was Well-Positioned for Healthcare Reform

885. In November 2009, St. Luke's concluded that it was "uniquely positioned for a smooth transition to expected health care reform. The hospital already focuses on quality and cost – key components of reform." (PX01072 at 001 ("Key Messages from St. Luke's Hospital"); Wakeman, Tr. 2620-2621). In particular, Mr. Wakeman noted in an e-mail in 2009 that St. Luke's was in a better position than other organizations in the Toledo community to get its cost structure in line with the expectations of health reform. (PX01408 (Feb. 2009 e-mail from Dan Wakeman, CEO, to David Oppenlander, former CFO); Wakeman, Tr. 2845-2846).

Response to Finding No. 885:

The proposed finding is misleading. Mr. Wakeman verified that St. Luke's quality scores

{ } (RPF 1462-1464, *in camera*). As of March 2011, St. Luke's was the lowest performing hospital of ProMedica's Toledo-area hospitals according to CMS scores. (RPF 1467). Moreover, 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).

886. In a "Competitive Profile Matrix" prepared in the ordinary course of business, St. Luke's concluded that its "low cost position" and "[i]nformation flow and infrastructure" meant that it had "much already in place to deal with possible upcoming changes" related to healthcare reform. (PX01132 at 004-005, *in camera*).

Response to Finding No. 886:

The same "Competitive Profile Matrix" also identified St. Luke's weaknesses with respect to healthcare reform, including that St. Luke's {

} (PX01132 at 004, *in camera*). Moreover, 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).

887. Further, St. Luke's could have likely participated in Lucas County ACOs without the Acquisition. (PX01920 at 030 (Wakeman, Dep. at 111), *in camera*).

Response to Finding No. 887:

The proposed finding is inaccurate and misleading. Mr. Wakeman testified that it was speculative to suggest that { } and further speculation to guess as to whether { .} (PX01920 (Wakeman, Dep. at 113-114), *in camera*).

888. At the time of the Acquisition, St. Luke's had adequate reserves and cash from operations to fully fund the installation of an EMR system, and still have money left over to fund other capital projects, pay off its debt, and retain sufficient reserves for future use. (PX02147 at 015-016, 041-042 (¶¶ 30, 74-75) (Dagen Expert Report)).

Response to Finding No. 888:

The proposed finding is inaccurate and misleading. At the time of the joinder, St. Luke's did not have sufficient IT staff to comply with the "meaningful use" requirements. (RPF 1727). St. Luke's was also not certain whether it would { } (RPF 1732, *in camera*). Furthermore, St. Luke's was unable to comply with the statutory requirements in any financially prudent manner. (RPF 1737, 1733). In addition, Mr. Dagen improperly 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. (RPF 2074; *see also* RPF 1635 (reserve funds exist for emergency cash needs that may arise outside of normal operations)).

889. St. Luke's ordinary course of business documents indicated that the cost of implementing an EMR system would be approximately $20 million over a seven year period. (PX01496 at 003 (EMR bid from vendor); PX01928 at 027, 029 (Perron, Dep. at 99-100, 109) (indicating that PX01496 represents price of implementing EMR at St. Luke's), *in camera*).

Response to Finding No. 889:

The proposed finding is inaccurate and misleading. Eclipsys's proposal would not cover all of the hospital systems that St. Luke's required. (RPF 1725). It also did not account for the operational expenses associated with implementing and maintaining that system. (RPF 1728).

{ }

(RPF 1729, *in camera*).

890. St. Luke's concluded that it would qualify for $6.3 million in federal subsidies to help fund its EMR system. (PX01281 at 012 (St. Luke's "Financial Pillar Challenge"); PX01503 at 001 (mid-2010 updated bid from EMR vendor), *in camera*).

Response to Finding No. 890:

The proposed finding is inaccurate and misleading. Neither of the cited documents include any analysis of whether St. Luke's would be able to meet the deadlines to qualify for the

federal subsidies. (PX01281 at 012; PX01503 at 001, *in camera*). Moreover, Mr. Perron, St. Luke's Computer Information Systems Director, testified that {

} (RPF 1732, *in camera*; RX-22 (Perron, Dep. at 111), *in camera*).

891. St. Luke's had a $6 million "placeholder" in its capital budget for EMR. (PX00022 at 002, *in camera*).

Response to Finding No. 891:

The proposed finding is misleading. St. Luke's never allocated funds to purchase a new EMR system and was unable to comply with the statutory requirements in any financially prudent manner. (RPF 1733, 1737).

892. St. Luke's CFO, Computer Information Systems Director, and CEO all advocated for St. Luke's to go forward with implementing EMR at the start of 2010. (PX01928 at 021, 023, 030 (Perron, Dep. at 75-76, 84-85, 113), *in camera*).

Response to Finding No. 892:

Mr. Perron testified that St. Luke's had not {

} so it was not {

} (PX01928 (Perron, Dep. at 76), *in camera*). Moreover, St. Luke's never allocated funds to purchase a new EMR system and was unable to comply with the statutory requirements in any financially prudent manner. (RPF 1733, 1737).

893. Douglas Deacon, St. Luke's Vice President of Professional Services, testified that St. Luke's "would have to move forward" with implementing an EMR system absent the Acquisition. (PX01908 at 055 (Deacon, IHT at 213), *in camera*).

Response to Finding No. 893:

Respondent has no specific response.

894. St. Luke's Chairman, James Black, testified that St. Luke's could have installed the new IT system on its own (without the Acquisition), given its financial condition and the asset value of its reserve fund. (Black, Tr. 5702).

Response to Finding No. 894:

At the time of the joinder, St. Luke's did not have sufficient IT staff to comply with the "meaningful use" requirements. (RPF 1727). St. Luke's was also not certain whether it would { } (RPF 1732, *in camera*). Furthermore, St. Luke's was unable to comply with the statutory requirements in any financially prudent manner. (RPF 1737, 1733). In addition, St. Luke's executives testified that St. Luke's could not access the entirety of its reserve funds, particularly its restricted reserves, to fund its operations. (RPF 2074; *see also* RPF 1635 (reserve funds exist for emergency cash needs that my arise outside of normal operations)).

895. The reason St. Luke's did not begin implementing EMR in early 2010 was the uncertainty caused by the Acquisition talks. (PX01928 at 037 (Perron, Dep. at 138), *in camera*; PX01933 at 039 (Oppenlander, Dep. at 147-148), *in camera*). Mr. Den Uyl, Respondent's own expert witness, testified that St. Luke's fully intended to start implementing EMR in 2010 were it not for the Acquisition. (Den Uyl, Tr. 6575-6576, *in camera*).

Response to Finding No. 895:

The exhibit Complaint Counsel cite (PX01933) does not contain the designated testimony.

XVI. RESPONDENT HAS FAILED TO MEET ITS BURDEN TO SHOW ST. LUKE'S IS A FAILING – OR FLAILING – FIRM

A. St. Luke's is Not a Failing Firm

896. Respondent cannot meet its burden to demonstrate that St. Luke's faced imminent failure and that it adequately pursued less harmful alternatives to the Acquisition, nor has Respondent asserted a failing-firm defense in this proceeding.

Response to Finding No. 896:

This proposed finding is not a fact but an improper legal argument. The proposed finding also violates the ALJ's Order on Post-Trial Briefs by failing to contain "specific references to the evidentiary record."

897. Respondent has admitted that, at the time of the Acquisition, St. Luke's was not a "failing firm" as defined under the *Horizontal Merger Guidelines* and U.S. Supreme Court precedent. (Joint Stipulations of Law and Fact, JX00002A ¶ 21; Response to RFA at ¶ 42).

Response to Finding No. 897:

Respondent has no specific response.

B. St. Luke's Successful Rebound Prior to the Acquisition Rebuts Respondent's "Flailing Firm" Claims

898. Before becoming St. Luke's CEO in early 2008, Daniel Wakeman was involved in improving the operating performance of several other hospitals. (Wakeman, Tr. 2473-2474; PX01911 at 008, 011, 013-014 (Wakeman, IHT at 27, 37-38, 45, 51-52), *in camera*).

Response to Finding No. 898:

This proposed finding is out of context and misleading in that it ignores Mr. Wakeman's extensive testimony describing how size, demographics, financial dynamics and managed care environment of the hospitals where he worked previously were vastly different from St. Luke's and the city of Toledo. For example, Herrick Memorial in Tecumseh, Michigan, War Memorial in Sault St. Mary Michigan, and Mercy Monroe in Monroe Michigan were all rural hospitals located in small communities with very limited competition. Also, all these hospitals were in Michigan where the managed care environment is very different than in Ohio. (Wakeman, Tr. 2706-2732).

899. Mr. Wakeman testified that all four of the previous hospitals he managed – he was President of three – experienced significant financial improvement during his tenure. (Wakeman, Tr. 2473-2474; PX01911 at 014 (Wakeman, IHT at 51-52), *in camera* ("positive trajectory in terms of revenue and operation")).

Response to Finding No. 899:

This proposed finding is out of context and misleading in that it ignores Mr. Wakeman's extensive testimony describing how size, demographics, financial dynamics and managed care environment of the hospitals where he worked previously were vastly different from St. Luke's and the city of Toledo. For example, Herrick Memorial in Tecumseh, Michigan, War Memorial in Sault St. Mary Michigan, and Mercy Monroe in Monroe Michigan were all rural hospitals located in small communities with very limited competition. Also, all these hospitals were in Michigan where the managed care environment is very different than in Ohio. (Wakeman, Tr. 2706-2732).

900. When first assessing St. Luke's, Mr. Wakeman concluded that it had "huge potential" because a "decline in revenue, in itself, in an area where you have growth, means opportunity." (PX01911 at 016-017 (Wakeman, IHT at 59-61), *in camera*; Wakeman, Tr. 2481) ("it sat in an optimal or better part of the community in the sense of growth and economic potential")).

Response to Finding No. 900:

This proposed finding is misleading and out of context in that it ignores Mr. Wakeman's testimony describing the problems and complexities he observed when first assessing St. Luke's. For example, he was concerned about its 10 year declining revenue stream and exodus of medical staff. (Wakeman, Tr. 2740-2741). Mr. Wakeman also testified that St. Luke's was losing money from operations when he arrived (Wakeman, Tr. 2770) and that St. Luke's had let go 80-100 managers two years before he arrived to try to improve its financial condition. (Wakeman, Tr. 2771). It is also misleading because it ignores Mr. Wakeman's testimony in which he described that did not have complete information regarding St. Luke's when he made his initial assessment. For example, he testified he did not have complete information about St. Luke's defined benefit pension problems, St. Luke's MCO contracting strategies, or St. Luke's MCO reimbursement rates. (Wakeman, Tr. 2745-2746). Moreover, Mr. Wakeman testified

that he never met with the CEO or senior management at St. Luke's before making his initial assessment and taking the position as CEO at St. Luke's. (Wakeman, Tr. 2735).

901. By 2010, St. Luke's volume and financial viability had improved. (Wakeman, Tr. 2597). Even as of November 2009, Mr. Wakeman referred to St. Luke's as "financially stable[.]" (PX00924 at 001 (Wakeman Nov. 2009 Email).

Response to Finding No. 901:

This proposed finding is misleading as it inaccurately uses two citations to suggest that Mr. Wakeman believed St. Luke's financial viability had improved in 2009, which was not the case. (*See*, e.g. Wakeman, Tr. 2942-2943 (Q: "Were you still concerned about the financial viability of St. Luke's around the middle of October [2009]...? A: Yes, I was.")). This proposed finding inaccurately cites Mr. Wakeman's testimony about improvement in St. Luke's volume and financial viability *in* 2010, not "by 2010" as Complaint Counsel asserts. (Wakeman, Tr. 2597). The citation to the email by Mr. Wakeman, PX00924, is out of context and misleading. In this email Mr. Wakeman is instructing St. Luke's head of public relations how to best frame St. Luke's poor financial performance in 2009 for an article in the Toledo Blade newspaper comparing area hospitals. Taking the full sentence from which Complaint Counsel draws the citation Mr. Wakeman writes: "We should let them know that our operational performance in 2009 is weak as well, although stress our balance sheet position, and that we are financially stable, yet understand the need to reverse our operational losses." (PX00924 at 001).

902. Theresa Konwinski, St. Luke's Vice President for Patient Care Services, wrote in August 2010 that St. Luke's was "growing, not downsizing." (PX01582 at 003 (Konwinski Aug. 2010 Monthly Report), *in camera*).

Response to Finding No. 902:

This proposed finding is misleading as St. Luke's and its parent OhioCare incurred significant financial losses in the first eight months of 2010 despite growth in activity and revenues. (RPF 1616-1620; PX02147 at 028-029).

903. According to James Black, Chairman of St. Luke's Board of Directors, by August 2010, St. Luke's was a profitable and well-performing hospital that was near its capacity. (Black, Tr. 5687). Mr. Black testified that St. Luke's financial indicators were "looking up" in August 2010. (Black, Tr. 5684-5685).

Response to Finding No. 903:

This proposed finding is misleading and inaccurately quotes Mr. Black's testimony. Mr. Black testified about St. Luke's performance *in* August 2010 not "by" August 2010. (Black, Tr. 5687). The small operating profit St. Luke's made in August 2010 ($7,000 on $36 million revenue) was an anomaly, augmented by a State of Ohio tax credit payment and a payment from UTMC that month. (RPF 1956, 1959). Moreover, Mr. Black testified that he did not believe St. Luke's was in a better financial position in 2010 than when Dan Wakeman arrived in 2008. (Black, Tr. 5662). The proposed finding is also misleading because St. Luke's and its parent OhioCare incurred significant financial losses in the first eight months of 2010 despite growth in activity and revenues. (RPF 1616-1620, 1941-1961). Mr. Black testified that St. Luke's improvement in revenues in 2010 "in no way alleviated [his] concerns of being able to keep St. Luke's as a full acute community hospital." (Black, Tr. 5662).

904. Respondent's expert witness, Bruce Den Uyl, testified that in the six months leading up to the consummation of the Acquisition, St. Luke's financial performance had "improved." (Den Uyl, Tr. 6562).

Response to Finding No. 904:

This proposed finding is misleading as Mr. Den Uyl's report and testimony highlight the fact that St. Luke's and its parent OhioCare experienced significant financial losses from 2007 through the joinder including a loss of $7.7 million in the first eight months of 2010. (RPF 1616-1617). Mr. Den Uyl also points out that OhioCare's EBIDTA {

} (RPF 1625-1627, *in camera*). In response to Complaint Counsel's question at

trial of whether St. Luke's financial performance improved in the eight months ending August 31, 2010, Mr. Den Uyl replied, { } (Den Uyl, Tr. 6562, *in camera*). This proposed finding is also inaccurate because Mr. Den Uyl did not make any statements during his trial testimony about St. Luke's financial performance in the six months leading up to the joinder; he only commented on the eight month period. (Den Uyl, Tr. 6561-6562).

905. Complaint Counsel's expert witness, Gabriel Dagen, concluded that "at the time that it was completing its transaction with ProMedica, St. Luke's was in the middle of executing a successful turnaround" that was "initiated in early 2008 under the direction of St. Luke's new CEO, Mr. Wakeman." (PX02147 at 026 (¶ 49) (Dagen Expert Report)).

Response to Finding No. 905:

Mr. Dagen's conclusion is contradicted by the evidence which demonstrates that St. Luke's financial problems continued despite the three-year plan implemented by Mr. Wakeman and that St. Luke's failed to meet the financial goals of the plan. (*See, e.g.* RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644, 1941-1954, 1955, *in camera*, 1956-1961).

1. Wakeman Three-Year Growth Plan, Sustainable Improvements

906. Mr. Wakeman instituted a "Three-Year Plan" in June 2008 that contained five strategic pillars: "Growth, People, Quality, Service, and Finance/Corporate." (PX01026 at 001 (St. Luke's Three-Year Plan); Joint Stipulations of Law and Fact, JX00002A ¶ 39).

Response to Finding No. 906:

Respondent has no specific response.

907. These pillars included several goals for turning St. Luke's finances around, including: increasing inpatient and outpatient net revenues, growing St. Luke's market share to 40 percent within its "core service area," hiring "core physicians" in various specialties, and attaining "access" to 90 percent of the managed care enrollees in the Toledo area. (PX01026 at 001-002 (St. Luke's Three-Year Plan); RX-56 at 20 (¶ 50) (Den Uyl Expert Report), *in camera*).

Response to Finding No. 907:

Respondent has no specific response.

908. By the time of the Acquisition – a little over two years into the three-year plan – St. Luke's already had achieved four of the five pillars in Mr. Wakeman's turnaround plan. (Wakeman, Tr. 2593-2594; PX01326 (Wakeman Sept. 2010 Email) ("guess that growth thing worked . . . we did a great job in 4 of the 5 pillars.")).

Response to Finding No. 908:

This proposed finding is misleading because it implies that St. Luke's achieved most of the three-year plan including its financial goals. In fact, St. Luke's did not achieve the financial goals of the three-year plan – it did not achieve the financial pillar. (1941-1954, 1955, *in camera*, 1956-1961). The evidence overwhelmingly demonstrates that St. Luke's financial problems continued despite the three-year plan implemented by Mr. Wakeman. (*See e.g.*, RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644).

909. Specifically, with respect to the first pillar, "Growth," Mr. Wakeman was successful on three of the four specific goals identified. (Response to IROG at ¶ 17).

Response to Finding No. 909:

This proposed finding is misleading because it implies that St. Luke's achieved most of the three-year plan including its financial goals. In fact, St. Luke's did not achieve the financial goals of the three-year plan – it did not achieve the financial pillar. (RPF 1941-1954, 1955, *in camera*, 1956-1961). The evidence overwhelmingly demonstrates that St. Luke's financial problems continued despite the three-year plan implemented by Mr. Wakeman. (*See e.g.*, RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644). For example, St. Luke's and its parent OhioCare incurred significant financial losses in 2008, 2009 and the first eight months of 2010 despite growth in activity and revenues during that period. (RPF 1616-1620; PX02147 at 028-029). In response to Complaint Counsel's

question to Mr. Wakeman suggesting that St. Luke's had improved during his tenure, Mr. Wakeman replied, "Activity, yes. Financial, no." (Wakeman, Tr. 2608).

910. Mr. Wakeman's first "Growth" goal was to increase inpatient net revenue by $3.5 million per year, within three years. (PX01026 at 001 (St. Luke's Three-Year Plan).

Response to Finding No. 910:

Respondent has no specific response.

911. By August 31, 2010, ahead of schedule St. Luke's already had increased inpatient net revenue by more than $3.5 million per year on average. (Joint Stipulations of Law and Fact, JX00002A ¶ 40; Response to IROG at ¶ 17).

Response to Finding No. 911:

This proposed finding is misleading because it implies that St. Luke's achieved a key financial goal of the three-year plan. In fact, St. Luke's did not achieve the financial goals of the three-year plan. (RPF 1941-1954, 1955, *in camera*, 1956-1961). The evidence overwhelmingly demonstrates that St. Luke's financial problems continued despite the three-year plan implemented by Mr. Wakeman. (*See e.g.*, RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644). For example, St. Luke's and its parent OhioCare incurred significant financial losses in 2008, 2009 and the first eight months of 2010 despite growth in activity and revenues during that period. (RPF 1616-1620; PX02147 at 028-029). In response to Complaint Counsel's question to Mr. Wakeman suggesting that St. Luke's had improved during his tenure, Mr. Wakeman replied, "Activity, yes. Financial, no." (Wakeman, Tr. 2608).

912. Mr. Wakeman's next "Growth" goal was to increase outpatient net revenue by $5 million per year, within three years. (PX01026 at 001 (St. Luke's Three-Year Plan).

Response to Finding No. 912:

Respondent has no specific response.

913. By August 31, 2010, ahead of schedule St. Luke's already had increased outpatient net revenue by more than $5 million per year on average. (Joint Stipulations of Law and Fact, JX00002A ¶ 41; Response to IROG at ¶ 17).

Response to Finding No. 913:

This proposed finding is misleading because it implies that St. Luke's achieved a key financial goal of the three-year plan. In fact, St. Luke's did not achieve the financial goals of the three-year plan. (RPF 1941-1954, 1955, *in camera*, 1956-1961). The evidence overwhelmingly demonstrates that St. Luke's financial problems continued despite the three-year plan implemented by Mr. Wakeman. (*See e.g.*, RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644). For example, St. Luke's and its parent OhioCare incurred significant financial losses in 2008, 2009 and the first eight months of 2010 despite growth in activity and revenues during that period. (RPF 1616-1620; PX02147 at 028-029). In response to Complaint Counsel's question to Mr. Wakeman suggesting that St. Luke's had improved during his tenure, Mr. Wakeman replied, "Activity, yes. Financial, no." (Wakeman, Tr. 2608).

914. Mr. Wakeman's third "Growth" goal was to achieve 40% inpatient market share in its core service area, within 3 years. (PX01026 at 001 (St. Luke's Three-Year Plan).

Response to Finding No. 914:

Respondent has no specific response.

915. By the end of 2010, ahead of schedule St. Luke's already had achieved more than 40% market share in its core service area. (Response to IROG at ¶ 17).

Response to Finding No. 915:

This proposed finding is misleading because it implies that St. Luke's achieved a key financial goal of the three-year plan. In fact, St. Luke's did not achieve the financial goals of the three-year plan. (RPF 1941-1954, 1955, *in camera*, 1956-1961). The evidence overwhelmingly demonstrates that St. Luke's financial problems continued despite the three-year plan

implemented by Mr. Wakeman. (*See e.g.*, RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644). For example, St. Luke's and its parent OhioCare incurred significant financial losses in 2008, 2009 and the first eight months of 2010 despite growth in market share during that period. (RPF 1616-1620; PX02147 at 028-029). Moreover, market shares in St. Luke's "core service area" are meaningless for antitrust analysis. (RPF 1036).

a. St. Luke's Increased Its Inpatient and Outpatient Net Revenues

916. By April 2009, one year into the three-year plan, St. Luke's already had achieved its goals for increasing inpatient and outpatient net revenues. (Wakeman, Tr. 2594; PX01911 at 042 (Wakeman, IHT at 161-162), *in camera*); PX02147 at 027 (¶ 51) (Dagen Expert Report); Joint Stipulations of Law and Fact, JX00002A ¶¶ 40-41 (both net revenue goals were achieved by Aug. 31, 2010)).

Response to Finding No. 916:

This proposed finding is misleading because it implies that St. Luke's achieved a key financial goal of the three-year plan. In fact, St. Luke's did not achieve the financial goals of the three-year plan. (RPF 1941-1954, 1955, *in camera*, 1956-1961). The evidence overwhelmingly demonstrates that St. Luke's financial problems continued despite the three-year plan implemented by Mr. Wakeman. (*See e.g.*, RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644). For example, St. Luke's and its parent OhioCare incurred significant financial losses in 2008, 2009 and the first eight months of 2010 despite growth in market share during that period. (RPF 1616-1620; PX02147 at 028-029). As Dan Wakeman explained, St. Luke's September 2009 year-to-date income statement and 2010 budget were {

} (Wakeman, Tr. 2942-2943, *in camera*; PX01283 at 002, *in camera*).

917. St. Luke's total net patient service revenues increased 27 percent from $126.7 million in 2007 to approximately $161.3 million in 2010 (2010 figure calculated by annualizing figures as of Aug. 31, 2010). (PX01265 at 004 (OhioCare Consolidated Statement of Operations as of Aug. 31, 2010)).

Response to Finding No. 917:

The proposed finding is misleading because St. Luke's incurred large losses from 2007 through August 31, 2010 despite increases in volume. (RPF 1616-1620; PX02147 at 028-029). For example, OhioCare lost $20.3 million in 2009 and $7.7 million in the first eight months of 2010. (RPF 1616). St. Luke's was struggling financially at the time of the acquisition and had not achieved the financial goals of the three year plan. (RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644 1941-1954, 1955, *in camera*, 1956-1961).

Also, the "annualized" statistics cited by Complaint Counsel are also inaccurate because they improperly include one time increases in revenue prior to the joinder such as St. Luke's addition to the Anthem network and acquisitions of physician practices. (RX-56 at 000036, *in camera*). The annualized numbers do not account for the fact that St. Luke's volume growth was likely to plateau before the end of 2010. (Wakeman, Tr. 2616).

918. Kathleen Hanley, ProMedica's CFO, testified that St. Luke's has experienced a positive trend in patient revenues since 2008. (Hanley, Tr. 4701-4702).

Response to Finding No. 918:

This proposed finding is misleading because it implies that Ms. Hanley and ProMedica believed that St. Luke's finances were improving prior to the joinder. However, as part of ProMedica's due diligence of St. Luke's prior to the acquisition, Ms. Hanley and her finance team at ProMedica projected that OhioCare's losses would be about $13.4 million for 2010. (Hanley, Tr. 4612-4613). Ms. Hanley expected that even though St. Luke's volume was increasing, St. Luke's was going to continue losing money throughout 2010. (Hanley, Tr. 4612-

4613). In addition, ProMedica understood that St. Luke's had significant capital needs prior to the joinder and did not believe that St. Luke's was capable of making those investments on its own. (RFP 925-926).

919. Mr. Wakeman testified that St. Luke's inpatient and outpatient revenue growth was "significant" during the twelve months prior to the Acquisition's consummation on August 31, 2010. (PX01920 at 010 (Wakeman, Dep. at 30-31), *in camera*; Wakeman, Tr. 2594).

Response to Finding No. 919:

This proposed finding is inaccurate and misleading. First, in his response to Complaint Counsel's question of whether revenues increased significantly in the twelve months leading up to the joinder, Mr. Wakeman emphasized only that "*gross* revenues" did increase. (Wakeman, Tr. 2594). Second, this proposed finding is misleading because it implies that St. Luke's finances were healthy by 2010. However, the evidence overwhelmingly demonstrates that St. Luke's financial problems were still present as of 2010. (*See e.g.*, RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644). For example, St. Luke's and its parent OhioCare incurred significant financial losses the first eight months of 2010 despite growth in revenues during that period. (RPF 1616-1620; PX02147 at 028-029). As Dan Wakeman explained, St. Luke's September 2009 year-to-date income statement and 2010 budget were {

} (Wakeman, Tr. 2942-2943, *in camera*; PX01283 at 002, *in camera*).

920. This inpatient and outpatient revenue growth "helped turn around the operating performance of St. Luke's and get the hospital closer to positive operating income. (Dagen, Tr. 3182).

Response to Finding No. 920:

Mr. Dagen provides no factual basis or analysis to support this statement Complaint Counsel's proposed finding. In contrast, the evidence demonstrates that St. Luke's continued to experience large losses despite increases in revenues and activity between 2008 and the joinder in August 31, 2010. (RPF 1616-1620; PX02147 at 028-029). As Dan Wakeman explained, St. Luke's September 2009 year-to-date income statement and 2010 budget were {

} (Wakeman, Tr. 2942-2943, *in camera*; PX01283 at 002, *in camera*). This scenario continued to be borne out in 2010 when St. Luke's and its parent OhioCare lost $7.7 million the first eight months of 2010 despite growth in activity and revenues during that period. (RPF 1616; PX02147 at 028-029).

These losses make sense given that St. Luke's overall cost coverage ratio was {

.} (RPF 1777, *in camera*). On average St. Luke's was {

.} (RPF 1781, *in camera*).

b. St. Luke's Increased Its Market Share

921. By the end of the first quarter of 2010, only two years into the three-year plan, St. Luke's surpassed its 40 percent market share goal by achieving a 43 percent share in its core service area (compared to 34.1 percent in 2007). (PX01235 at 003 (St. Luke's market share reports); Response to IROG at ¶ 17; Den Uyl, Tr. 6558 (St. Luke's surpassed its 40 percent market share goal prior to the Acquisition).

Response to Finding No. 921:

Market shares in St. Luke's "core service area" are meaningless for antitrust analysis. (RPF 1036). St. Luke's "core service area" represents only about 60 percent of St. Luke's own discharges. (RPF 1037). More importantly, no evidence exists showing that hospitals can price discriminate against residents of St. Luke's "core service area" and charge them a higher or

lower price. (RPF 1038). Moreover, residents of St. Luke's "core service area," like other Lucas County residents, use all eight hospitals in Lucas County. (RPF 1040).

922. Based on its own internal reports, St. Luke's market share in its core service area has increased in each year since 2007. (PX01235 at 003; Rupley, Tr. 1974-1975).

Response to Finding No. 922:

This proposed finding is misleading in that it suggests St. Luke's was financially healthy in the years leading up to the joinder and would continue to offer increased services to the community as an independent hospital. The evidence demonstrates that St. Luke's incurred large losses from 2008 through the joinder in 2010 despite increases in volume. (RPF 1616-1620, PX02147 at 028-029). In addition, St. Luke's large losses had precipitated its management and Board to conclude that without a joinder {

.} (RPF 1962, 1963-1965, *in camera*, 1966). Mr. Wakeman {

.} (RPF 1971.) For the specific services that St. Luke's cut the market share would drop down to zero, and St. Luke's overall market share would be reduced as well. (Guerin-Calvert, Tr. 7886-7889).

923. Respondent has not produced a single ordinary course document, analysis, projection, testimony, or any piece of evidence to demonstrate or suggest that St. Luke's market share would have declined as a standalone hospital, let alone declined so precipitously as to undermine the market concentration-based presumption that the Acquisition is unlawful in both relevant markets. Neither of Respondent's experts, and none of Respondent's executives or other witnesses concluded that such a market share decline was likely absent the Acquisition.

Response to Finding No. 923:

This proposed finding is not a fact, but improper legal argument. Also, St. Luke's large losses had precipitated its management and Board to conclude that without a joinder {

} (RPF 1962, 1963-1965, *in camera*, 1966). Mr. Wakeman determined {

} (RPF 1971).

Ms. Guerin-Calvert testified that for the specific services that St. Luke's cut the market share would drop down to zero and the overall market share would be reduced as well. (Guerin-Calvert, Tr. 7886-7889).

In addition, Mr. Den Uyl concluded that 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. (RPF 1634).

924. Specifically, Ms. Guerin-Calvert, Respondent's economic expert, did not project what St. Luke's market share levels would be absent the Acquisition. (Guerin-Calvert, Tr. 7889).

Response to Finding No. 924:

This proposed finding is not accurate. Ms. Guerin-Calvert testified that for the specific services that St. Luke's cut, the market share would drop down to zero, and St. Luke's overall market share would be reduced as well. (Guerin-Calvert, Tr. 7886-7889).

925. Similarly, Mr. Den Uyl, Respondent's financial expert witness, did not analyze whether St. Luke's market share absent the Acquisition would have increased or decreased. (Den Uyl, Tr. 6534). In fact, Mr. Den Uyl has no expert opinion on whether St. Luke's market share would have increased or decreased absent the Acquisition. (Den Uyl, Tr. 6534).

Response to Finding No. 925:

Respondent has no specific response.

926. Similarly, Mr. Den Uyl has no expert opinion on whether patient volume at St. Luke's would have increased or decreased absent the Acquisition. (Den Uyl, Tr. 6531-6532; PX01951 at 015 (Den Uyl, Dep. at 55), *in camera*).

Response to Finding No. 926:

This proposed finding misrepresents Mr. Den Uyl's testimony and report. Mr. Den Uyl did conclude that the volume increases that Mr. Dagen assumed for his financial projections overstated St. Luke's future volume because they relied on a trend line that included one-time additions to St. Luke's volume such as its addition to the Anthem network in 2009 and acquisition of physician practices in the years before the joinder. (RX-56 at 000036, *in camera*; Den Uyl, Tr. 6531-6534).

927. Mr. Wakeman testified that, absent the Acquisition, St. Luke's would have experienced additional volume growth at least through the end of 2010. (Wakeman, Tr. 2616). For instance, even as of late 2010, St. Luke's expected more volume growth from its addition to the Anthem provider network in July 2009. (PX01915 at 020 (Wagner, IHT at 74)).

Response to Finding No. 927:

This proposed finding misstates Mr. Wakeman's testimony. Mr. Wakeman testified that St. Luke's volume growth "would have plateaued" near the end of 2010 or 2011. (Wakeman, Tr. 2616). This proposed finding also misrepresents Mr. Wagner's October 15, 2010 investigational hearing testimony. First Mr. Wagner's testimony of "more growth" was limited to potential increases in the number of Anthem members treated at St. Luke's. It is not about Mr. Wagner's thoughts on overall volume changes at St. Luke's as Complaint Counsel imply. (PX01915 (Wagner, IHT at 73-74), *in camera*). Moreover, Mr. Wagner testified that "there [were] no volume projections" for these potential Anthem changes. (PX01915 (Wagner, IHT at 74), *in camera*).

c. St. Luke's Increased Its Number of Employed Physicians

928. Between January 2008 and June 2010, St. Luke's employed 23 new physicians. (RX-56 at 21 (¶ 53) (Den Uyl Expert Report), *in camera*; *see* PX01278 at 007 (St. Luke's "Growth" presentation), *in camera*).

Response to Finding No. 928:

Respondent has no specific response.

929. St. Luke's pursued its strategy of acquiring physician practices because it expected "that the physicians would generate inpatient and outpatient revenues at St. Luke's." (Joint Stipulations of Law and Fact, JX00002A ¶ 42). In its ordinary course, St. Luke's projected that employing physicians would generate a positive return on investment by 2013. (PX01080 at 003 ("Physician Strategy Investments")).

Response to Finding No. 929:

Respondent has no specific response.

930. According to Respondent's expert witness, Mr. Den Uyl, employing physicians since 2008 increased revenue at St. Luke's. (Den Uyl, Tr. 6479; RX-56 at 21 (¶ 54) (Den Uyl Expert Report), *in camera*). Mr. Dagen concluded that the physician strategy nearly {**doubled**} revenues between 2009 and 2010. (Dagen, Tr. 3410, *in camera*).

Response to Finding No. 930:

This proposed finding is misleading as it ignores the fact that any revenue increases resulting from physician practice acquisitions were offset by increased expenses from acquiring and running those practices. Mr. Dagen acknowledged this: {

} (Dagen, Tr. 3410, *in camera*) And Mr. Wakeman testified about these costs in detail explaining that 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). Mr. Den Uyl concluded that {

} (RX-56 at 000022, *in camera*). He pointed out that {

} (RX-56 at 000022, *in camera*).

{

} (RX-56 at 000022, *in camera*).

d. St. Luke's Increased Its Access to Health Plan Networks

931. St. Luke's successfully re-negotiated its participation in the Anthem provider network as of July 2009. (Wakeman, Tr. 2530-2531; PX01016 at 005 (Dec. 15, 2010 "St. Luke's Hospital Board Meeting Affiliation Update"), *in camera*; PX02276 at 002-003 (amendment to the Anthem-St. Luke's "Provider Agreement," effective July 2, 2009), *in camera*).

Response to Finding No. 931:

This finding is misleading as it ignores the unfavorable terms St. Luke's was forced to accept in order for Anthem to allow St. Luke's back into the Anthem network. First, although St. Luke's was negotiating with Anthem in the Spring of 2008, Anthem would not allow St. Luke's into its network until July of 2009. (RPF 1825-1826). Second, Anthem would not allow St. Luke's into the network unless St. Luke's agreed to an MFN clause before the state of Ohio passed a law making such clauses illegal. (RPF 1826). St. Luke's CEO Mr. Wakeman, "felt miserable" in agreeing to these terms with Anthem, but believed that he needed to capitulate to Anthem's demands in order to be able to serve the large portion of St. Luke's community insured by Anthem. (RPF 1828). St. Luke's also later determined that it was {

.} (RPF 1842, 1859 *in camera*).

932. As a result, St. Luke's achieved access to { } percent of the managed care enrollees in the Toledo area. (PX01289 at 003 ("Strategic Plan/Pillar Update"), *in camera*).

Response to Finding No. 932:

Respondent has no specific response.

933. According to Respondent's expert witness, Mr. Den Uyl, St. Luke's readmission to the Anthem provider network increased St. Luke's patient volume and revenue. (RX-56 at 11, 22 (¶¶ 30, 56) (Den Uyl Expert Report), *in camera*); *see also* Dagen, Tr. 3215-3216).

Response to Finding No. 933:

This proposed finding is misleading as it ignores the fact that Anthem {

} (RPF 1842, *in camera*). As Mr. Den Uyl emphasized, {

.} (RX-56 at 000022, *in camera*). Moreover, while {

.} (RX-56 at 000022, *in camera*).

934. Treating Anthem members generated a profit for St. Luke's during the first eight months of 2010. (PX01951 at 032 (Den Uyl, Dep. at 121), *in camera*); PX00512, *in camera* (spreadsheet containing Aug. 2010 year-to-date payer cost ratios). As a result, Mr. Den Uyl acknowledged that the addition to Anthem's provider network was a positive development for St. Luke's financial performance. (PX01951 at 033-034 (Den Uyl Dep. at 128-130), *in camera*).

Response to Finding No. 934:

This proposed finding mischaracterizes Mr. Den Uyl's testimony. When asked whether St. Luke's was making money on Anthem patients during the first eight months of 2010, Mr. Den Uyl responded, { } (PX01951 (Den Uyl, Dep. at 121), *in camera*). Mr. Den Uyl went on to describe the Anthem contract as { } for St. Luke's. (PX01951 (Den Uyl, Dep. at 128-129), *in camera*)). He added, {

} (PX01951 (Den Uyl, Dep. at 128-129), *in camera*). That is, St. Luke's was { } on the average Anthem inpatient and { } on each Anthem discharge if outpatients are factored in. (RX-56 at 000023, *in camera*). During the first

eight months of 2010, {

.} (RX-56 at 000010-000011, *in camera*). St. Luke's was not an in-network provider with Paramount from 2001 through August 31, 2010. (Joint Stipulations of Law and Fact, JX00002A ¶ 46).

935. St. Luke's was not an in-network provider with Paramount from 2001 through August 31, 2010. (Joint Stipulations of Law and Fact, JX00002A ¶ 46).

Response to Finding No. 935:

Respondent has no specific response.

936. Prior to the Acquisition, St. Luke's also sought readmission to Paramount's provider network, which would have resulted in St. Luke's achieving its goal of access to 90 percent of Toledo's managed care enrollees. (Wakeman, Tr. 2584-2585).

Response to Finding No. 936:

Respondent has no specific response.

937. However, ProMedica made a "business decision" to deny St. Luke's admission to Paramount's provider network. (Hanley, Tr. 4788-4789, *in camera*; PX01903 at 059-060 (Hanley, IHT at 229-231), *in camera*; Wakeman, Tr. 2586). Ronald Wachsman, ProMedica's Director of Managed Care and Reimbursement, testified that ProMedica prevented St. Luke's from becoming a member of the Paramount provider network prior to the Acquisition. (PX01905 at 052 (Wachsman, IHT at 203); Wachsman, Tr. 5193, *in camera*).

Response to Finding No. 937:

This proposed finding is misleading. Paramount and St. Luke's weren't able to come to an agreement to add St. Luke's to Paramount's network. (Randolph, Tr.7106). Paramount may have contracted with St. Luke's if St. Luke's had offered "appropriate rates". (Randolph, Tr. 7107).

e. St. Luke's Expanded Its Outpatient Service Offerings

938. Based on his experience at other hospitals, Mr. Wakeman also set out to increase St. Luke's outpatient revenue ratio to 60 percent, meaning that St. Luke's was to earn 60

percent of its revenues from outpatient procedures. (Wakeman, Tr. 2590-2591; PX01911 at 018, 030 (Wakeman, IHT at 68, 115-116), *in camera*).

Response to Finding No. 938:

This proposed finding mischaracterizes Mr. Wakeman's trial testimony. Mr. Wakeman testified that St. Luke's Board was "holding [him] accountable to a 50 percent goal" for the outpatient revenue ratio. He added, "I was more focused on the 50 percent number. My personal perspective was I would have liked to have seen us get to 60 percent" but "I don't think we were going to get to 60 percent...." (Wakeman, Tr. 2592-2593).

939. Increasing a hospital's outpatient ratio is beneficial because outpatient procedures typically generate higher margins than inpatient procedures. (Wakeman, Tr. 2590; Dagen, Tr. 3183; PX02147 at 027 (¶ 50) (Dagen Expert Report)).

Response to Finding No. 939:

Respondent has no specific response.

940. Indeed, St. Luke's earned a profit on its outpatient cases in both 2009 and the first eight months of 2010. (RX-56 at 24 (Table 15) (Den Uyl Expert Report), *in camera*).

Response to Finding No. 940:

This proposed finding is misleading. St. Luke's margins on outpatient cases in 2009 and the first eight months of 2010 were { } (RX-56 at 000024, *in camera*). These {

} (RX-56 at 000024, *in camera*).

941. St. Luke's increased its outpatient ratio from approximately 40 percent in 2008 to nearly 50 percent as of September 2010. (Wakeman, Tr. 2590-2591; Dagen, Tr. 3182; PX01911 at 030 (Wakeman, IHT at 115), *in camera*).

Response to Finding No. 941:

Respondent has no specific response.

942. St. Luke's acquired four offsite imaging centers at the close of 2008. (PX01908 at 008-009 (Deacon, IHT at 24-27), *in camera*). These facilities generated { } in profit in 2009. (PX01359 at 043 ("Our Missions" presentation), *in camera*).

Response to Finding No. 942:

Respondent has no specific response.

943. St. Luke's acquired another imaging center on August 31, 2010. (PX01908 at 008 (Deacon, IHT at 24), *in camera*). St. Luke's former CFO, David Oppenlander, called the acquisition of the imaging center a "no brainer," projecting that it would generate approximately { } in annual profit. (PX01162 at 001, 003 (Dec. 2009 St. Luke's e-mail), *in camera*).

Response to Finding No. 943:

Respondent has no specific response.

944. Mr. Dagen concluded that St. Luke's was in the midst of a successful financial turnaround at the time of the Acquisition. (Dagen, Tr. 3231; PX02147 at 06 (¶ 14) (Dagen Expert Report). He concluded that Mr. Wakeman's three-year plan was producing the desired results: increasing revenues, market share, and improving St. Luke's operating performance. (Dagen, Tr. 3230; PX02147 at 006 (¶ 14) (Dagen Expert Report)). Any analysis that stops in 2009 and overlooks St. Luke's 2010 financial rebound will provide a misleading view of St. Luke's financial stability. (PX02147 at 006 (¶ 14) (Dagen Expert Report)).

Response to Finding No. 944:

Mr. Dagen's conclusion contradicts overwhelming evidence showing that St. Luke's was struggling financially at the time of the joinder and had not achieved the financial goals of the three year plan. (RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644 1941-1954, 1955, *in camera*, 1956-1961). 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. Mr. Den Uyl 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. (RPF 1614).

2. Increases in Volume and Occupancy

945. Respondent's expert witness, Mr. Den Uyl, concluded that Mr. Wakeman's three-year plan increased St. Luke's inpatient and outpatient volumes. (Den Uyl, Tr. 6545-6546; RX-56 at 26 (¶ 64) (Den Uyl Expert Report), *in camera*).

Response to Finding No. 945:

This proposed finding is misleading and takes Mr. Den Uyl's statement out of context. Mr. Den Uyl concluded that St. Luke's did not achieve the financial goals of the three year plan, despite an increase in inpatient and outpatient volumes during the time of the plan. (RX-56 at 000026, *in camera*).

The paragraph of Mr. Den Uyl's report cited by Complaint Counsel in support of this proposed finding is entitled "The Plan was Unsuccessful" and highlights St. Luke's inability to achieve a break-even margin, Moody's downgrading of St. Luke's bonds, and St. Luke's continued negative cash flows from operations through the time of the joinder. (RX-56 at 000026, *in camera*).

946. Mr. Wakeman testified that St. Luke's experienced significant growth in acute inpatient admissions and discharges during the first eight months of 2010. (Wakeman, Tr. 2597-2598). A "2010 Strategic Planning" summary as of August 2010 states that, in the first eight months of 2010, St. Luke's outpatient visits increased { } over the previous year. (PX01199 at 001 (St. Luke's Top Three Strategic Issues (Growth), *in camera*).

Response to Finding No. 946:

This proposed finding is misleading. St. Luke's and its parent OhioCare experienced large losses in the first eight months of 2010 despite increases in volume. (RPF 1616-1620). OhioCare's loss for that period was $7.7 million. (RPF 1616). The document cited by Complaint Counsel for the { } increase for outpatient volume in the first eight months of 2010 also states that St. Luke's net revenue margin for this time period was { }. (PX01199 at 001, *in camera*).

947. In a memorandum to the St. Luke's Board of Directors, dated September 24, 2010, Mr. Wakeman wrote: "If there was one pillar [St. Luke's] attained a high level of success in [its] strategic plan in the past two years, it would be growth. The hard numbers prove that out, and almost every service." (PX00170 at 006 (Wakeman Aug. 2010 Monthly Report to St. Luke's Board of Directors). The Chairman of St. Luke's Board, James Black, agreed with this statement. (Black, Tr. 5686).

Response to Finding No. 947:

This proposed finding is misleading. St. Luke's incurred large losses in the first eight months of 2010 despite increases in volume. (RPF 1616-1620). OhioCare lost $20.3 million in 2009 and $7.7 million in the first eight months of 2010. (RPF 1616). St. Luke's was struggling financially at the time of the acquisition and had not achieved the financial goals of the three year plan. (RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644 1941-1954, 1955, *in camera*, 1956-1961).

948. Based on annualizing results as of August 31, 2010, St. Luke's total acute inpatient admissions were on pace to reach 11,725 for the full 2010 year, an 18 percent increase from 9,905 in 2007. (PX02129 at 002 (Hanley, Decl. Ex. 1); *see also* Hanley, Tr. 4698-4699 (outpatient visits increasing since 2008)). Inpatient volume increased {9.6} percent in 2010 compared to 2009. (PX00511 at 010 (St. Luke's 2010 Year End Our Mission Presentation), *in camera*).

Response to Finding No. 948:

The proposed finding is misleading because St. Luke's incurred large losses in the first eight months of 2010 despite increases in volume. (RPF 1616-1620). OhioCare lost $20.3 million in 2009 and $7.7 million in the first eight months of 2010. (RPF 1616). St. Luke's was struggling financially at the time of the acquisition and had not achieved the financial goals of the three year plan. (RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644 1941-1954, 1955, *in camera*, 1956-1961).

This finding is also inaccurate because it cites financial information for St. Luke's through December 31, 2010 that incorporates effects of the joinder. (PX00511, *in camera*). Moreover, the "annualized" statistics cited by Complaint Counsel are also misleading because

they would improperly include one time increases in revenue prior to the joinder such as St. Luke's addition to the Anthem network and acquisitions of physician practices. (RX-56 at 000036, *in camera*). The annualized numbers do not account for the fact that St. Luke's volume growth was likely to plateau before the end of 2010. (Wakeman, Tr. 2616).

949. Based on annualizing results as of August 31, 2010, St. Luke's patient days (a measure of inpatient volume) were on pace to reach 45,342 for the full 2010 year, a 21 percent increase from 37,589 in 2007. (PX02129 at 002 (Hanley, Decl. Ex. 1); *see also* Hanley, Tr. 4699 (positive trend in patient days since 2008)). St. Luke's actual end-of-year 2010 patient days was even higher than the projected figure as of August 31, 2010. (Dagen, Tr. 3197).

Response to Finding No. 949:

The proposed finding is misleading because St. Luke's incurred large losses in the first eight months of 2010 despite increases in volume. (RPF 1616-1620). OhioCare lost $20.3 million in 2009 and $7.7 million in the first eight months of 2010. (RPF 1616). St. Luke's was struggling financially at the time of the acquisition and had not achieved the financial goals of the three year plan. (RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644 1941-1954, 1955, *in camera*, 1956-1961).

This finding is also inaccurate because it cites financial information for St. Luke's through December 31, 2010 that incorporates effects of the joinder. (Dagen, Tr. 3197). Moreover, the "annualized" statistics cited by Complaint Counsel are also misleading because they would improperly include one time increases in revenue prior to the joinder such as St. Luke's addition to the Anthem network and acquisitions of physician practices. (RX-56 at 000036, *in camera*). The annualized numbers do not account for the fact that St. Luke's volume growth was likely to plateau before the end of 2010. (Wakeman, Tr. 2616).

950. Based on annualizing results as of August 31, 2010, St. Luke's outpatient visits were on pace to reach 221,365 for the full 2010 year, a 49 percent increase from 148,455 in 2007. (PX02129 at 002 (Hanley, Decl. Ex. 1); *see also* Hanley, Tr. 4700-4701 (positive trend in

outpatient visits since 2008)). St. Luke's actual end-of-year 2010 outpatient visits figure was even higher than the projected figure as of August 31, 2010. (Dagen, Tr. 3197).

Response to Finding No. 950:

The proposed finding is misleading because St. Luke's incurred large losses in the first eight months of 2010 despite increases in volume. (RPF 1616-1620). OhioCare lost $20.3 million in 2009 and $7.7 million in the first eight months of 2010. (RPF 1616). St. Luke's was struggling financially at the time of the acquisition and had not achieved the financial goals of the three year plan. (RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644 1941-1954, 1955, *in camera*, 1956-1961).

This finding is also inaccurate because it cites financial information for St. Luke's through December 31, 2010 that incorporates effects of the joinder. (Dagen, Tr. 3197). Moreover, the "annualized" statistics cited by Complaint Counsel are also inaccurate because they improperly include one time increases in revenue prior to the joinder such as St. Luke's addition to the Anthem network and acquisitions of physician practices. (RX-56 at 000036, *in camera*). The annualized numbers do not account for the fact that St. Luke's volume growth was likely to plateau before the end of 2010. (Wakeman, Tr. 2616).

951. The number of cases treated at St. Luke's ambulatory surgery center, Surgi+Care, increased from 2,507 in 2007 to 3,179 as of August 31, 2010 (which would annualize to 4,769 cases for all of 2010). (PX01214 at 006 ("Surgi+Care Board of Manager Meeting")).

Response to Finding No. 951:

This finding is misleading. SurgiCare is a joint venture in which St. Luke's has 50% ownership. (RPF 134). This means that St. Luke's only received 50% of any profits made at SurgiCare. It is indicative of St. Luke's financial problems and below cost reimbursement rates that St. Luke's made an effort to shift patients from St. Luke's to SurgiCare. (RPF 1939). 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. (RPF 1940). As Mr. Wakeman explained, "half of something positive is better than 100 percent of a total loss." (RPF 1940).

Moreover, despite any increase in volume at SurgiCare, St. Luke's still incurred large losses from 2007 through the joinder in August 31, 2010. (RPF 1616-1620). For example, OhioCare lost $20.3 million in 2009 and $7.7 million in the first eight months of 2010. (RPF 1616).

952. St. Luke's has increased capacity utilization during Mr. Wakeman's tenure. (Wakeman, Tr. 2637, *in camera*). St. Luke's overall occupancy rate in the twelve months prior to the Acquisition increased by approximately { } percent. (PX01920 at 010 (Wakeman. Dep. at 31), *in camera*). St. Luke's was at or near capacity for inpatient services during multiple periods in August 2010. (Black, Tr. 5682-5683; *see also* PX01403 (Konwinski Mar. 2010 Email) ("the beds are just about full.")).

Response to Finding No. 952:

This proposed finding is misleading as St. Luke's capacity constraints were a sign of St. Luke's financial weakness and competitive limitations and not a sign of financial strength as Complaint Counsel imply. St. Luke's capital freeze had prevented it from making important investments in expansion and private rooms prior to the joinder. (RPF 1949, 1961, 2113-2114). In addition, its hiring freeze made it more difficult for St. Luke's to serve its growing numbers of patients with its existing staff. (RPF 1919-1933, 1934-1935, *in camera*).

Moreover, the fact that St. Luke's as a stand alone hospital did not have excess capacity like its competitors was a limitation on its ability to provide high service to its patients. For example, St. Luke's capacity constraints forced it to divert patients from its emergency room to other hospitals potentially harming patient outcomes. (RPF 1743-1750). 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. (RPF 1750). St. Luke's capacity

constraints also made it more difficult for it to convert to private rooms, the local and national standard of care and an important driver of patient outcomes and satisfaction. (RPF 815-818, 1199, 1904, 2222, *in camera*, 2233-2234). This inability to convert to private rooms put St. Luke's at a competitive disadvantage. (RPF 1757, 2233-2234, 2240). Moreover, St. Luke's had to double the occupancy of some of the private rooms it did have, further decreasing its proportion of private rooms. (Johnston, Tr. 5371-5372).

The finding is also misleading because it suggests that St. Luke's volume increases were a sign of its financial health. St. Luke's {

} (RPF 1777-1781, *in camera*). Also, 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. (RPF 1616). As St. Luke's CEO, Dan Wakeman, explained, {

}. (Wakeman, Tr. 2942-2943, *in camera*; PX01283 at 002, *in camera*).

953. In September 2009, David Oppenlander, St. Luke's CFO at the time, noted that "the hospital is close to capacity with inpatients." (PX01292 at 003 (St. Luke's Board Minutes 9/22/09), *in camera*).

Response to Finding No. 953:

This proposed finding is misleading as St. Luke's capacity constraints were a sign of St. Luke's financial weakness and competitive limitations and not a sign of financial strength as Complaint Counsel imply. St. Luke's capital freeze had prevented it from making important investments in expansion and private rooms prior to the joinder. (RPF 1949, 1961, 2113-2114). In addition, its hiring freeze made it more difficult for St. Luke's to serve its growing numbers of patients with its existing staff. (RPF 1919-1933, 1934-1935, *in camera*).

Moreover, the fact that St. Luke's as a stand alone hospital did not have excess capacity like its competitors was a limitation on its ability to provide high service to its patients. For

example, St. Luke's capacity constraints forced it to divert emergency room patients to other hospitals potentially harming patient outcomes. (RPF 1743-1750). 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. (RPF 1750). St. Luke's capacity constraints also made it more difficult for it to convert to private rooms, the local and national standard of care and an important driver of patient outcomes and satisfaction. (RPF 815-818, 1199, 1904, 2222, *in camera*, 2233-2234). This inability to convert to private rooms put St. Luke's at a competitive disadvantage. (RPF 1757, 2234, 2240).

The finding is also misleading because it suggests that St. Luke's volume increases were a sign of its financial health. St. Luke's {

} (RPF 1777-1781, *in camera*). Also, 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. (RPF 1616). As St. Luke's CEO, Dan Wakeman, explained, {

}. (Wakeman, Tr. 2942-2943, *in camera*; PX01283 at 002, *in camera*).

954. A March 2010 letter to the Ohio Department of Health described a "surge in obstetrical patients" at St. Luke's that caused its maternity unit to be "full." (PX01086 at 001 (Konwinski Letter to OH Dep't of Health 3/19/10)).

Response to Finding No. 954:

This proposed finding is misleading as St. Luke's capacity constraints were a sign of St. Luke's financial weakness and competitive limitations and not a sign of financial strength as Complaint Counsel imply. St. Luke's capital freeze had prevented it from making important investments in expansion and private rooms prior to the joinder. (RPF 1949, 1961, 2113-2114). In addition, its hiring freeze made it more difficult for St. Luke's to serve its growing numbers of patients with its existing staff. (RPF 1919-1933, 1934-1935, *in camera*).

Moreover, the fact that St. Luke's as a stand alone hospital did not have excess capacity like its competitors was a limitation on its ability to provide high service to its patients. For example, St. Luke's capacity constraints forced it to divert emergency room patients to other hospitals potentially harming patient outcomes. (RPF 1743-1750). 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. (RPF 1750). St. Luke's capacity constraints also made it more difficult for it to convert to private rooms, the local and national standard of care and an important driver of patient outcomes and satisfaction. (RPF 815-818, 1199, 1904, 2222, *in camera*, 2233-2234). This inability to convert to private rooms put St. Luke's at a competitive disadvantage. (RPF 1757, 2234, 2240).

The finding is also misleading because it suggests that St. Luke's volume increases were a sign of its financial health. St. Luke's {

.} (RPF 1777-1781). Also, 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. (RPF 1616). As St. Luke's CEO, Dan Wakeman, explained, {

}.

(Wakeman, Tr. 2942-2943, *in camera*; PX01283 at 002, *in camera*).

955. Mr. Wakeman described St. Luke's inpatient capacity in June 2010 as "pretty tight." (PX01360 at 001 (Wakeman Aug. 2010 Email)).

Response to Finding No. 955:

This proposed finding is misleading as St. Luke's capacity constraints were a sign of St. Luke's financial weakness and competitive limitations and not a sign of financial strength as Complaint Counsel imply. St. Luke's capital freeze had prevented it from making important investments in expansion and private rooms prior to the joinder. (RPF 1949, 1961, 2113-2114).

In addition, its hiring freeze made it more difficult for St. Luke's to serve its growing numbers of patients with its existing staff. (RPF 1919-1933, 1934-1935, *in camera*).

Moreover, the fact that St. Luke's as a stand alone hospital did not have excess capacity like its competitors was a limitation on its ability to provide high service to its patients. For example, St. Luke's capacity constraints forced it to divert emergency room patients to other hospitals potentially harming patient outcomes. (RPF 1743-1750). 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. (RPF 1750). St. Luke's capacity constraints also made it more difficult for it to convert to private rooms, the local and national standard of care and an important driver of patient outcomes and satisfaction. (RPF 815-8181, 1199, 1904, 2222, *in camera*, 2233-2234). This inability to convert to private rooms put St. Luke's at a competitive disadvantage. (RPF 1757, 2234, 2240).

956. In an August 2010 monthly report to the St. Luke's Board of Directors, Mr. Wakeman stated that "inpatient capacity is limited." (PX00170 at 001 (Wakeman Aug. 2010 Monthly Report to St. Luke's Board of Directors)).

Response to Finding No. 956:

This proposed finding is misleading as St. Luke's capacity constraints were a sign of St. Luke's financial weakness and competitive limitations and not a sign of financial strength as Complaint Counsel imply. St. Luke's capital freeze had prevented it from making important investments in expansion and private rooms prior to the joinder. (RPF 1949, 1961, 2113-2114).
In addition, its hiring freeze made it more difficult for St. Luke's to serve its growing numbers of patients with its existing staff. (RPF 1919-1933, 1934-1935, *in camera*).

Moreover, the fact that St. Luke's as a stand alone hospital did not have excess capacity like its competitors was a limitation on its ability to provide high service to its patients. For example, St. Luke's capacity constraints forced it to divert emergency room patients to other

hospitals potentially harming patient outcomes. (RPF 1743-1750). 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. (RPF 1750). St. Luke's capacity constraints also made it more difficult for it to convert to private rooms, the local and national standard of care and an important driver of patient outcomes and satisfaction. (RPF 815-818, 1199, 1904, 2222, *in camera*, 2233-2234). This inability to convert to private rooms put St. Luke's at a competitive disadvantage. (RPF 1757, 2234, 2240).

957. St. Luke's volume growth in 2010 caused its losses to decrease and its operating cash flow to improve. (Dagen, Tr. 3191-3193; PX01925 at 054-055 (Guerin-Calvert, Dep. at 209-210); PX02129 at 002 (Hanley, Decl. Ex. 1)). This is due to the fact that St. Luke's did not, contrary to Respondent's claims, lose money on the commercial patients who received services at St. Luke's. (Dagen, Tr. 3190-3193).

Response to Finding No. 957:

The citation from Ms. Guerin-Calvert used by Complaint Counsel does not support the proposed finding. Ms Guerin-Calvert simply testified that St. Luke's occupancy rates increased in the first eight months of 2010 and, separately, that St. Luke's cash position became less negative during that time period. She does not make any causal connection between these two metrics. (PX01925 (Guerin-Calvert, Dep. at 209-210)). The exhibit to Ms. Hanley's declaration is simply a summary of St. Luke's financials. It also does not make the causal connection that Complaint Counsel assert in this finding. (PX01229 at 002, *in camera*).

It is only the expert witness hired by Complaint Counsel, Mr. Dagen, who assumes a relationship between the two metrics in his testimony at trial. However, he offers no analysis or documentary support for this assumption. Complaint Counsel asks Mr. Dagen "[what's] driving that improvement in St. Luke's cost coverage ratio before the acquisition?" Mr. Dagen replies, "To my knowledge, the only difference between 2009 and 2010 reimbursement wise would be a small escalator that's built into the contracts of less than, I believe, 4 percent. So, this 9 percent

increase is driven solely from the increase in volume of the patients that have been driven to St. Luke's Hospital during this timeframe." (Dagen, Tr. 3192-3193). Neither Mr. Dagen's report nor his rebuttal report provide further support for this assumption. Mr. Dagen simply assumes that St. Luke's increased volume has caused these somewhat smaller, but still large, losses. (PX02147 at 053; PX01852 at 017; RPF 1616). Nevertheless, Mr. Dagen admits that as of August 31, 2010, St. Luke's was generating an operating loss despite increases in volume. (Dagen, Tr. 3396).

In contrast, Mr. Den Uyl has done a detailed analysis of St. Luke's reimbursement data and exhibited the cost coverage ratios and profits or losses from the major government and commercial payors in his report. (RX-56 at 000022-000024, 000010-000011, *in camera*). In addition, he has aggregated this data for all payors. (RX-56 at 000022-000024, 000010-000011, *in camera*). This data demonstrates that {

} (RX-56 at 000010-000011, *in camera*). St. Luke's {

} (RX-56 at 000022-000024, *in camera*). And on aggregate {

} (RPF 1775-1781, *in camera*, 490, *in camera*, 496, 498, 499-504, 1351, *in camera*).

Moreover, at the time of the joinder, St. Luke's earnings per adjusted discharge figures ("EPAD") confirmed that, on average, St. Luke's was losing money on every commercially insured patient it treated. (RPF 1771).

In addition, St. Luke's CEO and senior management testified that {

} (RPF 1783-1784, *in camera*; Wakeman, Tr. 2942-2943, *in camera*; PX01283 at 002, *in camera*).

958. Mr. Den Uyl, Respondent's financial expert, testified that St. Luke's was profitable in the treatment of { } members during the first eight months of 2010. (Den Uyl, Tr. 6597-6598, *in camera*; PX01951 at 039-040 (Den Uyl, Dep. at 150-153), *in camera*; *see also* PX02136 at 056 (Guerin-Calvert, Supp. Decl., Table 11); Dagen, Tr. 3239-3240, *in camera*).

Response to Finding No. 958:

This proposed finding is misleading. While Mr. Den Uyl agreed that in the first eight months of 2008 the payments received from { } (Den Uyl, Tr. 6597-6598, *in camera*), he also testified that the reimbursements from these and the other MCO's were { } (Den Uyl, Tr. 6440-6441, *in camera*). Mr. Den Uyl concluded that overall St. Luke's reimbursements did not cover the costs of treating its patients during those eight months. (Den Uyl, Tr. 6423, 6441, *in camera*). This finding also ignores Mr. Den Uyl's and Mr. Dagen's testimony about St. Luke's { } Both experts agreed that { .} (Den Uyl, Tr. 6442, *in camera*; Dagen, 3239-3240, 3394, *in camera*).

This proposed finding is also contradicted by St. Luke's earnings per adjusted discharge figures ("EPAD") which showed that, on average, at the time of the joinder, St. Luke's was losing money on every commercially insured patient it treated. (RPF 1771).

959. In the last four months of 2010, St. Luke's received sufficient reimbursement to cover all direct and indirect costs – in other words, total costs – associated with treating { } members. (PX00513 at 001 (spreadsheet of St. Luke's Aug. 31, 2010 year-to-date payor cost coverage ratios), *in camera*; PX001951 at 040 (Den Uyl, Dep. at 155-156), *in camera*; PX01852 at 018-019 (¶ 27) (Dagen Rebuttal Report). In other words, during the last four months of 2010, St. Luke's was profitable with each and every commercial payor. (Den Uyl, Tr. 6599-6600, *in camera*).

Response to Finding No. 959:

This proposed finding is misleading because it concerns St. Luke's reimbursement after the joinder and incorporates the effects of the joinder. It does not reflect St. Luke's reimbursement or financial condition as an independent entity. St. Luke's overall cost coverage ratio was below one, meaning St. Luke's was not generating sufficient reimbursement to cover its total costs, through the time of the joinder on August 31, 2010. (RPF 1777, *in camera*; Den Uyl, Tr. 6423). This proposed finding is also rebutted by St. Luke's earnings per adjusted discharge figures ("EPAD") which showed that, on average, at the time of the joinder, St. Luke's was losing money on every commercially insured patient it treated. (RPF 1771).

960. Even before the Acquisition, St. Luke's covered its direct costs when treating { }. (PX01951 at 039-040 (Den Uyl, Dep. at 150-154), *in camera*; Dagen, Tr. 3239-3240, *in camera*; PX00513 at 001 (spreadsheet of St. Luke's Aug. 31, 2010 year-to-date payor cost coverage ratios), *in camera*).

Response to Finding No. 960:

This proposed finding is misleading because it focuses only on direct costs rather than evaluating the total costs of treating patients. To determine whether a particular MCO is reimbursing sufficiently to pay for the cost of treating patients insured by the MCO, hospitals consider the total cost of treating those patients, including both direct and indirect costs. (RPF 1773-1774, *in camera*; PX01925 (Guerin-Calvert, Dep. at 167-168)). St. Luke's overall cost coverage ratio was below one, meaning St. Luke's was not generating sufficient reimbursement to cover its total costs, through the time of the joinder on August 31, 2010. (RPF 1777, *in camera*; Den Uyl, Tr. 6423). This proposed finding is also rebutted by St. Luke's earnings per adjusted discharge figures ("EPAD") which showed that, on average, at the time of the joinder, St. Luke's was losing money on every MCO insured patient it treated. (RPF 1771).

961. Direct costs are those costs that are directly related to treating a patient, such as medications, supplies, laundry, and labor. (Dagen, Tr. 3189; PX01925 at 043 (Guerin-Calvert, Dep. at 162-164) (defining direct costs as "all of the costs that are directly assigned to [a] specific case").

Response to Finding No. 961:

This proposed finding is misleading as it is incomplete. Ms. Guerin-Calvert also testified that fixed costs could also be part of direct costs and, more generally described that there was not a clear line between direct and indirect costs. (PX01925 (Guerin-Calvert, Dep. at 167-168)). Mr. Den Uyl also testified that indirect costs can be directly related to patient care in the sense that some indirect costs increase when volume increases. (Den Uyl, Tr. 6475-6476).

This proposed finding is also misleading in that it suggests that hospitals do not consider indirect costs when evaluating patient reimbursement rates. They do. For example, to determine whether a particular MCO is reimbursing sufficiently to pay for the cost of treating patients insured by the MCO, hospitals consider the total cost of treating those patients, including both direct and indirect costs. (RPF 482, 1773-1774, *in camera*; PX01925 (Guerin-Calvert, Dep. at 167-168)).

962. Because St. Luke's covered its direct costs during the first eight months of 2010, growth in St. Luke's patient volume alone improved St. Luke's overall cost coverage ratio. (Dagen, Tr. 3191-3193, 3241-3242, *in camera* ("As patient volume increases . . . – as long as the reimbursement rates are higher than direct costs [–] the cost coverage ratio will improve.")).

Response to Finding No. 962:

This fact is misleading and inaccurate. St. Luke's like other hospitals needs to cover both its direct and indirect costs to stay in business. (RPF 482, 1773-1774, *in camera*; PX01925 (Guerin-Calvert, Dep. at 167-168)). Both direct and indirect costs are used to determine the cost coverage ratio and indirect costs also rise as volume increases. (Den Uyl, Tr. 6438-6439, 6476). Through the time of the joinder St. Luke's and its parent OhioCare continued to experience large

losses despite increases in volume. 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. (RPF 1616). St. Luke's CEO and senior management testified that {

} (RPF 1783-1784, *in camera*; Wakeman, Tr. 2942-2943, *in camera*; PX01283 at 002, *in camera*).

963. Mr. Dagen's analysis is confirmed by Mr. Wakeman's statement in an August 2010 monthly report to the St. Luke's Board of Directors – the last such report before the Acquisition – that St. Luke's "positive margin confirms that [St. Luke's] can run in the black if activity stays high." (PX00170 at 001 (Dan Wakeman's Aug. 2010 Monthly Report to St. Luke's Board of Directors)).

Response to Finding No. 963:

This proposed finding is inaccurate and misleading. First, Mr. Wakeman's report cited by Complaint Counsel was made to St. Luke's Board on September 24, 2010 nearly a month after the joinder, not in August 2010. (PX00170 at 001). Second, the positive margin in August 2010 that Mr. Wakeman describes in the report refers to a very small monthly margin: "$7,000 on $36.7 million in gross revenue" which was described by Mr. Wakeman as "not impressive." (PX00170 at 001). Moreover, this small monthly margin was an anomaly. It 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). "This was not a trend. This was one month." (Wakeman, Tr. 2606). In fact, OhioCare had lost $7.7 million year to date by the end of August 2010 despite increasing volume. (RPF 1616; PX02147 at 028-029).

3. St. Luke's Had Solid and Improving Financials

964. According to Mr. Den Uyl, during the first 8 months of 2010, St. Luke's "increased revenue and decreased cost." (RX-56 at 11 (¶ 30) (Den Uyl Expert Report), *in camera*; Den Uyl, Tr. 6593-6594, *in camera*). Mr. Dagen testified that, leading up to the Acquisition, St. Luke's experienced "improvement[s] . . . in all – pretty much all . . . financial metrics" and its operating performance indicated that St. Luke's was "turning around [its] operations." (Dagen, Tr. 3187).

Response to Finding No. 964:

This proposed finding is highly misleading as Mr. Den Uyl actually makes the exact opposite point in the paragraph of his report cited by Complaint Counsel. (RX-56 at 000011, *in camera*). Mr. Den Uyl explains that the revenue increases came from one time jolts such as St. Luke's addition to the Anthem network and its addition of new physician practices in 2009. (RX-56 at 000011, *in camera*). And that the reductions of expenses are the result of "the salary, hiring, and pension plan freezes instituted by St. Luke's." (RX-56 at 000011, *in camera*). Mr. Den Uyl concludes that the increase in revenue and decrease in costs that St. Luke's experienced in the first eight months of 2010 are "unlikely to persist" and "not sustainable." (RX-56 at 000011, *in camera*).

a. St. Luke's Profitability Was Improving

965. According to ProMedica's CFO, Kathleen Hanley, St. Luke's operating cash flow margin improved from negative 2.5 percent in 2009 to *positive* 3.8 percent as of August 31, 2010, and its operating income margin improved from -10.3 percent to -2.6 percent during the same time period. (PX02129 at 002 (Hanley, Decl. Ex. 1); Hanley, Tr. 4702-4703; *see also* Wakeman, Tr. 2594-2595; Den Uyl, Tr. 6479; RX-56 at 6-7 (Tables 1, 3) (Den Uyl Expert Report), *in camera*). In other words, during the first eight months of 2010, St. Luke's "produced [positive] cash from the operating revenue on operations." (Hanley, Tr. 4703).

Response to Finding No. 965:

This proposed finding is misleading because it focuses on the St. Luke's Hospital subsidiary only, rather than on St Luke's parent, OhioCare, and therefore ignores St. Luke's physician practice losses. OhioCare incurred significantly higher losses and achieved worse

margins than the ones Complaint Counsel cite in this proposed finding. (RPF 1616, 1625, *in camera*, 1633, *in camera*). This proposed finding is also misleading because OhioCare's financials were still extremely poor in the first eight months of 2010. (RPF 1616, 1625, *in camera*, 1633, *in camera*). For example, OhioCare's operating losses were $7.7 million and operating margin -6.9 percent (RPF 1616); its EBIDTA was { } and EBITDA margin { } (RPF 1625, *in camera*) despite the fact that it was { } for a hospital to have a negative EBIDTA (RPF 1626, *in camera*); and its operating cash flow minus capital expenditures was { }. (RPF 1633).

966. St. Luke's operating cash flow margin for the time period January 1, 2010 through August 31, 2010 was an improvement over St. Luke's operating cash flow margin for calendar year 2009. (Joint Stipulations of Law and Fact, JX00002A ¶ 28).

Response to Finding No. 966:

This proposed finding is misleading because it focuses on the St. Luke's Hospital subsidiary only, rather than on St Luke's parent, OhioCare, and therefore ignores St. Luke's physician practice losses. OhioCare incurred significantly higher losses and achieved worse margins than the ones Complaint Counsel cite in this proposed finding. (RPF 1616, 1625, *in camera*, 1633, *in camera*). This proposed finding is also misleading because OhioCare's financials were still extremely poor in the first eight months of 2010. (RPF 1616, 1625, *in camera*, 1633, *in camera*). For example, OhioCare's operating losses were $7.7 million and operating margin -6.9 percent (RPF 1616); its EBIDTA was { } and EBITDA margin { } (RPF 1625, *in camera*) despite the fact that it was { } for a hospital to have a negative EBIDTA (RPF 1626, *in camera*); and its operating cash flow minus capital expenditures was { }. (RPF 1633).

967. As of August 31, 2010, St. Luke's was on track to improve its operating cash flow, or earnings before interest, taxes, depreciation, and amortization ("EBITDA"), nearly by a factor of two over 2009 levels. (PX02129 at 002 (Hanley, Decl. Ex. 1); Hanley, Tr.

4694-4695 (operating cash flow in Exhibit 1 was calculated by removing interest, taxes, depreciation, and amortization from earnings); Dagen, Tr. 3187). St. Luke's actual end-of-year 2010 EBITDA was even higher than the projected figures as of August 31, 2010. (Dagen, Tr. 3198).

Response to Finding No. 967:

This proposed finding is misleading because it focuses on the St. Luke's Hospital subsidiary only, rather than on St Luke's parent OhioCare and, therefore, ignores St. Luke's physician practice losses. For the first eight months of 2010, OhioCare's EBIDTA was {- } and EBITDA margin { } (RPF 1625, *in camera*) despite the fact that it was { } for a hospital to have a negative EBIDTA (RPF 1626, *in camera*). Moreover, in that period leading up to the joinder OhioCare's operating cash flow minus capital expenditures, a more accurate measure its cash needs, was { }. (RPF 1633, *in camera*, 1621-1623).

968. St. Luke's [EBITDA] for the time period January 1, 2010 through August 31, 2010 [was] an improvement over St. Luke's EBITDA for calendar year 2009. (Joint Stipulations of Law and Fact, JX00002A ¶ 27).

Response to Finding No. 968:

This proposed finding is misleading because it focuses on the St. Luke's Hospital subsidiary only, rather than on St Luke's parent, OhioCare, and, therefore, ignores St. Luke's physician practice losses. This proposed finding is also misleading because OhioCare's financials were still extremely poor in the eight months before the joinder. (RPF 1616, 1625, *in camera*, 1633, *in camera*). For the first eight months of 2010, OhioCare's EBIDTA was {- } and EBITDA margin { } (RPF 1625, *in camera*) despite the fact that it was { } for a hospital to have a negative EBIDTA (RPF 1626, *in camera*). Moreover, in that period leading up to the joinder OhioCare's operating cash flow minus capital expenditures,

a more accurate measure its cash needs, was { }. (RPF 1633, *in camera*, 1621-1623).

969. St. Luke's operating income for the time period January 1, 2010 through August 31, 2010 was an improvement over St. Luke's operating income for calendar year 2009. (Joint Stipulations of Law and Fact, JX00002A ¶ 29).

Response to Finding No. 969:

This proposed finding is misleading because it focuses on the St. Luke's Hospital subsidiary only, rather than on St Luke's parent, OhioCare, and, therefore, ignores St. Luke's physician practice losses. This proposed finding is also misleading because OhioCare's financials were still extremely poor in the first eight months of 2010. (RPF 1616, 1625, *in camera*, 1633, *in camera*). In the first eight months of 2010, OhioCare's operating losses were $7.7 million and operating margin -6.9 percent. (RPF 1616).

970. As of August 31, 2010, St. Luke's was on track to improve its operating income by 43 percent from 2009 levels. (PX02129 at 002 (Hanley, Decl. Ex. 1); Dagen, Tr. 3187). St. Luke's actual end-of-year 2010 operating income was even higher than the projected figures as of August 31, 2010. (Dagen, Tr. 3198).

Response to Finding No. 970:

This proposed finding is misleading because it concerns St. Luke's reimbursement after the joinder and incorporates the effects of the joinder. It does not reflect St. Luke's financial condition as an independent entity. This proposed finding is also misleading because it focuses on the St. Luke's Hospital subsidiary only, rather than on St Luke's parent, OhioCare, and, therefore, ignores St. Luke's physician practice losses. In addition, the proposed finding is misleading because OhioCare's financials were still extremely poor in the first eight months of 2010. (RPF 1616, 1625, *in camera*, 1633, *in camera*). In the eight months before the joinder, OhioCare's operating losses were $7.7 million and operating margin -6.9 percent. (RPF 1616).

971. St. Luke's operating margin for the time period January 1, 2010 through August 31, 2010 was an improvement over St. Luke's operating margin for calendar year 2009. (Joint Stipulations of Law and Fact, JX00002A ¶ 30).

Response to Finding No. 971:

This proposed finding is also misleading because it focuses on the St. Luke's Hospital subsidiary only, rather than on St Luke's parent, OhioCare, and, therefore, ignores St. Luke's physician practice losses. In addition, the proposed finding is misleading because OhioCare's financials were still extremely poor in the first eight months of 2010. (RPF 1616, 1625, *in camera*, 1633, *in camera*). In the eight months before the joinder, OhioCare's operating losses were $7.7 million and operating margin -6.9 percent. (RPF 1616).

972. St. Luke's outpatient and inpatient net revenues both "increased in each calendar year from 2008 through 2010." (Joint Stipulations of Law and Fact, JX00002A ¶¶ 31-32).

Response to Finding No. 972:

The proposed finding is misleading because St. Luke's incurred large losses from 2007 through August 31, 2010, despite increases in volume. (RPF 1616-1620; PX02147 at 028-029). For example, OhioCare lost $20.3 million in 2009 and $7.7 million in the first eight months of 2010. (RPF 1616). St. Luke's was struggling financially at the time of the acquisition and had not achieved the financial goals of the three year plan. (RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644 1941-1954, 1955, *in camera*, 1956-1961).

973. St. Luke's projected 2010 total net revenues of $168 million for its hospital and all subsidiaries (based on annualizing Aug. 31, 2010 figures) was an increase of 26 percent over 2007 revenues of $133 million. (PX01003 at 005 (2007 OhioCare Consolidated Financial Report); PX01265 at 004 (OhioCare Consolidated Statement of Operations as of Aug. 31, 2010); *see also* Black, Tr. 5683). Based on actual end-of-year performance, St. Luke's net revenues in 2010 were even higher than the projected figures as of August, 31 2010. (PX02147 at 027 (¶ 50) (Dagen Expert Report)).

Response to Finding No. 973:

This proposed finding is misleading because it concerns St. Luke's revenues after the joinder and incorporates the effects of the joinder. It does not reflect St. Luke's financial condition as an independent entity. This proposed finding is also misleading because it focuses on the St. Luke's Hospital subsidiary only, rather than on St Luke's parent, OhioCare, and, therefore, ignores St. Luke's physician practice losses. In addition, the proposed finding is misleading because St. Luke's incurred large losses from 2007 through August 31, 2010 despite increases in volume. (RPF 1616-1620; PX02147 at 028-029). For example, OhioCare lost $20.3 million in 2009 and $7.7 million in the first eight months of 2010. (RPF 1616). St. Luke's was struggling financially at the time of the acquisition and had not achieved the financial goals of the three year plan. (RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644 1941-1954, 1955, *in camera*, 1956-1961).

974. St. Luke's overall cost coverage ratio (across all payors, including Medicare and Medicaid) improved by nine percent during the first eight months of 2010 (94 percent) compared to all of 2009 (86 percent). (Den Uyl, Tr. 6441, 6606, *in camera*; RX-56 at 10 (Table 6) (Den Uyl Expert Report), *in camera*; Dagen, Tr. 3187; PX01852 at 003 (Table 1), 018-019 (¶ 27) (Dagen Rebuttal Report)).

Response to Finding No. 974:

This proposed finding is misleading because OhioCare still lost $7.7 million in the first eight months of 2010 despite a small improvement in the overall cost coverage ratio as compared to 2009. (RPF 1616). St. Luke's overall cost coverage ratio was below one, meaning St. Luke's was not generating sufficient reimbursement to cover its total costs, through the time of the joinder on August 31, 2010, meaning that St. Luke's on average was losing money on every patient it admitted. (RPF 1777, *in camera*; Den Uyl, Tr. 6423).

975. St. Luke's patient volume growth during the last four months of 2010 caused its overall cost coverage ratio (including Medicare and Medicaid) to improve even further, to 99 percent. (Dagen, Tr. 3197).

Response to Finding No. 975:

This proposed fact is misleading because it draws conclusions about St. Luke's cost coverage ratio after the joinder, incorporating effects of the joinder. This proposed finding does not reflect St. Luke's financials as an independent entity. St. Luke's overall cost coverage ratio was below one, meaning St. Luke's was not generating sufficient reimbursement to cover its total costs, through the time of the joinder on August 31, 2010, meaning that St. Luke's on average was losing money on every patient it admitted. (RPF 1777, *in camera*; Den Uyl, Tr. 6423).

b. St. Luke's Has Substantial Cash Reserves

976. As of August 31, 2010, St. Luke's had approximately $65 million in cash and investment balances (incorporating both the assets limited as to use and the assets of SLF). (Joint Stipulations of Law and Fact, JX00002A ¶ 34; PX01265 at 001 (OhioCare Consolidated Balance Sheet as of Aug. 31, 2010: sum of "Assets limited as to use" and "Cash and cash equivalents" lines)).

Response to Finding No. 976:

This proposed finding is misleading because the $65 million cited by Complaint Counsel incorporates assets that were restricted and not available for ordinary course expenditures. St. Luke's unrestricted reserves { }. (RPF 1641, *in camera*). This amount had decreased significantly { }. (RPF 1641, *in camera*). { } (RPF 1642, *in camera*).

{ } (Den Uyl, Tr. 6460, *in camera*).

977. As of December 31, 2010, St. Luke's had approximately $70 million in cash and investment balances. (Joint Stipulations of Law and Fact, JX00002A ¶ 35).

Response to Finding No. 977:

This proposed finding is misleading because it concerns St. Luke's reserves after the joinder and incorporates the effects of the joinder such as Paramount revenues and stock market increases after the joinder. (Dagen, Tr. 3195, 3323-3328, 3245; RPF 2072, *in camera*). Mr. Dagen admits that about 23 percent of the revenue increases that St. Luke's experienced between September 1 and December 31, 2010 were a result of St. Luke's addition to the Paramount network. (Dagen, Tr. 3243). It does not reflect St. Luke's reserves as an independent entity. (Dagen, Tr. 3323-3328; RPF 2072). Moreover, this amount incorporates assets that were restricted and not available for ordinary course expenditures. (RX-56 at 000015-000016, *in camera*; RPF 2072, *in camera*).

978. Mr. Dagen concluded that, based on a review of ordinary course of business documents, it was appropriate to include assets from St. Luke's Foundation and board-designated funds when calculating St. Luke's total "reserves." (PX02147 at 013 (¶ 26 n.21) (Dagen Expert Report)); *see also* (PX01006 at 010 (OhioCare Consolidated Financial Report Dec. 31, 2009)) ("Assets limited as to use include assets designated by the board of directors for future capital improvements, over which the board retains control, and may, at its discretion, subsequently use for other purposes.").

Response to Finding No. 978:

Mr. Dagen's conclusion is inaccurate because 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. (RPF 2097).

979. Ms. Guerin-Calvert described St. Luke's "days of cash on hand" as of August 31, 2010 as "above its comparables." (PX02136 at 060 (¶ 74) (Guerin-Calvert, Supp. Decl.), *in camera*; *see also* PX01372 at 002 (Moody's Rating Update: St. Luke's, Feb. 3, 2010)).

Response to Finding No. 979:

This proposed finding is highly misleading as it takes Mr. Guerin-Calvert's quotation out of context. In reality, taking her complete sentence, Ms. Guerin-Calvert wrote, {

} (PX02136 at 060, *in camera*).

980. Notably, even in 2009, St. Luke's cash-to-debt ratio was 412 percent, compared to 102 percent for all Moody's-rated hospitals. (PX01372 at 002 (Moody's Rating Update: St. Luke's, Feb. 3, 2010); Brick, Tr. 3474).

Response to Finding No. 980:

This proposed finding is misleading. The document cited by Complaint Counsel is Moody's February 2010 downgrade of St. Luke's and where Moody's maintained a negative outlook. (PX01372 at 001-004). The Moody's downgrade describes in detail St. Luke's financial challenges that precipitated this downgrade. (PX01372 at 001-004). Despite St. Luke's cash-to-debt ratio of 412 percent as of November 30, 2009. Moody's downgraded St. Luke's in February 2010 and maintained a negative outlook despite these strengths. (PX01372 at 001-004). This was Moody's second downgrade of St. Luke's in two years leaving St. Luke's rating three grades lower than it had been in 2008, with a negative outlook, and "{

}." (RPF 1981-1986). Note that Mr. Brick, whose testimony is also cited in this proposed finding, did no independent analysis to support his opinions of St. Luke's credit rating, he relied exclusively on Moody's reports. (Brick, Tr. 3474, 3511-3557).

981. Consistent with its historical use, St. Luke's could draw from its cash reserves "to invest . . . in appropriate capital projects, as needed." (PX02147 at 015 (¶ 29) (Dagen Expert Report)). In particular, Mr. Dagen concluded that St. Luke's would have been able to fund necessary capital improvements and growth-minded investments without any additional borrowing. (PX02147 at 006 (¶ 12) (Dagen Expert Report)).

Response to Finding No. 981:

This proposed finding is not accurate. 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. (RPF 1634). St. Luke's was facing significant capital expenditures, and St. Luke's had to fund its underfunded pension plan. (RPF 1634).

Moreover, St. Luke's struggling financial situation would make it more difficult for St. Luke's to borrow money. (RPF 1634, 1732, *in camera*). As St. Luke's CEO, Mr. Wakeman, testified, "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." (RPF 1961).

c. St. Luke's Had a Positive Trajectory at Time of Acquisition

982. Mr. Dagen concluded that St. Luke's positive trajectory in 2010 would have caused it to reach increasingly higher levels of EBITDA in the next several years, including positive EBITDA in 2011, 2012, and 2013. (PX02147 at 040-042 (¶¶ 72-74) (Dagen Expert Report)).

<u>Response to Finding No. 982:</u>

This proposed finding is inaccurate. Mr. Dagen's reliance on EBITDA fails to consider the actual cash losses experienced by the hospital. (RX-56 at 000032, *in camera*). EBITDA does not reflect the true cash flow of the hospital because it does not consider capital expenditures. (RPF 1622). Moreover, Mr. Dagen's projections are wrong as they rely on a number of erroneous assumptions and inaccuracies as detailed in Mr. Den Uyl's report and testimony. (*See, e.g.*, RX-56 at 000032-000044, *in camera*; Den Uyl, Tr. 6413).

983. This positive trajectory would result in a standalone St. Luke's improving its operating income in 2011 and 2012, and reaching positive operating income in 2013. (Dagen, Tr. 3211-3214; PX02147 at 040-042 (¶¶ 72-74) (Dagen Expert Report)).

<u>Response to Finding No. 983:</u>

This proposed finding is inaccurate. Mr. Dagen's projections are wrong as they rely on a number of erroneous assumptions and inaccuracies as detailed in Mr. Den Uyl's report and testimony. (*See, e.g.*, RX-56 at 000032-000044, *in camera*; Den Uyl, Tr. 6413).

984. St. Luke's performance in the last quarter of 2010 confirms its positive financial trajectory at the time of the Acquisition. (Dagen, Tr. 3196-3199; PX01952 at 023 (Brick, Dep. at 86)). The fair market value of St. Luke's pension fund improved from $86.2 million, as of August 31, 2010, to $101.9 million by the end of the year due solely to market forces. (Dagen, Tr. 3164-3165). The fair market value of St. Luke's reserve fund improved from $59 million, as of August 31, 2010, to $70 million by the end of the year due solely to market forces. (Dagen, Tr. 3324).

Response to Finding No. 984:

This proposed finding is misleading because it references St. Luke's financials after the joinder and incorporates the effects of the joinder. This proposed finding does not reflect the financial condition of an independent St. Luke's. Mr. Dagen himself testified that most important time period in analyzing St. Luke's financial viability is from 2008 when Mr. Wakeman arrived, through 2010 when the joinder occurred. (RPF 1613).

The "positive trajectory" that Complaint Counsel's inaccurate citations purport to "confirm" is also itself inaccurate. OhioCare incurred losses of $7.7 million in the first eight months of 2010. (RPF 1616). And Mr. Dagen's projections on St. Luke's future financials had St. Luke's remained independent are wrong as they rely on a number of erroneous assumptions and inaccuracies as detailed in Mr. Den Uyl's report and testimony. (*See, e.g.*, RX-56 at 000032-000044, *in camera*; Den Uyl, Tr. 6413).

985. St. Luke's net patient service revenue finished 2010 with a 10.5 percent increase over 2009. (PX00596 (St. Luke's Statement of Operations Dec. 31, 2010)).

Response to Finding No. 985:

This proposed finding is misleading. St. Luke's continued to lose money through the time of the joinder despite increases in revenue. (RPF 1616; PX02147 at 028-029). Also, OhioCare's operating loss was $7.7 million in the first eight months of 2010. (RPF 1616).

986. Operating margin increased to -1.1 percent (from -10.3 percent in 2009) and EBITDA margin increased to *positive* 3.8 percent in 2010 (from -2.5 percent in 2009). (PX001265 (OhioCare Consolidated Balance Sheet); PX02129 at 002 (Hanley, Decl. Ex. 1);

PX00516 (St. Luke's Business Unit Statement of Revenue & Expenses Dec. 31, 2010), *in camera*).

Response to Finding No. 986:

This proposed finding is misleading because it focuses on the St. Luke's Hospital subsidiary only, rather than on St Luke's parent, OhioCare, and therefore ignores St. Luke's physician practice losses. OhioCare incurred significantly higher losses and achieved worse margins than the ones Complaint Counsel cite in this proposed finding. (RPF 1616, 1625, *in camera*, 1633, *in camera*). This proposed finding is also misleading because OhioCare's financials were still extremely poor in the first eight months of 2010. (RPF 1616, 1625, *in camera*, 1633, *in camera*). For example, OhioCare's operating losses were $7.7 million and operating margin -6.9 percent (RPF 1616); its EBIDTA was { } and EBITDA margin { } (RPF 1625, *in camera*) despite the fact that it was { } for a hospital to have a negative EBIDTA (RPF 1626, *in camera*); and its operating cash flow minus capital expenditures was { }. (RPF 1633).

4. Last Words to the Board as an Independent Hospital

987. On September 24, 2010, Mr. Wakeman sent a "Monthly Report" to the St. Luke's Board of Directors that analyzed St. Luke's operating performance. (PX00170 (Wakeman Aug. 2010 Monthly Report to St. Luke's Board of Directors)). This report covered August 2010, the last month in which St. Luke's was an independent hospital before it was acquired by ProMedica. (Wakeman, Tr. 2601). Mr. Wakeman testified in court that this document reflected accurate and truthful information. (Wakeman, Tr. 2601-2602).

Response to Finding No. 987:

Respondent has no specific response.

988. In this August 2010 monthly report, Mr. Wakeman advised St. Luke's Board that:

   a. "[I]n the past three years . . . [w]e went from an organization with declining activity to near capacity." (PX00170 at 007).

   b. "[W]e have built our volume up to a point where we can produce an operating margin and keep our variable expenses under control." (PX00170 at 001)

c. "Even with our increased activity, the patient satisfaction scores improved . . . ." (PX00170 at 004).

d. "Our leadership status in quality, service and low cost stayed firmly in place." (PX00170 at 007).

e. "In the past six months our financial performance has improved significantly. The volume increase and awareness of expense control were key." (PX00170 at 007).

Response to Finding No. 988:

This proposed finding is misleading. PX00170 is indicative of St. Luke's financial distress at the time of the joinder rather than its success as Complaint Counsel purports. First, Mr. Wakeman's report cited by Complaint Counsel was made to St. Luke's Board on September 24, 2010, nearly a month after the joinder. (PX00170 at 001). St. Luke's was "congratulating [itself]" for a positive margin "after years of losing money." (Wakeman, Tr. 2605). However, Mr. Wakeman admits that the positive margin was very small ("$7,000 on $36.7 million in gross revenue") and "not impressive." (PX00170 at 001). Moreover, this small monthly margin was an anomaly. It 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). "This was not a trend. This was one month." (Wakeman, Tr. 2606). In fact, OhioCare had lost $7.7 million year to date by the end of August 2010. (RPF 1616; PX02147 at 028-029). The fact that St. Luke's was "congratulating itself" on such a small monthly margin despite such large losses is indicative of its financial troubles at the time of the joinder.

The quotations from PX00170 cited by Complaint Counsel having to do with volume, capacity and quality are also misleading. St. Luke's capacity constraints were a sign of St. Luke's financial weakness and competitive limitations and not a sign of financial strength as

Complaint Counsel imply. St. Luke's capital freeze had prevented it from making important investments in expansion and private rooms prior to the joinder. (RPF 1949, 1961, 2113-2114). In addition, its hiring freeze made it more difficult for St. Luke's to serve its growing numbers of patients with its existing staff. (RPF 1919-1933, 1934-1935, *in camera*).

Moreover, the fact that St. Luke's as a stand alone hospital did not have excess capacity like its competitors was a limitation on its ability to provide high service to its patients. For example, St. Luke's capacity constraints forced it to divert emergency patients to other hospitals potentially harming patient outcomes. (RPF 1743-1750). 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. (RPF 1750). Mr. Wakeman highlights St. Luke's problems with its diversion ratio in his September 24, 2010 report to the Board and attributes it to "a lack of monitored beds." (PX00170 at 003). Mr. Wakeman's report also points to other signs that St. Luke's quality and service are suffering from a lack of capacity. For example, he explained that "the monthly average of combative patient calls in 2010 are 2.6 times greater than in 2009." (PX00170 at 003).

St. Luke's capacity constraints also made it more difficult for it to convert to private rooms, the local and national standard of care and an important driver of patient outcomes and satisfaction. (RPF 815-818, 1199, 1904, 2222, *in camera*, 2233-2234). This inability to convert to private rooms put St. Luke's at a competitive disadvantage. (RPF 1757, 2234, 2240).

The finding is also misleading because it suggests that St. Luke's volume increases were a sign of its financial health. In his September 24, 2010 report to the Board, Mr. Wakeman writes, "If there was one pillar we attained a high level of success in our strategic plan in the past two years it would be growth." (PX00170 at 006). However, for the purposes this report, Mr.

Wakeman omits the undisputed fact that St. Luke's did not succeed at the financial pillar of the three-year plan. (RPF 1941-1949). St. Luke's {I

.} (RPF 1777-1781). 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. (RPF 1616). St. Luke's CEO and senior management testified that {

} (RPF 1783-1784, *in camera*; Wakeman, Tr. 2942-2943, *in camera*; PX01283 at 002, *in camera*).

C. St. Luke's Not in Grave Danger of Imminent Failure

989. St. Luke's was not in grave danger of imminent failure. (*See* PX01920 at 037-038 (Wakeman, Dep. at 141-143), *in camera*; PX01915 at 054 (Wagner, IHT at 211), *in camera*; PX01918 at 013 (Oostra, Dep. at 45), *in camera*).

Response to Finding No. 989:

This proposed finding is an improper legal conclusion, not a fact. It is also misleading and inaccurate. In the testimony cited by Complaint Counsel, Mr. Wakeman, St. Luke's CEO, testified that St. Luke's might be able to keep its doors open for {

}. (PX01920 (Wakeman, Dep. at 141-143)); Mr. Wagner, as St. Luke's acting CFO, testified that St. Luke's could continue as an independent hospital for {

}. (PX01915 (Wagner, IHT at 211), *in camera*); and Mr. Oostra, ProMedica's CEO, testified that St. Luke's as an independent entity {

}. The testimony cited by Complaint Counsel highlights St. Luke's very serious financial problems.

990. St. Luke's CEO, Dan Wakeman, instituted a turnaround plan in 2008 that was successful and enabled St. Luke's to improve its financial condition significantly, as evidenced by numerous objective financial indicators. (PX01920 at 005 (Wakeman, Dep. at 13, *in camera*; PX01235 (Toledo Market Share Data); *See supra* Section XVI.B.).

Response to Finding No. 990:

This proposed finding is inaccurate. St. Luke's three year plan initiated by Dan Wakeman did not achieve its financial objectives. (RPF 1941-1954, 1955, *in camera*, 1956-1961; *See supra* responses to Complaint Counsel's proposed findings in Section XVI.B.).

991. Complaint Counsel's financial expert, Mr. Dagen, concluded that St. Luke's cash reserve and positive EBITDA enabled it to make all necessary debt payments, pay its bills on time, and make necessary capital expenditures throughout the last decade. (PX02147 at 005 (¶ 11) (Dagen Expert Report)).

Response to Finding No. 991:

This proposed finding is inaccurate and misleading. Mr. Dagen's conclusion is inaccurate because St. Luke's deferred many important capital expenditures in the years leading up to the joinder. (RPF 996, 1686-1702, 1703-1704, *in camera*, 1705-1706, 1707-1708, *in camera*, 1961, 2104, *in camera*, 2270, *in camera*). This finding is also misleading because it focuses on St. Luke's financial condition for the last ten years rather than the three years leading up to the joinder which Mr. Dagen and Mr. Den Uyl agree are the most relevant time period in assessing St. Luke's financial viability. (RPF 1613-1614, 2064, *in camera*). It is also misleading because it states that St. Luke's EBIDTA is indicative of what St. Luke's has available for capital expenditures. Yet, EBITDA does not consider capital expenditures and, therefore, does not reflect the true cash flow St. Luke's has available for operations and capital expenditures. (RPF 1622).

992. Mr. Dagen also concluded that focusing solely on St. Luke's operating margin or cost coverage ratios, as Respondent appears to do, does not capture St. Luke's ability to make investments to maintain facilities and quality of care, as well as grow its business. (PX02147 at 009-011 (¶¶ 20-22) (Dagen Expert Report)).

Response to Finding No. 992:

This proposed finding is inaccurate. Neither Mr. Den Uyl nor Respondent's counsel "focus solely on St. Luke's operating margin or cost coverage ratios" as this finding suggests. In

fact, Mr. Den Uyl explicitly evaluates St. Luke's operating cash flow minus its capital expenditures to help make a realistic determination of St. Luke's ability to make investments. (RX-56 at 000007-000008, *in camera*; RPF 1628, *in camera*, 1629-1632, 1633, *in camera*).

1. Pension Fund Loss is Misleading

993. St. Luke's reserve fund and pension fund assets, which are partially invested in equities, have consistently tracked stock market performance over the course of the last decade. (Dagen, Tr. 3162-3164). "[T]he drop in the financial markets in late 2008 accounted for a { ι} swing between the reserves and the defined benefit pension accounts." (PX00923 at 001 (Wakeman Mar. 2010 Email), *in camera*).

Response to Finding No. 993:

Complaint Counsel's proposed finding is misleading. Complaint Counsel fail to define what they mean by "tracking stock market performance." Reference to actual numbers shows that St. Luke's funds performed extremely poorly. For example, St. Luke's reserve fund achieved only a 0.7% return on its reserve fund over the ten-year period that ended December 31, 2009. (RPF 2107). In the three year period, that ended December 31, 2009, St. Luke's reserve fund lost 1.8%. (RPF 2108).

The decline of the stock market in late 2008 was just one factor that influenced the overall health of St. Luke's pension fund, whose funding level dropped by over 40 percent between the end of 2007 and the end of 2008. (RPF 1649).

994. Despite the negative impact of the financial markets, though, St. Luke's "only accessed the reserves for about { } [between 2008 and 2010] . . . [which was] offset by gains of almost { } in the market . . . ." (PX00923 at 001 (Wakeman Mar. 2010 Email), *in camera*).

Response to Finding No. 994:

Complaint Counsel's proposed finding is inaccurate and misleading. St. Luke's relied upon significant amounts of money from its reserve fund, but also drew down credit balances in its pension fund account which reduced the amount drawn from other reserves. (RX-34 (Dewey

IHT at 180). For example, for the plan year ending December 31, 2008, St. Luke's was required to contribute more than { } to its pension plan. (PX01602 at 015, *in camera*). St. Luke's contributed { } in cash during the 2008 calendar year, but rather than draw upon its reserve or ordinary funds to meet the remainder of this obligation at the start of 2009, St. Luke's instead { } in order to meet this obligation. (PX02366 at 001; PX01602 at 015, *in camera*). For the plan year ending December 31, 2009, St. Luke's had contributed { } to its plan during the 2009 calendar year, but still came up short and was required to { }. (RPF 1675-1678; PX02366 at 001; PX01392 at 005, *in camera*). Together these actions covered the remaining { } shortfall in St. Luke's contribution. (PX01392 at 005, *in camera*).

Even after the joinder, the burden of contributions to its pension remains very real for St. Luke's. For the plan year ending December 31, 2010, St. Luke's pension plan required ordinary contributions of { } (of which $800,000 was reallocated to 2009. (PX02366, *in camera*, PX01392 at 005, *in camera*). In addition, in order to assure adequate funding, the plan required an additional $5 million in 2011 that was reallocated to 2010. (RPF 1683).

Many factors, { }, have reduced the overall liability of the pension fund. (RPF 1658, *in camera*). At the time of the joinder, however, the liability was still calculated at approximately { }. (RPF 659, *in camera*). St. Luke's is obligated by law to make continued cash contributions to restore the pension plan to full funding. (RPF 1663-1665). These cash payments are currently calculated at { }, but this

{

}. (RPF 1685, *in camera*; Arjani, Tr. 6765, *in camera*).

995. Focusing solely on the funded status of St. Luke's defined benefits pension plan in 2009 ignores the cyclical nature of financial markets and St. Luke's demonstrated ability to rebound from such events. (PX02147 at 021 (¶ 41) (Dagen Expert Report)).

Response to Finding No. 995:

Complaint Counsel's proposed finding is inaccurate and misleading. In the aftermath of the market collapse of 2008, St. Luke's pension dropped from being 108 percent funded to 63 percent funded. (RPF 1649). St. Luke's has no "demonstrated ability" to recover from such a massive drop in the value of the fund, which represented a liability of approximately $50 million. (RPF 1649). Indeed, despite { } and infusing it with { }, St. Luke's has struggled to keep the plan at the 80% funded. (RPF 1650, 1675-1678, 1683). Projections that rely on "cyclical markets" to erase the funding deficit are overly rosy given existing financial conditions. (Arjani, Tr. 6765 *in camera*). Even with an annual return of { } percent, it will still take until { } for St. Luke's to restore the plan to full funding, and this timetable requires annual cash outlays of { }. (RPF 1685, *in camera*). The prior examples of "recovery" cited by Complaint Counsel's expert do not support this finding. Mr. Dagen himself admits that it took St. Luke's *seven years* to "recover" from the more mild recession of 2000-01. (PX02147 at 022). Even then, St. Luke's failed to achieve 100 percent funding within that time period before the value of the fund assets again plummeted. (PX02147 at 024).

996. Indeed, Mr. Wakeman described the impact of the financial crisis as "something like a perfect storm idea: equity market disaster, shorten time lines to fund and very conservative calculations create[d] an unrealistic expense on the income statement." (PX01230 at 001 (Wakeman Jan. 2009 Email), *in camera*).

Response to Finding No. 996:

Complaint Counsel's proposed finding is inaccurate and misleading. Despite Mr. Wakeman's colorful language, the accounting entry for pension liability has very real consequences. The accounting liability and the funding calculations made under ERISA are { }, and there is { } in the status of a pension plan, whether determined under accounting or ERISA rules. (Arjani, Tr. 6768, *in camera*). Witnesses testified that the entry made on the income statement is a significant measure of the plan's financial health that is assessed by an organization's board and independent credit rating agencies. (RPF 1656).

997. The minimum funding requirements for a pension plan are determined by ERISA law. (Arjani, Tr. 6757, *in camera*). The purpose of these funding requirements is to ensure that, in the long run, pension funds have enough assets to satisfy the expected obligations to their beneficiaries. (Arjani, Tr. 6757, *in camera*).

Response to Finding No. 997:

Respondent has no specific response.

998. To determine whether a pension plan is underfunded according to ERISA, an actuary calculates the adjusted funding target attainment percentage ("AFTAP"). (Arjani, Tr. 6757, *in camera*; PX01951 at 043 (Den Uyl, Dep. at 167), *in camera*). If the AFTAP is below 100 percent, that means that the pension plan is underfunded according to ERISA. (Arjani, Tr. 6758, *in camera*).

Response to Finding No. 998:

Respondent has no specific response.

999. In the last few years, it was very common to see pension plans underfunded. (Arjani, Tr. 6753, *in camera*; PX01943 at 014 (Arjani, Dep. at 48)).

Response to Finding No. 999:

Respondent has no specific response.

1000. Many plans became underfunded as a result of declines in stock market investments from 2007 until March 2009, which reduced the market values of most firms' pension fund assets. (Arjani, Tr. 6754, *in camera*; PX01943 at 014 (Arjani, Dep. at 48-49)).

Response to Finding No. 1000:

Complaint Counsel's proposed finding is inaccurate and misleading. The underfunding of a pension plan is determined by the relation of assets to obligations. (RPF 1665, 1660-1661). Many factors influence the value of the plan's assets, including employer contributions, benefit payments, and portfolio performance. (RPF 1646, 1648; RX-214 at 000011, *in camera*). Equally, the obligations depend upon many factors, including among others the status of the plan as active or frozen, the plan's census, life expectancies, and interest rates used to discount plan obligations. (1648, 1661; Arjani, Tr. 6732-6733).

Further, Complaint Counsel's fail to recognize testimony that confirms that many pension funds, { }, continued to be underfunded after March 2009. (RPF 1679, *in camera*, 1682, *in camera*). Moreover, stock market investments have also experienced { } after March 2009. (Arjani, Tr. 6765, *in camera*).

1001. Also, interest rates decreased during this time period, which increased the values of pension funds' expected future obligations. (PX01943 at 014 (Arjani, Dep. at 49)).

Response to Finding No. 1001:

Complaint Counsel's proposed finding is inaccurate and misleading. Complaint Counsel fails to define "this time period." To the extent that Complaint Counsel intended to limit this time period to the range of dates expressed in CCPF 1000, the proposed finding is inaccurate. Interest rate decreases were not limited to this period. Testimony shows that the interest rates used for pension funding calculations have declined for the last several years. (Arjani, Tr. 6734-6735).

1002. According to both ProMedica's current actuary, Neville Arjani, and Respondent's expert witness, Mr. Den Uyl, St. Luke's pension plan has never been certified with an AFTAP funding level { }. (Arjani, Tr. 6764, *in camera*; PX01951 at 042 (Den Uyl, Dep. at 163), *in camera*). St. Luke's pension plan was certified as { } AFTAP-funded as of January 1, 2010. (Arjani, Tr. 6763-6764, *in camera*). The plan was also certified as { } AFTAP-funded as of January 1, 2011. (Arjani, Tr. 6762-6763, *in camera*). St. Luke's pension fund will continue to be certified at { } AFTAP-funded through March 2012. (Arjani, Tr. 6763, *in camera*).

Response to Finding No. 1002:

Complaint Counsel's proposed finding is misleading. Complaint Counsel ignores the fact that certification at 80 percent merely avoids { }. (RPF 1669, *in camera*). Federal law requires St. Luke's to restore the pension plan to 100 percent funding and, regardless of the certification, this burden requires contributions of { }. (RPF 1664, 1685, *in camera*).

In addition, Complaint Counsel overlook the significant infusions of cash that St. Luke's was required to make in order to eke above the 80 percent funding level. (RPF 1675-1678, 1682, *in camera*; Arjani, Tr. 6741 ("St. Luke's contributed $5 million to the plan in March [2011] to be just over 80 percent [for January 1, 2011]."); PX01392 at 005, 006, *in camera* (reflecting contributions of { } to achieve { } percent funding at January 1, 2010)).

1003. There are no benefit restrictions under ERISA if a pension plan is 80 percent or more AFTAP-funded. (Arjani, Tr. 6759, *in camera*). If a pension plan is between 80 and 100 percent AFTAP-funded, the plan has seven years to make quarterly and annual cash contributions to bring the plan back to 100 percent funded. (Arjani, Tr. 6760-6762, *in camera*).

Response to Finding No. 1003:

Respondent has no specific response.

1004. St. Luke's has until 2016 to bring its pension plan back to 100 percent funded status. (Arjani, Tr. 6764, *in camera*). Based on the actuary's most up-to-date calculations, St. Luke's future required annual cash contributions are approximately { } (Arjani, Tr. 6765, *in camera*).

Response to Finding No. 1004:

Complaint Counsel's proposed finding is misleading. St. Luke's actuary indicated that contributions of at least { } would be required, but qualified this statement by saying that value depended upon various assumptions, including an { }.

(Arjani, Tr. 6765, *in camera*). Given current market conditions, Mr. Arjani testified that he {

.} (Arjani, Tr. 6765, *in camera*).

1005. If St. Luke's continues to make annual { } payments, based on the most recent analysis, its pension plan will face no restrictions under ERISA. (Arjani, Tr. 6765-6766, *in camera*). Any cash contributions above { } would be strictly elective. (Arjani, Tr. 6766, *in camera*).

Response to Finding No. 1005:

Complaint Counsel's proposed finding is misleading and inaccurate. As explained in Respondent's response to CCPF 1004, the annual payment figure Complaint Counsel relies upon is dependent upon various market assumptions which Mr. Arjani {

}. (Arjani, Tr. 6765, *in camera*). To the extent that the market does not perform up to expectations, future year contributions would either be greater than the calculated amount or the length of time required to continue payments would be extended. (PX01943 (Arjani, Dep. at 31). These payments would not be elective. (PX01943 (Arjani, Dep. at 31).

1006. Despite fluctuations in St. Luke's pension fund's funded status, a phenomenon experienced by many firms, at no time were payments to pensioners at risk. (Dagen, Tr. 3164-3165). St. Luke's has never missed – or even been late on – a payment to a pension recipient. (Arjani, Tr. 6551; PX01951 at 042 (Den Uyl, Dep. at 163), *in camera*).

Response to Finding No. 1006:

Complaint Counsel's proposed finding is misleading and inaccurate. Future payments to pensioners are at risk when a pension fund is underfunded and the {

}, as Complaint Counsel concedes in CCPF 997, is to ensure that pensioners will be able to receive their pension payments. (Arjani, Tr. 6757, *in camera*).

Complaint Counsel misrepresent the testimony of Mr. Arjani, who never testified with respect to St. Luke's payments to pension recipients.

Mr. Den Uyl testified that St. Luke's has not missed any payments to pensioners, but qualified his testimony by {

}. (Den Uyl, Tr. 6551; PX01951 (Den Uyl, Dep. at 163), *in camera*). The ability to make current payments does not eliminate the legal requirement of restoring a pension plan to full funding. (RPF 1665).

1007. Based on the current value of its pension fund { } and the average annual pension payments { } to St. Luke's retirees, St. Luke's has sufficient funds to meet its obligations to pensioners for the next decade and beyond, even assuming no increase in the value of fund assets. (Dagen, Tr. 3165; PX02147 at 023-024 (¶ 45) (Dagen Expert Report)).

Response to Finding No. 1007:

Complaint Counsel's proposed finding misrepresents the findings of their expert. Nowhere did Mr. Dagen estimate that the *average* value of annual pension payments was { }. (PX02147 at 023-024). Instead Mr. Dagen reported that this figure represented the maximum outflow that St. Luke's had faced within the prior ten years. Mr. Dagen provides a chart that shows over the course of those ten years, the value of outflows increase *by more than a factor of ten.* (PX02147 at 024). Increases in payments to pensions continue in the future. Mr. Dagen relied upon ordinary course documents from St. Luke's that project outflows of more than { }in the next ten years. (PX02391, *in camera*; PX02392, *in camera*).

Regardless, the focus on payments to pensioners is still misleading. The fact that a pension fund can meet financial obligations for some limited number of years does not alter the legal requirements faced by the employer. (RPF 1664, 1665). St. Luke's must bring its pension fund to 100% funding within the period determined by ERISA. (RPF 1665). This legal obligation requires it to contribute at least { }. (RPF 1685, *in camera*).

1008. The pension liability that appears on St. Luke's financial statements – and which is used by Respondent to calculate the "funded status" of St. Luke's pension fund – is calculated under a separate set of rules than the AFTAP and does not determine the cash contributions that St. Luke's must make into its pension fund per ERISA. (Arjani, Tr. 6767-6768, *in camera*; Response to RFA at ¶ 45 ("St. Luke's 'pension liability'. . . is not

the [AFTAP])). The pension liability does not reflect an actual cash obligation. (Arjani, Tr. 6768, *in camera*; Dagen, Tr. 3167; PX001951 at 043 (Den Uyl, Dep. at 168), *in camera*).

Response to Finding No. 1008:

Complaint Counsel's proposed finding is inaccurate and misleading. The accounting liability and the funding calculations made under ERISA are {

} in the status of a pension plan, whether determined under accounting or ERISA rules. (Arjani, Tr. 6768, *in camera*). Witnesses testified that the entry made on the income statement is a significant measure of the plan's financial health that is assessed by an organization's board and independent credit rating agencies. (RPF 1656).

The other measure of pension health, its funded status under ERISA rules, reveals that St. Luke's is obliged to contribute at least { }. (RPF 1685, *in camera*).

1009. It is not uncommon for firms to have an underfunded pension fund. (Dagen, Tr. 3168). At the end of 2009, St. Luke's pension had a funded status of { } percent, on par with large companies such as ExxonMobil (73.5 percent), CBS (71.1 percent), Disney (69.1 percent), and Motorola (67.0 percent). (PX02147 at 024 (¶ 45) (Dagen Expert Report); PX01060 at 015 (Feb. 2010 St. Luke's Retirement Plan Actuarial Valuation Report), *in camera*; *see also* PX01287 at 017 (St. Luke's Aug. 2010 Our Mission Presentation), *in camera*; Dagen, Tr. 3168-3171).

Response to Finding No. 1009:

Complaint Counsel's proposed finding is misleading and inaccurate. Regardless of other firms' pension funding status, the issue for St. Luke's in considering an underfunded pension remains the legal obligation to restore the pension to full funding, the size of the annual contributions required to get to full funding, and the burden such large cash outflows place on an already struggling institution. (RPF 1664, 1685, *in camera*).

1010. St. Luke's pension fund assets have increased in value from their 2008 levels. (Black, Tr. 5699-5700). In 2008, the fair market value of the plan assets was { }. (PX02147 at 022-023 (¶ 43) (Dagen Expert Report); PX01060 at 015 (Feb. 2010 St. Luke's Retirement Plan Actuarial Valuation Report), *in camera*). As of September 2010, the fair market value of the assets had increased to { }. (PX01288 at 018 (St. Luke's Sep. 2010 interim financial statements), *in camera*). The fair market value of the pension assets further increased to $101.9 million by the end of 2010. (Dagen, Tr. 3165).

Response to Finding No. 1010:

Complaint Counsel's proposed finding is inaccurate and misleading. The value of the assets alone reveal nothing about the overall health of the pension plan. (RPF 1651, 1655, 1661; Arjani, Tr. 6732-6733). A plan's obligations are not static and change over time just as the value of assets fluctuate. (RPF 1661). Without information about the state of St. Luke's pension obligations, these asset figures offer no meaningful view of the state of St. Luke's pension plan. In addition, Complaint Counsel cite interim estimated numbers for September 2010. A more reliable figure would be the actuarial report prepared by St. Luke's actuaries, which states that the fair market value of the plan's assets at the time of the joinder (August 31, 2010) was { .} (RX-214, *in camera*).

1011. By December 31, 2010, St. Luke's pension liability represented a funded level of { } percent. (PX02369 at 001 (St. Luke's Pension Plan), *in camera*).

Response to Finding No. 1011:

The proposed finding is inaccurate and misleading. The evidence identified does not support this finding.

1012. Mr. Arjani estimates that between August 31, 2010 and December 31, 2010, St. Luke's pension liability improved (i.e., decreased) by { }, predominantly due to improvements in the equity markets. (Arjani, Tr. 6755-6756, *in camera*); RX-214 at 1, *in camera*; Dagen, Tr. 3166, 3171 (improvement caused by a "market-driven increase" which "would have happened with or without the [Acquisition]")).

Response to Finding No. 1012:

Complaint Counsel's proposed finding is inaccurate and misleading. Mr. Arjani did not testify that the plan's liability improved by { } in four months. The improvement in the fair value of plan assets for the entire year was only { }. (RX-214 at 000011, *in camera*). Part of this came from { }; St. Luke's contributed { } in cash, as Mr. Arjani noted generally in his testimony. (Arjani, Tr. 6755, *in camera* ({ }; RX-214 at 000011, *in camera*). Mr. Arjani notes that the { } was unusually strong. (Arjani, Tr. 6755, *in camera*). The { }, however, had been { } for the plan's performance. (Arjani, Tr. 6745, *in camera*). Between January 1 and August 31, the plan had only obtained a return of approximately { }. (RX-214 at 000008, *in camera*). The projected return was for that period was approximately { }, leading to a { }. (Arjani, Tr. 4745, *in camera*; RX-214 at 000009, *in camera*). The improvement in the last trimester helped, but the plan's return on assets still finished the year { }. (RX-214 at 000012, *in camera*). The return on assets did not even match the performance obtained in 2009. (RX-214 at 000011, *in camera*). Mr. Arjani feared that performance this year would { } either. (Arjani, Tr. 6755, *in camera*).

2. St. Luke's Credit Rating is Not a Sign of a Firm in Distress

1013. Moody's Investors Service, Inc. ("Moody's") assigns a credit rating by performing a holistic qualitative and quantitative analysis of the borrower. (PX01370 at 001 (Moody's Rating Methodology); PX02146 at 009-010 (¶ 15) (Brick Expert Report)). Moody's examines certain variables over time and in relation to the industry generally. (PX01370 at 005 (Moody's Rating Methodology); PX02146 at 009-010 (¶ 15) (Brick Expert Report)).

Response to Finding No. 1013:

Respondent has no specific response.

1014. Moody's February 2010 credit rating downgrade was not relevant to St. Luke's because it did not intend to – nor did it need to – borrow money for the foreseeable future. (PX02147 at 18 (¶ 35) (Dagen Expert Report); Hanley, Tr. 4706-4707).

Response to Finding No. 1014:

This proposed finding is not accurate. "Maintaining Moody's A rating" was one of the key financial goals in Dan Wakeman's three year plan in 2008. (RPF 1906,1943). {

.}

(Wakeman, Tr. 2993, *in camera*; PX01016 at 14, *in camera*). Moreover, St. Luke's had significant capital needs at the time of the joinder, many of which had been deferred, and it was uncertain how St. Luke's would have financed those capital needs as an independent entity. (RPF 996, 1686-1702, 1703-1704, *in camera*, 1705-1706, 1707-1708, *in camera*, 1961, 2104, *in camera*, 2270, *in camera*).

1015. St. Luke's did not attempt to issue new bond debt any time between January 1, 2009 and August 31, 2010. (Joint Stipulations of Law and Fact, JX00002A ¶¶ 37-38).

Response to Finding No. 1015:

Respondent has no specific response.

1016. Ms. Hanley, ProMedica's CFO, testified that Moody's rating had no "practical effect" on St. Luke's in early 2010 because St. Luke's had no intention to borrow money. (Hanley, Tr. 4706-4707).

Response to Finding No. 1016:

This proposed finding is inaccurate and misleading. Ms. Hanley actually testified that the Moody's downgrade in February 2010 did not have a practical effect only at that specific point in time as St. Luke's was not borrowing in February of 2010. (Hanley, Tr. 4707). She added that she expected the downgrade would affect St. Luke's ability to borrow in the future: "You look at

a company for the future sustainability." She noted that the downgrade would constrain St. Luke's ability to access debt and affect St. Luke's "potential for future funding." (Hanley, Tr. 4706-4707).

In addition, "[m]aintaining Moody's A rating" was one of the key financial goals in Dan Wakeman's three year plan in 2008. (RPF 1906,1943). {

} (Wakeman, Tr. 2993, *in camera*; PX01016 at 14, *in camera*). Moreover, St. Luke's had significant capital needs at the time of the joinder, many of which had been deferred, and it was uncertain how St. Luke's would have financed those capital needs as an independent entity. (RPF 996, 1686-1702, 1703-1704, *in camera*, 1705-1706, 1707-1708, *in camera*, 1961, 2104, *in camera*, 2270, *in camera*).

1017. Immediately before the Acquisition, St. Luke's had a medium-grade, "Baa2" credit rating from Moody's. (PX01372 at 001 (Moody's Rating Update: St. Luke's, Feb. 3, 2010); PX01371 at 004 (Moody's Rating Symbols and Definitions); Brick, Tr. 3474-3475; PX02146 at 005 (¶ 9) (Brick Expert Report)). This is in the same category of credit rating as 28 percent of other hospitals. (PX02146 at 005-006 (¶ 9) (Brick Expert Report)).

Response to Finding No. 1017:

The proposed finding is misleading. The document cited by Complaint Counsel is Moody's February 2010 downgrade of St. Luke's in which Moody's maintained a "negative outlook." (PX01372 at 001-004). A "negative outlook" means that it is more likely there will be a further downgrade than an upgrade in the future. (Den Uyl, Tr. 6463). The Moody's downgrade describes in detail St. Luke's financial challenges that precipitated this downgrade (PX01372 at 001-004). The primary reason for the Moody's downgrade was St. Luke's "[t]hird consecutive year of large operating losses and operating cash flow deficit posted for the first time

through 11 months of FY 2009 (-9.8% operating margin and -2.0% cash flow margin)." (PX01372 at 002). The second reason listed by Moody's downgrade was St. Luke's "[c]urrently unfavorable commercial contracts and ongoing challenges with negotiating higher commercial reimbursement rates with SLH's two largest commercial payors, who account for approximately 22% of SLH's gross revenues." (PX01372 at 002). This was Moody's second downgrade of St. Luke's in two years leaving St. Luke's rating three grades lower than it had been in 2008, with a "negative outlook", and "{one small step above junk status}." (RPF 1981-1986). Mr. Brick, whose testimony is also cited in this proposed finding, did no independent analysis to support his opinions of St. Luke's credit rating, he relied exclusively on Moody's reports. (Brick, Tr. 3474, 3511-3557).

1018. As Complaint Counsel's bond-rating expert, Errol Brick, stated, "if Moody's is concerned about a hospital's financial viability, it will not hesitate to reduce that hospital's credit rating to speculative grade." (PX01854 at 002 (¶ 4) (Brick Rebuttal Report)). Had Moody's been concerned about St. Luke's ability to continue to thrive in its marketplace, Moody's would have downgraded St. Luke's to a "Ba" or lower credit rating, as Moody's had done with many hospitals in Massachusetts, New Jersey, and Ohio. (Brick, Tr. 3542-3543).

Response to Finding No. 1018:

The proposed finding is misleading. Mr. Brick, did no independent analysis to support his opinions of St. Luke's credit rating; he relied exclusively on Moody's reports and Mr. Dagen's conclusions. (Brick, Tr. 3474, 3511-3557).

1019. Investors and the capital markets have an appetite from debt issuers of medium grade risk, with "Baa" rated hospitals and healthcare systems issuing $2.6 billion in debt from January 2010 through January 2011. (PX02146 at 005 (¶ 9) (Brick Expert Report); PX02146 at 015 (Appendix 1) (Brick Expert Report); Brick, Tr. 3480-3483).

Response to Finding No. 1019:

The proposed finding is misleading. Ms. Hanley, ProMedica's CFO who evaluated St. Luke's financials during the joinder discussions and is currently responsible for them, testified

that she expected St. Luke's downgrade from Moody's would affect St. Luke's ability to borrow in the future. She stated that the downgrade would constrain St. Luke's ability to access debt and affect St. Luke's "potential for future funding." (Hanley, Tr. 4706-4707). In addition, Mr. Den Uyl, a financial expert who conducted an in depth analysis of St. Luke's financial condition, testified that St. Luke's "didn't really have the wherewithal to borrow money," (Den Uyl, Tr. 6547), and that 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*).

1020. In August 2010, St. Luke's would have been able to access the tax-exempt capital markets for up to $75 million in debt for a reasonable interest rate no more than 7 percent. (Brick, Tr. 3483-3490).

Response to Finding No. 1020:

The proposed finding is misleading. Ms. Hanley, ProMedica's CFO who evaluated St. Luke's financials during the joinder discussions and is currently responsible for them, testified that she expected the downgrade would affect St. Luke's ability to borrow in the future. She stated that St. Luke's downgrade from Moody's would constrain St. Luke's ability to access debt and affect St. Luke's "potential for future funding." (Hanley, Tr. 4706-4707). In addition, Mr. Den Uyl, a financial expert who conducted an in depth analysis of St. Luke's financial condition, testified that St. Luke's "didn't really have the wherewithal to borrow money," (Den Uyl, Tr. 6547), and that 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*).

In addition, Mr. Brick did no independent analysis to support his opinions of St. Luke's credit rating; he relied exclusively on Moody's reports and Mr. Dagen's conclusions. (Brick, Tr. 3474, 3511-3557).

1021. Respondent's expert witness, Mr. Den Uyl, did not analyze – and has no expert opinion on – whether St. Luke's could have issued additional debt as a standalone organization. (Den Uyl, Tr. 6530-6531; PX01951 at 014 (Den Uyl Dep. at 51-52), *in camera*).

Response to Finding No. 1021:

This proposed finding is not accurate. Mr. Den Uyl testified that St. Luke's struggling financial situation would have made it more difficult for St. Luke's to borrow money. (RPF 1634).

1022. Similarly, he did not analyze – and has no expert opinion – on what interest rate St. Luke's would have paid if it had issued additional debt as a standalone hospital. (Den Uyl, Tr. 6531; PX01951 at 014 (Den Uyl Dep. at 51-52), *in camera*).

Response to Finding No. 1022:

This proposed finding is misleading. Mr. Den Uyl also testified that St. Luke's struggling financial situation would have made it more difficult for St. Luke's to borrow money. (RPF 1634).

1023. In its last ratings update for an independent St. Luke's, Moody's identified certain factors that "could change the rating - UP[,]" including: "[c]ontinued growth and stability of inpatient and outpatient volume trends; significantly improved and sustainable operating performance for multiple years; strengthening of debt coverage measures and liquidity balance; improved market share." (PX01372 at 003 (Moody's Rating Update: St. Luke's, Feb. 3, 2010)). Mr. Wakeman testified that St. Luke's had met several of the factors that could lead to a ratings upgrade referenced by Moody's. (Wakeman, Tr. 3034-3035).

Response to Finding No. 1023:

This proposed finding is misleading. In February 2010, Moody's downgraded St. Luke's and maintained a "negative outlook." (PX01372 at 001-004). A "negative outlook" means that it is more likely there will be a further downgrade than an upgrade in the future. (Den Uyl, Tr. 6463). The Moody's downgrade describes in detail St. Luke's financial challenges that precipitated this downgrade. (PX01372 at 001-004). The analysis also lists what could "change the rating—DOWN" including St. Luke's "[c]ontinued weak operating performance." (PX01372 at 004). This was Moody's second downgrade of St. Luke's in two years leaving St. Luke's rating three grades lower than it had been in 2008, and was "{

}." (RPF 1981-1986).

1024. Specifically, St. Luke's had experienced growth and stability of inpatient and outpatient volume in the period before the Acquisition and expected to continue this trend as an independent hospital. (PX00170 at 001-002, 006 (Wakeman Aug. 2010 Monthly Report to St. Luke's Board of Directors); PX01915 at 020 (Wagner, IHT at 73-74), *in camera*; Brick, Tr. 3491-3494.

Response to Finding No. 1024:

This proposed finding is misleading. St. Luke's incurred significant operating losses through the time of the joinder despite volume increases. (RPF 1616-1620; PX02147 at 028-029). OhioCare's operating losses in the first eight months of 2010 were $7.7 million. (RPF 1616). "Continued weak operating performance" was the primary factor Moody's cited for why it would change St. Luke's rating down in the future. (PX01372 at 004). Also, Mr. Brick did no independent analysis to support his opinions of St. Luke's credit rating. Mr. Brick relied exclusively on Moody's reports and Mr. Dagen's conclusions. (Brick, Tr. 3474, 3511-3557).

1025. Mr. Den Uyl testified that, in the seven months between the issuance of Moody's downgrade in February 2010 and the consummation of the Acquisition, St. Luke's increased its inpatient and outpatient volumes. (Den Uyl, Tr. 6545-6546; PX001951 at 055 (Den Uyl, Dep. at 213), *in camera*).

Response to Finding No. 1025:

This fact is misleading. St. Luke's incurred significant operating losses through the time of the joinder despite volume increases. (RPF 1616-1620; PX02147 at 028-029). OhioCare's operating losses in the first eight months of 2010 were $7.7 million. (RPF 1616). "Continued weak operating performance" was the primary factor Moody's cited for why it would change St. Luke's rating down in the future. (PX01372 at 004). Also, Mr. Brick did no independent analysis to support his opinions of St. Luke's credit rating. Mr. Brick relied exclusively on Moody's reports and Mr. Dagen's conclusions. (Brick, Tr. 3474, 3511-3557).

1026. St. Luke's operating performance was steady with positive cash flows and, as Mr. Dagen concludes, this trend would have improved even more with time. (PX02147 at 010, 036 (¶¶ 21, 65) (Dagen Expert Report); PX02122 at 041-042 (¶¶ 67, 69, 71-72) (Guerin-Calvert, Decl.); PX02129 at 002 (Hanley, Decl. Ex. 1); Brick, Tr. 3495-3498).

Response to Finding No. 1026:

This proposed finding is inaccurate. In particular, the paragraphs of Ms. Guerin-Calvert's report cited by Complaint Counsel in no way support this proposed finding, quite the opposite.

Ms. Guerin-Calvert explains that St. Luke's has not had sufficient revenues to offset its operating expenses and, "as a result...moved from a positive operating income of $3.1 million in 2004 to an operating loss of $15.2 million in 2009." (PX02122 at 041).

In ¶ 69 Ms. Guerin-Calvert states, "These 2010 year-to-date data misleadingly suggest that certain St. Luke's financial improvements in the eight month period prior to its joinder with ProMedica were indicative of longer term reversal of its overall declining financial condition." (PX02122 at 041).

¶ 71 of Ms. Guerin-Calvert's report consists of a table that shows by year, from 2004 through the first eight months of 2010, (1) St. Luke's Moody's rating, (2) St. Luke's operating margin, (3) St. Luke's operating cash flow margin, and (4) St. Luke's days cash on hand. St Luke's Moody's rating is A2 until 2008 when it declines to Baa1 and then declines again to Baa2 in 2010; St. Luke's operating margin is negative in all those time periods except 2004 and 2006. (PX02122 at 042).

In ¶ 72 Ms. Guerin Calvert writes: "While some measures may suggest positive results, such as operating cash flows where were positive in some recent periods, other and more relevant measures confirm the poor financial condition of St. Luke's....When compared with other hospitals with similar bond rating by Moody's...St. Luke's statistics support the position that it remains at substantial financial risk. Even compared with other low performing hospitals, as evidenced by its very low bond rating, St. Luke's operating cash flows are significantly below

its comparables and its days cash on hand is only slightly above its comparables, even after taking drastic measures discussed above to mitigate its deteriorating condition." (PX02122 at 042).

1027. St. Luke's debt coverage measures and liquidity balance had also strengthened before the Acquisition. (PX02146 at 011 (¶ 17, n.37) (Brick Expert Report); PX01854 at 006-007 (¶ 10) (Brick Rebuttal Report)). St. Luke's maximum annual debt service ratio had improved from negative 2.0 in 2009 to *positive* 3.7 in 2010. (PX02129 at 002 (Hanley, Decl. Ex. 1)). Even in 2009, St. Luke's cash-to-debt ratio was 412 percent, compared with a median of 102 percent for all hospitals rated by Moody's. (PX01372 at 004 (Moody's Rating Update: St. Luke's, Feb. 3, 2010); PX01368 at 010 (Moody's 2009 Median Report)).

Response to Finding No. 1027:

This proposed finding is misleading. St. Luke's incurred significant operating losses through the time of the joinder despite the debt coverage, liquidity balance, and cash-to-debt ratio statistics cited by Complaint Counsel. (RPF 1616-1620). St. Luke's operating losses were the primary reason Moody's downgraded St. Luke's in February 2010 and maintained its "negative outlook." (PX01372 at 001). Moreover, these "strengths" of St. Luke's were acknowledged and accounted for by Moody's when it downgraded St. Luke's in February 2010 and maintained the "negative outlook." (PX01372 at 001-002). A "negative outlook" means that it is more likely there will be a further downgrade than an upgrade in the future. (Den Uyl, Tr. 6463). "Continued weak operating performance" was the primary factor Moody's cited for why it would change St. Luke's rating down in the future. (PX01372 at 004). Also, OhioCare's operating losses in the first eight months of 2010 were $7.7 million. (RPF 1616).

Also, Mr. Brick did no independent analysis to support his opinions of St. Luke's credit rating. Mr. Brick relied exclusively on Moody's reports and Mr. Dagen's conclusions. (Brick, Tr. 3474, 3511-3557).

1028. Finally, St. Luke's market share had increased from 36 percent in 2009 to 43 percent in 2010 within its core service area. (PX01235 at 003 (Toledo Market Share Analysis)).

Mr. Den Uyl testified that, in the seven months between the issuance of Moody's downgrade in February 2010 and the consummation of the Acquisition, St. Luke's market share in its core service area increased. (Den Uyl, Tr. 6558; PX001951 at 055 (Den Uyl, Dep. at 213), *in camera*). Mr. Dagen testified that St. Luke's growing market share reflected positively on St. Luke's quality of care, service offerings, and the investments that were made under Mr. Wakeman's turnaround plan. (Dagen, Tr. 3184-3185).

Response to Finding No. 1028:

This proposed finding is misleading. St. Luke's incurred significant operating losses through the time of the joinder despite any market share increases. (RPF 1616-1620). St. Luke's operating losses were the primary reason Moody's downgraded St. Luke's in February 2010 and maintained its "negative outlook." (PX01372 at 001). A "negative outlook" means that it is more likely there will be a further downgrade than an upgrade in the future. (Den Uyl, Tr. 6463). "Continued weak operating performance" was the primary factor Moody's cited for why it would change St. Luke's rating down in the future. (PX01372 at 004). Also, OhioCare's operating losses in the first eight months of 2010 were $7.7 million. (RPF 1616).

Finally, Mr. Brick did no independent analysis to support his opinions of St. Luke's credit rating. Mr. Brick relied exclusively on Moody's reports and Mr. Dagen's conclusions. (Brick, Tr. 3474, 3511-3557).

1029. St. Luke's recent financial turnaround has produced results that would have led Moody's to upgrade St. Luke's credit rating. (PX02146 at 009-013 (¶¶ 15-20) (Brick Expert Report); Brick, Tr. 3490-3491).

Response to Finding No. 1029:

This proposed finding is inaccurate and misleading. St. Luke's was struggling financially at the time of the joinder and had not achieved the financial goals of the three year plan – there was no turnaround. (RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644 1941-1954, 1955, *in camera*, 1956-1961). St. Luke's operating losses were the primary reason Moody's downgraded St. Luke's in February 2010.

(PX01372 at 001-002). Moody's downgraded St. Luke's despite a number of "strengths" acknowledged by Moody's including St. Luke's relatively low debt position, adequate liquidity, and St. Luke's joinder discussions with ProMedica – without these "strengths" Moody's downgrade may have been even lower. (PX01372 at 001-002).

Moody's also maintained its "negative outlook" on St. Luke's in February 2010. (PX01372 at 001). A "negative outlook" means that it is more likely there will be a further downgrade than an upgrade in the future. (Den Uyl, Tr. 6463). "Continued weak operating performance" was the primary factor Moody's cited for why it would change St. Luke's rating down in the future. (PX01372 at 004). OhioCare's operating losses in the first eight months of 2010 were $7.7 million. (RPF 1616).

On cross-examination, Mr. Brick admitted that Moody's typically looks for three years of sustained operating performance when it comes to ratings upgrades, which means Moody's would not have upgraded St. Luke's until February 2013 or three years after its last downgrade for St. Luke's at the earliest. (Brick, Tr. 3544).

1030. Respondent's expert witness, Mr. Den Uyl, did not analyze – and has no expert opinion on – what credit rating St. Luke's would have received as a standalone hospital. (Den Uyl, Tr. 6531; PX01951 at 016 (Den Uyl, Dep. at 57-58), *in camera*).

Response to Finding No. 1030:

This proposed finding is not accurate. Mr. Den Uyl did testify at trial that the fact Moody's maintained St. Luke's "negative outlook" when Moody's downgraded St. Luke's in February 2010 meant that "there was more of a likelihood there would be a further downgrade than an upgrade." (Den Uyl, Tr. 6493).

1031. Other factors that would be viewed as positives by Moody's include St. Luke's acquisitions of physician practices to drive volume to the hospital and St. Luke's position as a high-quality and low-cost provider. (Brick, Tr. 3500-3501; PX001369 at 001 (Moody's Quality Initiative Report) ("From a credit perspective, a not-for-profit hospital's focus on a quality agenda can translate into improved ratings through increased

volume and market share, operational efficiencies, better rates from commercial payers, and improved financial performance.")).

Response to Finding No. 1031:

This proposed finding is inaccurate and misleading. To the extent Moody's would consider any effects on St. Luke's rating from its acquisition of physician practices or level of quality they would have been incorporated in Moody's 2010 downgrade of St. Luke's in February 2010. (*See* PX01372). "Moody's Quality Initiative Report" cited here by Complaint Counsel to support proposition was published in February 2008. (PX01369-001). The vast majority of physician acquisitions at St. Luke's occurred in 2008 and 2009, (RX-56 at 000021, *in camera*), and there is no evidence that there was a substantial quality improvement at St. Luke's between February 2010 and August 31, 2010. In fact, {

}. (RPF 1462-1464, *in camera*).

Moreover, Mr. Brick did no independent analysis to support his opinions of St. Luke's credit rating. Mr. Brick relied exclusively on Moody's reports and Mr. Dagen's conclusions. (Brick, Tr. 3474, 3511-3557).

3. St. Luke's Had Minimal Outstanding Debt

1032. St. Luke's total outstanding debt as of August 31, 2010 was { }. (PX01265 at 002 (OhioCare Consolidated Balance Sheet as of August 31, 2010: sum of "Current Portion of Long-term Debt" and "Long-term Debt, less current portions"); Joint Stipulations of Law and Fact, JX00002A ¶ 33 ("St. Luke's owed less than $11 million in total bond debt as of Aug. 31, 2010.")).

Response to Finding No. 1032:

Respondent has no specific response.

1033. As of August 31, 2010, St. Luke's had enough cash and investments on its financial statements to pay off all of its outstanding debt. (Joint Stipulations of Law and Fact, JX00002A ¶ 24; Response to RFA at ¶ 48).

Response to Finding No. 1033:

This proposed finding is misleading. Defeseasing the bonds would not have been financially prudent for St. Luke's in 2010 because St. Luke's was trying to conserve cash, the interest on the bonds was relatively low, and it would have been very expensive to do so (RPF 2027; Den Uyl, Tr. 6465-6466). Because they were non-callable bonds it would have cost St. Luke's more to defease the bonds than the face value of the bonds outstanding. (RPF 2026-2027; Den Uyl, Tr. 6465-6466).

1034. St. Luke's has never missed or been late on any debt payment. (PX01920 at 027 (Wakeman, Dep. at 100), *in camera*)). In particular, St. Luke's has never missed or been late on a payment on its Series 2004 bonds, which had $8.6 million outstanding at the time of the Acquisition. (Joint Stipulations of Law and Fact, JX00002A ¶¶ 22-23; Response to RFA at ¶ 47; PX02147 at 039 (¶ 71, n.120) (Dagen Expert Report)).

Response to Finding No. 1034:

Respondent has no specific response.

1035. Notes from a St. Luke's February 2010 Finance Committee meeting described the bond payments as "a car payment" and not a risk to St. Luke's because "we have [] enough cash to completely defease these." (PX01204 at 011 (St. Luke's Finance Committee Notes), *in camera*). Mr. Wakeman testified that St. Luke's considered buying back its bonds in February 2009 using its cash reserves. (Wakeman, Tr. 2569).

Response to Finding No. 1035:

This proposed finding is misleading. {

.} (RPF 2024, 2027-2028, *in camera*).

1036. Mr. Wakeman stated, "[a]s bond issues go for not-for-profit organizations, it wasn't a large bond issue for a hospital our size." (PX01920 at 029 (Wakeman, Dep. at 107), *in camera*). Mr. Den Uyl, Respondent's expert witness, concluded that St. Luke's had a "relatively small outstanding balance of bonds" at the time of the Acquisition. (RX-56 at

19 (¶ 48) (Den Uyl Expert Report), *in camera*; Dagen, Tr. 3153 (St. Luke's debt is small relative to the typical hospital)).

Response to Finding No. 1036:

The proposed finding is misleading and out of context. The paragraph of Mr. Den Uyl's report cited by Complaint Counsel states in full: "The Moody's downgrades and corresponding outlook guidance was { ;} given the relatively small outstanding balance of the Bonds at issue. (RPF 1993, *in camera*, RX-56 at 000019, *in camera*). Mr. Den Uyl also testified about this issue at trial, "{

}" (Den Uyl, Tr. 6364, RPF 1993, *in camera*). Moody's downgrade of St. Luke's in February 2010 confirms Mr. Den Uyl's analysis as Moody's downgraded St. Luke's bonds and maintained a negative outlook despite acknowledging that St. Luke's debt level was relatively low. (PX01372 at 001 and 002).

1037. Bruce Gordon, a former Ambac analyst who oversaw St. Luke's outstanding bonds through the time of the Acquisition, believed that St. Luke's has a "very modest debt position." (Gordon, Tr. 6858, *in camera*). Further, he concluded in early 2010 that St. Luke's cash reserves were "significant" relative to the amount of debt it had outstanding and that St. Luke's had sufficient cash on hand to repay the entire balance of its Ambac-insured bonds. (Gordon, Tr. 6858-6859, *in camera*).

Response to Finding No. 1037:

This proposed finding is misleading. In 2010, prior to the joinder, {

(RPF 2021, 2034, *in camera*); AMBAC issued a notice of default (RPF 2031, 2032, *in camera*); and AMBAC

{

.} (RPF 2038-2041, *in camera*, Gordon, Tr. 6858, *in camera*).

AMBAC believed there was {

} (RPF 2023, *in camera*). {

} {RPF 2025, *in camera*, 2043, 2044, *in camera*, 2045-2047). {

} (RPF 2042, 2048, *in camera*).

In addition, {

} (RPF 2024, 2027-2028, *in camera*).

1038. In fact, St. Luke's had sufficient cash and investments at the time of the Acquisition to pay off not just its Ambac-insured bonds, but all of its outstanding debt. (Response to RFA at ¶ 48).

Response to Finding No. 1038:

This proposed finding is misleading because {

} (RPF 2024, 2027-2028, *in camera*).

1039. Although a "technical default" of a bond covenant occurred when St. Luke's debt service coverage ratio fell below 1.3, (PX01854 at 006 (¶10) (Brick Rebuttal Report); Gordon, Tr. 6848-6849, *in camera*), St. Luke's has not missed a payment on its Ambac-insured bonds. (Response to RFA at ¶ 47; Black, Tr. 5700). As a result, holders of St. Luke's bonds received every one of their regularly scheduled principal and interest payments in full and on time. (Gordon, Tr. 6850, *in camera*; Black, Tr. 5700).

Response to Finding No. 1039:

This proposed finding is misleading. St. Luke's 2008 and 2009 violation of its debt coverage service ratio was a {

} as opposed to a {

}. (RPF 2002-2005, *in camera*).

St. Luke's debt coverage service ratio was 0.5 in 2008 and *negative* 2.9 in 2009, well below the required 1.3 threshold. (RPF 2008-2009, 2011). As a result in 2010, prior to the joinder, {

, (RPF 2021, 2034, *in camera*); AMBAC issued a notice of default (RPF 2031, 2032, *in camera*); and AMBAC { } (RPF 2038-2041, *in camera,* Gordon, Tr. 6858, *in camera*). AMBAC believed there was {

.} (RPF 2023, *in camera*). {

.} {RPF 2025, *in camera,* 2043, 2044, *in camera*, 2045-2047). {

.} (RPF 2042, 2048, *in camera*).

1040. By the time of the Acquisition, St. Luke's debt service coverage ratio was 3.7, above the 1.3 level that was required. (PX02129 at 002 (Hanley, Decl. Ex. 1); Hanley, Tr. 4708-4710).

Response to Finding No. 1040:

Respondent has no specific response.

1041. Technical bond defaults were common among hospitals and other firms from 2008 to 2010. As Mr. Gordon testified, from 2008 through 2010, {
} that he oversaw experienced technical defaults. (Gordon, Tr. 6851-6852, *in camera*). In fact, the parent company for Mercy, Catholic Health Partners, experienced a technical default in 2009,

prompting Mr. Wakeman to note that "many groups are talking with their . . . [b]anks for waivers for [d]ebt service coverage [sic]." (PX01318 at 001 (Wakeman Jul. 2009 Email); PX01920 at 028 (Wakeman, Dep. at 103), *in camera*).

Response to Finding No. 1041:

This proposed finding is misleading. St. Luke's 2008 and 2009 violation of its debt coverage service ratio was a {

} as opposed to a {

}. (RPF 2002-2005, *in camera*).

St. Luke's debt coverage service ratio was 0.5 in 2008 and *negative* 2.9 in 2009, well below the required 1.3 threshold. (RPF 2008-2009, 2011). As a result in 2010, prior to the joinder, {

, (RPF 2021, 2034, *in camera*); AMBAC issued a notice of default (RPF 2031, 2032, *in camera*); and AMBAC { } (RPF 2038-2041, *in camera,* Gordon, Tr. 6858, *in camera*). AMBAC believed there was {

} (RPF 2023, *in camera*). {

} {RPF 2025, *in camera,* 2043, 2044, *in camera*, 2045-2047). {

} (RPF 2042, 2048, *in camera*).

1042. Ambac's only remedy in response to St. Luke's technical default may have been to require St. Luke's to retain an independent consultant to make recommendations for increasing its debt service coverage ratio. (PX01854 at 006 (¶10) (Brick Rebuttal Report)). Mr. Gordon testified that

} (Gordon, Tr. 6860, *in camera*).

Response to Finding No. 1042:

This proposed finding in is not accurate. Remedies to St. Luke's default that were considered by AMBAC and St. Luke's senior managers included: (1) complete defeasance of St. Luke's bonds (RPF 2021); (2) St. Luke's providing collateral to AMBAC that would offset the value of the bonds if St. Luke's did not make its payments (RPF 2021); (3) forcing St. Luke's to have an outside management firm take over the hospital if St. Luke's did not cure its default. (RPF 3009, *in camera*).

AMBAC believed there was { } (RPF 2023, *in camera*). { } {RPF 2025, *in camera,* 2043, 2044, *in camera*, 2045-2047). { } (RPF 2042, 2048, *in camera*).

1043. Finally, Mr. Gordon testified that the { } performed internally by Ambac concluded that St. Luke's was { } (Gordon, Tr. 6864, *in camera*). Out of { }, St. Luke's was placed in { } (Gordon, Tr. 6864, *in camera*). One of the reasons Mr. Gordon gave for this classification was that { } (Gordon, Tr. 6865, *in camera*).

Response to Finding No. 1043:

This proposed finding is misleading. AMBAC { } (RPF 2038-2041, *in camera,* Gordon, Tr. 6858, *in camera*). AMBAC believed there was { } (RPF 2023, *in camera*). { } {RPF 2025, *in camera,* 2043, 2044, *in camera,*

2045-2047). {

} (RPF 2042, 2048, *in camera*).

Moreover, AMBAC's April 2010 credit downgrade and "negative outlook" details the negative developments including: {

} (RPF 2039).

4. St. Luke's Cost-Saving Measures are Not a Sign of a Firm in Distress

1044. St. Luke's engaged in prudent and responsible cost-cutting and expense reductions during 2008 and 2009, as was widespread in the hospital industry. (Brick, Tr. 3561-3562); Wakeman, Tr. 2573-2574; PX01368 at 004-005, 013 (Moody's 2009 Median Report) (showing industry trend reducing expenses and capital expenditures). Mr. Dagen concluded that St. Luke's cost-cutting measures were "sound business practices" that are commonly instituted by well-run businesses. (PX02147 at 034 (¶ 61) (Dagen Expert Report)).

Response to Finding No. 1044:

This proposed finding is not accurate. During the capital freeze which continued through the time of the joinder, St. Luke's deferred numerous capital projects that were important to patient care. (RPF 1686-1702, 1703-1704, *in camera*, 1909). In the Fall of 2010, St. Luke's identified { } of critical projects requested for immediate funding. (RPF 1708). During the capital freeze, St. Luke's Vice Presidents did not even propose capital requests to Mr. Wakeman "unless they were absolutely necessary replacements or a part of the strategic plan and

had to be justified." (RPF 1913). 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. (RPF 1914). St. Luke's capital freeze was { } and { } (RPF 1916, 1917, *in camera*). {

} (RPF 1918, *in camera*).

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. (RPF 1921). In addition, St. Luke's cut benefits for all employees and in 2009, all St. Luke's executives took a 10% pay cut. (RPF 1922-1923). 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, especially given the shortage in Lucas County for many key clinical positions. (RPF 1926-1927). 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. (RPF 1929, 1934, *in camera*).

Also, Mr. Brick did not do an independent analysis to support his opinions of St. Luke's financial status. Mr. Brick relied on Moody's reports and Mr. Dagen's conclusions. (Brick, Tr. 3474, 3511-3557).

1045. Many businesses, including non-profit hospitals, engaged in the practice of evaluating positions before replacing employees who left voluntarily as a cost-saving measure, as St.

Luke's did from 2008 to 2010. (Wakeman, Tr. 2573-2574). Any employee who left St. Luke's would be replaced if the position had a direct impact on the quality of patient care. (Wakeman, Tr. 2574). Mr. Wakeman agreed that this was a good practice. (Wakeman, Tr. 2573).

Response to Finding No. 1045:

This finding is misleading and inaccurate. 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). 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). 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). At the same time, other Lucas County hospitals were giving pay increases. (Johnston, Tr. 5327-5328). This created a situation where employees had the incentive and ability to leave St. Luke's to work for other Lucas County hospitals, especially given the shortage in Lucas County for many key clinical positions. (Johnston, Tr. 5328-5329).

1046. St. Luke's was the only hospital in Lucas County not to lay off any employees from 2008 to 2010. (Wakeman, Tr. 2572; PX01274 at 001 (Wakeman May 2009 Email), *in camera* ({ })).

Response to Finding No. 1046:

This finding is misleading. 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). 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). 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). At the same time, other Lucas County hospitals were giving pay increases. (Johnston, Tr. 5327-5328). This created a situation where employees had the incentive and ability to leave St. Luke's to work for other Lucas County hospitals, especially given the shortage in Lucas County for many key clinical positions. (Johnston, Tr. 5328-5329).

1047. In fact, St. Luke's hired additional full-time employees during both calendar years 2009 and 2010. (Joint Stipulations of Law and Fact, JX00002A ¶¶ 44-45).

Response to Finding No. 1047:

This finding is misleading. 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).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). 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). At the same time, other Lucas County hospitals were giving pay increases. (Johnston, Tr. 5327-5328). This created a situation where employees had the incentive and ability to leave St. Luke's to work for other Lucas County hospitals, especially given the shortage in Lucas County for many key clinical positions. (Johnston, Tr. 5328-5329).

1048. St. Luke's also did not cut any service lines provided by the hospital. (Black, Tr. 5703-5704).

Response to Finding No. 1048:

This proposed finding is misleading. In the Fall of 2009, St. Luke's management and Board concluded that it would have to cut major service lines in order to remain a viable independent entity { }, and decided that it would pursue a joinder so that it could maintain its service lines and keep serving the community. (RPF 1962, 1963-1965, *in camera*, 1966, 1969, *in camera*).

1049. In the last few years, ProMedica has also been forced to take steps to reduce expenses in response to economic conditions. (PX01918 at 014 (Oostra, Dep. at 48), *in camera*).

Response to Finding No. 1049:

This finding is misleading, Mr. Oostra testifies about the steps that ProMedica took in response to the economic downturn, not in response to large, unsustainable operating losses and significant financial distress that continued well after the financial crisis through the time of the joinder August 31, 2010, as was the case for St. Luke's. (*See* RPF 1616, 1634, 1993, *in camera*). Unlike St. Luke's, ProMedica maintained A level ratings and stable or positive outlooks from both Moody's and S&P. (RPF 1981-1982, RPF 117).

1050. In contrast to St. Luke's, ProMedica laid off employees, increased the amount its employees had to pay for health insurance, eliminated services, cut child care services during the same period, and did not replace retiring employees. (PX01918 at 014-015 (Oostra, Dep. at 48-50), *in camera*; Johnston, Tr. 5443-5444).

Response to Finding No. 1050:

This finding is misleading, Mr. Oostra testifies about the steps that ProMedica took in response to the economic downturn, not in response to large, unsustainable operating losses and significant financial distress that continued well after the financial crisis through the time of the joinder August 31, 2010, as was the case for St. Luke's. (*See* RPF 1616, 1634, 1993, *in camera*). Unlike St. Luke's, ProMedica maintained A level ratings and stable or positive outlooks from both Moody's and S&P. (RPF 1981-1982, RPF 117). The proposed finding is also inaccurate

and misleading as to ProMedica's closing of its daycare center, which it did, in part, because a highway was to come through the building. (Johnston, Tr. 5444).

1051. Even while under a "capital freeze" in 2008 and 2009, St. Luke's spent $14 million and $7 million on capital expenditures in those years, respectively. (Joint Stipulations of Law and Fact, JX00002A ¶ 43; PX01006 at 007 (OhioCare Consolidated Financial Report Dec. 31, 2009); PX02147 at 035 (¶ 63) (Dagen Expert Report); PX01951 at 069 (Den Uyl Dep. at 269), *in camera*; RX-56 at 24 (¶ 61) (Den Uyl Expert Report), *in camera*).

Response to Finding No. 1051:

This proposed finding is misleading. During the capital freeze which started in 2009 and continued through the time of the joinder, St. Luke's deferred numerous capital projects that were important to patient care. (RPF 1686-1702, 1703-1704, *in camera*, 1909). In the Fall of 2010, St. Luke's identified { } of critical projects requested for immediate funding. (RPF 1708). During the capital freeze, St. Luke's Vice Presidents did not even propose capital requests to Mr. Wakeman "unless they were absolutely necessary replacements or a part of the strategic plan and had to be justified." (RPF 1913). 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. (RPF 1914). St. Luke's capital freeze was { } and { } (RPF 1916, 1917, *in camera*). { } (RPF 1918, *in camera*).

1052. In October 2009, Mr. Wakeman noted that the capital freeze had "melted down quickly" as he signed off on many 'big-ticket" capital items. (Wakeman, Tr. 2575; PX01361 (Wakeman Oct. 2009 Email)).

Response to Finding No. 1052:

This finding is misleading. This quotation refers to an October 2009 e-mail Dan Wakeman sent to CFO Dave Oppenlander in which he expressed concern that St. Luke's was still spending too much on capital given its financial difficulties. In response 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*).

1053. In 2010, St. Luke's made capital expenditures of approximately $5 million. (Black, Tr. 5702-5703; PX02147 at 035 (¶ 63) (Dagen Expert Report)).

Response to Finding No. 1053:

This proposed finding is misleading because it combines capital expenditures made by St. Luke's prior to the joinder with those made after the joinder which incorporate the benefits of the joinder such as capital injections by ProMedica and increased revenues being added to the Paramount network. St. Luke's capital expenditures in the first eight months of 2010 were $1.8 million. (RX-56 at 000024, *in camera*). Although St. Luke's total capital expenditures for 2010 were still far below its historical average of $11.3 million, the $3.2 million of investments made after the joinder, in the fourth quarter of 2010, put St. Luke's back much closer to its historical capital spending rates ($3.2 for the quarter would be $9.6 million annualized). (RX-56 at 000024, *in camera*).

1054. Mr. Den Uyl, Respondent's expert witness, testified that St. Luke's capital spending was lower in the first eight months of 2010 than it was in the last four months of 2010 because St. Luke's was "waiting for the [Acquisition] to go through." (PX001951 at 063 (Den Uyl Dep. at 246-247), *in camera*; Den Uyl, Tr. 6567, *in camera*).

Response to Finding No. 1054:

This proposed finding is misleading and inaccurate. Mr. Den Uyl concluded that in 2009 and 2010 St. Luke's spent much less than its historical $11 million on capital expenditures "because of the capital spending freeze." (RX-56 at 000024, *in camera*). St. Luke's capital

expenditures were $7 million in 2009 and $1.8 million in the first eight months of 2010. (RX-56 at 000024, *in camera*).

In his deposition cited here by Complaint Counsel Mr. Den Uyl suggests that {

} (PX001951 (Den Uyl, Dep. at 246-247), *in camera*). In his trial testimony he stated that St. Luke's {

} Den Uyl, Tr. 6567, *in camera*). Complaint Counsel's proposed finding misstates Mr. Den Uyl's deposition and trial testimony.

1055. Despite the capital expenditure slowdown in 2009 and 2010, St. Luke's continued to replace medical equipment as needed. (Den Uyl, Tr. 6566-6567; PX01951 at 049 (Den Uyl, Dep. at 191), *in camera.*)

Response to Finding No. 1055:

This proposed finding is misleading to the extent it suggests that St. Luke's had not significantly restricted its capital expenditures starting in 2009; it had. 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). Mr. Den Uyl emphasized in his testimony cited by Complaint Counsel that St. Luke's spent money on replacing medical equipment because it was "needed." (Den Uyl, Tr. 6566-6567). Replacing medical equipment was something that St. Luke's needed for safety and patient care. Moreover, St. Luke's deferred capital spending on medical equipment such as patient beds, surgical tables, and a sleep lab. (RPF 1688).

1056. St. Luke's continued to make millions of dollars of strategic investments in 2008 and 2009, including acquiring physician practices and off-site imaging sites, as well as

implementing EMR systems at physicians' practices. (Wakeman, Tr. 2575; PX01852 at 005-006 (¶ 8) (Dagen Rebuttal Report)).

Response to Finding No. 1056:

This proposed finding is misleading. During the capital freeze which started in 2009 and continued through the time of the joinder, St. Luke's deferred numerous capital projects that were important to patient care. (RPF 1686-1702, 1703-1704, *in camera*, 1909). In 2009, St. Luke's capital expenditures were 36 percent below St. Luke's historical average despite the fact that St. Luke's was investing in physician EMR and physician practices that year. (RX-56 at 000024, *in camera*). This is indicative of the severity of the capital freeze and its serious impact on St. Luke's.

1057. As of April 2010, Mr. Wakeman believed that St. Luke's capital spending had enabled it to keep its plant and grounds in great condition. (Wakeman, Tr. 2615-2616; PX01279 at 002 (Apr. 2010 Wakeman Self-Evaluation)).

Response to Finding No. 1057:

This proposed finding is misleading. Mr. Wakeman testified that "[w]ith 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).

1058. In mid-2009, St. Luke's briefly considered – and rejected – eliminating service lines as a cost-cutting strategy. (Black, Tr. 5703-5704; PX02136 at 062-063 (¶¶ 80-85) (Guerin-Calvert, Decl. in Prelim. Inj. Proceeding), *in camera*). St. Luke's management presented the option to its Board in August 2010. (*See* PX01018 at 008 (Options for St. Luke's), *in camera*; Wakeman, Tr. 2655-2656, *in camera*). However, discussions about eliminating service lines involved mere "generalities" and St. Luke's management never "developed any distinctive plan" for pursuing the strategy. (PX01909 at 048 (Dewey, IHT at 187), *in camera*).

Response to Finding No. 1058:

This proposed finding is misleading. In the Fall of 2009, St. Luke's management and Board concluded that it would have to cut major service lines in order to remain a viable independent entity { }, and decided that it would pursue a joinder so that it could maintain its service lines and keep serving the community. (RPF 1962, 1963-1965, *in camera*, 1966, 1969, *in camera*).

1059. St. Luke's Board rejected cutting service lines because it would have diminished the hospital's ability to serve its community. (Black, Tr. 5703-5704). St. Luke's Chairman, James Black, testified that service line cuts were not a major topic of discussion because St. Luke's Board found them to be "distasteful." (Black, Tr. 5704; *see also* PX02106 at 004 (¶ 13) (Black, Decl.) ("The Board . . . decided that cutting these service lines was neither in the best interests of the hospital nor the community.")).

Response to Finding No. 1059:

This proposed finding is misleading. In the Fall of 2009, St. Luke's management and Board concluded that it would have to cut major service lines in order to remain a viable independent entity { }, and decided that it would pursue a joinder so that it could maintain its service lines and keep serving the community. (RPF 1962, 1963-1965, *in camera*, 1966, 1969, *in camera*).

1060. St. Luke's management believed that cutting services "would be very painful" and would cause St. Luke's to "no longer be able to fulfill [its] current mission to fully serve the community." (PX01018 at 008 (Options for St. Luke's), *in camera*; PX01909 at 048 (Dewey, IHT at 187-188), *in camera*). According to Mr. Wakeman, "St Luke's ultimately rejected drastic cuts in services and employees because they would have diminished the hospital's ability to serve the community and made it even less attractive to patients, employers, physicians and payors." (PX02102 at ¶ 22 (Wakeman, Decl.)).

Response to Finding No. 1060:

This proposed finding is misleading. In the Fall of 2009, St. Luke's management and Board concluded that it would have to cut major service lines in order to remain a viable independent entity { }, and decided that it would pursue a joinder so

that it could maintain its service lines and keep serving the community. (RPF 1962, 1963-1965, *in camera*, 1966, 1969, *in camera*).

1061. As a result, presentations by St. Luke's management to its Board after August 2010 did not discuss eliminating service lines. (*See e.g.*, PX01030 (Oct. 2009 Affiliation Analysis Update), *in camera*; PX01016 (Dec. 2009 Affiliation Update), *in camera*).

<u>Response to Finding No. 1061:</u>

This proposed finding is misleading. In the Fall of 2009, St. Luke's management and Board concluded that it would have to cut major service lines in order to remain a viable independent entity { }, and decided that it would pursue a joinder so that it could maintain its service lines and keep serving the community. (RPF 1962, 1963-1965, *in camera*, 1966, 1969, *in camera*).

1062. In fact, there is no evidence in the record that, after 2009 and during any time leading up to the Acquisition, St. Luke's ever revisited the issue of eliminating service lines as a standalone hospital. Subsequent presentations to St. Luke's Board did, however, discuss the following options: remaining independent and negotiating higher reimbursement rates with certain health plans, a service line joint venture with Mercy, a full affiliation with UTMC or Mercy, and an affiliation with other regional hospitals. (*See e.g.*, PX01030 at 002-006, 021 (Oct. 2009 Affiliation Analysis Update), *in camera*; PX01016 at 012-013, 023-024 (Dec. 2009 Affiliation Update), *in camera*).

<u>Response to Finding No. 1062:</u>

This proposed finding is misleading and inaccurate. In the Fall of 2009, St. Luke's management and Board concluded that it would have to cut major service lines in order to remain a viable independent entity { } and decided that it would pursue a joinder so that it could maintain its service lines and keep serving the community. Numerous documents and testimony that support this proposition. (RPF 1962, 1963-1965, *in camera*, 1966, 1969, *in camera*).

The specific presentations cited by Complaint Counsel created in the Fall of 2009 to evaluate various joinder options are consistent St. Luke's understanding it would need to cut

service lines if it remained independent. Those presentations include numerous slides on {

} (PX01030 at 007;

PX01016 at 014, 023-024, *in camera*); { } (PX01030 at 010

and PX01016 at 018, 023-024) ; and on {

} (PX01030 at 007, 009,

011, *in camera*; PX01016 at 019, *in camera*).

5. St. Luke's Losses in 2009 Do Not Indicate Financial Distress

1063. Focusing narrowly on St. Luke's 2008 and 2009 operating performance provides a misleading and inaccurate view of St. Luke's financial viability due to one-time anomalous events stemming from the 2008 financial crisis, as well as higher than normal expenditures related to implementing Mr. Wakeman's three-year turnaround plan. (Dagen, Tr. 3162-3163, 3179-3180; PX02147 at 006 (¶ 14) (Dagen Expert Report)).

Response to Finding No. 1063:

This proposed finding is misleading. 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. Mr. Den Uyl 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. (RPF 1614). Moreover, Mr. Den Uyl evaluated a broad range of St. Luke's financial metrics including operating cash flow, EBITDA, operating cash flow minus capital expenditures, reserve funds, age of plant, debt ratios, rating agency ratings, and reimbursement rates from MCO's and government payors. (RX-56, *in camera*).

1064. St. Luke's books a pension expense on its income statement in order to reflect the annual costs of maintaining a defined benefits pension plan. (PX02147 at 022 (¶ 42) (Dagen Expert Report); Dagen, Tr. 3167-3168). The 2008 financial crisis not only caused St. Luke's pension fund assets to decrease, but it also increased St. Luke's pension expense to $8.8 million in 2009, $6 million higher than in 2008. (PX01006 at 023 (OhioCare Consolidated Financial Report Dec. 31, 2009); PX02147 at 022-023 (¶ 43) (Dagen Expert Report); Black, Tr. 5698).

Response to Finding No. 1064:

Complaint Counsel's proposed finding is misleading and inaccurate. The value of the assets in St. Luke's pension plan is determined by several factors, including employer contributions into the pension plan, disbursements to retirees, and the performance of plan assets. (Johnston, Tr. 5338). Likewise, the benefit cost reported on St. Luke's consolidated financial statements is comprised of many elements, only one of which is return on assets. (PX01006 at 024). The difference in the benefit cost reported on St. Luke's consolidated financial statements is only partially attributable to a change in investment performance. Other line item adjustments account for approximately half the difference. (PX01006 at 024).

1065. The increase in St. Luke's pension expense explains a portion of the increase in St. Luke's total expenses in 2009 and, therefore, St. Luke's higher operating loss in 2009 compared to 2008. (PX01016 at 002 (Affiliation Update Board Presentation), *in camera*; PX02147 at 009 (¶ 20) (Dagen Expert Report)).

Response to Finding No. 1065:

Complaint Counsel's proposed finding is misleading. The same phenomenon also demonstrates that {

} because the line entry for benefit costs { }. (Den Uyl, Tr. 6594, *in camera*). Complaint Counsel's focus on the entry for benefit cost also obscures the fact that St. Luke's also reported its overall pension liability on its consolidated balance sheet and this figure was $34 million at the end of 2009. (PX01006 at 004). The overall liability highlights the true concern regarding St. Luke's pension plan, which is the continuing need for St. Luke's to make substantial cash contributions to return the pension fund to 100% funding, per federal law. (RPF 1664).

1066. As David Oppenlander, St. Luke's CFO at the time, wrote: "[t]ake out the effect of the pension plan, [and] the hospital is performing better than last year[.]" (PX01356 at 001 (Oppenlander May 2009 Email)).

Response to Finding No. 1066:

Complaint Counsel's proposed finding is misleading and inaccurate. As much as Mr. Oppenlander would have liked to ignore the pension plan, he was unable to do so. It exerted a real and significant drag on the hospital's finances. Mr. Oppenlander's brief note also "takes out the effect" of several other pressing capital demands. He makes no mention of the substantial, required and impending investments in information technology to comply with federal healthcare legislation. (RPF 1709-1717, 1724-17226, 1727, *in camera*, 1728, 1733). He ignores the fact that St. Luke's had deferred both routine and strategic capital investments which meant, among other things, that St. Luke's was behind every regional competitor in terms of private bed offerings and was holding its air handler systems "together with duct tape and tie-wires". (*Compare* RPF 1756 *and* 2222, *in camera* with RPF *172, in* camera, 206-207, 1197-1201; Johnston, Tr. 5360).

1067. However, most of St. Luke's $8.8 million pension expense in 2009 was, in effect, a "paper loss" because St. Luke's only paid $1.5 million in cash into its pension plan for the entire year. (PX01006 at 023 (OhioCare Consolidated Financial Report Dec. 31, 2009); PX02147 at 022-023 (¶ 43 n.54) (Dagen Expert Report); Dagen, Tr. 3173-3174; Black, Tr. 5698).

Response to Finding No. 1067:

Complaint Counsel's proposed finding is inaccurate and misleading. In 2008 in the midst of the financial collapse, St. Luke's had reduced its cash contribution to its pension plan to a mere { }. (PX01602 at 007, *in camera*). This amount was substantially below the minimum required contribution of over { }. (PX01602 at 007, *in camera*). At the start of 2009, to meet its obligations to the pension plan, St. Luke's was forced to forfeit { }, essentially drawing down a separate pension reserve fund. (PX01602 at 007, *in camera*). Without the ability to use the cash reserves built up in its pension fund account, this cash would have come directly from St. Luke's funds in 2009. St. Luke's contributed an additional $1.5 million in cash in 2009, but this was not sufficient to meet its

obligations to the fund. At the start of 2010, additional funds totaling $2.2 million had to be allocated to cover St. Luke's 2009 obligations. (RPF 1675-1678). In contrast to Complaint Counsel's erroneous view, St. Luke's faced—and continues to face—real obligations related to its pension fund.

1068. In 2010, St. Luke's pension expense decreased to $600,000. (PX02369 at 001 (St. Luke's Pension Plan), *in camera*; PX02147 at 023 (¶ 44) (Dagen Expert Report)).

Response to Finding No. 1068:

Complaint Counsel's proposed finding is misleading. The *benefit cost accounting entry* that St. Luke's reports in its financial statements declined in 2010. This number, however, has no bearing on the cash contributions St. Luke's is required to make to restore its pension plan to 100 percent funding. (RPF 1664). St. Luke's faces a minimum contribution of {

}. (RPF 1685, *in camera*).

1069. The decline in St. Luke's EBITDA and operating income in 2009 was also caused by an increase in expenses associated with implementing Mr. Wakeman's turnaround plan. (Dagen, Tr. 3176-3179). In 2009, for instance, St. Luke's was making "significant investments in its future," including $4.6 million to operate recently-acquired physician practices (compared to $2.5 million in 2008), as well as other costs associated with increasing hospital staff (i.e., physicians, medical directors, etc.) to accommodate an increase in patient volumes in 2009. (RX-56 at 22 (¶ 55, Table 12) (Den Uyl Expert Report), *in camera*; Dagen, Tr. 3178-3179).

Response to Finding No. 1069:

This proposed finding is inaccurate and misleading. St. Luke's volume did increase – likely in part due to its acquisitions of physicians in 2008 and 2009. But St. Luke's continued to large amounts of lose money from operations. For example, St. Luke's parent OhioCare's *operating* loss was $20.3 million in 2009 and $7.4 million in the first eight months of 2010 despite increasing volume. (RPF 1616-1620; PX02147 at 028-029). St. Luke's overall cost coverage ratio was below one through the time of the joinder, meaning on average St. Luke's was losing money on every patient it admitted. RPF 1777, *in camera*; Den Uyl, Tr. 6423). St.

Luke's was not generating sufficient reimbursement to cover its total costs, through the time of the joinder on August 31, 2010. (RPF 1777, *in camera*; Den Uyl, Tr. 6423). Moreover, at the time of the joinder, St. Luke's earnings per adjusted discharge figures showed that, on average, St. Luke's was even losing money on every MCO patient it treated. (Johnston, Tr. 5318-5322). St. Luke's CEO and senior management testified that {

.} (RPF 1783-1784, *in camera*; Wakeman, Tr. 2942-2943, *in camera*; PX01283-002, *in camera*). Finally, St. Luke's financial performance in 2009 and the first eight months of 2010 would have been even worse had it not deferred capital expenditures, frozen salaries, and cut benefits and other expenses. (RPF 1686-1702, 1703-1704, *in camera*, 1705-1706, 1707-1708, *in camera*, 1911-1915, 1916-1918, *in camera*, 1919-1933, 1934-1935, *in camera*).

1070. Therefore, St. Luke's losses in 2009 are not indicative of poor financial health. (Dagen, Tr. 3179-3180, 3184 ("you don't typically see investments being made in building physician practices, buying ... outpatient ... facilities, [and] adding staff [] when [a hospital is] in grave financial difficulties.")).

Response to Finding No. 1070:

This proposed finding is inaccurate and misleading. St. Luke's volume did increase – likely in part due to its acquisitions of physicians in 2008 and 2009. But St. Luke's continued to large amounts of lose money from operations. St. Luke's parent OhioCare's *operating* loss was $20.3 million in 2009 and $7.4 million in the first eight months of 2010 despite increasing volume. (RPF 1616-1620; PX02147 at 028-029). St. Luke's overall cost coverage ratio was below one through the time of the joinder, meaning on average St. Luke's was losing money on every patient it admitted. (RPF 1777, *in camera*; Den Uyl, Tr. 6423). St. Luke's was not generating sufficient reimbursement to cover its total costs, through the time of the joinder on August 31, 2010. (RPF 1777, *in camera*; Den Uyl, Tr. 6423). Moreover, at the time of the

joinder, St. Luke's earnings per adjusted discharge figures showed that, on average, St. Luke's was even losing money on every MCO patient it treated. (Johnston, Tr. 5318-5322). St. Luke's CEO and senior management testified that {

} (RPF 1783-1784, *in camera*; Wakeman, Tr. 2942-2943, *in camera*; PX01283-002, *in camera*). Finally, St. Luke's financial performance in 2009 and the first eight months of 2010 would have been even worse had it not deferred capital expenditures, frozen salaries, and cut benefits and other expenses. (RPF 1686-1702, 1703-1704, *in camera*, 1705-1706, 1707-1708, *in camera*, 1911-1915, 1916-1918, *in camera*, 1919-1933, 1934-1935, *in camera*).

D. Even in the Worst Case Scenario, St. Luke's Would Have Been Financially Viable for at Least Four to Seven Years

1071. At the end of 2009, St. Luke's CEO told its Board of Directors that St. Luke's would stay open for at least three to seven years if it did not partner with another hospital. (Wakeman, Tr. 2624-2625; PX01920 at 037-038 (Wakeman, Dep. at 141-142), *in camera*; *see also* PX01915 at 054 (Wagner, IHT at 211), *in camera*).

<u>Response to Finding No. 1071:</u>

This proposed finding is misleading and inaccurate because it is an incomplete reflection of the witnesses' testimony on the issues of St. Luke's viability. Mr. Wakeman, St. Luke's CEO, testified that St. Luke's might be able to keep its doors open for {

}. (PX01920 (Wakeman, Dep. at 141-143)); and Mr. Wagner, as St. Luke's acting CFO, testified that St. Luke's could continue as an independent hospital for {

}. (PX01915 (Wagner, IHT at 211), *in camera*).

1072. By the time of the Acquisition, St. Luke's financial condition had improved from its position in late 2009. (PX02147 at 021 (¶ 40) (Dagen Expert Report)). The 2010 improvements in the equities markets and St. Luke's positive cash-flow operating margins would, according to Mr. Wakeman's own calculus, extend this timeframe even further. (Wakeman, Tr. 2626; PX01920 at 038 (Wakeman, Dep. at 144-145), *in camera*).

<u>Response to Finding No. 1072:</u>

This testimony is misleading. St. Luke's was losing money from operations through the time of the joinder. (*See, e.g.*, RPF 1616).

1073. From December 31, 2009 through August 31, 2010, the fair market value of St. Luke's "assets limited as to use" increased as a result of positive performance in financial markets and stock markets. (Joint Stipulations of Law and Fact, JX00002A ¶ 36).

Response to Finding No. 1073:

This proposed finding is misleading as these funds are not available for ordinary and routine use. (RPF 2097). Moreover, it does not change the fact that St. Luke's was losing money from operations through the time of the joinder. (*See, e.g.*, RPF 1616).

1074. As of August 31, 2010, St. Luke's had approximately $65 million in cash and investment balances. (Joint Stipulations of Law and Fact, JX00002A ¶ 34; PX01265 at 001 (OhioCare Consolidated Balance Sheet as of Aug. 31, 2010: sum of "Assets Limited As to Use" and "Cash and Cash Equivalents" lines); PX01274 at 001 (Wakeman May 2009 Email), *in camera* ("[w]e are blessed to have reserves.").

Response to Finding No. 1074:

This proposed finding is misleading because the $65 million cited by Complaint Counsel incorporates assets that were restricted and not available for ordinary course expenditures. St. Luke's unrestricted reserves { }. (RPF 1641, *in camera*). This amount had decreased significantly { }. (RPF 1641, *in camera*). {

} (RPF 1642, *in camera*).

{ }

(Den Uyl, Tr. 6460, *in camera*).

1075. As of December 31, 2010, St. Luke's held a total of at least $70 million in cash and investment balances. (Joint Stipulations of Law and Fact, JX00002A ¶ 35).

Response to Finding No. 1075:

This proposed finding is misleading because it concerns St. Luke's reserves after the joinder and incorporates the effects of the joinder such as Paramount revenues and stock market increases after the joinder. (Dagen, Tr. 3195, 3323-3328, 3245; RPF 2072) Mr. Dagen admits that about 23 percent of the revenue increases that St. Luke's experienced between September 1 and December 31, 2010 as a result of St. Luke's addition the Paramount network. (Dagen, Tr. 3243). It does not reflect St. Luke's reserves as an independent entity. (Dagen, Tr. 3323-3328; RPF 2072). Moreover, this amount incorporates assets that were restricted and not available for ordinary course expenditures. (RX-56 at 000015-000016, *in camera*; RPF 2072). Limitations of St. Luke's pre-joinder reserves as an indicator of St. Luke's financial viability are explained in Respondent's reply to CCPF 1074.

1076. St. Luke's reserves have been, and can continue to be, used for appropriate capital projects. (PX01006 at 010 (OhioCare Consolidated Financial Report Dec. 31, 2009) ("Assets limited as to use include assets designated by the board of directors for future capital improvements . . . over which the board retains control, and may, at its discretion, subsequently use for other purposes.")). St. Luke's "established its investment policy to provide a financial reserve for long-term replacement, modernization and expansion of hospital facilities." (PX01275 at 047 (St. Luke's Credit Presentation)).

Response to Finding No. 1076:

This proposed finding is misleading as the funds described by Complaint Counsel not available for ordinary and routine use. (RPF 2097). St. Luke's unrestricted reserves {

}. (RPF 1641, *in camera*). This amount had decreased

significantly { }. (RPF 1641, *in camera*). {

.} (RPF 1642, *in camera*). {

.} (Den Uyl, Tr. 6460, *in camera*).

1077. St. Luke's has spent an average of $11.3 million annually on capital projects over the past ten years, including a heart center in 2001, a physical rehabilitation center in 2003, and

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).

1095. As a result, Dr. Gold was "disappointed when St. Luke's informed [UTMC] that its Board of Trustees decided in late Summer 2009 to instead pursue an affiliation with ProMedica, and ended affiliation discussions with UTMC." (PX02064 at 003 (Gold, Decl. ¶ 8)).

Response to Finding No. 1095:

This proposed finding is misleading because UTMC and St. Luke's had never engaged in full due diligence as explained in Respondent's reply to CPPF 1089 above. In addition, this proposed finding is misleading to the extent it implies that St. Luke's had not identified serious obstacles to a successful joinder with UTMC as described in Respondent's reply to CPPF 1091 above. Moreover, it ignores the fact that 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).

1096. At the time St. Luke's terminated affiliation discussions, UTMC was still sincerely interested in moving forward to explore an affiliation with St. Luke's and was still willing to devote substantial resources to that effort. (Gold, Tr. 249).

Response to Finding No. 1096:

This proposed finding is misleading because UTMC and St. Luke's had never engaged in full due diligence as explained in Respondent's reply to CPPF 1089 above. In addition, this proposed finding is misleading to the extent it implies that St. Luke's had not identified serious obstacles to a successful joinder with UTMC as described in Respondent's reply to CPPF 1091

above. Moreover, it ignores the fact that 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).

1097. Partnering with UTMC would have been the best option for the community and would have fit with St. Luke's mission. (PX01112 at 001 (St. Luke's Integration Decision Grid), *in camera*; *see also* Black, Tr. 5739, *in camera*).

Response to Finding No. 1097:

This proposed finding is inaccurate. 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).

In addition St. Luke's management and Board had concerns 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). UTMC also had not offered to make a capital contribution to St. Luke's nor had they evaluated St. Luke's financial health. (Gold, Tr. 318, 320). Along the same lines, 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). Finally, St. Luke's had concerns about UTMC's quality and costs (RPF 867, 868-869).

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).

1098. "St. Luke's leadership believes this affiliation is in the best interests of the community with the potential partnership leading the way for economic change." (PX01030 at 020 (St. Luke's Oct. 30, 2009 Affiliation Analysis Update), *in camera*).

Response to Finding No. 1098:

This proposed finding is misleading. The St. Luke's presentation cited by Complaint Counsel for this proposed finding also includes the following conclusions about UTMC as a potential affiliation partner:

- { }

  (PX01030 at 008, *in camera*).

- { } (PX0130 at 008, *in camera*).

- { } (PX01030 at 009, *in camera*).

- { } (PX01030 at 012, *in camera*).

- { } (PX01030 at 012, *in camera*).

- { } (PX01030 at 012).

- { } (PX01030 at 13).

- {

} (PX01030 at 015).

- {

}

(emphasis added) (PX01030 at 016).

- {

} (PX01030 at 018).

1099. St. Luke's Board of Directors and executives saw substantial benefits to partnering with UTMC. (PX01920 at 039 (Wakeman, Dep. at 148-149), *in camera*; PX01321 at 002 (St. Luke's Dec. 2009 e-mail), *in camera*; PX01130 at 005 (St. Luke's Recovery/Strategic Plan), *in camera*).

Response to Finding No. 1099:

This proposed finding is inaccurate. 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).

In addition St. Luke's management and Board had concerns 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). UTMC also had not offered

to make a capital contribution to St. Luke's nor had they evaluated St. Luke's financial health. (Gold, Tr. 318, 320). Along the same lines, 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

1100. UTMC does not offer obstetrics services, and thus a merger of St. Luke's and UTMC would not increase market share or market concentration in the Lucas County obstetrics services market. (Gold, Tr. 203).

Response to Finding No. 1100:

The proposed finding is not a fact, but an improper legal conclusion. The proposed finding is also inaccurate because in the testimony cited by Complaint Counsel to support this proposed finding, Dr. Gold only testifies regarding UTMC's OB service offerings, he does not make any statements about market, market share, or market concentration. (*See* Gold, Tr. 203).

Moreover, the factual portion of this citation is incomplete and misleading. Although Dr. Gold testifies that UTMC does perform inpatient OB services, he also states that UTMC does perform outpatient OB services, gynecology services, and inpatient pediatrics. (Gold, Tr. 203).

1101. In the market for general acute-care services, the combination of UTMC and St. Luke's would result in a smaller combined share than Mercy, and a combined share more than 60 percent smaller than ProMedica. (PX02148 at 143 (Town Expert Report, Ex. 6), *in camera*; PX02150 at 001 (Market Share Chart)).

Response to Finding No. 1101:

Professor Town's market shares for inpatient general acute care services are flawed because he limits his "market" to only those general acute care inpatient services (identified as "diagnostic related groups" or "DRGs") that both ProMedica and St. Luke's provided to at least three commercially-insured patients (RPF 1491), thereby eliminating from his "market" (and his share calculations) many services that ProMedica, Mercy, and UTMC offer and provide. (RPF 1489-1493, 1504, 1510, *in camera*). Professor Town also excluded overlapping St. Luke's and

ProMedica DRGs for which St. Luke's and ProMedica compete with hospitals outside of Lucas County (RPF 1494-1495), and DRGs with a case weight index, which reflects complexity of care, greater than two. (RPF 1496). {

} (RX-71(A) at 000015-000018, *in camera*). Professor Town included, however, some DRGs with case weights higher than four, which captures some services that could be classified as tertiary or quaternary medical services. (RPF 1500). His separate inpatient OB services product market share calculation is similarly flawed because it is also based on less than one year's worth of data and 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. (RPF 1501).

Moreover, Professor Town's market share is based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). Professor Town's market definitions exclude DRGs for which Mercy, ProMedica, and UTMC have considerable discharges, thereby understating their competitive influence and overstating St. Luke's competitive significance. (RPF 1489, 1490, 1504, 1510, *in camera*).

1102. UTMC officials also believed that a St. Luke's/UTMC affiliation could have led to substantial efficiencies, including the same types of efficiencies Respondent claims may result from the Acquisition. (Gold, Tr. 245-246 (including "back-of-the-house functions: finance, information technology, human resources services, and many others that are typically used to run hospitals" and "consolidation of clinical services [which] would allow us to deliver higher volume, higher quality services, and be more efficient."); PX01406 at 001 (Wakeman Jul. 2009 Email) (benefits to UTMC partnership are "endless"); PX01407 at 001 (Wakeman (St. Luke's) Oct. 2009 Email to Dr. Gold

(UTMC)) (a UTMC affiliation "would provide just as much [expense reduction] as the two systems [Mercy and ProMedica]."")).

Response to Finding No. 1102:

The proposed finding is misleading and inaccurate. 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).

1103. UTMC has been profitable for at least the last three years. (Gold, Tr. 269). UTMC recently spent $7 million to expand its intensive care unit, and is currently undergoing "extensive" renovations to its hospital. (Gold, Tr. 224, 266). Dr. Gold testified that it was his understanding from affiliation discussions with St. Luke's that "dollars would flow [to St. Luke's]" and that some of St. Luke's capital needs "would have to be managed by [UTMC]." (Gold, Tr. 267).

Response to Finding No. 1103:

The proposed finding is misleading. UTMC had not offered to make a capital contribution to St. Luke's nor had they evaluated St. Luke's financial health. (Gold, Tr. 318, 320). Along the same lines, 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). And 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)).

1104. ProMedica's CEO, Randall Oostra, testified that UTMC continues to and has made "major" investments in its facilities that are of interest to ProMedica, including upgrading their intensive care unit and making improvements to its campus. (Oostra, Tr. 5815-5816). Mr. Oostra also noted that UTMC built a whole new outpatient wing two or three years ago, and has announced plans to make some major investments in their cancer program. (Oostra, Tr. 5815-5816).

Response to Finding No. 1104:

Respondent has no specific response.

1105. Respondent's expert, Ms. Guerin-Calvert, testified extensively on room renovations and technology upgrades recently under way at UTMC, finding that "UTMC has very

recently completed a number of renovations and expansion to its facilities[.]" (Guerin-Calvert, Tr. 7287-7288, 7543). Ms. Guerin-Calvert concluded that "UTMC [has] staked out positions that they want to be survivors in this marketplace and that they have every intent to go forward and make the necessary investments." (Guerin-Calvert, Tr. 7310-7311).

Response to Finding No. 1105:

Respondent has no specific response.

1106. St. Luke's was concerned, however, that UTMC would not be able to deliver sufficient pricing leverage with health plans. (PX01018 at 017 (St. Luke's Partnership Options Presentation), *in camera*) ("Would . . . [UTMC] give us . . . enough managed care clout?"); Black, Tr. 5721-5722, *in camera*; (PX01130 at 004 (St. Luke's Aug. 2009 Due Diligence Meeting Notes), *in camera*) ("Concern that [UTMC] does/may not have as high of reimbursement rates as ProMedica or Mercy"). St. Luke's also feared retaliation by ProMedica if it affiliated with UTMC. (*See supra* at Section X.C).

Response to Finding No. 1106:

The proposed finding is inaccurate and misleading. MCO rates were not among the many significant reasons why St. Luke's chose to end its affiliation discussions with UTMC. In fact, in one of the St. Luke's presentations cited by Complaint Counsel here St. Luke's management highlights { } as one of the benefits of a potential joinder with UTMC. (PX01030 at 13). Similarly, in another presentation cited by Complaint Counsel here, St. Luke's management emphasizes that { .} (PX01018 at 013, *in camera*). And to the extent MCO rates are mentioned at all in St. Luke's presentations, it is always among 10 to 12 additional factors that St. Luke's management and Board are also considering. (*See,* e.g. PX01018 at 016 and 017; PX01030; Respondent's Reply to CCPF 1098).

2. Potential Affiliation with Mercy

1107. St. Luke's and Mercy discussed { } a potential affiliation. (Shook, Tr. 1003-1004, *in camera*; PX01030 at 011 (St. Luke's Oct. 15, 2009 Affiliation Analysis Update), *in camera*).

Response to Finding No. 1107:

Respondent has no specific response.

1108. At the end of 2009, Mr. Wakeman believed that Mercy was more focused on quality and patient satisfaction than ProMedica. (Wakeman, Tr. 2560).

Response to Finding No. 1108:

The proposed finding is misleading. Mr. Wakeman testified that {

} (Wakeman, Tr. 3002, *in camera*).

1109. Nonetheless, St. Luke's ended discussions while Mercy remained interested in an affiliation. (Wakeman, Tr. 2559; PX01922 at 021, 023 (Shook, Dep. at 80, 89), *in camera*). Mercy was surprised and disappointed by St. Luke's decision to end affiliation discussions. (Shook, Tr. 1002, *in camera*).

Response to Finding No. 1109:

This proposed finding is misleading. St. Luke's criteria for evaluating joinder partners are described in RPF 819-826. St. Luke's reasons for ending discussions with Mercy are detailed in RPF 877-902. And St. Luke's reasons for choosing ProMedica are detailed in RPF 903-921.

XVII. RESPONDENT'S EXPERTS FAIL TO REBUT PRESUMPTION THAT THE ACQUISITION IS ILLEGAL

A. Flaws in Margaret Guerin-Calvert's Analysis

1110. Ms. Guerin-Calvert was retained by Respondent to provide an economic assessment of the competitive effects of the Acquisition and to review and respond to the reports provided by Professor Town. (RX-71(A) at 5 (Guerin-Calvert Expert Report), *in camera*).

Response to Finding No. 1110:

Respondent has no specific response.

1111. Ms. Guerin-Calvert concluded that the Acquisition is unlikely to lessen competition for general acute-care services in the Toledo area, despite the unanimous testimony from health plan witnesses at trial that ProMedica will be able to raise rates for hospital services post-Acquisition, due to its increased bargaining power. (RX-71(A) at 5 (Guerin-Calvert Expert Report), *in camera*; (*See supra* at Section XI.).

Response to Finding No. 1111:

The proposed finding violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record with regard to the statement "despite the unanimous testimony from health plan witnesses at trial that ProMedica will be able to raise rates for hospital services post-Acquisition, due to its increased bargaining power." To the extent Complaint Counsel references other portions of its findings, Respondent will address those findings there.

1112. Ms. Guerin-Calvert did not conduct interviews of third party health plans or hospitals in her analyses of the transaction. (Guerin-Calvert, Tr. 7625-7626). Ms. Guerin-Calvert only conducted interviews of two ProMedica executives, and St. Luke's general counsel in analyzing this transaction. (Guerin-Calvert, Tr. 7617-7625). Ms. Guerin-Calvert did not interview any consumers of hospital services in the Toledo area in conjunction with her analysis in the transaction. (Guerin-Calvert, Tr. 7627-7628).

Response to Finding No. 1112:

Respondent has no specific response.

1113. Ms. Guerin-Calvert toured St. Luke's Hospital, but no ProMedica facility, Mercy facility, or any other hospital discussed in her analysis of the transaction. (Guerin-Calvert, Tr. 7613-7616).

Response to Finding No. 1113:

Respondent has no specific response.

1114. Ms. Guerin-Calvert does not dispute Professor Town's conclusion that a health plan's bargaining leverage is determined, in part, by its ability to contract with alternative hospitals. (*See supra* Section V.). In fact, Ms. Guerin-Calvert agrees that the relevant economic question when evaluating bargaining outcomes is how many alternative providers a health plan could have contracted with when reaching an agreement with a provider. (Guerin-Calvert, Tr. 7950).

Response to Finding No. 1114:

This proposed finding is inaccurate. Ms. Guerin-Calvert testified that sometimes there may be more competitors or a different mix of competitors than just the hospitals for outpatient services. (Guerin-Calvert, Tr. 7640).

1122. Ms. Guerin-Calvert excludes inpatient psychiatric services from her relevant product market, despite the fact that these services are negotiated as part of the same contract as the services in her relevant product market. (Guerin-Calvert, Tr. 7638). Inpatient psychiatric services are also excluded from Professor Town's relevant product markets. (Guerin-Calvert, Tr. 7638).

Response to Finding No. 1122:

This proposed response is inaccurate. MCOs negotiate for quaternary inpatient services, psychiatric and substance abuse services, and outpatient services as part of the same contract but are excluded from the relevant product market because they have involve a different use of hospitals resources and services than general acute care inpatient services. (Guerin-Calvert, Tr. 7187-7188).

1123. Laboratory services, physical and occupational therapy, inpatient rehabilitation, inpatient substance abuse and inpatient long-term acute care services are excluded from Ms. Guerin-Calvert's relevant product market despite the fact that these services are included in the typical health plan agreements between hospitals and health plans. (Guerin-Calvert, Tr. 7638-7639). These services are also excluded from Professor Town's relevant product markets. (*See generally* Town, Tr. 3684-3687).

Response to Finding No. 1123:

This proposed response is inaccurate. MCOs negotiate for rehabilitation, skilled care, psychiatric care an detoxification as part of the same contract but are excluded from the relevant product market because they have involve a different use of hospitals resources and services than general acute care inpatient services. (Guerin-Calvert, Tr. 7187-7188).

1124. Ms. Guerin-Calvert excludes MDC-2 (diseases and disorders of the eye) from her relevant product market despite the fact that these services are the subject of the same negotiation between hospitals and health plans as the services in her relevant product market. (Guerin-Calvert, Tr. 7643).

Response to Finding No. 1124:

Respondent has no specific response.

1125. Professor Town excludes MDC-2 from his relevant market because different competitive conditions exist for the services within MDC-2. (Town, Tr. 4027-4028). Ms. Guerin-Calvert admits that MDC-2 has different competitive conditions than most inpatient MDCs. (Guerin-Calvert, Tr. 7643).

Response to Finding No. 1125:

This proposed finding misstates Ms. Guerin-Calvert's testimony. She testified:

> Q: And so you excluded any inpatient DRGs that fall under MDC 2 in your product market; is that right?
>
> A.: Yes. MDC 2 is a variety of procedures that are increasingly outpatient and/or are done in a larger proportion outpatient, so yes, similar to Dr. Town, I did exclude MDC 2.
>
> Q.: Why did you exclude the inpatient procedures captured in MDC 2 for this matter?
>
> A.: Because in that category are still some that are thought to be ones that are inclined to go more so for outpatient, but I did exclude the entire MDC code.
>
> Q. Okay. Let me make sure I understand you. Why did you exclude the inpatient DRGs from your product market that are included in MDC 2?
>
> A. The reason why I did is I excluded the MDC code. And again, my understanding is that a lot of the procedures and increasingly more of the procedures that are in MDC code 2, all of which are inpatient, because everything that is in an MDC code that is a DRG

This proposed finding misrepresents Ms. Guerin-Calvert's testimony. Ms. Guerin-Calvert pointed out that the situation is hypothetical, and stated that the "hypothetical has the prospect of concern that OB prices for that full range of OB services could materially change," (not that ProMedica would be able to raise prices for OB services). (Guerin-Calvert, Tr. 7679-7680).

2. Ms. Guerin-Calvert Failed to Analyze Market Concentration

1143. Ms. Guerin-Calvert admits that the appropriate starting point in merger analysis involves calculating market shares and HHI concentration indices. (Guerin-Calvert, Tr. 7718-7719; PX01925 at 005 (Guerin-Calvert, Dep. at 11)).

Response to Finding No. 1143:

This proposed finding misrepresents Ms. Guerin-Calvert's testimony. Ms. Guerin-Calvert testified that the starting point of merger analysis is to assess market definition, and that to look at market share or market concentration, one must first start with market. (Guerin-Calvert, Tr. 7718-7719). She goes on to testify that one does not necessarily calculate an HHI or concentration, but rather one "may well just look at the overall structure and look at relative size" of the market. (Guerin-Calvert, Tr. 7719).

1144. Ms. Guerin-Calvert did not calculate HHIs in conjunction with her analysis of this Acquisition. (Guerin-Calvert, Tr. 7723).

Response to Finding No. 1144:

Respondent has no specific response.

1145. Ms. Guerin-Calvert testified that she has calculated HHIs in previous merger matters where she has testified as an expert, and in all of those instances the merger did not meet the presumption. (Guerin-Calvert, Tr. 7720-7721).

Response to Finding No. 1145:

Respondent has no specific response.

1146. Ms. Guerin-Calvert admits that based on the relevant market she defined for this Acquisition, that the pre-HHI meets the *Merger Guidelines* presumption of a highly concentrated market. (Guerin-Calvert, Tr. 7730).

Response to Finding No. 1146:

This proposed finding misrepresents Ms. Guerin-Calvert's testimony. Ms. Guerin-Calvert testified that based on her market share calculations presented in her report by discharges and billed charges, the pre-merger HHI *could be* 3000. (Guerin-Calvert, Tr. 7728-7730). Ms. Guerin-Calvert goes on to testify that the presumption of a highly concentrated market is a legal presumption, not an economic one. (Guerin-Calvert, Tr. 7730-7731).

1147. Ms. Guerin-Calvert admits that the post-HHI would be over 4000 for the relevant markets she has defined. (Guerin-Calvert, Tr. 7730).

Response to Finding No. 1147:

This proposed finding misstates Ms. Guerin-Calvert's testimony. Ms. Guerin-Calvert testified that the post-merger HHI "may not be as high as [4000] but probably something in that general range." (Guerin-Calvert, Tr. 7730).

3. Ms. Guerin-Calvert's Market Share Analysis Is Flawed

1148. Ms. Guerin-Calvert omitted market share calculations from her expert report filed April 26, 2011, 14 months after she was hired to assess the transaction. (Guerin-Calvert, Tr. 7716). On May 13, during Ms. Guerin-Calvert's deposition, she submitted new market share analysis to the FTC. (Guerin-Calvert, Tr. 7716-7717). On June 30, 2011, Ms. Guerin-Calvert produced another market share table to the FTC. (Guerin-Calvert, Tr. 7717).

Response to Finding No. 1148:

This proposed finding is inaccurate. Ms. Guerin-Calvert's report filed on April 26, 2011 contained share calculations for bed capacity. (Guerin-Calvert, Tr. 7715-7716). At her May 13 deposition, Ms. Guerin-Calvert provided additional, but not new, tables, some of which were configured differently from tables that had been provided in her April report. (Guerin-Calvert,

Tr. 7716-7717). On June 30, Ms. Guerin-Calvert provided a slight modification to one table she had previously provided. (Guerin-Calvert, Tr. 7717-7718).

1149. Ms. Guerin-Calvert did not calculate market shares for obstetrics or women's services in this matter. (Guerin-Calvert, Tr. 7744).

Response to Finding No. 1149:

This proposed finding is misleading. Ms. Guerin-Calvert did not calculate market shares for obstetrics or women's services because she disagrees that those are separate relevant product markets. (Guerin-Calvert, Tr. 7155-7156, 7210-7211). Ms. Guerin-Calvert included these services in her calculation of market share for all general acute care services. (Guerin-Calvert, Tr. 7652; RX-71(A) at 000161-000163, *in camera*).

1150. Ms. Guerin-Calvert testified that the inclusion or exclusion of quaternary services would not change her share analysis. (Guerin-Calvert, Tr. 7695).

Response to Finding No. 1150:

This proposed finding misrepresents Ms. Guerin-Calvert's testimony. Ms. Guerin-Calvert testified that the inclusion of one or two quaternary discharges would not change her opinion or the validity of her share numbers for reflecting general acute care services of primary, secondary, and tertiary services. (Guerin-Calvert, Tr. 7695).

1151. Ms. Guerin-Calvert calculated shares by billed charges, despite admitting that billed charges are not the actual prices paid to the hospital by the health plans. (Guerin-Calvert, Tr. at 7734).

Response to Finding No. 1151:

This proposed finding is misleading. Ms. Guerin-Calvert explained that billed charges, or gross revenues, "give you a superior way to look at the overall revenues taking into account range of services" and that gross revenues is a "way of reflecting both the nature of services involved at a hospital and also a measure of overall size." (Guerin-Calvert, Tr. 7733-7734).

1152. Ms. Guerin-Calvert calculated shares for MMO which accounts for 10 percent of the market in Lucas County, but no other health plan, despite having the data from all health plans which would have enabled her to do so. (Guerin-Calvert, Tr. 7734-7735).

Response to Finding No. 1152:

This proposed finding is inaccurate. Ms. Guerin-Calvert calculated shares of the general acute care inpatient services market based on billed charges, discharges and bed capacity. (Guerin-Calvert, Tr. 7276; RX-71(A) at 000036-000037, 000162, *in camera*).

4. Ms. Guerin-Calvert's Drive Time Analysis Fails to Address Impact on Patients

1153. In her empirical analysis, Ms. Guerin-Calvert quantified the incremental drive time for patients in Lucas County to seek care from alternative hospitals, but neglected to quantify the associated welfare loss for those patients. (Guerin-Calvert, Tr. 7698). Ms. Guerin-Calvert's analysis fails to incorporate the substantial record evidence regarding patients' preferences for hospitals, and the cost of increased travel for physicians. (*See supra* Section XI.E.).

Response to Finding No. 1153:

This proposed finding is inaccurate. Ms. Guerin-Calvert analyzed the incremental drive time for patients in and around in Lucas County. (RX-71(A) at 000030-000035, *in camera*). Because the incremental drive time would not be substantial, and patients are already willing to travel, if St. Luke's were not available, this suggests that any welfare loss would not be large, if it exists at all. (RX-71(A) at 000030-000035, *in camera*).

To the extent Complaint Counsel references other portions of its findings, Respondent will address those findings there.

1154. Ms. Guerin-Calvert's drive time analysis represents a 40 percent increase in travel time for patients. (Guerin-Calvert, Tr. 7697).

Response to Finding No. 1154:

This proposed finding is misleading. For the 95th percentile of patients – approximately 20 to 30 patients – they would have an additional drive time of 11 minutes if they drove to a

hospital other than St. Luke's. (Guerin-Calvert, Tr. 7697). Moreover, using Professor Town's drive time analysis shows that 49 percent of general acute care patients would have a *negative* drive time if they drove to a hospital other than St. Luke's (Guerin-Calvert, Tr. 7350).

1155. Ms. Guerin-Calvert did not survey patients or Lucas County residents to see what impact a 40 percent increase in drive time would have for those patients. (Guerin-Calvert, Tr. 7698).

Response to Finding No. 1155:

Respondent has no specific response.

5. Ms. Guerin-Calvert's Claims Regarding Excess Capacity in the Market Lack Evidentiary Foundation

1156. Ms. Guerin-Calvert's MSA analysis of populations of similar size to the Toledo area demonstrates that the Toledo area is not an outlier in terms of the number of beds per thousand persons. (Guerin-Calvert, Tr. 7760).

Response to Finding No. 1156:

This proposed finding mischaracterizes Ms. Guerin-Calvert's testimony. Ms. Guerin-Calvert testified that she "didn't use the word 'outlier'" but rather she testified that Toledo has "among the highest number of beds per thousand of MSAs in the country of comparable population. . . . It has a very large number of beds relative to the demand for beds." (Guerin-Calvert, Tr. 775-7759).

1157. Ms. Guerin-Calvert's MSA analysis of populations of similar size to the Toledo area demonstrates that the Toledo area has fewer competitors than other MSAs. (Guerin-Calvert, Tr. 7760).

Response to Finding No. 1157:

This proposed finding misstates Ms. Guerin-Calvert's testimony. Ms. Guerin-Calvert testified that Toledo "as a general matter, [has] a relatively large number of competitors, again, for the population." (Guerin-Calvert, Tr. 7759). Moreover, the number of competitors does not indicate their relative size. (Guerin-Calvert, Tr. 7759).

1158. The joinder does not change the number of hospitals in Lucas County. (Guerin-Calvert, Tr. 7762). ProMedica has no plans to eliminate or reduce bed capacity as a result of the Acquisition. (Guerin-Calvert, Tr. 7762-7763). ProMedica is adding inpatient capacity by opening Wildwood Orthopedic hospital. (Guerin-Calvert, Tr. 7763).

Response to Finding No. 1158:

This proposed finding misstates Ms. Guerin-Calvert's testimony. Ms. Guerin-Calvert testified that ProMedica is reconfiguring, in other words repurposing, beds from their other hospitals to the Wildwood Orthopaedic Hospital. (Guerin-Calvert, Tr. 7763).

6. Ms. Guerin-Calvert's Diversion Analysis is Flawed

1159. Ms. Guerin-Calvert did not calculate the diversions from St. Luke's to individual hospitals or hospital systems. (Guerin-Calvert, Tr. 7802).

Response to Finding No. 1159:

This proposed finding is misleading. Ms. Guerin-Calvert did calculate diversion ratios from St. Luke's to other hospital systems based on Professor Town's model for more years than Professor Town calculated. (Guerin-Calvert, Tr. 7375-7377; RX-71(A) at 000193, *in camera*). Professor Town also did not calculate the diversions from St. Luke's to individual hospitals. (PX02148 at 163, *in camera*).

1160. If St. Luke's were not available, ProMedica would capture the highest percentage of patients relative to any other hospital for all health plans except MMO and BCBS Michigan. (Guerin-Calvert, Tr. 7799).

Response to Finding No. 1160:

The proposed finding is misleading. MMO alone {

.} (RX-71(A) at 000191-193, *in camera*).

1161. Diversion to ProMedica from St. Luke's for MMO was increasing over the last four to five years. (Guerin-Calvert, Tr. 7800-7801).

Response to Finding No. 1161:

This proposed finding is misleading. Ms. Guerin-Calvert testified that the increase of the diversion from St. Luke's to ProMedica over the last four to five years was due to MMO's network opening up to include ProMedica during that time period. (Guerin-Calvert, Tr. 7800).

7. Ms. Guerin-Calvert Does Not Present Analysis that Rebuts the Evidence That ProMedica Has the Highest Prices in Lucas County

1162. Ms. Guerin-Calvert makes issue of the complexity of the bargaining relationship between hospitals and health plans, yet ignores testimony that health plans compare the rates charged by hospitals in the ordinary course of business. (See supra Section XI).

Response to Finding No. 1162:

To the extent Complaint Counsel references other portions of its findings, Respondent will address those findings there.

1163. Ms. Guerin-Calvert did not present analysis to rebut health plan testimony that ProMedica's rates reflect its considerable market power, and are the highest in Lucas County. (See supra Section V, XI).

Response to Finding No. 1163:

To the extent Complaint Counsel references other portions of its findings, Respondent will address those findings there.

1164. Ms. Guerin-Calvert did not calculate price differentials to refute the case-mix adjusted pricing calculations made by Professor Town. (Guerin-Calvert, Tr. 7859-7867, in camera).

Response to Finding No. 1164:

This proposed finding is misleading. Ms. Guerin-Calvert did not calculate price differentials because 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 in time 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). Rather, she used actual pre- and post-joinder contract rates to evaluate the competitiveness of the reimbursement rates. (RX-71(A) at 000053-000058, *in camera*). Furthermore, Professor Town's case-mix adjusted prices do not indicate the reason for the difference in prices across hospitals in Lucas County, and therefore cannot isolate what is causing any specific price differences, including cost differences or differences on intrinsic value. (Guerin-Calvert, Tr. 7449-7451, 7457-7458). Professor Town agrees that the presence of price differences alone are not sufficient to determine the exercise of market power. (RPF 1515).

1165. Indeed, the only economic expert that actually calculated case-mix adjusted prices was Professor Town. (Guerin-Calvert, Tr. 7859-7867, in camera).

Response to Finding No. 1165:

This proposed finding is misleading. Ms. Guerin-Calvert did not calculate price differentials because 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 in time 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). Rather, she used actual pre- and post-joinder contract rates to evaluate the competitiveness of the reimbursement rates. (RX-71(A) at 000053-000058, *in camera*). Furthermore, Professor Town's case-mix adjusted prices do not indicate the reason for the difference in prices across hospitals in Lucas County, and Professor Town agrees that the presence of price differences alone are not sufficient to determine the exercise of market power. (RPF 1515).

1166. Ms. Guerin-Calvert states that elements and conditions of contracting may explain differences in prices across hospitals, but does not conclude that any of these elements

and conditions actually explain ProMedica's prices. (RX-71(A) at 37-50 (Guerin-Calvert Expert Report), in camera).

Response to Finding No. 1166:

This proposed finding is misleading. Ms. Guerin-Calvert did examine these elements and conditions when examining the but-for prices. For example, ProMedica's prices may be higher because MMO constitutes a large amount of revenue for ProMedica, so it's heavily weighted. Thus, ProMedica's prices with its newly renegotiated contract, all else equal, may be higher than other hospitals. (Guerin-Calvert, Tr. 7469-7471). In addition, MMO's prices with ProMedica may be higher because they do not have the history of negotiations like MMO and Mercy. (Guerin-Calvert, Tr. 7481-7472). Similarly, St. Luke's MMO contract was important to it because St. Luke's had a high volume of MMO patients. But its rates are below-cost, which is obscured with Professor Town's model. (Guerin-Calvert, Tr. 7469-7471). Furthermore, Professor Town's case-mix adjusted prices 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. (RPF 1515).

1167. Ms. Guerin-Calvert does not conclude that any of the "competitively benign factors" listed in her report explain the price differentials found by Professor Town or by fact witnesses in this matter. (RX-71(A) at 37-50 (Guerin-Calvert Expert Report), in camera).

Response to Finding No. 1167:

This proposed finding is misleading. Ms. Guerin-Calvert did examine these elements and conditions when examining the but-for prices. For example, ProMedica's prices may be higher because MMO constitutes a large amount of revenue for ProMedica, so it's heavily weighted. Thus, ProMedica's prices with its newly renegotiated contract, all else equal, may be higher than other hospitals. (Guerin-Calvert, Tr. 7469-7471). In addition, MMO's prices with ProMedica may be higher because they do not have the history of negotiations like MMO and Mercy.

(Guerin-Calvert, Tr. 7481-7472). Similarly, St. Luke's MMO contract was important to it because St. Luke's had a high volume of MMO patients. But its rates are below-cost, which is obscured with Professor Town's model. (Guerin-Calvert, Tr. 7469-7471). Furthermore, Professor Town's case-mix adjusted prices 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. (RPF 1515).

8. Ms. Guerin-Calvert's Analysis of Repositioning is Flawed

1168. Ms. Guerin-Calvert analyzed the impact of "diversion" from St. Luke's to Mercy as a result of Mercy's { }. (RX-71(A) at 29 (¶ 45) (Guerin-Calvert Expert Report), *in camera*). Ms. Guerin-Calvert's analysis predicted that St. Luke's would experience dramatic losses. (RX-71(A) at 29 (¶ 45) (Guerin-Calvert Expert Report), *in camera*).

Response to Finding No. 1168:

This proposed finding is misleading. Ms. Guerin-Calvert also analyzed the effect of physicians changing affiliation and payor networks. She found that when "{ ,} the result was a substantial shift of revenues and volumes from { } (RX-71(A) at 000029, *in camera*). Furthermore, Ms. Guerin-Calvert clarified that 16 months is not a long time given the competitiveness of the market. (Guerin-Calvert, Tr. 7781-7782, *in camera*). This is especially true because { } (RX-286 at 000015, *in camera*).

1169. Ms. Guerin-Calvert's analysis is not a diversion analysis, which, by definition, considers changes in shares resulting from a hypothetical change in price. (*Horizontal Merger Guidelines* § 6.1; PX01850 at 014 (¶ 19) (Town Rebuttal Report), *in camera*).

Response to Finding No. 1169:

The proposed finding is not a fact, but an improper legal argument.

1170. Ms. Guerin-Calvert's analysis of Mercy's { } fails to examine Mercy's market share over the 16 months of the implementation of the { }. (Guerin-Calvert, Tr. 7880, *in camera*). Mr. Shook testified that Mercy's { } has been { } and has { }. (Shook, Tr. 987, *in camera*).

Response to Finding No. 1170:

This proposed response is misleading. Ms. Guerin-Calvert clarified that 16 months is not a long time given the competitiveness of the market. (Guerin-Calvert, Tr. 7781-7782, *in camera*). This is especially true because { } (RX-286 at 000015, *in camera*). Ms. Guerin-Calvert further testified that { } has deployed more primary care family practice physicians, which has changed the competitive dynamic with regard to St. Luke's. (Guerin-Calvert, Tr. 7882, *in camera*).

1171. Ms. Guerin-Calvert did not examine what, if any, impact Mercy's { } has had on St. Luke's admissions in the 16 months of the strategy. (Guerin-Calvert, Tr. 7882, *in camera*).

Response to Finding No. 1171:

This proposed response is misleading. Ms. Guerin-Calvert clarified that 16 months is not a long time given the competitiveness of the market. (Guerin-Calvert, Tr. 7781-7782, *in camera*). This is especially true because { .} (RX-286 at 000015, *in camera*). Ms. Guerin-Calvert further testified that { } has deployed more primary care family practice physicians, which has changed the competitive dynamic with regard to St. Luke's. (Guerin-Calvert, Tr. 7882, *in camera*).

1172. Despite Ms. Guerin-Calvert's predictions that St. Luke's would lose market share to Mercy, St. Luke's market share actually increased during the time period of Mercy's { }. (*See generally* Wakeman, Tr. 2519-2520, 2527). Ms. Guerin-Calvert admits that St. Luke's inpatient admissions have increased in this time period. (Guerin-Calvert, Tr. 7883, in camera).

Response to Finding No. 1172:

This proposed response is misleading. Ms. Guerin-Calvert testified that across all payors, including government-insured st. Luke's inpatient admissions have increased. (Guerin-Calvert, Tr. 7884, *in camera*). Mr. Wakeman testified that St. Luke's market share in its core services area, which not the relevant geographic market, has increased since 2007. (Wakeman, Tr. 2519-2520). Moreover, {

} (RX-286 at 000015, *in camera*).

9. Ms. Guerin-Calvert's Claims of St. Luke's Financial Distress Are Baseless

1173. Ms. Guerin-Calvert does not claim that St. Luke's is a failing firm under the *Merger Guidelines*. (Guerin-Calvert, Tr. 7885, *in camera*).

Response to Finding No. 1173:

Respondent has no specific response.

1174. Ms. Guerin-Calvert does not project St. Luke's inpatient volume absent the Acquisition. (Guerin-Calvert, Tr. 7885, *in camera*).

Response to Finding No. 1174:

This proposed finding mischaracterizes Ms. Guerin-Calvert's testimony. Ms. Guerin-Calvert testified that she observed the market conditions and concluded that there would be continued pressure on St. Luke's from UTMC, Wood and Mercy as well as ProMedica, absent the joinder and she would expect St. Luke's is at significant risk of losing commercial insurance volumes. (Guerin-Calvert, Tr. 7886-7887).

1175. Ms. Guerin-Calvert does not project St. Luke's market share absent the Acquisition. (Guerin-Calvert, Tr. 7889, *in camera*).

Response to Finding No. 1175:

This proposed finding mischaracterizes Ms. Guerin-Calvert's testimony. Ms. Guerin-Calvert testified that she observed the market conditions and concluded that there would be

continued pressure on St. Luke's from UTMC, Wood and Mercy as well as ProMedica, absent the joinder and she would expect St. Luke's is at significant risk of losing commercial insurance volumes, which would suggest a decline in St. Luke's market share. (Guerin-Calvert, Tr. 7886-7889).

1176. Ms. Guerin-Calvert did not project St. Luke's future profitability in terms of EBITDA or operating income. (Guerin-Calvert, Tr. 7889, *in camera*).

Response to Finding No. 1176:

This proposed finding is misleading and mischaracterizes Ms. Guerin-Calvert's testimony. Ms. Guerin-Calvert did not project St. Luke's future profitability in terms of EBITDA or operating income because she was not asked to do so as part of her retention for this case. (Guerin-Calvert, Tr. 7889).

10. Ms. Guerin-Calvert Does Not Present an Efficiencies Analysis

1177. Ms. Guerin-Calvert did not conduct an efficiencies analysis of the Acquisition. (Guerin-Calvert, Tr. 7913).

Response to Finding No. 1177:

This proposed finding is misleading and mischaracterizes Ms. Guerin-Calvert's testimony. Ms. Guerin-Calvert did not conduct an efficiencies analysis because she was not asked to do so as part of her retention for this case. (Guerin-Calvert, Tr. 7913).

1178. Ms. Guerin-Calvert did not analyze whether ProMedica's alleged efficiencies claims are cognizable under the *Horizontal Merger Guidelines*. (Guerin-Calvert, Tr. 7913).

Response to Finding No. 1178:

This proposed finding is misleading and mischaracterizes Ms. Guerin-Calvert's testimony. Ms. Guerin-Calvert did not conduct an efficiencies analysis because she was not asked to do so as part of her retention for this case. (Guerin-Calvert, Tr. 7913).

1179. Ms. Guerin-Calvert did not assess whether ProMedica's alleged efficiencies claims are merger specific. (Guerin-Calvert, Tr. 7913).

Response to Finding No. 1179:

This proposed finding is misleading and mischaracterizes Ms. Guerin-Calvert's testimony. Ms. Guerin-Calvert did not conduct an efficiencies analysis because she was not asked to do so as part of her retention for this case. (Guerin-Calvert, Tr. 7913). However, Ms. Guerin-Calvert did analyze the community benefits that would result from the joinder. (Guerin-Calvert, Tr. 7913).

1180. Ms. Guerin-Calvert did not analyze what efficiencies would result from the partnership of St. Luke's and UTMC. (Guerin-Calvert, Tr. 7914).

Response to Finding No. 1180:

This proposed finding is misleading and mischaracterizes Ms. Guerin-Calvert's testimony. Ms. Guerin-Calvert did not conduct an efficiencies analysis because she was not asked to do so as part of her retention for this case. (Guerin-Calvert, Tr. 7913).

11. Ms. Guerin-Calvert's But-For Pricing Analysis is Flawed

1181. Ms. Guerin-Calvert's calculations of St. Luke's but-for pricing analysis are based on a contract negotiation that was never agreed to by the parties, or signed into a contract between a hospital and a health plan. (Guerin-Calvert, Tr. 7870, *in camera*).

Response to Finding No. 1181:

This proposed finding is inaccurate. The rates were agreed to St. Luke's and { }. (Guerin-Calvert, Tr. 7422; Pirc, Tr. 2355-2356, *in camera*). The agreed upon rate increases over a three year period plus a bonus formula could have resulted in an overall reimbursement increase of about { } (RPF 1384, *in camera.*) The only reason the contract was not implemented with those agreed upon rate increases was because { } (RPF 1816, *in camera*). { } (RPF 1816, *in camera*; 1819, *in camera*). Because the walk-away point in the negotiations was

not the amount of the increase, but rather {

} is indicative of the price increase that would have occurred but-for St. Luke's joinder with ProMedica. (RPF 1822, *in camera*).

1182. Prior to the Aquisition, St. Luke's negotiated a 5-6 percent annual rate increase in its contract with FrontPath. (Guerin-Calvert, Tr. 7872-7873, *in camera*). Yet, Ms. Guerin-Calvert elected not to use this actual price information to calculate St. Luke's but-for pricing. (Guerin-Calvert, Tr. 7872-7873, *in camera*).

Response to Finding No. 1182:

This proposed finding mischaracterizes Ms. Guerin-Calvert's testimony and analysis. Ms. Guerin-Calvert was asked what the rate increase as a percentage change was for the contract St. Luke's negotiated with FrontPath. (Guerin-Calvert, Tr. 7872, *in camera*). She replied that the percentage change taken out of context is not meaningful but that the new rates resulted in a { } cost coverage for St. Luke's. (Guerin-Calvert, Tr. 7872, *in camera*). Ms. Guerin-Calvert compared this cost coverage rate to the cost coverage rate of { } ProMedica negotiated on behalf of St. Luke's post-joinder to analyze the but-for pricing. (Guerin-Calvert, Tr. 7429-7432, *in camera*).

1183. Ms. Guerin-Calvert admits that ProMedica negotiated a contract between St. Luke's and MMO under the purview of the hold separate. (Guerin-Calvert, Tr. 7875, *in camera*).

Response to Finding No. 1183:

This proposed finding is misleading. Ms. Guerin-Calvert also testified that the hold separate agreement did not taint the post-joinder negotiations because both {

} had incentives to negotiate a contract. (Guerin-Calvert, Tr. 7430-7431, *in camera*). In addition, { } had alternatives that would have been lower in cost for it than the contract it negotiated with ProMedica. (Guerin-Calvert, Tr. 7430-7431, *in camera*). Finally, Ms. Guerin-Calvert did not observe any difference in bargaining power that { } exercised over St. Luke's in negotiations as compared to the bargaining power MMO exercised over ProMedica

under the hold-separate agreement. (Guerin-Calvert, Tr. 7430-7431, *in camera*). Moreover, ProMedica is locked into this contract for four years. (RPF 1382).

1184. Ms. Guerin-Calvert admits that the hold separate order may have given MMO additional bargaining leverage in negotiations with ProMedica. (Guerin-Calvert, Tr. 7876, *in camera*).

Response to Finding No. 1184:

This proposed finding mischaracterizes Ms. Guerin-Calvert's testimony. Ms. Guerin-Calvert testified that she was not sure that the hold-separate agreement gave MMO any more clout or bargaining leverage as opposed to the amount of bargaining leverage they already had over St. Luke's. (Guerin-Calvert, Tr. 7876). Ms. Guerin-Calvert did not observe any difference in bargaining power that { } had over St. Luke's as compared to over ProMedica under the hold-separate agreement. (Guerin-Calvert, Tr. 7430-7431, *in camera*).

12. Ms. Guerin-Calvert's Analysis and Criticism of the Econometric Model is Incorrect

1185. Ms. Guerin-Calvert's additions to Professor Town's willingness-to-pay model predict a statistically significant price increase of 7.3 percent. (Guerin-Calvert, Tr. 7928). This amounts to an 18 percent price increase at St. Luke's and a 5 percent increase at ProMedica's legacy hospitals. (Guerin-Calvert, Tr. 7928-7929).

Response to Finding No. 1185:

This proposed finding is inaccurate. Ms. Guerin-Calvert is estimating a price increase of 7.3 percent. (Guerin-Calvert, Tr. 7928). However, the system willingness-to-pay variable is not statistically significant. (Guerin-Calvert, Tr. 7928). This means that the price increase *is not caused* by the joinder; it is caused by something other by the joinder. (Guerin-Calvert, 7525-7526, 7537-7539).

1186. Ms. Guerin-Calvert's analysis and criticisms of the *Willingness-to-Pay* merger simulation model are invalid. (PX01850 at 005-006 (¶ 5) (Town Rebuttal Report), *in camera*).

Response to Finding No. 1186:

The proposed finding is not a fact, but an argument not supported by specific reference to the evidentiary record.

1187. Ms. Guerin-Calvert has put forward no rationale or evidence that factors not included in Professor Town's case-mix adjustment algorithm systematically bias the results. (PX01850 at 066-067 (¶ 101) (Town Rebuttal Report), *in camera*).

Response to Finding No. 1187:

This proposed finding is inaccurate. Ms. Guerin-Calvert testified as to why Professor Town's methodology is flawed, including that his fixed-effect variable does not account for the complexity in the bargaining process, that it is based on the hypothetical situations that all of the patients for MMO went to all of the hospitals in Lucas County when that is not the case, it does not account for the time period in which the contracts were negotiated, and assumes that all reimbursement rates are in equilibrium when that is not necessarily true. (*See* Guerin-Calvert, Tr. 7469-7476).

Moreover, the evidence does not support Professor Town's case-mix adjusted prices. { } (Radzialowski, Tr. 684, *in camera*; RX-129 at 000001, *in camera*, PX02148 at 145, *in camera*). However, Professor Town's case-mix-adjusted price calculations result in Mercy's prices being higher. (Town, Tr. 4181-4182). { }. (Radzialowski, Tr. 684, *in camera*; PX02148 at 145, *in camera*) { } (Town, Tr. 4183, 4185-4186).

1188. Including additional explanatory variables, such as Ms. Guerin-Calvert has done here, is a well-known means to diminish the magnitude and statistical significance of any regression result. (PX01850 at 067 (¶ 102) (Town Rebuttal Report), *in camera*).

Response to Finding No. 1188:

This proposed finding is inaccurate. The additional explanatory variables that Ms. Guerin-Calvert included are ones that are commonly included in empirical models of hospital pricing and merger simulation models like Professor Town's. (RPF 1574). When added into his model, these variables can help explain the reason for the price differences among the hospitals and show that the alleged price effect of the joinder predicted by his model may not differ from zero. (Guerin-Calvert, Tr. 7501-7504; RX-71(A) at 000078-000083, *in camera*). As Ms. Guerin-Calvert shows in her report, the sign and significance of the coefficient on system willingness-to-pay, which determines the magnitude of the price-change effects due to the joinder, decreases with the successive addition of these omitted variables. (RX-71(A) at 000079-000080, *in camera*). These results show that Professor Town's model is unreliable and not robust. (RX-71(A) at 000079-000080, *in camera*).

1189. This is because the additional variables included by Ms. Guerin-Calvert are correlated with the variable of interest but add no explanatory power that is not already captured by the variables included by Professor Town in the regression model. (PX01850 at 067 (¶ 102) (Town Rebuttal Report), *in camera*).

Response to Finding No. 1189:

This proposed finding is inaccurate. The additional explanatory variables that Ms. Guerin-Calvert included are ones that are commonly included in empirical models of hospital pricing and merger simulation models like Professor Town's. (RPF 1574). When added into his model, these variables can help explain the reason for the price differences among the hospitals and show that the alleged price effect of the joinder predicted by his model may not differ from zero. (Guerin-Calvert, Tr. 7501-7504; RX-71(A) at 000078-000083, *in camera*). As Ms. Guerin-Calvert shows in her report, the sign and significance of the coefficient on system willingness-to-pay, which determines the magnitude of the price-change effects due to the joinder, decreases with the successive addition of these omitted variables. (RX-71(A) at 000079-

000080, *in camera*). These results show that Professor Town's model is unreliable and not robust. (RX-71(A) at 000079-000080, *in camera*).

1190. The addition of redundant explanatory variables can render regression coefficient estimates highly unreliable. (PX01850 at 068-072 (¶ 104) (Town Rebuttal Report), *in camera*).

Response to Finding No. 1190:

This proposed finding is inaccurate. The additional explanatory variables that Ms. Guerin-Calvert included are ones that are commonly included in empirical models of hospital pricing and merger simulation models like Professor Town's. (RPF 1574). When added into his model, these variables can help explain the reason for the price differences among the hospitals and show that the alleged price effect of the joinder predicted by his model may not differ from zero. (Guerin-Calvert, Tr. 7501-7504; RX-71(A) at 000078-000083, *in camera*). As Ms. Guerin-Calvert shows in her report, the sign and significance of the coefficient on system willingness-to-pay, which determines the magnitude of the price-change effects due to the joinder, decreases with the successive addition of these omitted variables. (RX-71(A) at 000079-000080, *in camera*). These results show that Professor Town's model is unreliable and not robust. (RX-71(A) at 000079-000080, *in camera*).

1191. Ms. Guerin Calvert's addition of Medicare share in the *Willingness-to-Pay* merger simulation model is inappropriate. (PX01850 at 068-072 (¶ 104) (Town Rebuttal Report), *in camera*). Ms. Guerin-Calvert puts forward no rationale for including Medicare share that is consistent with the facts of this case. (PX01850 at 068-072 (¶ 104) (Town Rebuttal Report), *in camera*).

Response to Finding No. 1191:

This proposed finding is inaccurate. The percent of Medicaid and Medicare discharge variables explains that the larger the proportion of Medicaid and Medicare patients a hospital has, the more its reimbursement shortfalls may affect its need to use MCO contracts to cover these shortfalls, which may also explain prices. (Guerin-Calvert, Tr. 7515-7516). When added

into his model, these variables can help explain the reason for the price differences among the hospitals and show that the alleged price effect of the joinder predicted by his model may not differ from zero. (Guerin-Calvert, Tr. 7501-7504; RX-71(A) at 000078-000083, *in camera*). As Ms. Guerin-Calvert shows in her report, the sign and significance of the coefficient on system willingness-to-pay, which determines the magnitude of the price-change effects due to the joinder, decreases with the successive addition of these omitted variables. (RX-71(A) at 000079-000080, *in camera*). These results show that Professor Town's model is unreliable and not robust. (RX-71(A) at 000079-000080, *in camera*).

1192. The cost-shifting rationale is inconsistent with economic intuition and Ms. Guerin-Calvert's testimony. (PX01850 at 068-072 (¶ 104) (Town Rebuttal Report), *in camera*). St. Luke's has low prices, and low *Willingness-to-Pay,* and high Medicare share, while ProMedica has high prices, high *Willingness-to-Pay,* and low Medicare share. Ms. Guerin-Calvert puts forward no rationale for the negative relationship between Medicare share and prices. (PX01850 at 068-072 (¶ 104) (Town Rebuttal Report), *in camera*).

Response to Finding No. 1192:

This proposed finding is inaccurate. The share of Medicare discharges tells one that if Medicare reimbursements are important financially to a hospital. (Guerin-Calvert, Tr. 7935-7936). Hospitals must cover their costs of providing services to Medicare/Medicaid patients with their reimbursements from commercial payors. (RPF 475-479, 4829). 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). In addition, other studies have included the percent of Medicaid and Medicare discharges. (RX-71(A) at 000079, *in camera*).

1193. Including case-mix index is inappropriate because Profssor Town's prices are already case-mix adjusted. (PX01850 at 068-072 (¶ 104) (Town Rebuttal Report), *in camera*).

Response to Finding No. 1193:

This proposed finding is inaccurate. The case mix index variable accounts for the distribution of the intensity of care for the *actual* patient population at a hospital. (Guerin-Calvert, Tr. 7513-7514). Professor Town's case-mix adjusted prices are based a *hypothetical* population. (Guerin-Calvert, Tr. 7467-7468). 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). When added into his model, these variables can help explain the reason for the price differences among the hospitals and show that the alleged price effect of the joinder predicted by his model may not differ from zero. (Guerin-Calvert, Tr. 7501-7504; RX-71(A) at 000078-000083, *in camera*). As Ms. Guerin-Calvert shows in her report, the sign and significance of the coefficient on system willingness-to-pay, which determines the magnitude of the price-change effects due to the joinder, decreases with the successive addition of these omitted variables. (RX-71(A) at 000079-000080, *in camera*). These results show that Professor Town's model is unreliable and not robust. (RX-71(A) at 000079-000080, *in camera*).

1194. Including assets per bed is inappropriate. Even if one assumed that it is a reasonable proxy measure for the quality of a hospital, all hospital attributes that affect patient preferences over hospitals are already accounted for in *Willingness-to-Pay.* (PX01850 at 069 (¶ 104) (Town Rebuttal Report), *in camera*).

Response to Finding No. 1194:

This proposed finding is inaccurate. The assets per bed variable is a measure of equipment and facilities at a hospital that explains costs, and, therefore, prices. (Guerin-Calvert, Tr. 7514-7515). When added into his model, these variables can help explain the reason for the price differences among the hospitals and show that the alleged price effect of the joinder predicted by Professor Town's model may not differ from zero. (Guerin-Calvert, Tr. 7501-7504; RX-71(A) at 000078-000083, *in camera*). As Ms. Guerin-Calvert shows in her report, the sign

and significance of the coefficient on system willingness-to-pay, which determines the magnitude of the price-change effects due to the joinder, decreases with the successive addition of these omitted variables. (RX-71(A) at 000079-000080, *in camera*). These results show that Professor Town's model is unreliable and not robust. (RX-71(A) at 000079-000080, *in camera*).

1195. Including average hospital *Willingness-to-Pay* is incorrect because doing so is inconsistent with standard bargaining theory. (Town, Tr. 3903-3904). No peer-viewed, published research includes average hospital *Willingness-to-Pay*. (PX01850 at 070 (¶ 104) (Town Rebuttal Report), *in camera*).

Response to Finding No. 1195:

This proposed finding is inaccurate. 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). No previous peer-reviewed study examined hospitals systems, as are present in Lucas County. (RX-71(A) at 000213, *in camera*). However, in focusing his empirical analysis on hospital systems, Professor Town disregards relevant information about hospital quality. (RX-71(A) at 000213, *in camera*). "A natural way to account for hospital quality and isolate the effects of bargaining leverage is to control directly for average hospital willingness-to-pay per person. (RX-71(A) at 000213-000214, *in camera*). When added into his model, this variable can help explain the reason for the price differences among the hospitals and show that the alleged price effect of the joinder predicted by Professor Town's model may not differ from zero. (Guerin-Calvert, Tr. 7501-7504; RX-71(A) at 000078-000083, *in camera*).

1196. Adding correlated but unrelated variables can produce unreliable results, particularly when sample sizes are modest, as they are in hospital merger simulation models. (Town, Tr. 3886).

Response to Finding No. 1196:

This proposed finding is inaccurate. When added into his model, the omitted variables can help explain the reason for the price differences among the hospitals and show that the alleged price effect of the joinder predicted by his model may not differ from zero. (Guerin-Calvert, Tr. 7501-7504; RX-71(A) at 000078-000083, *in camera*). As Ms. Guerin-Calvert shows in her report, the sign and significance of the coefficient on system willingness-to-pay, which determines the magnitude of the price-change effects due to the joinder, decreases with the successive addition of these omitted variables. (RX-71(A) at 000079-000080, *in camera*). These results show that Professor Town's model is unreliable and not robust. (RX-71(A) at 000079-000080, *in camera*).

1197. Notably, even with the inappropriately added variables, Ms. Guerin-Calvert's analysis produces a predicted price increase that is economically significant (7.3 percent) and statistically significant at the 3.8 percent level. (RX-71(A) at 80-81 (¶ 152) (Guerin-Calvert Expert Report), *in camera*).

Response to Finding No. 1197:

This proposed finding is inaccurate. Ms. Guerin-Calvert is estimating a price increase of 7.3 percent. (Guerin-Calvert, Tr. 7928). However, the system willingness-to-pay variable is not statistically significant. (Guerin-Calvert, Tr. 7928). This means that the price increase *is not caused* by the joinder; it is caused by something other by the joinder. (Guerin-Calvert, 7525-7526, 7537-7539).

1198. Professor Town's *Willingness-to-Pay* merger simulation model appropriately accounts for the bargaining power of both the hospital and the MCO. (PX01850 at 067-068 (¶ 103) (Town Rebuttal Report), *in camera*; Town, Tr. 3885). The joint statistical significance of the bargaining power of both the hospital and the MCO is the material consideration in evaluating the precision of the predicted price effect of the merger. (Guerin-Calvert, Tr. 7930-7931).

Response to Finding No. 1198:

This proposed finding is inaccurate. The results from Professor 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). Further, Professor Town's simulation model does not take into consideration the complexity of the bargaining process because his "fixed effect" variable does not explain why there is a difference in price between hospitals. (Town, Tr. 4155; Guerin-Calvert, Tr. 7469-7471).

B. Flaws in Bruce Den Uyl's Analysis

1199. Bruce Den Uyl was retained by Respondent to present his opinions regarding the financial condition of St. Luke's leading up to the Acquisition, as well as to respond to the opinions presented by Complaint Counsel's expert, Gabriel Dagen. (RX-56 at 1 (¶ 1) (Den Uyl Expert Report), *in camera*).

Response to Finding No. 1199:

Respondent has no specific response.

1200. Mr. Den Uyl concluded that, going forward, a standalone St. Luke's faced certain "obstacles" – such as capital needs and health care reform – that it "*might* not be able to achieve." (Den Uyl, Tr. 6503-6504 (emphasis added)).

Response to Finding No. 1200:

This proposed finding is misleading. Mr. Den Uyl's testimony on the page cited by Complaint Counsel was that St. Luke's was "faced with *significant financial obstacles* as an independent hospital.... [T]hey put themselves in a *very difficult position.*" (Den Uyl, Tr. 6503-6504) (emphasis added).

1201. Mr. Den Uyl was not asked to analyze whether St. Luke's would have been insolvent or a "failing firm" absent its acquisition by ProMedica. (Den Uyl, Tr. 6519-6521). Mr. Den Uyl did not conclude that St. Luke's would be insolvent or "failing" absent the Acquisition, despite having rendered such an expert opinion in at least one prior hospital merger case. (Den Uyl, Tr. 6519-6521).

Response to Finding No. 1201:

Respondent has no specific response.

1202. Mr. Den Uyl did not analyze – and has no expert opinion regarding – how long St. Luke's could have survived as a standalone hospital had it not been acquired by

ProMedica. (Den Uyl, Tr. 6521-6522). For example, Mr. Den Uyl did not offer an expert opinion projecting St. Luke's reserve fund levels absent the Acquisition. (Den Uyl, Tr. 6588-6589, *in camera*). At the time of the Acquisition, St. Luke's had $65 million in cash and investments. (Joint Stipulations of Law and Fact, JX00002A ¶ 34).

Response to Finding No. 1202:

This proposed finding is misleading. Mr. Den Uyl did conduct a critique of Mr. Dagen's projection analysis and resultant reserve levels. (RX-56 at 000036-000044, *in camera*). The $65 million figure is misleading as it includes funds that were restricted or limited as to use. OhioCare's unrestricted reserves at the tie of the joinder were {   } million. (RX-56 at 000015-000016, *in camera*).

1203. Mr. Den Uyl also has not analyzed – and has no expert opinion on – whether St. Luke's patient volume or market share would have decreased or increased absent the Acquisition. (Den Uyl, Tr. 6533-6534).

Response to Finding No. 1203:

This proposed finding is misleading and inaccurate. Mr. Den Uyl did test and critique Mr. Dagen's assumptions about patient volume. (Den Uyl, Tr. 6532-6544; RX-56 at 000036-000044).

1204. Mr. Den Uyl did not analyze – and has no expert opinion regarding – whether St. Luke's would have been profitable absent the Acquisition, despite having concluded in at least one previous merger case that a hospital was highly unlikely to operate at a profit in the future. (Den Uyl, Tr. 6522-6523). In fact, in this case, Mr. Den Uyl acknowledged that it is "possible" that St. Luke's would have been a profitable standalone hospital absent the Acquisition. (Den Uyl, Tr. 6523-6524).

Response to Finding No. 1204:

This proposed finding is misleading and inaccurate. Mr. Den Uyl also testified that it would be unlikely that St. Luke's would have been profitable two years after the acquisition. (Den Uyl, Tr. 6523-6524). Furthermore, Mr. Den Uyl testified that St. Luke's operating and cash flow losses were not sustainable. (Den Uyl, Tr. 6434-6435).

1205. Mr. Den Uyl did not conclude that St. Luke's financial condition worsened in the months leading up to the Acquisition; to the contrary, Mr. Den Uyl testified that St. Luke's financial performance "improved" during the eight months leading up to the Acquisition. (Den Uyl, Tr. 6562).

Response to Finding No. 1205:

This proposed finding is misleading. Mr. Den Uyl testified that St. Luke's was still "running significant losses during that eight month period.... It was less of a loss, but it was still a significant loss." (Den Uyl, Tr. 6562). Also, Mr. Den Uyl's analysis of St. Luke's was not limited to the first eight months of 2010; it was conducted over the period just before Mr. Wakeman's arrival through the time of the joinder. (Den Uyl, Tr. 6416-6417). Complaint Counsel's expert agrees that 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).

1206. Mr. Den Uyl concludes in his own expert report that, during the first eight months of 2010 (prior to the Acquisition), St. Luke's "increased revenues and decreased costs." (RX-56 at 11 (¶ 30) (Den Uyl Expert Report), *in camera*; Den Uyl, Tr. 6593-6594, *in camera*). Mr. Den Uyl's expert report shows St. Luke's improving during the first eight months of 2010 across various financial metrics, including: operating income, EBITDA, and overall cost coverage ratio (*i.e.*, across all payors). (RX-56 at 6-7, 10 (Tables 1, 3, 6) (Den Uyl Expert Report), *in camera*). During trial, Mr. Den Uyl testified that St. Luke's operating income, EBITDA, and overall cost coverage ratio improved during the first eight months of 2010 compared to 2009. (Den Uyl, Tr. 6590-6591, 6603-6604, *in camera*).

Response to Finding No. 1206:

This proposed finding is misleading and out of context. In the paragraph of Mr. Den Uyl's report cited by Complaint Counsel he concluded that {

} (RX-56 at 000011, *in camera*).

With respect to EBITDA, Mr. Den Uyl concluded that {

.} (Den Uyl, Tr. 6591-6592, *in camera*).

With respect to cost coverage, Mr. Den Uyl concluded that {

.}

(Den Uyl, Tr. 6441-6442, *in camera*; RX-56 at 000010, *in camera*).

Also, Mr. Den Uyl' analysis of St. Luke's was not limited to the first eight months of 2010; it was conducted over the period just before Mr. Wakeman's arrival through the time of the joinder. (Den Uyl, Tr. 6416-6417). Complaint Counsel's expert agrees that 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).

1207. Mr. Den Uyl testified that he did not analyze Respondent's claimed efficiencies to determine whether they are cognizable under the *Merger Guidelines*, despite having performed such an analysis in prior hospital merger cases. (Den Uyl, Tr. 6515-6516). For instance, Mr. Den Uyl did not analyze whether Respondent's alleged efficiencies are merger-specific. (Den Uyl, Tr. 6515).

Response to Finding No. 1207:

Respondent has no specific response.

1. Mr. Den Uyl Exaggerates the Need for Rate Increases to Sustain St. Luke's Financial Turnaround

1208. In the eight months leading up to the Acquisition, St. Luke's had profitable contracts with all of its commercial health plans except for one, { }. (Dagen, Tr. 3239-3240, *in camera*; PX00512 at 001 (Aug. 2010 year-to-date payor cost ratio spreadsheet), *in camera*).

Response to Finding No. 1208:

This proposed finding is misleading and inaccurate. {

} (Den Uyl, Tr. 6441-6442, *in camera*; RX-56 at 000010, *in camera*). 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).

1209. During those eight months, contracts with all payors – including { } and government programs such as Medicare and Medicaid – reimbursed St. Luke's enough to cover all direct costs of treating patients. (PX01951 at 039-040 (Den Uyl, Dep. at 150-154), *in camera*; Dagen, Tr. 3239-3241, *in camera*; PX00512 at 001 (Aug. 2010 year-to-date payor cost ratio spreadsheet), *in camera*).

Response to Finding No. 1209:

This proposed finding is misleading and inaccurate. {

} (Den Uyl, Tr. 6441-6442, *in camera*; RX-56 at 000010, *in camera*). In addition, 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).

1210. By the last four months of 2010, St. Luke's was earning a profit when treating patients for every commercial health plan, including { }. (Den Uyl, Tr. 6598-6000, *in camera*; PX01852 at 018-019 (¶ 27) (Dagen Rebuttal Report); PX00513 (Sept. through Dec. 2010 payor cost ratio spreadsheet), *in camera*).

Response to Finding No. 1210:

Den Uyl, Tr. 6550). ERISA law grants St. Luke's until 2016 to get its pension plan back to a 100% funding level. (Arjani, Tr. 6764, *in camera*).

Response to Finding No. 1220:

Complaint Counsel's proposed finding is inaccurate and misleading. St. Luke's pension plan has not been *certified* as being less than 80 percent funded, but this fact is only because St. Luke's has allocated { } over the past three years to assure the fund could get above the 80 percent threshold. (RPF 1676-1677, 1682, *in camera*; PX01602 at 007, 015, *in camera*; Arjani, Tr. 6741). Even Complaint Counsel's expert acknowledges that the fund has dropped below 80 percent in its actual funding level prior to certifications. (PX02147 at 024).

Complaint Counsel further misleadingly suggest that there is no concern for a pension fund until it is deemed "at risk" according to ERISA rules. A pension plan does not need to be deemed "at risk" for the plan's sponsor to face cash funding requirements. The "at risk" determination is an ERISA term of art that relates to *additional* obligations *above and beyond* the cash funding requirements that every underfunded plan faces regardless of the degree of underfunding. (RPF 1663-1664, 1669, *in camera*). St. Luke's does have seven years to restore its pension plan to full funding, but during those seven years must make contributions of { }. (RPF 1664, 1685, *in camera*). This figure is based upon an { }, which Mr. Arjani { }. (RPF 1685, *in camera*; Arjani, Tr. 6765, *in camera*). Complaint Counsel's own expert's analysis reveal that after the relatively more mild recession of 2000-2001, St. Luke's was unable to reach full funding within seven years. (PX02147 at 024).

1221. Mr. Den Uyl acknowledged that St. Luke's has never missed or been late on a payment to a pension recipient. (Den Uyl, Tr. 6551). And Mr. Den Uyl did not conclude that St.

Luke's would have failed to make payments to pensioners absent the Acquisition. (Den Uyl, Tr 6551-6552). According to Mr. Dagen's analysis, St. Luke's has sufficient funds in its pension plan today to cover its payout obligations for many years into the future. (Dagen, Tr. 3165; PX02147 at 023-024 (¶ 45) (Dagen Expert Report).

Response to Finding No. 1221:

Complaint Counsel's proposed finding is inaccurate and misleading. The ability to make current payments to plan beneficiaries has no effect on the obligation to restore the plan to full funding. (RPF 1665). St. Luke's is still obligated to restore the pension plan to full funding by 2016, which will require annual cash contributions of { }. (RPF 1685, *in camera*). This figure is based upon an { }, which Mr. Arjani { }. (RPF 1685, *in camera*; Arjani, Tr. 6765, *in camera*). Benefit payments to plan beneficiaries *do* reduce the assets in the pension fund and, thus, have an impact on the calculation of the funded status of the fund. (RX-214 at 000011, *in camera*). Mr. Dagen's analysis misrepresents the impact of future payments to plan beneficiaries. (PX02147 at 023-024). Annual benefit payments to St. Luke's plan beneficiaries are { }. (PX02391 at 001, *in camera*; PX02392 at 001, *in camera*). Mr. Dagen was in possession of this information. (PX02147 at 024 n. 57). Although Mr. Dagen acknowledged payments increase annually, he focused his analysis backwards over the past ten years, which dramatically understates the impact benefit payments will have on the plan's assets in the coming years. (*Compare* PX02147 at 024 *with* PX02392 at 001, *in camera*). Mr. Dagen based his flawed analysis on an annual payment of $3.6 million, the maximum benefit payment St. Luke's had experienced within the last ten years. (PX02147 at 024). St. Luke's annual benefit payments will { }. (PX02392 at 001, *in camera*).

1222. Mr. Den Uyl's analysis of St. Luke's pension fund ends at August 31, 2010. (RX-56 at 11-13 (¶¶ 31-34) (Den Uyl Expert Report), *in camera*). However, within just four

months of the Acquisition's closing, St. Luke's pension liability improved by almost { } – having decreased from approximately { } to { } – almost exclusively as the result of financial market performance. (PX02363 at 001 (Jan. 31, 2011 Financial Statement Disclosures as of Dec. 31, 2010), *in camera*; PX02369 at 001 (Findley Davies' Pension Update), *in camera*; Arjani, Tr. 6755, *in camera*; PX01943 at 027 (Arjani, Dep. at 101-102), *in camera*; *see also* PX01852 at 016 (¶¶ 24) (Dagen Rebuttal Report)).

Response to Finding No. 1222:

Complaint Counsel's proposed finding is inconsistent. Complaint Counsel suggest in CCPF 1217 and 1218 that the pension liability shown on financial statements is not an accurate measure of the costs of the pension underfunding to St. Luke's yet here suggest that the improvement in that liability is beneficial to St. Luke's.

Complaint Counsel's proposed finding is also inaccurate and misleading. Complaint Counsel misrepresent witness testimony and documentary evidence. The improvement in St. Luke's pension liability was not due almost exclusively to market performance. Plan assets did increase in 2010, but the improvement in the fair value of plan assets for the entire year was only { }. (RX-214 at 000011, *in camera*). A substantial part of this increase came from { }; St. Luke's contributed { } in cash, as Mr. Arjani noted generally in his testimony. (Arjani, Tr. 6755, *in camera* ({ }; RX-214 at 000011, *in camera*).

Complaint Counsel misleadingly focus on the gains in late 2010, but ignore the results of the prior eight months as well as the overall results for the year. Mr. Arjani noted that the { } was unusually strong. (Arjani, Tr. 6755, *in camera*). The { }, however, had been { } for the plan's performance. (Arjani, Tr. 6745, *in camera*). Between January 1 and August 31, the plan had obtained a total return of only approximately { }. (RX-214 at 000008, *in camera*). The projected return was for that period was approximately { }, leading to a { }. (Arjani,

Tr. 4745, *in camera*; RX-214 at 000009, *in camera*). The improvement in the last trimester helped, but the plan's return on assets still finished the year {

}. (RX-214 at 000012, *in camera*). The return on assets did not even match the performance obtained in 2009. (RX-214 at 000011, *in camera*). Mr. Arjani feared that performance in 2011 would { } either. (Arjani, Tr. 6755, *in camera*). Finally, Complaint Counsel, who have focused on ERISA calculations as the true measure of the pension plan's health, ignore the fact that, in spite of the end-of-year growth in 2010, St. Luke's { } to assure that the pension plan would be {

} at the end of the 2010 plan year. (RPF 1682, *in camera*). In other words, not even the growth cited by Complaint Counsel was sufficient to keep St. Luke's plan from being under 80 percent funding according to ERISA measures. Moreover, the growth cited by Complaint Counsel does not alter the level of annual required cash contribution that Respondent has reported. The annual required cash contributions were calculated by St. Luke's actuaries after the 2010 year closed and have already accounted for the end-of-year growth. (RPF 1680-1682, *in camera*). St. Luke's still faces a { }. (RPF 1685, *in camera*).

4. Mr. Den Uyl's Alternative Pro Forma is Based on Unfounded Assumptions

1223. In presenting his own version of a pro forma of a standalone St. Luke's financial performance from 2011 to 2013, Mr. Den Uyl makes several changes to the assumptions that Mr. Dagen has used in his own model. However, Mr. Den Uyl testified that he is not presenting his alternative projections of a standalone St. Luke's as what would actually have happened absent the Acquisition. (Den Uyl, Tr. 6585-6587, *in camera*).

Response to Finding No. 1223:

This proposed finding is misleading. Mr. Den Uyl was asked to analyze and respond to Mr. Dagen's opinions, including his analysis and projections. Mr. Den Uyl found that "several

of the assumptions Mr. Dagen relied upon in his analysis are flawed, rendering his conclusions unreliable." (RX-56 at 00036, *in camera*). Mr. Den Uyl's substitution of more realistic assumptions in Mr. Dagen's model concretely illustrates its flaws. (RX-56 at 000042-000043, *in camera*).

1224. Although his alternate pro forma shows end-of-year reserve fund levels for each year from 2011 to 2013, Mr. Den Uyl has not offered the expert opinion that these reserve fund levels were the likely outcome for St. Luke's absent the Acquisition. (Den Uyl, Tr. 6588-6589, *in camera*; PX01951 at 070 (Den Uyl, Dep. at 274), *in camera*).

Response to Finding No. 1224:

This proposed finding is misleading. Mr. Den Uyl was asked to analyze and respond to Mr. Dagen's opinions, including his analysis and projections. (RX-56 at 000001, *in camera*). Mr. Den Uyl found that "several of the assumptions Mr. Dagen relied upon in his analysis are flawed, rendering his conclusions unreliable." (RX-56 at 000036, *in camera*). Mr. Den Uyl's substitution of more realistic assumptions in Mr. Dagen's model and the resultant reserve levels concretely illustrate its flaws. (RX-56 at 000042-000043, *in camera*).

1225. Although his pro forma shows St. Luke's depleting its reserve fund by 2012, Mr. Den Uyl testified that he has not concluded that St. Luke's reserve fund was, in fact, likely to be depleted by 2012 – or even 2013 – absent the Acquisition. (Den Uyl, Tr. 6588-6589, *in camera*).

Response to Finding No. 1225:

This proposed finding is misleading. Mr. Den Uyl was asked to analyze and respond to Mr. Dagen's opinions, including his analysis and projections. (RX-56 at 000001, *in camera*). Mr. Den Uyl found that "several of the assumptions Mr. Dagen relied upon in his analysis are flawed, rendering his conclusions unreliable." (RX-56 at 000036, *in camera*). Mr. Den Uyl's substitution of more realistic assumptions in Mr. Dagen's model and the resultant reserve levels concretely illustrate its flaws. (Den Uyl, Tr. 6588-6589, *in camera*; RX-56 at 000042-000043, *in camera*).

1226. Mr. Den Uyl's alternate pro forma is unreliable because it is based on assumptions that lack foundation in the factual record. (PX01852 at 019-022 (¶¶ 28-32) (Dagen Rebuttal Report)). For instance, at the time of the Acquisition, St. Luke's had $65 million in cash and investments, which grew to at least $70 million by the end of 2010. (Joint Stipulations of Law and Fact, JX00002A ¶¶ 34-35). Mr. Den Uyl's model, however, shows St. Luke's depleting its reserve fund as early as 2012, despite the fact that he could not identify a single ordinary course document that projected such a scenario. (Den Uyl, Tr. 6587, *in camera*).

Response to Finding No. 1226:

This proposed finding is misleading and inaccurate.

First, the figures used by Complaint Counsel for this proposed finding are misleading because they incorporate restricted funds which were not available for capital expenditures and include the effects of the joinder. (RX-56 at 000015-000016, 000038, 000042, *in camera*).

Second, St. Luke's did not conduct an analysis like the one conducted by Mr. Dagen and critiqued by Mr. Den Uyl, so there were no ordinary course documents that showed such projections for St. Luke's. (Den Uyl, Tr. 6587).

1227. Further, Mr. Den Uyl's results directly contradict the ordinary course analysis of St. Luke's CEO, Daniel Wakeman, who at the end of 2009 believed St. Luke's could have survived as a standalone hospital for at least another three to five years – and even longer if the financial markets improved and St. Luke's attained positive operating cash flow. (Wakeman, Tr. 2625; *see also* PX01852 at 020 (¶ 28) (Dagen Rebuttal Report) (indicating that, indeed, St. Luke's financial performance did improve significantly from the time that Mr. Wakeman made his late 2009 projections); *see also* PX02147 at 026 (¶ 48) (Dagen Expert Report) (broad market rally from Aug. 31, 2010 through Dec. 31, 2010)).

Response to Finding No. 1227:

This proposed finding is inaccurate and misleading. Mr. Wakeman testified that St. Luke's might be able to keep its doors open for {

}. (PX01920 (Wakeman, Dep. at 141-143)); Mr. Wagner, as St. Luke's acting CFO, testified that St. Luke's could continue as an independent hospital for { }. (PX01915 (Wagner, IHT at 211), *in camera*). In any case, Mr. Wakeman's testimony predicts that St.

This proposed finding is inaccurate. First, as discussed in the response to finding to 1235 above, Mr. Den Uyl does rely on ordinary course documents in addition to testimony of St. Luke's executives, financial and IT professionals as well as St. Luke's historical capital expenditures, all of which Mr. Dagen disregards. (RX-56 at 000024, 000060, *in camera*). Second, the ordinary course documents on which Mr. Dagen relies were created after the joinder and do not reflect the total cash needs of St. Luke's on a stand-alone basis. (PX01494, *in camera*, PX00396, *in camera*).

XVIII. REMEDY

A. Divestiture is the Proper Remedy and Will Restore Competition

1237. Prior to the Acquisition, ProMedica and St. Luke's competed vigorously against each another, particularly in southwest Lucas County. (Town, Tr. 3596; PX02148 at 054-055, 076 (¶¶ 95, 136) (Town Expert Report), *in camera*; *See supra* Section X). This competition resulted in lower healthcare costs, higher quality, and greater choice for Lucas County residents. (PX02148 at 084-088 (¶¶ 155-161) (Town Expert Report), *in camera*; *See supra* Sections XI-XIII). Even ProMedica's CEO acknowledges that competition between hospitals benefits the local community by resulting in enhanced customer service, higher quality care, better access for patients, and improved facilities. (Oostra, Tr. 6039).

Response to Finding No. 1237:

This proposed finding is misleading to the extent that it suggests that ProMedica and St. Luke's were each other's closest competitors. Mercy and ProMedica were and remain each other's closest competitors. (*See* RPF III.B.)

1238. The Acquisition eliminates these benefits of competition and creates anticompetitive harm for consumers in the form of increased healthcare costs, reduced choice, lower clinical quality, and diminished quality of patient experience. (Town, Tr. 3600-3601, 3605-3606; PX02148 at 058-059 (¶ 104) (Town Expert Report), *in camera*).

Response to Finding No. 1238:

Professor Town has not and cannot cite any evidence that post-joinder there has been a reduction in non-price competition. (RPF 1606). Nor has Professor Town attempted to quantify

his statement that quality-promoting, non-price competition will be eliminated as a result of the joinder or examined any evidence of adverse patient outcomes, either now or in the future, as a result of the joinder. (RPF 1607-1608). Moreover, to the extent this finding relies on the results of Professor Town's econometric analysis, Respondent's reply is more thoroughly explained in its response to Complaint Counsel's proposed findings numbered 457-467. (*See also* RPF III.I.3).

1239. A complete divestiture of St. Luke's by ProMedica is required in order to restore these benefits and the competition eliminated by the Acquisition. (*See* Complaint Counsel's Proposed Order at Part II, Section O and Complaint Counsel's Proposed Conclusions of Law at XX.I.).

Response to Finding No. 1239:

The proposed finding is not a fact, but an improper legal argument. It also violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record. To the extent Complaint Counsel reference other portions of their findings, Respondent will address those findings there.

B. Divestiture Is Straightforward Because the FTC's Hold Separate Agreement Maintained St. Luke's as a Viable Hospital

1240. ProMedica entered into a Hold Separate Agreement with the FTC prior to the consummation of the transaction. (PX00069 at 001 (Hold Separate Agreement)). Under the preliminary injunction order of U.S. District Judge David A. Katz, ProMedica must continue "to abide by [the] terms of the current Hold Separate Agreement until either (1) the completion of all legal proceedings by the Commission challenging the Acquisition, including all appeals, or (2) further order of the Court, including upon the request of the Commission before completion of such legal proceedings." (*Federal Trade Commission v. ProMedica Health System, Inc.*, 2011 U.S. Dist. LEXIS 33434 at *41; 2011-1 Trade Cas. (CCH) P77,395).

Response to Finding No. 1240:

Respondent has no specific response.

1241. Due to the Hold Separate Agreement, St. Luke's has remained a viable entity that can be relatively easily divested from ProMedica. The Hold Separate Agreement requires ProMedica to "maintain the viability, competitiveness, and marketability of St. Luke's."

(PX00069 at 001 (Hold Separate Agreement)). The Hold Separate Agreement accomplishes this requirement by prohibiting ProMedica from:

a. eliminating, transferring, or consolidating "any clinical service that is offered at St. Luke's on the day before the Acquisition is consummated" (PX00069 at 001);

b. terminating any St. Luke's employees (except "for cause consistent with the procedures in place at St. Luke's on the day before the Acquisition") (PX00069 at 001);

c. modifying, changing, or cancelling any physician privileges at St. Luke's in place on the day before the Acquisition (however "ProMedica may revoke the privileges of any individual physician consistent with the practices and procedures in place at St. Luke's on the day before the Acquisition") (PX00069 at 001); or

d. terminating, or causing or allowing termination of any contract between a health plan and St. Luke's (PX00069 at 001).

Response to Finding No. 1241:

Complaint Counsel's proposed finding that St. Luke's can be relatively easily divested from ProMedica violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record and is unsupported by the cited facts. Respondent has no specific response as to the remaining findings in this paragraph.

1242. If a health plan's contract with St. Luke's expires during the term of the Hold Separate Agreement, ProMedica must offer to "continue to accept the same terms of the contract for the remaining term" of the Hold Separate Agreement. (PX00069 at 001 (Hold Separate Agreement)). Ronald Wachsman, ProMedica's Senior Vice President of Managed Care, Reimbursement, and Revenue Cycle Management, confirmed that ProMedica has complied with this provision. (Wachsman, Tr. 5074, *in camera*). This provision gives health plans additional leverage in negotiating St. Luke's rates with ProMedica that health plans would not have had otherwise. (Town, Tr. 3857, 4370-4371, 4474).

Response to Finding No. 1242:

Respondent agrees that the Hold Separate requires ProMedica to offer to "continue to accept the same terms of the contract for the remaining term" of the Hold Separate Agreement. (PX00069 at 001). Despite being aware of this provision, two MCOs negotiated new contracts

with ProMedica for St. Luke's. (RPF 1380-1381, *in camera*, 1388, 1397, *in camera*, 1400-1401, *in camera*).

1243. The Hold Separate Agreement maintains St. Luke's viability by requiring ProMedica to "provide sufficient working capital to operate St. Luke's at its current rate of operation." (PX00069 at 001 (Hold Separate Agreement)).

Response to Finding No. 1243:

Respondent has no specific response.

C. Divestiture Is Straightforward Because St. Luke's Has Not Significantly Integrated with ProMedica

1244. Although St. Luke's intended to implement an electronic medical record ("EMR") system on its own in 2010, the plan was put on hold due to the Acquisition. (Johnston, Tr. 5484, *in camera*). By July 2011, ProMedica and St. Luke's had only developed a time line describing what steps were needed to achieve the government's meaningful use requirements for EMR, but no actual implementation had occurred. (Johnston, Tr. 5380-5381)

Response to Finding No. 1244:

While St. Luke's may have "intended" to implement an EMR system in 2010, Ms. Johnston further testified that {

} making it impossible for St. Luke's to have *actually* implemented an EMR system in 2010. (Johnston, Tr. 5481-5483, *in camera*; *see also* RPF 1724-1726, 1727, *in camera*, 1728, 1729, *in camera*, 1733-1737). Complaint Counsel's second statement is contradicted by the facts in evidence. Ms. Johnston testified that St. Luke's has "done the implementation of several of the components to getting [to the meaningful use requirement] and we're getting ready to kick off the implementation teams for the actual clinical documentation and medical – medical administration and bar-coding systems and will be putting a team together [] to start the actual implementation work for that – the next big component that we're working on right now." (Johnston, Tr. 5381).

1245. Although ProMedica commissioned an architect to provide final St. Luke's facility renovation plans, there is no evidence that this renovation has occurred. (Johnston, Tr. 5372).

Response to Finding No. 1245:

Respondent has no specific response.

1246. After receiving FTC approval, ProMedica removed St. Luke's Inpatient Rehabilitation Center and consolidated inpatient rehabilitation services at Flower. (Oostra, Tr. 5907-5908, *in camera*). ProMedica replaced St. Luke's vacant inpatient rehabilitation space with medical-surgical beds and private rooms. (Hanley, Tr. 4681, 4814, *in camera*; Johnston, Tr. 5374).

Response to Finding No. 1246:

Respondent has no specific response.

1247. Despite testimony from Lori Johnston, St. Luke's CFO/COO, that ProMedica has initiated a project to add 17 more private rooms to St. Luke's (Johnston, Tr. 5376-5377), ProMedica's CEO testified that ProMedica is "making no investment at St. Luke's at this point for private rooms," absent the small number of private rooms created in St. Luke's former inpatient rehabilitation space. (Oostra, Tr. 5907, *in camera*).

Response to Finding No. 1247:

Respondent has no specific response.

D. Anticompetitive Harm Will Result if No Divestiture or Remedy

1. ProMedica Plans to Increase Hospital Reimbursement Rates

1248. Under the Agreement, ProMedica has taken over the management and negotiation of St. Luke's contracts with health plans. (Oostra, Tr. 6134-6135; Wachsman, Tr. 5095-5096; PX00058 at 058 (Joinder Agreement, Ex. 9).

Response to Finding No. 1248:

Respondent has no specific response.

1249. The Acquisition has eliminated significant, beneficial competition. As a result, health plans, employers, and St. Luke's Board and executives expect ProMedica to increase St. Luke's rates significantly. (*See supra* Section XI.A. If St. Luke's rates increase to the rates at ProMedica's hospitals, as health plans expect, this would represent a rate increase of more than 70 percent, on average. (PX02148 at 037 (¶ 68) (Town Expert Report), *in camera* (stating that ProMedica's prices were { } percent higher than St. Luke's);

PX02125 at 027 (Town, Decl., Ex. 4, *in camera*) (severity adjusted price differential between ProMedica and St. Luke's)).

Response to Finding No. 1249:

Complaint Counsel's first statement is not a fact, but an improper legal argument. Complaint Counsel's first and second statements violate the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record. To the extent that Complaint Counsel reference other portions of their findings, Respondent will address those findings there. Furthermore, the remaining finding is duplicative of its finding numbered 429. Respondent has addressed finding number 429 there.

1250. Without a divestiture, Lucas County employers and their employees will suffer substantial, immediate, and irreversible harm from higher healthcare-insurance prices, as ProMedica plans to raise St. Luke's rates as soon as possible. (Wachsman, Tr. 5083, *in camera*; PX01927 at 022-023 (Wachsman, Dep. at 82-83, 85-87), *in camera*).

Response to Finding No. 1250:

The evidence that Complaint Counsel cites states only that ProMedica intends to try to renegotiate MCO contracts {

}

for St. Luke's. (Wachsman, Tr. 5083-5084, *in camera*; PX01927 (Wachsman, Dep. at 82-83, 85-87), *in camera*). The remaining statements constitute improper legal argument and also violate the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record.

1251. Ultimately, higher healthcare costs will be borne by Lucas County residents, many of whom already are struggling financially. (*See supra* Section XII). In response, some Lucas County employers may reduce healthcare benefits for their employees, and some insured employees may forgo medical treatment due to higher out-of-pocket expenses. (*See supra* Section XII).

Response to Finding No. 1251:

The proposed finding violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record. To the extent Complaint Counsel reference other portions of their findings, Respondent will address those findings there.

2. The Joinder Agreement Does Not Maintain the Competitive Viability of St. Luke's as an Independent Hospital

1252. In addition to the significant harm that will result from ProMedica's ownership of a once-vibrant rival, it is uncertain that ProMedica will preserve St. Luke's as a stand-alone, full-service general acute-care hospital. Under Section 7.1 of the Joinder Agreement ("Agreement"), ProMedica is only obligated to retain six specified service categories at St. Luke's. (PX00058 at 023 (Joinder Agreement § 7.1) (the covered service categories are: emergency room, ambulatory surgery, inpatient surgery, obstetrics, inpatient nursing, and a CLIA-certified laboratory)). Even for these basic service categories, the Agreement does not include minimum operational or quality standards.

Response to Finding No. 1252:

Respondent does not dispute Complaint Counsel's statement that the Joinder Agreement obligates ProMedica to retain emergency room, ambulatory surgery, inpatient surgery, obstetrics, inpatient nursing, and a CLIA-certified laboratory services at St. Luke's and that the Joinder Agreement does not include minimum operational or quality standards. The remaining statements, however, constitute improper legal argument and also violate the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record. Further, no evidence exists to suggest that ProMedica has any plans to eliminate St. Luke's as a quality stand-alone, full-service general acute-care hospital.

1253. ProMedica's CEO, Randall Oostra, confirmed that any services not listed in Section 7.1 of the Agreement are not protected from being transferred or eliminated from St. Luke's. (Oostra, Tr. 6136). ProMedica's CEO also affirmed that ProMedica could choose to eliminate or transfer these services from St. Luke's to another ProMedica hospital. (Oostra, Tr. 6138).

Response to Finding No. 1253:

Mr. Oostra confirmed that the Joinder Agreement terms are accurate and further stated that ProMedica would work with St. Luke's board with respect to any service changes. (Oostra, Tr. 6139).

1254. ProMedica faces no obligation whatsoever to preserve critical services at St. Luke's such as oncology, cardiology, orthopedics, radiology and imaging, spinal neurosurgery, pediatrics, and diabetes care, among others. (Oostra, Tr. 6136-6138; *compare* PX00058 at 023 (Joinder Agreement § 7.1) *with* PX02102 at 002 (Wakeman, Decl. ¶ 5) (listing current services); RX-51 at 40 (Wakeman, Dep. at 152-153), *in camera*; *see also* PX00396 at 002-003 (Navigant Consulting, Clinical Integration Strategy: Executive Summary, Jan. 11, 2011), *in camera* (seven areas analyzed for potential consolidation or "reconfiguration.")).

Response to Finding No. 1254:

Respondent has no specific response.

1255. ProMedica is explicitly examining what services can be changed at its hospitals, including St. Luke's. (Oostra, Tr. 6139; PX00396 at 002-003 (Navigant Consulting, Clinical Integration Strategy: Executive Summary, Jan. 11, 2011), *in camera* (seven areas analyzed for potential consolidation or "reconfiguration.")). ProMedica hired Navigant Consulting to study the "rationalization of services" at ProMedica's hospitals, including St. Luke's. (Oostra, Tr. 6139).

Response to Finding No. 1255:

Respondent has no specific response.

1256. If, for example, ProMedica were to discontinue open-heart surgery at St. Luke's (which is permissible under the Agreement), this could undermine the overall viability of St. Luke's Heart Center and its interventional cardiology program. (*see* Gbur, Tr. 3112-3113 (local cardiologist concerned that if St. Luke's open heart program is removed it will affect his ability to do cardiac interventions at St. Luke's)).

Response to Finding No. 1256:

Complaint Counsel's citation to Dr. Gbur's testimony does not support its proposed finding. Dr. Gbur testified that he was worried that, if the open heart program went away, that it affects his ability to do interventions there. He did not testify about the viability of St. Luke's Heart Center or its interventional cardiology program. (Gbur, Tr. 3112-3113). Nor could he. Complaint Counsel has not established that Dr. Gbur has the foundation to so testify. (*See also*

Nolan, Tr. 6342, *in camera* (stating that TTH has one of the lowest heart attack mortality rates while St. Luke's mortality rates are double TTH's rates or higher)).

1257. ProMedica can amend the Agreement with approval from St. Luke's Board, which is subject to the exercise of ProMedica's reserve powers. (Oostra, Tr. 6133-6134; PX00058 at 051-052 (Joinder Agreement § 17.3).

Response to Finding No. 1257:

The cited evidence does not support Complaint Counsel's proposed finding. The Joinder Agreement states as follows: "Except as otherwise provided in this Agreement, no amendment of any provision of this Agreement shall be effective unless the same shall be in writing and signed by the Parties…." (PX00058 at 051 at 052). Mr. Oostra's testimony does not state that the St. Luke's Board is subject to the exercise of ProMedica's reserve powers.

1258. ProMedica already has considerable control over St. Luke's Board. ProMedica has the power to approve all nominations to the St. Luke's Hospital Board and St. Luke's Foundation Board. (Oostra, Tr. 6132). ProMedica has the power to remove any St. Luke's trustee from the board with or without cause. (Oostra, Tr. 6132). After an initial term, ProMedica can appoint any board member to St. Luke's board. (Oostra, Tr. 6132). ProMedica has the power to authorize and approve amendments to St. Luke's governing documents, including St. Luke's articles of incorporation and bylaws. (Oostra, Tr. 6132-6133).

Response to Finding No. 1258:

The Joinder Agreement provides that

> The [St. Luke's] board of directors shall consist of twenty-five (25) persons. [ProMedica] shall have the right to appoint *two (2) members* of the board of directors of [St. Luke's] (the "PHS Hospital Appointees") and, consistent with the [ProMedica] Reserve Powers, shall have the right to approve all individuals nominated by [St. Luke's] for appointment to the [St. Luke's] board (collectively, the "SLH Hospital Appointees"), *which approval shall not be unreasonably withheld.*

(PX00141 at 001 (emphasis added)). Complaint Counsel's statement that ProMedica has considerable control over St. Luke's Board is an unsupported conclusion and violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record.

1259. ProMedica also has significant power over St. Luke's financial decisions. ProMedica has the power to authorize and approve all nonbudgeted operating and capital expenditures of St. Luke's above half a million dollars. (Oostra, Tr. 6133). ProMedica has the power to authorize and approve any incurrence of debt at St. Luke's. (Oostra, Tr. 6133).

Response to Finding No. 1259:

Complaint Counsel's statement that ProMedica has significant power over St. Luke's financial decisions is an unsupported conclusion and violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record.

3. ProMedica Plans to Close and Consolidate Hospital Services and to Reduce Staffing at St. Luke's

1260. Gary Akenberger – ProMedica's Senior Vice President of Finance and the lead individual responsible for the financial analysis, substantiation, and verification of Respondent's alleged efficiencies – indicated in his affidavit that Respondent intends to close services lines and reduce staffing at St. Luke's. (*See, e.g.*, PX02104 at 005-007 (¶¶ 9-10, 13) (Akenberger, Decl.), *in camera*; PX01931 at 025-026, 034 (Akenberger, Dep. at 93, 100, 131), *in camera*).

Response to Finding No. 1260:

One of the service lines that Mr. Akenberger discussed is the consolidation of {

}, which Complaint Counsel explicitly approved. (RPF 2230, *in camera*). Mr. Akenberger further testified that ProMedica anticipated that it would be able to

{

} (PX02104 at 007-008, *in camera*).

1261. The Compass Lexecon report initially identified several of St. Luke's service lines as candidates for consolidation, including heart/vascular, orthopedics, women's obstetrics and gynecology (OB/GYN), neuro/stroke, cancer, and pulmonary services. (PX00020 at 013 (Compass Lexecon Report), *in camera*). ProMedica then hired Navigant specifically to determine which services to transfer or consolidate. (PX00222 at 002 (Navigant Service Line and Clinical Integration Report), *in camera*; *see also* PX01912 at 033, 043 (Akenberger, IHT at 122-125, 162-164), *in camera*).

Response to Finding No. 1261:

Respondent has no specific response.

1262. In January 2011, Navigant analyzed seven service lines for consolidation, including open-heart surgery, and it also looked at integration opportunities in psychiatry and rehabilitation services. (PX01946 at 016 (Nolan, Dep. at 56-57); PX00396 at 003, 008-010 (Navigant Consulting, Clinical Integration Strategy: Executive Summary, Jan. 11, 2011), *in camera* (the seven service lines were cancer, heart and vascular, neurosciences, orthopedics, women's (obstetrics and gynecology), pediatrics, and gastroenterology/urology)).

Response to Finding No. 1262:

Respondent has no specific response.

1263. Navigant recommended that ProMedica remove complex vascular and open-heart surgery, inpatient rehabilitation services, and inpatient psychiatry services from St. Luke's and consolidate them at other ProMedica hospitals. (Nolan, Tr. 6302-6303, 6328, *in camera*).

Response to Finding No. 1263:

Respondent has no specific response.

1264. Navigant also recommended that all of St. Luke's pediatric patients who require hospitalization should be transferred to Toledo Children's Hospital. (Nolan, Tr. 6299, *in camera*).

Response to Finding No. 1264:

Respondent has no specific response.

1265. ProMedica has already closed St. Luke's inpatient rehabilitation center and consolidated these services at Flower Hospital. (Oostra, Tr. 5907-5908, *in camera*). This has resulted in fewer, less convenient inpatient rehabilitation options for St. Luke's rehabilitation patients. (Andreshak, Tr. 1797-1799).

Response to Finding No. 1265:

Complaint Counsel explicitly approved the consolidation of {

} (RPF 2230, *in camera*). Furthermore, Dr. Andreshak did not testify that the consolidation resulted in "less convenient" options for patients. (Andreshak, Tr. 1797-1799).

1266. Assuming that Flower has higher average rates for inpatient rehabilitation services than St. Luke's, a health plan, employer, or self-pay patient will pay more to receive these

services after the inpatient rehabilitation consolidation. (Hanley, Tr. 4739-4740, *in camera*).

Response to Finding No. 1266:

Respondent has no specific response.

1267. In the recent past, ProMedica has closed service lines at its legacy hospitals. (Oostra, Tr. 6138 (ProMedica's CEO acknowledged that ProMedica closed obstetrical services at its hospital in Tecumseh, Michigan)).

Response to Finding No. 1267:

Decisions to close service lines at ProMedica hospitals were made by those hospital's local boards. (Oostra, Tr. 6138).

1268. The same process of service consolidation took place at Flower following its acquisition by ProMedica in the mid-1990s. ProMedica's CFO, Kathleen Hanley, testified that Flower had a significant number of redundant practices, and ProMedica consolidated service lines and department heads. (PX01903 at 045 (Hanley, IHT at 172), *in camera*).

Response to Finding No. 1268:

Respondent has no specific response.

1269. ProMedica also plans to reduce staffing at St. Luke's. Compass Lexecon's report indicates that ProMedica plans to lower St. Luke's overall staffing levels to those of Flower Hospital. (PX00020 at 015 (Compass Lexecon Report), *in camera*). The Agreement does not prevent ProMedica from immediately reducing the number of St. Luke's employees.

Response to Finding No. 1269:

Mr. Akenberger testified that ProMedica anticipated that it would be able to {

} (PX02104 at 007-008, *in camera*).

1270. St. Luke's has a strong reputation for quality and patient care in the community. (Wakeman, Tr. 2477-2478). ProMedica's CEO agreed that prior to the Acquisition, St. Luke's was a patient-centered hospital and "maintained a real strong patient focus." (Oostra, Tr. 6028). St. Luke's ranks highly in quality and patient satisfaction scores, and patient satisfaction levels at St. Luke's have increased further, relative to last year. (RX-

51 at 6, 24 (Wakeman, Dep. at 16-17, 89), *in camera*; PX00390 at 001 (May 2010 ProMedica Press Release); PX01072 at 001 (Key Messages from St. Luke's)).

Response to Finding No. 1270:

In the beginning of 2009, other hospitals in Toledo were quickly catching up to St. Luke's quality and service levels. (RPF 1461). When St. Luke's entered ProMedica's system, {

} (RX-1738, *in camera*, RX-1739, *in camera*).

1271. Despite St. Luke's rapid growth in patient volume in 2010, patient satisfaction and quality were unaffected and remained at very high levels. (Wakeman, Tr. 2495-2498; Black, Tr. 5685, 5690).

Response to Finding No. 1271:

Mr. Wakeman acknowledged that {

} (RPF 1462-1464, *in camera*; *see also* RPF 1465-1472, 1473, *in camera*).

1272. Providing uninterrupted, high-quality patient care and patient safety were the precise reasons that St. Luke's chose not to lay off employees and in fact *continued hiring* over the past two years. (RX-51 at 8-9 (Wakeman, Dep. at 22-27), *in camera*; *see also* PX01274 at 001 (Wakeman e-mail), *in camera*).

Response to Finding No. 1272:

Respondent has no specific response.

1273. ProMedica's Chief Financial Officer testified that ProMedica "continually look[s] for opportunities to downsize or right-size programs and services." (Hanley, Tr. 4798, *in camera*). In fact, during the recent economic downturn, ProMedica laid off employees, closed its daycare center, and eliminated services that it previously offered to Toledo residents. (Oostra, Tr. 6125-6126). ProMedica's policies and actions suggest that staffing and services at St. Luke's are likely to be reduced post-Acquisition.

Response to Finding No. 1273:

Ms. Hanley's entire statement was that ProMedica {

}

(Hanley, Tr. 4798-4799, *in camera* (emphasis added)).f The proposed finding is also inaccurate and misleading as to ProMedica's closing of its daycare center, which it did, in part, because a highway was to come through the building. (Johnston, Tr. 5444). Complaint Counsel's conclusory statement regarding what ProMedica is likely to do with St. Luke's post-Acquisition violated the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record.

1274. ProMedica alleges that the Acquisition may enable it to avoid constructing a new hospital at its Arrowhead property near Maumee and a new bed tower at Flower Hospital. (PX02104 at 005-007 (¶¶ 9-10, 13) (Akenberger, Decl.), *in camera*). If true, then the Acquisition could very well be "removing an expenditure that would create value" to Toledo consumers. (Town, Tr. 3928-3929). Firms invest in their businesses to better compete and thus enhance consumer welfare, and if these competition-driven investments are "avoided," consumers generally are left worse off. (PX02148 at 094 (¶ 172) (Town Expert Report), *in camera*). Kathleen Hanley, ProMedica's CFO, admitted that a new hospital at Arrowhead would be in "direct competition" with St. Luke's, and that ProMedica acquired St. Luke's "instead of investing millions of dollars in a *competing facility*." (PX01903 at 063 (Hanley, IHT at 243-245), *in camera* (emphasis added)).

Response to Finding No. 1274:

To the extent this finding is duplicative of complaint counsel's finding numbered 801, Respondent has addressed this finding there.

XIX. WITNESS BACKGROUNDS

A. Lay Witnesses Who Testified at Trial

1. Complaint Counsel's Witnesses

a. Third Party Hospitals

Edward Beck

1275. Mr. Beck is the Administrator of Fulton County Health Center ("FCHC"), and has held that position for 36 years. He has worked at FCHC for almost 43 years, and was the Director of Finance prior to becoming Administrator. As Administrator, Mr. Beck's responsibilities include the day-to-day operations of the hospitals, overseeing the medical staff, and setting the strategic plan and vision for FCHC. (Beck, Tr. 369-371). Mr. Beck also oversees contract negotiations with commercial health plans. (Beck, Tr. 370, 406, 426).

Response to Finding No. 1275:

Respondent has no specific response.

1276. Mr. Beck has held officer positions with the Hospital Council of Northwest Ohio and the Hospital Financial Management Organization, and has been a member of those organizations for over 30 years. (Beck, Tr. 372-374). He has also been involved with the Ohio Hospital Association's hospital committee for several years. (Beck, Tr. 372).

Response to Finding No. 1276:

Respondent has no specific response.

1277. Mr. Beck has a bachelor's degree in business from Defiance College. (Beck, Tr. 375).

Response to Finding No. 1277:

Respondent has no specific response.

1278. Mr. Beck testified during the administrative proceeding pursuant to a subpoena. (Beck, Tr. 369-370). Prior to testifying, he made himself available and spoke with counsel for the Respondent. (Beck, Tr. 370).

Response to Finding No. 1278:

Respondent has no specific response.

1279. FCHC is a general acute-care hospital located in Wauseon, Ohio, in Fulton County. It is a nonprofit hospital with a 14-member board of directors. FCHC opened in 1973, and is currently a critical access hospital. (Beck, Tr. 376, 382).

Response to Finding No. 1279:

Respondent has no specific response.

1280. As a critical access hospital, FCHC has a maximum of 25 inpatient beds, can only retain patients for 96 hours average over a year, and is allowed a 10-bed psychiatric unit. (Beck, Tr. 376-377). Of the 25 inpatient beds at FCHC, seven are designated critical care beds, five are obstetric beds, and the remaining beds are medical-surgical beds. (Beck, Tr. 378).

Response to Finding No. 1280:

Respondent has no specific response.

Dr. Jeffrey Gold

1281. Dr. Jeffrey Gold serves as Chancellor and Executive Vice President for Biosciences and Health Affairs and Dean of the College of Medicine for the University of Toledo. (Gold, Tr. 184). Dr. Gold joined the University of Toledo as Dean of the College of Medicine in 2005. (Gold, Tr. 186). The University of Toledo owns the University of Toledo Medical Center ("UTMC," formerly called the Medical College Hospital), which it acquired when it merged with the Medical College of Ohio in 2006. (Gold, Tr. 186).

Response to Finding No. 1281:

Respondent has no specific response.

1282. UTMC is an academic medical center that provides tertiary and quaternary care to the community. (Gold, Tr. 192-193). UTMC's mission is to support the academic needs of the University of Toledo and, "in so doing, deliver healthcare that exemplifies the highest quality of knowledge and skill and professionalism." (Gold, Tr. 192-193).

Response to Finding No. 1282:

Respondent has no specific response.

1283. Notably, UTMC does not offer (and has never offered) inpatient obstetrics services, which includes labor and delivery. (Gold, Tr. 203).

Response to Finding No. 1283:

Respondent has no specific response.

1284. Dr. Gold is responsible for UTMC and its clinics. (Gold, Tr. 190). The staff members who negotiate with health plans on behalf of UTMC also report directly to Dr. Gold, and he discusses any significant negotiations with the University of Toledo's senior leadership team. (Gold, Tr. 190-191).

Response to Finding No. 1284:

Respondent has no specific response.

1285. Dr. Gold serves as chair of the board of the physician practice plan, which is the full-time practicing faculty of the University. (Gold, Tr. 190). As the chief academic officer for all health sciences, Dr. Gold is responsible for the academic programs in the College of Medicine, the College of Nursing, the College of Pharmacy, and the allied health programs of the University of Toledo and all the clinical and basic science research of these programs. (Gold, Tr. 190).

Response to Finding No. 1285:

Respondent has no specific response.

1286. Dr. Gold is an accomplished cardiac surgeon and has taught medicine at several well-known institutions. Dr. Gold received his undergraduate degree from Cornell University College of Engineering and subsequently received his medical degree from Cornell University. (Gold, Tr. 185). Next, he performed five years of general surgery at Presbyterian Healthcare System in New York, followed by an adult cardiac surgery residency and fellowship at Brigham and Women's Hospital in Boston. (Gold, Tr. 185). Dr. Gold completed his training at Boston Children's Hospital as a congenital heart surgeon. (Gold, Tr. 185). Dr. Gold is board certified in cardiothoracic surgery. (Gold, Tr. 186-187).

Response to Finding No. 1286:

Respondent has no specific response.

1287. In addition to his work as a cardiothoracic surgeon, Dr. Gold has worked in a teaching capacity. (Gold, Tr. 186). Within the Department of Cardiothoracic Surgery in New York Presbyterian Hospital and Cornell University College of Medicine, Dr. Gold advanced from assistant to associate to full professor of cardiothoracic surgery. (Gold, Tr. 186). Next, Dr. Gold became Chair of the Department of Cardiothoracic and Vascular Surgery at the Albert Einstein College of Medicine and Montefiore Medical System in New York until assuming his role at the University of Toledo. (Gold, Tr. 186).

Response to Finding No. 1287:

Respondent has no specific response.

1288. Dr. Gold sits on the Council of Medical Education for the American Medical Association and is a member of the House of Delegates representing the Society of Thoracic Surgeons, which he has been a board member of for many years. (Gold, Tr. 187). He also sits on the American Heart Association's liaison committee for medical education, which accredits all medical schools in the United States and Canada. (Gold, Tr. 187). Dr. Gold has been affiliated or employed with approximately 10 or 11 different hospital associations over the course of his career. (Gold, Tr. 187-188).

Response to Finding No. 1288:

Respondent has no specific response.

1289. Dr. Gold has been recognized by students, by faculty, and by colleagues for distinguished service, and by the American Heart Association through its Lifetime Achievement Award, as well as through many other honors. (Gold, Tr. 189).

Response to Finding No. 1289:

Respondent has no specific response.

1290. In July 2010, the University of Toledo and ProMedica signed an agreement stating that the University of Toledo would manage ProMedica's academic activities. (Gold, Tr. 191-192). This led to the formation of the Academic Health Center Corporation "which has a duly represented board and has a number of responsibilities in the areas of research and in the areas of education." (Gold, Tr. 192). Dr. Gold holds several positions on the Academic Health Center Corporation and devotes approximately 10 to 20 percent of his time to it. (Gold, Tr. 191-192).

Response to Finding No. 1290:

Respondent has no specific response.

Stanley Korducki

1291. Mr. Korducki is the President of Wood County Hospital ("WCH"). (Korducki, Tr. 446). He joined WCH as Assistant Administrator in 1996. (Korducki, Tr. 455-456). In 2001, Mr. Korducki became the President of WCH. (Korducki, Tr. 461). As President, Mr. Korducki sits on the WCH Board of Trustees and is responsible for, among other things, hospital operations, vision planning, the medical staff, and financial management. (Korducki, Tr. 462; *see also* Korducki, Tr. 463-468).

Response to Finding No. 1291:

Respondent has no specific response.

1292. Mr. Korducki has an undergraduate degree and baccalaureate in business administration from Marquette University and a Master's Degree in health services administration from The Ohio State University. (Korducki, Tr. 446-447).

Response to Finding No. 1292:

Respondent has no specific response.

1293. After graduating from Ohio State in 1982, Mr. Korducki worked for 10 years at Children's Hospital in Milwaukee, Wisconsin, where he held various positions, progressing from administrative fellow/resident to Vice President of Professional Services. (Korducki, Tr. 447, 449).

Response to Finding No. 1293:

Respondent has no specific response.

1294. In 1992, Mr. Korducki joined St. Mary's Hospital in Centralia, Illinois as Vice President for Planning and Marketing. (Korducki, Tr. 451).

Response to Finding No. 1294:

Respondent has no specific response.

1295. Mr. Korducki moved to Washington, DC in 1994, and provided independent consulting services to area hospitals and other organizations, including Children's National Medical Center. (Korducki, Tr. 453-454).

Response to Finding No. 1295:

Respondent has no specific response.

1296. WCH is a general acute-care hospital located in Bowling Green, Ohio, in Wood County. It is a not-for-profit hospital association and operates about 85 staffed beds. (Korducki, Tr. 475-477). WCH's average daily census is about 38. (Korducki, Tr. 478-479). WCH is the only hospital in Northwest Ohio with a Center of Excellence in bariatrics. (Korducki, Tr. 512).

Response to Finding No. 1296:

Respondent has no specific response.

Scott Shook

1297. Scott Shook is the Senior Vice President of Business Development and Advocacy for Mercy's regional office in Toledo, Ohio. (Shook, Tr. 859-860, 869-870). Mr. Shook assumed the position of Senior Vice President for Strategic Initiatives in early 2002, and even though his title has changed to Mercy's Senior Vice President of Business Development and Advocacy, his responsibilities remain the same. (Shook, Tr. 869).

Response to Finding No. 1297:

Respondent has no specific response.

1298. In his business development role, Mr. Shook is responsible for searching for business opportunities for Mercy in the Toledo area. (Shook, Tr. 870). He analyzes five service lines: cardiology, neurology/orthopedics, trauma, outreach, and oncology, to determine what Mercy's strengths and weaknesses are and how to develop and improve the quality, efficiency, and patient satisfaction for these services. (Shook, Tr. 870). Mr. Shook also has operational responsibility for Mercy's oncology infusion centers and trauma transport services. (Shook, Tr. 871). In the advocacy role, Mr. Shook has the "primary responsibility in the [Toledo] region for liaisoning with all levels of government" and serves on advocacy committees for Catholic Healthcare Partners and the Ohio Hospital Association. (Shook, Tr. 870-871). Approximately 80 percent of Mr. Shook's time is spent on business development and the remainder on advocacy. (Shook, Tr. 871).

Response to Finding No. 1298:

Respondent has no specific response.

1299. Mercy is a not-for-profit hospital system owned by Catholic Healthcare Partners. (Shook, Tr. 889-890). Mercy falls within the northern division of Catholic Healthcare Partners and is headquartered in Toledo with six hospitals in northwest Ohio. (Shook, Tr. 890). Within the Toledo area, Mercy operates St. Vincent, St. Anne, and St. Charles. (Shook, Tr. 892). St. Vincent is a tertiary facility, while the others are general acute-care facilities. (Shook, Tr. 892). Notably, St. Anne does not provide obstetrical services. (Shook, Tr. 899-900).

Response to Finding No. 1299:

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

1300. Mr. Shook is a member of Mercy's senior management group and its senior organizational group. (Shook, Tr. 872). Mercy's operational group examines monthly reports on the operation of Mercy's hospitals, transportation system, and infusion centers and determines what plans should be implemented or changed in Mercy's services. (Shook, Tr. 872-873). Both the operational and senior management groups discuss and approve proposed implementations or changes to Mercy's services. (Shook, Tr. 873).

Response to Finding No. 1300:

Respondent has no specific response.

1301. Mr. Shook is also a member of Mercy's strategic planning group. (Shook, Tr. 871-872). Mr. Shook attends Mercy's board of trustees' business development and finance committees meetings as staff. (Shook, Tr. 875, 883). Mr. Shook provides regular updates to the board on the progress of past projects that they approved, updates on strategic initiatives, and legislative updates. (Shook, Tr. 884-885).

Response to Finding No. 1301:

Respondent has no specific response.

1302. Mr. Shook has a long history of experience in the healthcare field. Prior to his current position, Mr. Shook worked in several positions at Riverside Hospital, which eventually became part of the Mercy system. (Shook, Tr. 864-867). In 1980, Mr. Shook's first role at Riverside was as CFO, and four years later he became the COO. (Shook, Tr. 864-865). After working as COO for three years, Mr. Shook assumed the role of CEO around 1994 after Riverside's CEO left. (Shook, Tr. 865-866). As CEO, Mr. Shook had responsibility for the entire hospital, including strategic planning. (Shook, Tr. 866-867). He served as Riverside's CEO until Riverside was acquired by the Sisters of Mercy, which eventually

became Mercy Health Partners. (Shook, Tr. 867-868). Mr. Shook left the position of CEO to work in his current position in Mercy's regional office in Toledo in 2002. (Shook, Tr. 869-870).

Response to Finding No. 1302:

Respondent has no specific response.

1303. Prior to his positions at Riverside, Mr. Shook served as the Assistant Financial Director and Administrator of the Family Practice Residency Program at Mercy Hospital of Toledo from 1975 through 1980. (Shook, Tr. 863-864). Before joining Mercy Hospital of Toledo, Mr. Shook worked as an internal auditor from 1973 through 1975 at St. Luke's Hospital, which was then located in the Old West End section of Toledo. (Shook, Tr. 862-863).

Response to Finding No. 1303:

Respondent has no specific response.

1304. Mr. Shook's first position in healthcare was with Blue Cross of Northwestern Ohio in 1968 as a summer intern auditor. (Shook, Tr. 860). That health plan eventually was merged with others and is now part of Medical Mutual of Ohio. (Shook, Tr. 861-862). After serving in the U.S. Marine Corps, Mr. Shook worked through 1973 as an auditor, auditing Medicare cost reports and Blue Cross hospital cost reports. (Shook, Tr. 861-862).

Response to Finding No. 1304:

Respondent has no specific response.

1305. Mr. Shook holds a graduate and undergraduate degree in accounting from the University of Toledo which he earned in 1975 and 1970 respectively. (Shook, Tr. 860-861). Mr. Shook also taught a healthcare economics course at the University of Toledo for ten years. (Shook, Tr. 868). The course examined healthcare trends and contained actual case studies of the economics of opening a new service line in a hospital. (Shook, Tr. 868-869).

Response to Finding No. 1305:

Respondent has no specific response.

b. Health Plans

Thomas McGinty

1306. Mr. McGinty is the Director of Network Development for Humana, and has held that title since 2003. (McGinty, Tr. 1156).

Response to Finding No. 1306:

Respondent has no specific response.

1307. Mr. McGinty is responsible for Humana's contracts with hospitals, physician groups and ancillary services. (McGinty, Tr. 1160-1161). He is responsible for all of Ohio except the for the metropolitan Cincinnati and Dayton areas. (McGinty, Tr. 1161).

Response to Finding No. 1307:

Respondent has no specific response.

1308. Mr. McGinty has 35 years of experience working in the healthcare industry. He has worked on both the provider side and on the health plan side. (McGinty, Tr. 1160). Prior to working at Humana, Mr. McGinty worked for WellPoint Health Networks, where he was the executive director of network development, and Kaiser Permanente, where he was a regional operations administrator. (McGinty, Tr. 1156-1158). On the provider side, he was an administrator at Lakewood Hospital, a community hospital with 410 beds located near Cleveland, Ohio. (McGinty, Tr. 1158-1159).

Response to Finding No. 1308:

Respondent has no specific response.

1309. Humana is a national health plan and is headquartered in Louisville, Kentucky. Humana is in all 50 states plus Puerto Rico, with more than 14 million lives nationally. (McGinty, Tr. 1154-1155).

Response to Finding No. 1309:

Complaint Counsel's proposed finding is inaccurate. Humana has 10.2 million members nationwide in its commercial and government insurance programs combined. (McGinty, Tr. 1225).

1310. Since Mr. McGinty joined Humana in 2003, Humana has had a presence in Lucas County. (McGinty, Tr. 1156). Mr. McGinty visits Lucas County about 5 to 10 times a year. (McGinty, Tr. 1167).

Response to Finding No. 1310:

Complaint Counsel's proposed finding is inaccurate and misleading. Mr. McGinty visits Lucas County *on average* five to ten times a year, but visits depend on whether a renegotiation is occurring or he encounters a problem with a provider. (McGinty, Tr. 1167).

1311. In Lucas County, Humana has about 2,000 commercial members and 7,000 Medicare Advantage members. (McGinty, Tr. 1168).

Response to Finding No. 1311:

Respondent has no specific response.

1312. Humana had more than 1,000 Medicare Advantage discharges at St. Luke's in 2010. (McGinty, Tr. 1270).

Response to Finding No. 1312:

Complaint Counsel's proposed finding is misleading and inaccurate. Medicare Advantage is Humana's government product, a replacement for Medicare, and is not in the relevant product market. (McGinty, Tr. 1218). Mr. McGinty has less than 100 commercially insured discharges *a year* at St. Luke's. (RPF 405).

Donald Pirc

1313. Mr. Pirc is currently Medical Mutual of Ohio's ("MMO") vice president of network management for Ohio, Indiana, and Kentucky. (Pirc, Tr. 2160). While Mr. Pirc has been in his current position at MMO for six months, he has worked for MMO for almost 21 years. (Pirc, Tr. 2160, 2165-2166).

Response to Finding No. 1313:

Respondent has no specific response.

1314. In his current position, Mr. Pirc is responsible for contracting with hospitals, physicians, and ancillary providers in these states, to have these providers treat MMO's members at pre-negotiated reimbursement rates. (Pirc, Tr. 2160). Specifically, Mr. Pirc is responsible for contracting with hospitals in Lucas County, Ohio. (Pirc, Tr. 2162).

Response to Finding No. 1314:

Respondent has no specific response.

1315. Mr. Pirc has approximately seventeen years of experience negotiating with healthcare providers on behalf of MMO, and approximately eight years negotiating with healthcare providers in Lucas County, Ohio. (Pirc, Tr. 2172).

Response to Finding No. 1315:

Respondent has no specific response.

1316. Mr. Pirc oversees a staff of approximately 50 MMO employees, who handle the day-to-day activities of managing provider contracts and negotiating provider reimbursement rates. (Pirc, Tr. 2161). Mr. Pirc receives information about the activities in this office from a director who reports directly to him. (Pirc, Tr. 2161).

Response to Finding No. 1316:

Respondent has no specific response.

1317. During the five to six years prior to his assumption of his current position, Mr. Pirc was MMO's director of network management for Northern Ohio and Indiana. (Pirc, Tr. 2166). In that position, Mr. Pirc was responsible for overseeing the management and negotiation of MMO's contracts with hospitals, physicians, and ancillary providers in northern Ohio and Indiana. (Pirc, Tr. 2166; PX01944 at 003 (Pirc, Dep. at 8)). Mr. Pirc's responsibilities in that position also required him to be familiar with, among other things, the scope of services and quality of care offered at the Toledo-area hospitals and the preferences of MMO's members with respect to these hospitals. (Pirc, Tr. 2166-2167).

Response to Finding No. 1317:

Complaint Counsel's proposed finding is misleading. MMO has not performed any marketing studies to determine how far its patients will travel for hospital services, or {

} (RPF 1264, 1266, *in camera*).

1318. Before becoming MMO's director of network management for northern Ohio and Indiana, Mr. Pirc spent approximately three years as MMO's manager of professional contracting in Northern Ohio and parts of Indiana. (Pirc, Tr. 2169). MMO's Northern Ohio region includes the Toledo area. (Pirc, Tr. 2169).

Response to Finding No. 1318:

Respondent has no specific response.

1319. Mr. Pirc's other previous positions at MMO include being a hospital contractor in the Ohio region encompassing Akron, Canton, and Youngstown, a physician contractor, and a member of the customer service branch of MMO's operations department. (Pirc, Tr. 2170-2171). He has personally participated in provider contract negotiations with hospitals and physicians. (Pirc, Tr. 2170-2171).

Response to Finding No. 1319:

Respondent has no specific response.

1320. The experience that he gained as a member of the customer service branch of MMO's operations department informed Mr. Pirc's ability to negotiate provider contracts on

behalf of MMO by teaching him about the workings of the healthcare system and of health insurance. (Pirc, Tr. 2171-2172).

Response to Finding No. 1320:

Respondent has no specific response.

1321. Mr. Pirc holds a bachelor's degree from John Carroll University and a master's degree in business administration from Cleveland State University. (Pirc, Tr. 2172).

Response to Finding No. 1321:

Respondent has no specific response.

1322. MMO is a health insurance company. (Pirc, Tr. 2175). MMO is a mutual company, and as such, it is owned by its policyholders or members. (Pirc, Tr. 2172-2173).

Response to Finding No. 1322:

Respondent has no specific response.

1323. MMO does not pay dividends. (Pirc, Tr. 2173). All of the revenue that MMO generates in excess of claims and other costs is saved and used to pay future claims, as opposed to being distributed to shareholders in the model of a Wall Street firm. (Pirc, Tr. 2173).

Response to Finding No. 1323:

Respondent has no specific response.

1324. In 2010, MMO set a profit goal of zero and earned a margin of zero to one percent. (Pirc, Tr. 2173).

Response to Finding No. 1324:

Respondent has no specific response.

1325. MMO's customers are primarily employer groups. (Pirc, Tr. 2175). MMO has both fully-insured and self-insured customers. (Pirc, Tr. 2175). About 60 percent of MMO's commercially insured membership is self-insured and about 40 percent is fully-insured. (Pirc, Tr. 2274).

Response to Finding No. 1325:

Respondent has no specific response.

1326. MMO has state-wide healthcare provider networks in Ohio, Indiana, Georgia, and South Carolina. MMO also has healthcare provider networks in 17 counties in Kentucky. (Pirc, Tr. 2174).

Response to Finding No. 1326:

Respondent has no specific response.

1327. MMO offers PPO, POS, and HMO products. (Pirc, Tr. 2174-2175). Approximately 85 percent of MMO's business runs through the PPO product. (Pirc, Tr. 2175). About eight to ten percent of MMO's business runs through the HMO product. (Pirc, Tr. 2175). The remainder runs through the POS product. (Pirc, Tr. 2175).

Response to Finding No. 1327:

Respondent has no specific response.

1328. Approximately 1.4 million individuals in Ohio have health insurance through MMO. (Pirc, Tr. 2177-78). Approximately 90,000 to 100,000 individuals in Lucas County have health insurance through MMO. (Pirc, Tr. 2177-2178; PX 1944 at 004 (Pirc, Dep. at 10, *in camera*)).

Response to Finding No. 1328:

Respondent has no specific response.

1329. MMO's market share in Lucas County is about 25 percent. (Pirc, Tr. 2178; PX01944 at 010 (Pirc, Dep. at 36, *in camera*)). In terms of the size of its membership, it is one of the largest health plans in Lucas County, roughly neck-in-neck with Paramount. (PX01944 at 010 (Pirc, Dep. at 37)).

Response to Finding No. 1329:

Respondent has no specific response.

1330. Mr. Pirc did not meet or speak with representatives of the FTC to prepare for his testimony at trial. (Pirc, Tr. 2162-2163).

Response to Finding No. 1330:

Respondent has no specific response.

1331. MMO has an ongoing business relationship with ProMedica, and this relationship is an important part of Mr. Pirc's work at MMO. Mr. Pirc does not bear any ill will towards ProMedica. (Pirc, Tr. 2164).

Response to Finding No. 1331:

Respondent has no specific response.

James Pugliese

1332. Mr. Pugliese has been employed by Anthem/WellPoint ("Anthem") for 26 years. (Pugliese, Tr. 1427).

Response to Finding No. 1332:

Respondent has no specific response.

1333. For the past six years, Mr. Pugliese has been the Regional Vice President of Provider Engagement and Contracting for Anthem in Northern Ohio. (Pugliese, Tr. 1420). Northern Ohio includes the northern part of the state, including the area from Toledo to Youngstown to just south of Canton, Ohio. (Pugliese, Tr. 1420).

Response to Finding No. 1333:

Respondent has no specific response.

1334. As Regional Vice-President of Provider Engagement and Contracting, Mr. Pugliese oversees and participates in contract negotiations with hospitals and physicians. (Pugliese, Tr. 1421). Mr. Pugliese regularly interfaces with Anthem's sales and marketing team. (Pugliese, Tr. 1422). He participates in sales and marketing staff meetings, as well as informal discussions with the sales and marketing team about provider relationships and Anthem's network. (Pugliese, Tr. 1422-1423). Mr. Pugliese travels to Lucas County about once every two months. (Pugliese, Tr. 1438).

Response to Finding No. 1334:

Respondent has no specific response.

1335. Previously, for ten years, Mr. Pugliese was the Director of Contracting at Anthem for the Akron-Canton, Ohio market. (Pugliese, Tr. 1426). Before that, he was an Area Representative – a provider (primarily physician) service position – for Anthem for five years. (Pugliese, Tr. 1426). Prior to that, he was an auditor for the Anthem business line that manages Medicare plans with hospitals and physicians. (Pugliese, Tr. 1426).

Response to Finding No. 1335:

Respondent has no specific response.

1336. Mr. Pugliese has a Bachelor of Science degree in accounting from the University of Akron. (Pugliese, Tr. 1427).

Response to Finding No. 1336:

Respondent has no specific response.

1337. WellPoint is a national health insurer. (Pugliese, Tr. 1420). WellPoint is the parent company for the Anthem organization, also known as Community Insurance Company in Ohio, and markets products in various states under the Anthem Blue Cross and Blue Shield name. (Pugliese, Tr. 1427, 1530-1531).

Response to Finding No. 1337:

Respondent has no specific response.

1338. Anthem offers health-plan products in Lucas County, primarily to employers, as well as to individuals and Medicare beneficiaries. (Pugliese, Tr. 1429). Anthem's employer customers include large employers, national businesses that are based in Toledo, mid-size and small employers. (Pugliese, Tr. 1429-1430). About half of Anthem's commercial business in Lucas County consists of self-insured business. (Pugliese, Tr. 1432).

Response to Finding No. 1338:

Respondent has no specific response.

1339. Anthem's primary product in Lucas County is a broad-access PPO product (and a narrower Medicare Advantage network) that does not require primary care physician authorization to see a specialist. (Pugliese, Tr. 1434-1435). Anthem also provides HMO, POS, and traditional indemnity plans in Ohio. (Pugliese, Tr. 1532). Individuals (commercial customers) primarily purchase PPO products. (Pugliese, Tr. 1430). Unlike Anthem's commercial products, the Medicare Advantage product is marketed directly to individuals approaching age 65. (Pugliese, Tr. 1435-1436).

Response to Finding No. 1339:

Complaint Counsel's proposed finding is misleading. Medicare Advantage is a replacement product for Medicare and is not part of the relevant product market. (*see* McGinty, Tr. 1218).

1340. Anthem's significant competitors in Lucas County include MMO, Paramount, United, Aetna, and Cigna. (Pugliese, Tr. 1436). Anthem is one of the three largest health plans in Lucas County, along with Paramount and MMO. (Pugliese, Tr. 1436).

Response to Finding No. 1340:

Respondent has no specific response.

Greg Radzialowski

618, 626). Of Aetna's 30,000 commercial members, approximately 10,000 are fully insured and 20,000 are self-funded. (Radzialowski, Tr. 626).

Response to Finding No. 1351:

Complaint Counsel's proposed finding is misleading. Medicare Advantage is a replacement product for Medicare and not in the relevant product market. (*see* McGinty, Tr. 1218).

1352. In Lucas County, Aetna's primary competitors are MMO, Anthem, United, FrontPath, and Paramount. (Radzialowski, Tr. 626). Aetna estimates that its commercial market share in Lucas County is approximately 10%. (Radzialowski, Tr. 626-627).

Response to Finding No. 1352:

Respondent has no specific response.

Barbara Sandusky

1353. Ms. Sandusky is a self-employed healthcare management and employee benefits consultant in Toledo, Ohio, who has worked with FrontPath since 1994. (Sandusky, Tr. 1276-77). Ms. Sandusky lives in Sylvania, a northwest suburb of Toledo, and has lived in the Toledo area for more than 30 years. (Sandusky, Tr. 1282-1283).

Response to Finding No. 1353:

Respondent has no specific response.

1354. As a self-employed consultant, Ms. Sandusky has assisted clients in building PPO networks in Ohio, Indiana, Michigan, North Carolina, and California and worked on strategic engagements with hospitals across the United States. (Sandusky, Tr. 1279).

Response to Finding No. 1354:

Respondent has no specific response.

1355. Ms. Sandusky's primary responsibility with FrontPath has been to contract with healthcare providers – including hospitals, physicians, and ancillary care providers – to create FrontPath's PPO network that covers northwest Ohio and parts of Michigan and Indiana. (Sandusky, Tr. 1280-1281). Ms. Sandusky has been responsible for all of FrontPath's hospital negotiations in Lucas County from 1994-2005 and from 2007 to the present. (Sandusky, Tr. 1281). Ms. Sandusky reports to FrontPath's CEO, Ms. Susan Szymanski. (Sandusky, Tr. 1282).

Response to Finding No. 1355:

Respondent has no specific response.

1356. Prior to becoming a self-employed consultant, Ms. Sandusky worked as Chief Operations Officer for a hospital consortium, a consultant with an employee benefits healthcare management firm, and held positions relating to home healthcare, outpatient services, acute care, and healthcare administration. (Sandusky, Tr. 1278).

Response to Finding No. 1356:

Respondent has no specific response.

1357. Ms. Sandusky has a bachelor's degree from Bowling Green University and a J.D. from the University of Toledo. (Sandusky, Tr. 1277-1278).

Response to Finding No. 1357:

Respondent has no specific response.

1358. FrontPath is a not-for-profit business coalition on health. It is a membership organization, governed by its members and managed by its members. FrontPath's members are public and corporate entities and labor organizations. (Sandusky, Tr. 1283-1284).

Response to Finding No. 1358:

Respondent has no specific response.

1359. Some of FrontPath's public entity members include the City of Toledo, Lucas County, Wood County, Toledo area firefighters, and school districts. (Sandusky, Tr. 1284). FrontPath's corporate entity members include Libbey Glass and Owens-Illinois. (Sandusky, Tr. 1285-1286). FrontPath's labor organization members include construction trades such as the plumbers and carpenters. (Sandusky, Tr. 1285).

Response to Finding No. 1359:

Respondent has no specific response.

1360. The employers that are involved as FrontPath's members range anywhere from 200-300 to 10,000 employees or participants. (Sandusky, Tr. 1286).

Response to Finding No. 1360:

Respondent has no specific response.

1361. FrontPath members participate in the PPO network and some participate in the pharmacy benefit management program. (Sandusky, Tr. 1284-1287).

Response to Finding No. 1361:

Respondent has no specific response.

c. Employers

Kent Buehrer

1362. Mr. Buehrer is President of Buehrer Group Architectural and Engineering, Inc. ("Buehrer Group"), located in Maumee, Ohio, approximately two miles east of St. Luke's. (Buehrer, Tr. 3057-3058). Mr. Buehrer became President of Buehrer Group in 2001. (Buehrer, Tr. 3060).

Response to Finding No. 1362:

Respondent has no specific response.

1363. Buehrer Group was founded in 1984 and provides non-residential architecture and engineering services to a variety of public and private clients, primarily in Ohio and southeastern Michigan. (Buehrer, Tr. 3060-3061). The company has 24 employees. (Buehrer, Tr. 3061).

Response to Finding No. 1363:

Respondent has no specific response.

1364. Mr. Buehrer is actively involved in managing one-third to one-half of the company's projects, as well as the company's employee benefits, including health insurance. (Buehrer, Tr. 3061-3062).

Response to Finding No. 1364:

Respondent has no specific response.

1365. Mr. Buehrer currently resides in Monclova Township, which is approximately 500 feet outside the city limits of Maumee. (Buehrer, Tr. 3058). Apart from his time in college, Mr. Buehrer has lived in either Monclova or Maumee his entire life. (Buehrer, Tr. 3059).

Response to Finding No. 1365:

Respondent has no specific response.

1366. Buehrer Group and St. Luke's have both made contributions to local community projects, including the Performing Arts Center at Maumee High School, as well as the Maumee Public Library and the Waterville Branch Library. (Buehrer, Tr. 3070-3071).

Response to Finding No. 1366:

Respondent has no specific response.

Hugh Caumartin

1367. From 1997 through January 1, 2011, Hugh Caumartin served as Superintendent of Bowling Green Schools. (Caumartin, Tr. 1833). During this time, Mr. Caumartin was responsible for overseeing the healthcare benefits for employees of Bowling Green Schools. (Caumartin, Tr. 1833).

Response to Finding No. 1367:

Respondent has no specific response.

1368. Mr. Caumartin also served as Chairman of the Wood County Schools Health Consortium ("Consortium") during his last two years as Superintendent of Bowling Green Schools, and prior to that, served as Vice Chairman of the Consortium for eight years. (Caumartin, Tr. 1833).

Response to Finding No. 1368:

Respondent has no specific response.

1369. The Consortium was created in the mid-1980s by school districts throughout Wood County who formed a coalition for the sole purpose of purchasing healthcare and sharing the financial risk amongst themselves. (Caumartin, Tr. 1833-1835, 1866).

Response to Finding No. 1369:

Respondent has no specific response.

1370. The Consortium is self-insured and pays its own claims and healthcare costs. (Caumartin, Tr. 1836). Including individuals, spouses, and children, the Consortium's health plan currently covers approximately 1,500 lives. (Caumartin, Tr. 1841). A large concentration of Consortium members' employees reside in Perrysburg, Rossford, and Northwood, located in northern Wood County near St. Luke's. (Caumartin, Tr. 1850).

Response to Finding No. 1370:

Respondent has no specific response.

1371. Prior to his time at Bowling Green Schools and the Consortium, Mr. Caumartin worked as a Senior Account Executive for Medical Mutual of Ohio in direct sales of accounts to large employers in northwest Ohio, including Lucas and Wood counties. (Caumartin, Tr. 1829-1832). Through his work with clients, Mr. Caumartin discovered what factors were important to employers and employees in selecting a health plan, such as having a network that includes a broad range of high quality of care providers that are close to employees' homes. (Caumartin, Tr. 1830-1831).

Response to Finding No. 1371:

Respondent has no specific response.

Kenneth J. Lortz

1372. Mr. Lortz has been the Director of the United Auto Workers ("UAW"), Region 2B since April 2009. (Lortz, Tr. 1681). As Director of Region 2B, Mr. Lortz is responsible for all UAW members and retirees in the state of Ohio. (Lortz, Tr. 1681-1682). Mr. Lortz regularly meets with his staff of 19 servicing representatives to discuss bargaining issues. (Lortz, Tr. 1692-1693).

Response to Finding No. 1372:

Respondent has no specific response.

1373. Region 2B includes the entire state of Ohio and is headquartered in Maumee, Ohio. (Lortz, Tr. 1681). Region 2B covers between 41,000 and 50,000 active members and approximately 130,000 retirees. (Lortz, Tr. 1687, 1690). Approximately 20,000 active UAW members and approximately 45,000 to 50,000 UAW retirees currently reside throughout Lucas County, including southwest Lucas County. (Lortz, Tr. 1687, 1690-1691).

Response to Finding No. 1373:

Respondent has no specific response.

1374. The UAW is a labor organization, which negotiates collective bargaining agreements between UAW members and their employers including benefits, such as healthcare coverage. (Lortz, Tr. 1681, 1693-1694).

Response to Finding No. 1374:

Respondent has no specific response.

1375. Mr. Lortz has a long history with the UAW. In 1974, he was elected as a union steward at his home plant, Atlas Crankshaft, and served in that position for six years. (Lortz, Tr. 1683). Mr. Lortz has also held positions on the UAW shop bargaining committee at Atlas Crankshaft, was President of the local union and served in that position for three years, and served as a servicing representative for UAW, Region 2B. (Lortz, Tr. 1683-1684).

Response to Finding No. 1375:

Respondent has no specific response.

1376. In 2002, Mr. Lortz was appointed Assistant Director for Region 2B. (Lortz, Tr. 1682). Mr. Lortz served as Assistant Director until becoming Director of the region in 2009. (Lortz, Tr. 1682). As Assistant Director, Mr. Lortz worked closely with the negotiating staff to provide advice on negotiations with employers. (Lortz, Tr. 1682-1683).

Response to Finding No. 1376:

Respondent has no specific response.

Kathleen Neal

1377. Ms. Neal serves as Director, Integrated Healthcare and Disability, at Chrysler Group, LLC in Auburn Hills, Michigan. (Neal, Tr. 2085).

Response to Finding No. 1377:

Respondent has no specific response.

1378. Ms. Neal has "overall responsibility for benefits in the United States and Canada, including healthcare, disability, nonoccupational disability, and life insurance programs." (Neal, Tr. 2085). Her responsibilities include procuring healthcare benefits for employees in the Toledo area, as well as the administration, compliance, performance management, and overall purchasing of healthcare benefits for Chrysler, which is self-insured for its health insurance. (Neal, Tr. 2085-2086, 2088, 2097).

Response to Finding No. 1378:

Ms. Neal has about 50 individuals who report to her. (Neal, Tr. 2161). Ms. Neal has no specific knowledge of hospitals in Lucas County, the details of the amount Chrysler spends on healthcare in Lucas County, or the number of employees who received care at Lucas County hospitals. (Neal, Tr. 2145-2148, 2151-2152).

1379. Ms. Neal started working for Chrysler in 1987 as a healthcare benefits analyst and has been continuously promoted into progressively responsible positions in the company. (Neal, Tr. 2086-2087). From 2005 through 2008, Ms. Neal served as Senior Manager of Chrysler's Benefits Group. (Neal, Tr. 2087). In this position, she was responsible for the performance and measurement of Chrysler's healthcare plans, including their "hospital, surgical, medical, pharmacy, dental, and vision plans" and ascertaining whether these benefits were competitive and adequate for Chrysler's employees and retirees and their families. (Neal, Tr. 2087-2088). In March 2009, Ms. Neal was promoted to her current position of Director, Integrated Healthcare and Disability. (Neal, Tr. 2088).

Response to Finding No. 1379:

Ms. Neal has no specific knowledge of hospitals in Lucas County, the details of the amount Chrysler spends on healthcare in Lucas County, or the number of employees who received care at Lucas County hospitals. (Neal, Tr. 2145-2148, 2151-2152).

1380. Chrysler Group is "an automotive manufacturer in the United States, Canada, and Mexico ... [with] brands Chrysler, Dodge, Jeep ... [and] an alliance with Fiat Automotive Group." (Neal, Tr. 2085).

Response to Finding No. 1380:

Respondent has no specific response

1381. Chrysler has several facilities in the Toledo area, including an assembly plant, a machining operation, and a small transport facility. (Neal, Tr. 2090). Of the employees who are eligible to receive health insurance in the Toledo area, 2,563 are included in Chrysler's health plan. (Neal, Tr. 2091). When dependents such as spouses and children are included, the health plan covers approximately 8,900 lives. (Neal, Tr. 2091).

Response to Finding No. 1381:

Ms. Neal has no specific knowledge of hospitals in Lucas County, the details of the amount Chrysler spends on healthcare in Lucas County, or the number of employees who received care at Lucas County hospitals. (Neal, Tr. 2145-2148, 2151-2152).

d. Physicians

Dr. Thomas Andreshak

1382. Dr. Andreshak is an orthopedic surgeon practicing at Consulting Orthopedic Associates ("COA"), a private practice with two offices in the Toledo area. (Andreshak, Tr. 1744, 1746). One of COA's offices is located closer to the city of Toledo in its Sylvania township, and the other office is located outside of Toledo in the Bowling Green community. (Andreshak, Tr. 1746-1748).

Response to Finding No. 1382:

The first office is located near Flower Hospital, the second is located at Wood County Hospital. (Andreshak, Tr. 1746-1747).

1383. Dr. Andreshak holds an M.D. and is certified by the American Board of Orthopedic Surgery to practice orthopedic surgery. (Andreshak, Tr. 1741-1742). As an orthopedic

surgeon, he performs procedures such as hand and spine surgery and hip replacement. (Andreshak, Tr. 1742).

Response to Finding No. 1383:

Respondent has no specific response.

1384. Dr. Andreshak is Co-Chair of the Departments of Orthopedics at both Mercy St. Vincent Hospital and St. Luke's, positions for which he receives no compensation. (Andreshak, Tr. 1745).

Response to Finding No. 1384:

Respondent has no specific response.

1385. Dr. Andreshak has been an independent practitioner in the Toledo area for 18 years, during which time he has never been employed by any hospital. (Andreshak, Tr. 1745).

Response to Finding No. 1385:

Respondent has no specific response.

1386. At the COA offices, Dr. Andreshak provides consultations, x-ray examinations, and some minor care to his patients. (Andreshak, Tr. 1749).

Response to Finding No. 1386:

Respondent has no specific response.

1387. Dr. Andreshak performs an average of 12 to 15 surgeries per week. (Andreshak, Tr. 1751). He performs surgeries at one of five hospitals where he has admitting privileges: St. Luke's, Mercy St. Vincent Hospital, Flower Hospital, The Toledo Hospital, and Wood County Hospital. (Andreshak, Tr. 1751-1753). However, he performs most of his surgeries at either St. Luke's or Mercy St. Vincent Hospital. (Andreshak, Tr. 1753).

Response to Finding No. 1387:

Respondent has no specific response.

1388. Dr. Andreshak received his undergraduate degree from Loyola University of Chicago, and attended Chicago Medical School. He completed his internship and residency at UTMC. (Andreshak, Tr. 1743). Dr. Andreshak then received an additional year of specialized training during a fellowship in reconstructive spine surgery at the Medical College of Wisconsin, Milwaukee. (Andreshak, Tr. 1743).

Response to Finding No. 1388:

Respondent has no specific response.

Dr. Charles Gbur

1389. Dr. Charles Gbur is an interventional cardiologist who has practiced in the Toledo area for approximately 15 years. (Gbur, Tr. 3098). Dr. Gbur currently practices at Ohio Heart and Vascular Consultants (legally named Paradox Consulting), a practice he owns with his wife, who is also a cardiologist. (Gbur, Tr. 3098, 3101, 3104).

Response to Finding No. 1389:

Respondent has no specific response.

1390. Ohio Heart and Vascular Consultants' office is located directly on the campus of St. Luke's Hospital. (Gbur, Tr. 3104). Dr. Gbur holds privileges at St. Luke's, The Toledo Hospital, Flower, Bay Park, St. Vincent, St. Charles, and St. Anne. (Gbur, Tr. 3105). However, he admits most of his patients to St. Luke's. (Gbur, Tr. 3105).

Response to Finding No. 1390:

Respondent has no specific response.

1391. As an interventional cardiologist, Dr. Gbur performs procedures in both inpatient and outpatient settings. (Gbur, Tr. 3103). Diagnostic catheterizations are typically outpatient procedures, whereas interventional procedures, such as angioplasties and stents, are usually overnight, inpatient procedures. (Gbur, Tr. 3103-3104).

Response to Finding No. 1391:

Respondent has no specific response.

1392. Dr. Gbur came with his wife to the Toledo area to work at the Medical College of Ohio in the mid-1990s. (Gbur, Tr. 3101). After about two or three years, they formed their own private practice in Perrysburg, which they operated for about seven years. (Gbur, Tr. 3102). During the next three years, they worked with Northwest Ohio Cardiology Consultants, a large cardiology practice based in Toledo with offices in the Northwest Ohio and Southeastern Michigan area. (Gbur, Tr. 3102). Dr. Gbur worked primarily in the cardiac catheterization labs at The Toledo Hospital, St. Vincent, or St. Luke's. (Gbur, Tr. 3102-3103).

Response to Finding No. 1392:

Respondent has no specific response.

1393. Dr. Gbur received his undergraduate degree from Youngstown State University. (Gbur, Tr. 3098-3099). He attended medical school and performed his residency at The Ohio State University. (Gbur, Tr. 3099). Dr. Gbur performed his cardiology training at the

Medical College of Virginia in Richmond. He is board certified in internal medicine, cardiology (with added qualifications in interventional cardiology), and undersea and hyperbaric medicine. (Gbur, Tr. 3099).

Response to Finding No. 1393:

Respondent has no specific response.

Dr. Christopher Marlowe

1394. Dr. Christopher Marlowe has practiced obstetrics and gynecology ("OB/GYN") as an independent solo practitioner in south Toledo for over 30 years. (Marlowe, Tr. 2388-2389).

Response to Finding No. 1394:

Respondent has no specific response.

1395. Dr. Marlowe holds obstetrics privileges at The Toledo Hospital and St. Luke's, and recently acquired obstetrics privileges at St. Vincent. (Marlowe, Tr. 2387, 2397). Dr. Marlowe delivers approximately 120 babies per year. (Marlowe, Tr. 2388-2389). Nearly all of the deliveries that Dr. Marlowe performs are split between St. Luke's and The Toledo Hospital. (Marlowe, Tr. 2397). Dr. Marlowe holds gynecological privileges at The Toledo Hospital, St. Luke's, and St. Anne. (Marlowe, Tr. 2397).

Response to Finding No. 1395:

Respondent has no specific response.

1396. Although Dr. Marlowe practiced OB/GYN with two other physicians in Michigan for a year and a half, he desired to return home to Toledo, where he was born and raised. (Marlowe, Tr. 2391-2392).

Response to Finding No. 1396:

Respondent has no specific response.

1397. Dr. Marlowe currently serves as Chair of Gynecology at St. Anne and is on St. Anne's medical staff executive committee and Physicians-Hospital Organization ("PHO") board. (Marlowe, Tr. 2387, 2394). Dr. Marlowe is chairman of the PHO credentialing committee. (Marlowe, Tr. 2394). He has served as Chair of Obstetrics at St. Luke's and was the Chair of OB/GYN at Riverside Hospital. He served as Chair of Obstetrics at St. Anne up until its obstetrics unit closed in 2005. (Marlowe, Tr. 2387-2388).

Response to Finding No. 1397:

Mercy closed the obstetrical unit at St. Anne in early 2008 because St. Anne experienced a significant decrease in deliveries and no longer performed enough delivers to maintain quality standards or beak-even financially. (RPF 156).

1398. Dr. Marlowe attended The Ohio University for undergraduate work and went to medical school at Universidad Autónoma de Guadalajara, in Guadalajara, Mexico. (Marlowe, Tr. 2391). Dr. Marlowe also received training at Morristown Memorial Hospital in Morristown, New Jersey and performed his residency at Beaumont Hospital in Royal Oak, Michigan. (Marlowe, Tr. 2391).

Response to Finding No. 1398:

Respondent has no specific response.

e. Respondent's Executives

Scott Rupley

1399. Mr. Rupley is the marketing and planning director for St. Luke's, a position which he has held for the past 12 years. (Rupley, Tr. 1904). He has been employed by St. Luke's for 23 years, and a member of St. Luke's management team for 20 years, (Rupley, Tr. 1903, 1910).

Response to Finding No. 1399:

This proposed finding is misleading. St. Luke's "management team" is not St. Luke's Senior Leaders who are St. Luke's top managers including the CEO and all the Vice Presidents. The "management team" of about 100 people, is mostly middle managers that typically meet monthly for presentations by Senior Leaders. (RX-14 (Rupley Dep. at 37-38, 54-55) Mr. Rupley is not a Senior Leader and never has been in his 23 year tenure at St. Luke's. (Rupley, Tr. 1903, 2077; RX-14 (Rupley Dep. at 50)).

The Senior Leadership Team in the three years leading up to the joinder included Dan Wakeman, President and CEO of St. Luke's; David Oppenlander and Denny Wagner, Vice President of Finance and Treasurer; Theresa Konwinski, Vice President of Patient Care Services;

Doug Deacon, Vice President of Professional Services; Dave Dewey, Vice President of Business Development; and Debra Ball, Vice President of Human Resources. (Rupley, Tr. 2046).

1400. As marketing and planning director, Mr. Rupley is responsible for supporting and coordinating St. Luke's strategic planning processes in addition to completing certificate of need applications, coordinating market research and patient satisfaction studies, supporting the planning of new clinical services, preparing market share reports, and marketing the occupational health services program. (Rupley, Tr. 1907-1908).

Response to Finding No. 1400:

Respondent has no specific response.

1401. As part of St. Luke's management team, Mr. Rupley meets monthly with other St. Luke's managers. (Rupley, Tr. 1910). Mr. Rupley also attends senior leadership committee meetings and St. Luke's Board of Directors' planning council meetings. (Rupley, Tr. 1910-1911; Wakeman, Tr. 2640, *in camera*). The planning council is a committee of St. Luke's board of directors that assesses how St. Luke's is performing on its strategic objectives and discusses other strategic issues related to the hospital. (Rupley, Tr. 1911).

Response to Finding No. 1401:

This proposed finding is misleading. St. Luke's "management team" is not St. Luke's Senior Leaders who are St. Luke's top managers including the CEO and all the Vice Presidents. The "management team" of about 100 people, is mostly middle managers that typically meet monthly for presentations by Senior Leaders. (RX-14 (Rupley Dep. at 37-38, 54-55). Mr. Rupley is not a Senior Leader and never has been in his 23 year tenure at St. Luke's. (Rupley, Tr. 1903, 2077; RX-14 (Rupley Dep. at 50)). Mr. Rupley did not regularly attend the weekly Senior Leadership Team meetings prior to the joinder. (Rupley, Tr. 2046). Moreover, Mr. Rupley's role at the Board planning council meeting was primarily in a staff function where Mr. Rupley would, for example, help with the agendas and take notes. (PX01937 (Rupley Dep. at 26, 42).

1402. Mr. Rupley helped create every key presentation that was used to inform St. Luke's Board on its decision to pursue an affiliation. (*See* Wakeman, Tr. 2656, *in camera* (Mr. Rupley involved in creating PX01018); *see also* PX01911 at 021, 044, 056, 062 (Wakeman, IHT at 77-78, 169-171, 218, 241), *in camera* (Mr. Rupley involved in

This proposed finding is out of context and misleading in that it ignores Mr. Wakeman's extensive testimony describing how size, demographics, financial dynamics and managed care environment of the hospitals where he worked previously were vastly different from St. Luke's and the city of Toledo. For example, Herrick Memorial in Tecumseh, Michigan, War Memorial in Sault St. Mary Michigan, and Mercy Monroe in Monroe Michigan were all rural hospitals located in small communities with very limited competition. Also, all these hospitals were in Michigan where the managed care environment is very different than in Ohio. (Wakeman, Tr. 2706-2732).

1417. Once at St. Luke's, Mr. Wakeman implemented a "Three-year Plan" in June 2008 that contained five strategic pillars: "Growth, People, Quality, Service, and Finance/Corporate." (PX01026 at 001 (St. Luke's Three-Year Plan); Joint Stipulations of Law and Fact, JX00002A ¶ 39).

Response to Finding No. 1417:

This proposed finding is misleading because it implies that St. Luke's achieved most of the three-year plan including its financial goals. In fact, St. Luke's did not achieve the financial goals of the three-year plan – it did not achieve the financial pillar, as Mr. Wakeman himself testified. (RPF 1941-1954, 1955, *in camera*, 1956-1961). The evidence overwhelmingly demonstrates that St. Luke's financial problems continued despite the three-year plan implemented by Mr. Wakeman. (*See e.g.*, RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644). For example, St. Luke's and its parent OhioCare incurred significant financial losses in 2008, 2009 and the first eight months of 2010 despite growth in activity and revenues during that period. (RPF 1616-1620; PX02147 at 028-029). In response to Complaint Counsel's question to Mr. Wakeman suggesting that St. Luke's had improved during his tenure, Mr. Wakeman replied, "Activity, yes. Financial, no." (Wakeman, Tr. 2608).

1418. The three-year plan's strategic pillars included goals for turning St. Luke's financial performance around. (PX01026 at 001-002 (St. Luke's Three-Year Plan); RX-56 at 20 (¶ 50) (Den Uyl Expert Report), *in camera*). By the time of the Acquisition – a little over two years into the three-year plan – St. Luke's already had achieved four of the five pillars in Mr. Wakeman's turnaround plan. (Wakeman, Tr. 2593-2594).

Response to Finding No. 1418:

This proposed finding is misleading because it implies that St. Luke's achieved most of the three-year plan including its financial goals. In fact, St. Luke's did not achieve the financial goals of the three-year plan – it did not achieve the financial pillar, as Mr. Wakeman himself testified. (RPF 1941-1954, 1955, *in camera*, 1956-1961). The evidence overwhelmingly demonstrates that St. Luke's financial problems continued despite the three-year plan implemented by Mr. Wakeman. (*See e.g.*, RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644). For example, St. Luke's and its parent OhioCare incurred significant financial losses in 2008, 2009 and the first eight months of 2010 despite growth in activity and revenues during that period. (RPF 1616-1620; PX02147 at 028-029). In response to Complaint Counsel's question to Mr. Wakeman suggesting that St. Luke's had improved during his tenure, Mr. Wakeman replied, "Activity, yes. Financial, no." (Wakeman, Tr. 2608).

1419. Mr. Wakeman testified that St. Luke's experienced "significant" growth in inpatient and outpatient revenue – as well as in acute inpatient admissions, discharges, and outpatient visits – prior to the Acquisition. (Wakeman, Tr. 2594, 2597-2598; PX01920 at 010 (Wakeman, Dep. at 30-31), *in camera*). Mr. Wakeman also testified that St. Luke's operating cash flow margin (*i.e.*, EBITDA margin) and operating income improved significantly prior to the Acquisition. (Wakeman, Tr. 2594-2596).

Response to Finding No. 1419:

This proposed finding is inaccurate and misleading. First, in his response to Complaint Counsel's question of whether revenues increased significantly in the twelve months leading up to the joinder, Mr. Wakeman emphasized only that "*gross* revenues" did increase. (Wakeman,

Tr. 2594) (emphasis added). Second, the proposed finding is misleading because it implies that St. Luke's finances were healthy by 2010. However, the evidence overwhelmingly demonstrates that St. Luke's financial problems were still present as of 2010. (*See e.g.*, RPF 1616-1624, 1625-1628, *in camera*, 1629-1632, 1633, *in camera*, 1634-1640, 1641-1643, *in camera*, 1644). For example, St. Luke's and its parent OhioCare incurred significant financial losses the first eight months of 2010 despite growth in revenues during that period. (RPF 1616-1620; PX02147 at 028-029). As Mr. Wakeman explained, St. Luke's September 2009 year-to-date income statement and 2010 budget were {

} (Wakeman, Tr. 2942-2943, *in camera*; PX01283-002, *in camera*).

Although St. Luke's EBITDA margin improved prior to the joinder, {

} (RPF 1627, *in camera*). Furthermore, {

} (RPF 2068, *in camera*). Indeed, OhioCare's EBITDA and EBITDA margin were negative from 2008 through the joinder. (RPF 1625). In addition, {

} (RPF 2067, *in camera*).

1420. At the end of 2009, Mr. Wakeman told St. Luke's Board of Directors that St. Luke's would stay open for at least four to seven years if it did not partner with another hospital. (Wakeman, Tr. 2624-2625; PX01920 at 037-038 (Wakeman, Dep. at 141-142), *in camera*).

Response to Finding No. 1420:

This proposed finding is inaccurate and misleading. Mr. Wakeman testified that St. Luke's might be able to keep its doors open for {

}. (PX01920 (Wakeman, Dep. at 141-143)). Mr. Wagner, as St. Luke's acting CFO, testified that St. Luke's could continue as an independent hospital for { }. (PX01915 (Wagner, IHT at 211), *in camera*). While Mr. Oostra, ProMedica's CEO, testified that St. Luke's as an independent entity { }, he could not answer whether St. Luke's would have had to close its doors after { }. PX01918 at 013 (Oostra, Dep. at 45-46), *in camera*).

1421. Mr. Wakeman spent eighteen hours with Respondent's counsel preparing for his trial testimony. (Wakeman, Tr. 2462-2463).

Response to Finding No. 1421:

Respondent has no specific response.

2. Respondent's Witnesses

Neville Arjani

1422. Mr. Arjani is a principal and chief actuary at Findley Davies. (Arjani, Tr. 6721). He has been chief actuary for Findley Davies since 2000, and is responsible for the actuarial practice, as well as monitoring actuarial standards and practices. (Arjani, Tr. 6722).

Response to Finding No. 1422:

Respondent has no specific response.

1423. Findley Davies is a human resource and employee benefits consulting firm. It provides actuarial and administration services relating to defined benefit pension funds. (Arjani, Tr. 6721).

Response to Finding No. 1423:

Respondent has no specific response.

1424. ProMedica has been an actuarial client of Findley Davies since at least 2000 when Mr. Arjani joined the company. (Arjani, Tr. 6774). Mr. Arjani has personally worked with ProMedica as his client for more than ten years, and considers ProMedica to be a large

and important client. (Arjani, Tr. 6774). ProMedica is also a client of other practices at Findley Davies. (Arjani, Tr. 6774).

Response to Finding No. 1424:

Complaint Counsel's proposed finding is misleading. Mr. Arjani testified that ProMedica is no more important than any of its clients. (Arjani, Tr. 6777).

1425. Prior to the Acquisition, St. Luke's has not been an actuarial client of Findley Davies. (Arjani, Tr. 6775). St. Luke's was a client of Towers Watson, a competitor to Findley Davies. (Arjani, Tr. 6775-6776). Mr. Arjani and Findley Davies had tried to get St. Luke's business for actuarial services but did not succeed in doing so until after ProMedica acquired St. Luke's. (Arjani, Tr. 6775-6776).. Findley Davies will now be providing all actuarial services to St. Luke's for the foreseeable future. (Arjani, Tr. 6776).

Response to Finding No. 1425:

Complaint Counsel's proposed finding is misleading. Mr. Arjani testified that he hopes to continue providing services to ProMedica, but that such decisions ultimately rest with the client. (Arjani, Tr. 6776).

1426. Respondent's counsel notified Mr. Arjani approximately two and a half months prior to his testimony that he would be called to testify. (Arjani, Tr. 6771). Mr. Arjani met with Respondent's counsel for approximately four hours the day before testifying. (Arjani, Tr. 6771-6772).

Response to Finding No. 1426:

Respondent has no specific response.

1427. Mr. Arjani had an idea of some of the questions he would be asked by Respondent's counsel while on the witness stand. (Arjani, Tr. 6772). Mr. Arjani and Respondent's counsel discussed the answers to questions that he would be asked while testifying. (Arjani, Tr. 6772).

Response to Finding No. 1427:

Complaint Counsel misstates Mr. Arjani's testimony. Mr. Arjani stated that he had "some idea of the questions" that he would be asked during his testimony, but that he did not know whether they were identical to the questions he was asked at trial. (Arjani, Tr. 6772).

1428. Mr. Arjani spent time discussing a memo with ProMedica employee and witness Lori Johnston in conjunction with this litigation. (Arjani, Tr. 6773).

Response to Finding No. 1428:

Complaint Counsel's proposed finding is misleading. Mr. Arjani was unable to recall which memo was discussed and the conversation he described occurred more than a month before his testimony. (Arjani, Tr. 6773).

1429. Mr. Arjani charged the time that he spent preparing for his testimony and testifying at trial to ProMedica. (Arjani, Tr. 6773).

Response to Finding No. 1429:

Complaint Counsel misrepresents Mr. Arjani's testimony. Mr. Arjani testified that he charged his time, as he does for all his work, to the proper internal code. (Arjani, Tr. 6773). He has no knowledge whether his firm's relationship managêment partner will actually bill ProMedica for his time or not. (Arjani, Tr. 6773).

James Black

1430. Mr. Black is the Chairman of the Board of Directors of St. Luke's Hospital. (Black, Tr. 5529). He has been a member of the Board since 2000. (Black, Tr. 5529). Mr. Black assumed chairmanship of the Board in March of 2010, and his term will run until March of 2012. (Black, Tr. 5538).

Response to Finding No. 1430:

Respondent has no specific response.

1431. Mr. Black previously served as Vice-Chairman of the Board. (Black, Tr. 5542-5543). He also serves on the St. Luke's Foundation Board. (Black, Tr. 5540).

Response to Finding No. 1431:

Respondent has no specific response.

1432. Since the Acquisition, Mr. Black now also serves on the Toledo metro acute-care hospital council, the investment council, and the board development council of ProMedica Health System. (Black, Tr. 5547-5549).

Response to Finding No. 1432:

Respondent has no specific response.

1433. Mr. Black met with counsel for about eight to ten hours in preparation for his testimony at trial. (Black, Tr. 5667-5668).

Response to Finding No. 1433:

Respondent has no specific response.

Bruce Gordon

1434. Mr. Gordon currently works for Radian Asset Assurance, a bond insurer that guarantees the payment of principal and interest on bonds that are issued by various organizations. (Gordon, Tr. 6783).

Response to Finding No. 1434:

Respondent has no specific response.

1435. At Radian, Mr. Gordon's responsibility is to conduct credit reviews of the companies that issued Radian-insured bonds. (Gordon, Tr. 6784). Mr. Gordon's portfolio of companies primarily consists of hospitals and healthcare systems. (Gordon, Tr. 6784).

Response to Finding No. 1435:

Respondent has no specific response.

1436. From October 2007 until October 2010, Mr. Gordon was First Vice President at Ambac Assurance, also a bond insurer. (Gordon, Tr. 6784).

Response to Finding No. 1436:

Respondent has no specific response.

1437. At Ambac, Mr. Gordon's responsibilities included conducting credit reviews of Ambac's existing insurance commitments. (Gordon, Tr. 6785). His portfolio of approximately 50 to 70 companies consisted of hospitals and healthcare systems. (Gordon, Tr. 6785-6786).

Response to Finding No. 1437:

Respondent has no specific response.

1438. While at Ambac, Mr. Gordon had primary responsibility for tracking the performance of St. Luke's Series 2004 bonds, which were insured by Ambac. (Gordon, Tr. 6789).

Response to Finding No. 1438:

Respondent has no specific response.

1439. Mr. Gordon testified that St. Luke's has a "very modest debt position." (Gordon, Tr. 6858). He also testified that, in early 2010, St. Luke's cash reserves were "significant" relative to the amount of debt it had outstanding and that St. Luke's had sufficient cash on hand to repay the entire balance of its Ambac-insured bonds. (Gordon, Tr. 6858-6859).

Response to Finding No. 1439:

The material in Finding No. 1439 should be marked *in camera*, per the Court's order on September 16, 2011 granting non-party Ambac's *in camera* motion. In addition, Complaint Counsel misstates Mr. Gordon's testimony because he also explained that { } (Gordon, Tr. 6879, *in camera*). Mr. Gordon also testified that the { } (Gordon, Tr. 6879-6880, *in camera*).

1440. Mr. Gordon testified that an { } performed internally by Ambac concluded that St. Luke's was not considered an { } (Gordon, Tr. 6864, *in camera*). Out of { }, St. Luke's was placed in the category associated with the } – in part due to St. Luke's { }. (Gordon, Tr. 6864-6865, *in camera*).

Response to Finding No. 1440:

Respondent has no specific response.

1441. For purposes of the { }, Mr. Gordon did not have access to { }. (Gordon, Tr. 6865-6866, *in camera*). As a result, Mr. Gordon was not aware of { }. (Gordon, Tr. 6869-6870, 6873, 6876, 6878, *in camera*). Mr. Gordon testified that, had he been aware of them, he { }. (Gordon, Tr. 6869-6871, 6874-6878, *in camera*).

Response to Finding No. 1441:

Complaint Counsel misstates Mr. Gordon's testimony. Mr. Gordon testified that he

{

} (Gordon, Tr. 6865, *in camera*). Further, Mr. Gordon testified that {

} (Gordon, Tr. 6871, *in camera*). Further, Mr. Gordon testified that {

} (Gordon, Tr. 6881, *in camera*).

Kathleen Hanley

1442. Ms. Hanley has been the Chief Financial Officer ("CFO") of ProMedica since 1995. (Hanley, Tr. 4500-4501). Ms. Hanley has also served as the Chief Strategic Planning and Business Development Officer since July 2010 and the President of ProMedica Indemnity Corporation, ProMedica's captive insurance company since 2006. (Hanley, Tr. 4517).

Response to Finding No. 1442:

Respondent has no specific response.

1443. Ms. Hanley is among the most highly paid executives at ProMedica, receiving over $670,000 in salary and compensation in 2009 and the same, if not more, in 2010. (Hanley, Tr. 4686-4687). Forty percent of Ms. Hanley's compensation is a bonus determined by the compensation committee of ProMedica. (Hanley, Tr. 4687).

Response to Finding No. 1443:

Respondent has no specific response.

1444. As CFO of ProMedica, Ms. Hanley is responsible for providing oversight of the financial planning, budgeting, capital planning, treasury, risk management, and audit functions at ProMedica. (Hanley, Tr. 4501). Ms. Hanley reports directly to ProMedica's CEO, Randall Oostra. (Hanley, Tr. 4501).

Response to Finding No. 1444:

Respondent has no specific response.

1445. As Chief Strategic Planning and Business Development Officer, Ms. Hanley is responsible for developing a three-year strategic plan for ProMedica. (Hanley, Tr. 4520).

Response to Finding No. 1445:

Respondent has no specific response.

1446. As President of ProMedica Indemnity Corporation, Ms. Hanley oversees the corporation responsible for bearing professional and general liability risk as well as ProMedica's insurance and risk management functions. (Hanley, Tr. 4521-4522).

Response to Finding No. 1446:

Respondent has no specific response.

1447. Ms. Hanley supports several ProMedica board committees: the finance committee, the investment committee, the audit and compliance committee, and the indemnity corporation board. (Hanley, Tr. 4523).

Response to Finding No. 1447:

Respondent has no specific response.

1448. Ms. Hanley has worked for the Respondent for 30 years. (Hanley, Tr. 4684).

Response to Finding No. 1448:

Respondent has no specific response.

1449. Ms. Hanley was personally and significantly involved in a leadership role in the acquisition of St. Luke's – an important event for ProMedica as an organization. (Hanley, Tr. 4692).

Response to Finding No. 1449:

Respondent has no specific response.

1450. Ms. Hanley is not directly involved in the negotiations of provider contracts with commercial payers in Toledo. (Hanley, Tr. 4515).

Response to Finding No. 1450:

Respondent has no specific response.

1451. Ms. Hanley testified that she has no basis to testify on the seasonality of St. Luke's business and its impact on St. Luke's performance during the last four months of 2010, beyond her experience at ProMedica. (Hanley, Tr. 4827, *in camera*).

Response to Finding No. 1451:

Ms. Hanley testified that "admissions for hospitals are seasonal" and explained how admissions vary by the time of the year. (Hanley, Tr. 4697). Further, she testified that her basis for testifying on the seasonality at St. Luke's was her "experience in the healthcare industry" which includes over 30 years at ProMedica. (CCPF 1448).

1452. In preparation for her testimony, Ms. Hanley met with counsel for approximately five hours. (Hanley, Tr. 4682).

Response to Finding No. 1452:

Respondent has no specific response.

Lori Johnston

1453. Ms. Johnston is the Chief Financial Officer and the Chief Operating Officer of St. Luke's. (Johnston, Tr. 5303, 5306). Ms. Johnston reports directly to both St. Luke's CEO, Daniel Wakeman, and ProMedica's Senior Vice President of Finance, Gary Akenberger. (Johnston, Tr. 5303).

Response to Finding No. 1453:

Respondent has no specific response.

1454. Ms. Johnston has had a title at St. Luke's only since September 1, 2010, as a result of the Acquisition. (Johnston, Tr. 5421).

Response to Finding No. 1454:

Respondent has no specific response.

1455. Ms. Johnston had no responsibilities relating to St. Luke's prior to September 1, 2010. (Johnston, Tr. 5424). For example, she had no responsibilities relating to: negotiations on behalf of St. Luke's, competitive strategies on behalf of St. Luke's, seeking debt or financing on behalf of St. Luke's, decision making on behalf of St. Luke's, or development of goals for or implementation of Mr. Wakeman's three-year turnaround plan. (Johnston, Tr. 5424-5426).

Response to Finding No. 1455:

Respondent has no specific response.

1456. Ms. Johnston has worked for the Respondent for 15 years. (Johnston, Tr. 5415). Ms. Johnston's compensation, including the size of her bonus, is determined by the board of ProMedica Health System. (Johnston, Tr. 5416). The scope of Ms. Johnston's responsibilities is also determined by the ProMedica board of directors. (Johnston, Tr. 5416-5417).

Response to Finding No. 1456:

Respondent has no specific response.

1457. Ms. Johnston has never worked for a health plan. (Johnston, Tr. 5420).

Response to Finding No. 1457:

Respondent has no specific response.

1458. Ms. Johnston has never participated in a negotiation relating to the rates a commercial health plan would pay to ProMedica, St. Luke's, or any other hospital for hospital services. (Johnston, Tr. 5420-5421).

Response to Finding No. 1458:

Respondent has no specific response.

1459. Ms. Johnston was not involved in negotiations between ProMedica and St. Luke's relating to the Acquisition. (Johnston, Tr. 5426). She neither conducted a formal efficiencies analysis nor did she quantify the efficiencies that might be achieved through the Acquisition. (Johnston, Tr. 5427). Ms. Johnston never met with Compass Lexecon to discuss how efficiencies might be achieved through the Acquisition. (Johnston, Tr. 5428). She did not see or review Compass Lexecon's report on efficiencies prior to the Acquisition. (Johnston, Tr. 5428). As of February 4, 2011 (more than five months after the Acquisition), Ms. Johnston had not had direct dealings with Compass Lexecon. (Johnston, Tr. 5428-5429).

Response to Finding No. 1459:

As of February 4, 2011, however, Ms. Johnston had seen the Compass Lexecon report and was very involved in integration activities. (Johnston, Tr. 5429).

1460. Ms. Johnston is not an expert on the specifics of bond covenants or in seeking debt financing. (Johnston, Tr. 5449, 5461).

Response to Finding No. 1460:

Respondent has no specific response.

1461. Ms. Johnston is currently not involved in obtaining financing at any of the ProMedica hospitals. (Johnston, Tr. 5461-5462).

Response to Finding No. 1461:

Respondent has no specific response.

1462. Ms. Johnston is not a pension plan expert. (PX01926 at 007 (Johnston, Dep. at 19), *in camera*). She is neither an actuary nor an expert on actuarial accounting. (Johnston, Tr. 5505, *in camera*). Similarly, Ms. Johnston is not an expert on pension plan accounting. (PX01926 at 009 (Johnston, Dep. at 28-29, *in camera*).

Response to Finding No. 1462:

Complaint Counsel's proposed finding is misleading. Ms. Johnston testified that she has substantial experience with pension funds, particularly for someone who is not an actuary. She has done pension auditing since 1983 and worked with pension plans at ProMedica in her roles as vice president of finance for Toledo and Flower Hospitals. (Johnston, Tr. 5503). She also was responsible for pension plans as ProMedica's senior vice president for continuing care. (Johnston, Tr. 5503).

1463. Ms. Johnston had not heard of the acronym "AFTAP" at the time of her deposition in February 2011 and at the time of her testimony in July 2011 could still not identify what the acronym "AFTAP" meant. (Johnston, Tr. 5506-5507).

Response to Finding No. 1463:

Complaint Counsel's proposed finding is misleading. Ms. Johnston is completely familiar with the underlying concept, but testified that she was merely not familiar with the acronym. (Johnston, Tr. 5507).

1464. Ms. Johnston met with ProMedica's counsel on three separate occasions for a total of 10 to 11 hours to prepare for her testimony and was compensated by ProMedica for this time, and for her time testifying at trial. (Johnston, Tr. 5417-5419).

Response to Finding No. 1464:

Respondent has no specific response.

Kevin Nolan

1465. Mr. Nolan has been the managing director responsible for the healthcare strategy practice at Navigant Consulting since 2002. (Nolan, Tr. 6246). Mr. Nolan's responsibilities include selling and delivering engagements to healthcare clients. (Nolan, Tr. 6250).

Response to Finding No. 1465:

Respondent has no specific response.

1466. Respondent's counsel reviewed Navigant's work product before it was discussed with ProMedica with respect to the clinical integration strategy project. (Nolan, Tr. 6324).

Response to Finding No. 1466:

The proposed finding is misleading. Mr. Nolan testified that Respondent's counsel's review of Navigant's work product changed neither its conclusions or recommendations as a result of the attorney review. (Nolan, Tr. 6397).

1467. Navigant and Mr. Nolan did not do a detailed review of St. Luke's financials. (Nolan, Tr. 6376). Mr. Nolan's level of knowledge of St. Luke's financial condition was at the "30,000 foot" level. (Nolan, Tr. 6376).

Response to Finding No. 1467:

Respondent has no specific response.

1468. ProMedica, not Navigant, generated the efficiencies estimates in the Navigant report. (Nolan, Tr. 6364-6365). Navigant only reviewed the efficiencies estimates for reasonableness. (Nolan, Tr. 6365).

Response to Finding No. 1468:

Respondent has no specific response.

1469. Mr. Nolan does not know how ProMedica and St. Luke's calculated the efficiencies estimates. (Nolan, Tr. 6365). Mr. Nolan also does not know how much, if any, of the efficiencies savings in the Navigant report are tied to moving services out of St. Luke's. (Nolan, Tr. 6365).

Response to Finding No. 1469:

Respondent has no specific response.

1470. Mr. Nolan is not a quality expert. (Nolan, Tr. 6338)

Response to Finding No. 1470:

However, Mr. Nolan has over 25 years of experience in healthcare consulting and is familiar with hospital quality rankings. (Nolan, Tr. 6246-6247, 6338).

1471. Since at least 2009, Navigant has engaged in a recurring relationship with both St. Luke's and ProMedica. (Nolan, Tr. 6388). Mr. Nolan testified that Navigant hopes to obtain additional projects from ProMedica in the future. (Nolan, Tr. 6388).

Response to Finding No. 1471:

Respondent has no specific response.

1472. Mr. Nolan was the lead individual on a clinical integration project that Navigant conducted for ProMedica between 2010 and 2011. (Nolan, Tr. 6382). Navigant was paid $200,000 for its services. (Nolan, Tr. 6382). Navigant also earned between $50,000 and $85,000 for assisting ProMedica during its due diligence process for the Acquisition. (Nolan, Tr. 6385-6386).

Response to Finding No. 1472:

Respondent has no specific response.

1473. Mr. Nolan oversaw several projects that Navigant performed for St. Luke's in the last couple of years, including: a coding and documentation study in 2009, support for St. Luke's Board retreats in both 2009 and 2010, and technical assistance to St. Luke's evaluation of affiliation options. (Nolan, Tr. 6382-6385). Navigant also performed a managed care reimbursement study for St. Luke's in 2009. (Nolan, Tr. 6385).

Response to Finding No. 1473:

Mr. Nolan was not involved in the coding and documentation project that Navigant performed for St. Luke's. (Nolan, Tr. 6383). Mr. Nolan was not involved in the managed care reimbursement study, either. (Nolan, Tr. 6385).

1474. Mr. Nolan was represented by Respondent's legal counsel in all matters relating to his trial and deposition testimony in this matter. (Nolan, Tr. 6389). Bills associated with Mr. Nolan's legal representation in this matter were sent to ProMedica. (Nolan, Tr. 6391). In addition, Mr. Nolan has also been paid by ProMedica for the time he has spent preparing for and attending his deposition and examination in court. (Nolan, Tr. 6392).

Response to Finding No. 1474:

The proposed finding is misleading. Mr. Nolan testified that "[a]s part of our standard

contract with our clients, if we get subpoenaed as a result of some of our work, in our contract language it typically says that they will pay for our time and expenses associated with the depositions and the testimony, so that's very likely the case." (Nolan, Tr. 6390).

Randall Oostra

1475. Mr. Oostra is President and CEO of ProMedica Health System. He has held this position for almost two years. (Oostra, Tr. 5759).

Response to Finding No. 1475:

Respondent has no specific response.

1476. Mr. Oostra spends half of his time on externally focused events such as community outreach and half of his time on internally focused events such as meetings with the executive council, other management groups, and the board. (Oostra, Tr. 5761-5762).

Response to Finding No. 1476:

Respondent has no specific response.

1477. Mr. Oostra joined ProMedica Health System in 1997. (Oostra, Tr. 5763). Before October 2009, Mr. Oostra was the President and Chief Operating Officer. (Oostra, Tr. 5764). Mr. Oostra has also served as ProMedica's Director of Strategic Planning and Business Development. (Oostra, Tr. 5768).

Response to Finding No. 1477:

Respondent has no specific response.

1478. Mr. Oostra has a bachelor of arts degree in biology, a medical technology degree, a master's degree in science, a master's degree in healthcare administration, and a doctorate in management. (Oostra, Tr. 5770).

Response to Finding No. 1478:

Respondent has no specific response.

1479. With respect to ProMedica's contracting with health plans, Mr. Oostra is involved at a high level with the strategy and general parameters underlying these contracts, including ProMedica's approach to reimbursement rates. (Oostra, Tr. 6079). At the very least, Mr. Oostra has a general understanding of the contracting process and of the dynamic between health plans and ProMedica. (Oostra, Tr. 6079).

Response to Finding No. 1479:

Respondent has no specific response.

1480. Mr. Oostra called the CEO of MMO specifically to discuss the testimony of MMO's Vice President of Network Management during this trial. (Oostra, Tr. 5961-5962).

Response to Finding No. 1480:

The proposed finding is misleading. Mr. Oostra called the CEO of MMO, Mr. Chiricosta, after listening to a portion of the testimony of MMO's Vice President of Network Management during this trial. (Oostra, Tr. 5961-5962). Mr. Oostra called Mr. Chiricosta to ask him if he had any concerns with ProMedica. (Oostra, Tr. 5961).

John Randolph

1481. Mr. Randolph is employed by Respondent ProMedica Health System and has worked there for his entire 30-year career. (Randolph, Tr. 7053-7054). Mr. Randolph reports to Randall Oostra, the President and CEO of the Respondent. (Randolph, Tr. 7054). ProMedica determines the scope of Mr. Randolph's responsibilities at Paramount, as well as his promotions, his salary, and his bonuses and incentives. (Randolph, Tr. 7054).

Response to Finding No. 1481:

Respondent has no specific response.

1482. Mr. Randolph has held multiple business roles within ProMedica concurrently with serving as president of Paramount, including as Chief Merger and JV Acquisitions Officer and Chief Construction and Property Management Officer. (Randolph, Tr. 7055-7056).

Response to Finding No. 1482:

The proposed finding is an incomplete statement of the record. Mr. Randolph served as Chief Merger and JV Acquisitions Officer from 2009 until July 2010. (Randolph, Tr. 7055). He has served as Chief Construction and Property Management Officer since July 2010. (Randolph, Tr. 7055).

1483. Mr. Randolph serves on ProMedica's Managed Care Oversight Committee with ProMedica's Director of Managed Care Contracting Ron Wachsman, CFO Kathy Hanley and CEO Randall Oostra. (Randolph, Tr. 7056-7057).

Response to Finding No. 1483:

The proposed finding is an incomplete statement of the record. Mr. Randolph is sometimes required to be excused from Managed Care Oversight Committee meetings when, for example, the Committee holds discussions relating to ProMedica's dealings with MCOs that are competitors of Paramount, and if confidential information with respect to ProMedica's contracts with other health plans is discussed. (Randolph, Tr. 7056).

1484. Mr. Randolph serves on the Executive Council with the heads of other business units at ProMedica and the CEO. (Randolph, Tr. 7057). The Executive Council meets to discuss operational and policy matters. (Randolph, Tr. 7057).

Response to Finding No. 1484:

Respondent has no specific response.

1485. Mr. Randolph previously served on the Customer Services Steering Council, in connection with his previous responsibilities for ProMedica's customer satisfaction services. (Randolph, Tr. 7057-7078).

Response to Finding No. 1485:

Respondent has no specific response.

1486. In 2008, Mr. Wachsman shared terms and dates from Anthem's contract with Mr. Randolph that were not publicly available at the time. (Randolph, Tr. 7088-7090).

Response to Finding No. 1486:

The proposed finding misstates and mischaracterizes the record. The only information shared with Mr. Randolph was { } (Randolph, Tr. 7090). However, it was "commonly known in the marketplace" that St. Luke's was in discussions with Anthem. (Randolph, Tr. 7089). No specific financial information, or any other terms, were shared with Mr. Randolph. (Randolph, Tr. 7088-7089). Mr. Randolph further testified that "Mr. Wachsman does not disclose specific information about provider contracts." (Randolph, Tr. 7089).

Dr. Elizabeth Read

Response to Finding No. 1498:

Respondent has no specific response.

Ronald Wachsman

1499. Mr. Wachsman is the Senior Vice President for Managed Care, Reimbursement and Revenue Cycle Management at ProMedica Health Systems. (Wachsman, Tr. 4833). He has held this position for about two years. (Wachsman, Tr. 4836).

Response to Finding No. 1499:

Respondent has no specific response.

1500. Mr. Wachsman is responsible for ProMedica's relationships with managed care companies, monitoring government reimbursement issues, and billing. (Wachsman, Tr. 4833). Mr. Wachsman negotiates with commercial health plans who contract with ProMedica Health System hospitals, including its Lucas County hospitals. (Wachsman, Tr. 4833-4836).

Response to Finding No. 1500:

Respondent has no specific response.

1501. Mr. Wachsman's bonus is tied to obtaining favorable rates for ProMedica in negotiations with commercial health plans. (Wachsman, Tr. 5097-5099).

Response to Finding No. 1501:

The proposed finding is inaccurate and misleading. Mr. Wachsman's total compensation includes an incentive system that allows him to receive an annual bonus based on a formula derived from a blended set of individual goals and a set of ProMedica Health System goals. (PX01945 (Wachsman, Dep. at 19-20)). One of Mr. Wachsman's goals is to achieve contract agreements with MCOs consistent with ProMedica's cost coverage parameters. (PX01945 (Wachsman, Dep. at 21)). Mr. Wachsman's incentive does not correlate with how high the reimbursement rates might be under ProMedica's contracts with MCOs. (PX01945 (Wachsman, Dep. at 21)).

1502. Mr. Wachsman, and other members of ProMedica's system management, have taken over managed care contracting for St. Luke's since the Acquisition. (Wachsman, Tr. 5095-

5096). No one associated with St. Luke's prior to the Acquisition has directly participated in contract negotiations since the Acquisition, nor will they going forward under ProMedica's current plans. (Wachsman, Tr. 5096).

Response to Finding No. 1502:

Respondent has no specific response.

1503. Mr. Wachsman has been employed by ProMedica or its predecessor his entire career, over 20 years. (Wachsman, Tr. 4837-4838).

Response to Finding No. 1503:

Respondent has no specific response.

B. Expert Witnesses Who Testified at Trial

1. Complaint Counsel's Witnesses

a. Gabriel Dagen

1504. Gabriel Dagen has worked for the Federal Trade Commission's ("FTC") Bureau of Economics Office of Accounting and Financial Analysis for the last thirteen years. (Dagen, Tr. 3138; PX02127 at 001 (Gabriel Dagen Resume)). For the last eight years, he has held the position of Assistant Director. (Dagen, Tr. 3138; PX02127 at 001 (Gabriel Dagen Resume)). Before becoming Assistant Director, Mr. Dagen was a Senior Financial Analyst for three years. (Dagen, Tr. 3139; PX02127 at 001 (Gabriel Dagen Resume)).

Response to Finding No. 1504:

Respondent has no specific response.

1505. As Assistant Director, Mr. Dagen is the principal accounting and financial advisor to the FTC. (PX02127 at 001 (Gabriel Dagen Resume)). He also conducts financial seminars for FTC staff. (PX02127 at 001 (Gabriel Dagen Resume)).

Response to Finding No. 1505:

Respondent has no specific response.

1506. While at the FTC, Mr. Dagen has analyzed the financial condition of over fifty companies, including over a dozen hospitals. (Dagen, Tr. 3140-3141). At least half of those instances involved a company that was alleged to be "failing" or "flailing." (Dagen, Tr. 3141).

Response to Finding No. 1506:

Respondent references back to its replies to Complaint Counsel's proposed findings of fact in previous sections which detail flaws in Mr. Dagen's analysis. (*See supra* Sections XV, XVI).

1517. Mr. Dagen concluded that Respondent's claimed efficiencies "should not be credited by the Court because they either are not actual efficiencies, do not require the joinder to be accomplished, or are speculative and unsubstantiated." (PX02147 at 005 (¶ 10) (Dagen Expert Report)). His analysis found that a "de minimis portion of the alleged efficiencies might be credited under the *Horizontal Merger Guidelines*." (PX02147 at 007 (¶ 17) (Dagen Expert Report)).

Response to Finding No. 1517:

Respondent references back to its replies to Complaint Counsel's proposed findings of fact in previous sections which detail flaws in Mr. Dagen's analysis. (*See supra* Sections XV, XVI).

b. Errol Brick

1518. Mr. Brick is the founder, president, and CEO of Killarney Advisors, Inc. (Brick, Tr. 3422). Killarney Advisors, Inc., founded in 1995, provides financial advisory services to nonprofit hospitals, universities, and colleges in connection with their accessing the tax-exempt bond markets. (Brick, Tr. 3422).

Response to Finding No. 1518:

Respondent has no specific response.

1519. In connection with his work at Killarney Advisors, Mr. Brick regularly assists clients to review the financial feasibility of proposed projects, to review the information clients provide to the bond rating agencies relating to their own finances and the proposed project, as well as assists clients throughout the stages of financing from selecting an underwriter until the funds are delivered. (Brick, Tr. 3422-3423). A very important part of this process includes developing a strategy for dealing with the credit rating agencies, assisting with presentations to the credit rating agencies, and analyzing the client's credit rating and the impact of proposed projects on that rating. (Brick, Tr. 3423-3424).

Response to Finding No. 1519:

Respondent has no specific response.

1520. Killarney Advisors' clients include very large academic medical systems, like Johns Hopkins Health System, smaller academic medical systems, like Rush University

Medical Center, and smaller community hospitals, such as those with between 100 and 300 beds. (Brick, Tr. 3423).

Response to Finding No. 1520:

Respondent has no specific response.

1521. Prior to founding Killarney Advisors, Mr. Brick was a vice president in the municipal bond department at Goldman Sachs & Company from 1979 to 1995. (Brick, Tr. 3424). In that position, Mr. Brick provided underwriting services, including assisting clients to develop financing plans, assisting clients with the rating agencies, and structuring bond issues, for healthcare clients. (Brick, Tr. 3425). Mr. Brick raised approximately $4 billion for clients through the issuance of tax-exempt bond during this time. (Brick, Tr. 3425)

Response to Finding No. 1521:

Respondent has no specific response.

1522. From 1976 to 1979, Mr. Brick provided financial advisory services to nonprofit hospitals seeking project financing while he was employed by North Atlantic Capital Corporation. (Brick, Tr. 3425-3426).

Response to Finding No. 1522:

Respondent has no specific response.

1523. From 1972 to 1976, Mr. Brick was a senior management consultant at Touche Ross & Company, now known as Deloitte & Touche. (Brick, Tr. 3426). At Touche Ross & Company, Mr. Brick assisted hospitals to evaluate financial feasibility by investigating and projecting hospital project costs and revenues. (Brick, Tr. 3427).

Response to Finding No. 1523:

Respondent has no specific response.

1524. Mr. Brick received a bachelor's of commerce degree in economics, a certificate in the theory of accountancy, and a master's degree in business administration with a concentration in economics from the University of Witwatersrand in Johannesburg, South Africa. (Brick, Tr. 3427).

Response to Finding No. 1524:

Respondent has no specific response.

1525. Mr. Brick is licensed as a certified public accountant by the State of New York and is licensed as a general securities representative, a general securities principal, and an investment banking agent by FINRA. (Brick, Tr. 3428).

Response to Finding No. 1525:

Respondent has no specific response.

1526. Mr. Brick has previously provided expert testimony before the Maryland Health Services Cost Review Commission relating to access to capital and before the Internal Revenue Service on the use of interest rate swaps to synthetically fix the cost of floating rate debt. (Brick, Tr. 3428-3429). Mr. Brick has also served as a consultant to the FTC in connection with a hospital merger investigation in 2008. (Brick, Tr. 3429).

Response to Finding No. 1526:

Respondent has no specific response.

1527. Mr. Brick was asked to evaluate whether the downgrade of St. Luke's Hospital to Baa2 in any way precluded it from being a significant competitor in the marketplace then and in the future. (Brick, Tr. 3429-3430).

Response to Finding No. 1527:

Respondent has no specific response.

1528. Mr. Brick concluded that the downgrade did not impair St. Luke's ability to be a significant competitor in the market place. (Brick, Tr. 3430).

Response to Finding No. 1528:

Respondent references back to its replies to Complaint Counsel's proposed findings of fact in previous sections which detail flaws in Mr. Brick's analysis. (*See supra* Section XVI).

c. Robert Town

1529. Professor Town is a healthcare economist. (Town, Tr. 3579). His research and teaching focus principally on health economics, competition in healthcare markets, applied econometrics, the industrial organization of healthcare, and other fields directly related to health economics. (Town, Tr. 3579; PX02148 at 004 (¶ 2), 115 (Ex. 1) (Town Expert Report), *in camera*).

Response to Finding No. 1529:

Respondent has no specific response.

1530. Professor Town received his B.A. in Economics in 1984 from the University of Washington in Seattle. (Town, Tr. 3575).

Response to Finding No. 1530:

Respondent has no specific response.

1531. Professor Town received his M.S. and Ph.D. in economics in 1987 and 1990, respectively, from the University of Wisconsin, Madison. (Town, Tr. 3575). His Ph.D. dissertation focused on theoretical and econometric analysis of mergers, acquisitions, and cartel behavior. (Town, Tr. 3575-3576).

Response to Finding No. 1531:

Respondent has no specific response.

1532. Professor Town is currently an associate professor in the Department of Healthcare Management at the Wharton School of the University of Pennsylvania. (Town, Tr. 3576). He has occupied this position since July 1, 2011. (Town, Tr. 3576). In this position, Professor Town is responsible for teaching students pursuing M.B.A. and Ph.D. degrees and for continuing his research. (Town, Tr. 3576-3577).

Response to Finding No. 1532:

Respondent has no specific response.

1533. Professor Town is also a Research Associate at the National Bureau of Economic Research ("NBER"). (Town, Tr. 3577-3578). The NBER is the largest non-profit economics research organization in the country. (Town, Tr. 3577). One becomes a member by invitation only. (Town, Tr. 3577). Eighteen of the last 33 Nobel Prize winners in Economics are among its members. (Town, Tr. 3578). Professor Town was invited to join as a Faculty Research Fellow in 2004, and was promoted to Research Associate – the equivalent of a tenured position – in 2006. (Town, Tr. 3578).

Response to Finding No. 1533:

Respondent has no specific response.

1534. From 2007 to 2011, Professor Town held the James A. Hamilton Professorship in Health Economics at the University of Minnesota's School of Public Health. (Town, Tr. 3578). At that time, Professor Town was also an Adjunct Professor in that university's Department of Economics. (Town, Tr. 3578-3579).

Response to Finding No. 1534:

Respondent has no specific response.

1535. From 2005 to 2007, Professor Town was an Associate Professor (with tenure), focusing on healthcare management and policy, in the University of Minnesota's School of Public Health. (Town, Tr. 3579-3580).

Response to Finding No. 1535:

Respondent has no specific response.

1536. From 2001 to 2005, Professor Town was an Assistant Professor at the University of Minnesota. (Town, Tr. 3580).

Response to Finding No. 1536:

Respondent has no specific response.

1537. During the majority of his career at the University of Minnesota, Professor Town taught healthcare economics to enrollees of the university's hospital executive training program, a highly ranked program for training established and aspiring hospital employees in hospital administration. (Town, Tr. 3580-3581).

Response to Finding No. 1537:

This proposed finding is inaccurate. Professor Town did not testify that the training program was "highly ranked." (Town, Tr. 3580).

1538. From 1996 to 2001, Professor Town was an Assistant Professor at the Graduate School of Management at the University of California, Irvine. (Town, Tr. 3580-3581). In that position, he taught primarily microeconomics and strategy. (Town, Tr. 3581).

Response to Finding No. 1538:

Respondent has no specific response.

1539. From 1990 to 1996, Professor Town was a Staff Economist in the Antitrust Division at the United States Department of Justice. (Town, Tr. 3581). In that position, he was principally responsible for providing economic analysis on mergers and price-fixing cases. (Town, Tr. 3581). During his time in that position, he reviewed between 30 and 50 mergers. (Town, Tr. 3582).

Response to Finding No. 1539:

Respondent has no specific response.

1540. Professor Town has been an author on numerous peer-reviewed economics articles. (*See* PX02148 at 116-118 (Town Expert Report, Ex. 1), *in camera*). For example:

a. Professor Town co-authored the first paper to implement empirically a simulation of the impact of hospital mergers, accounting for the bargaining dynamic between hospitals and managed care organizations. (Town, Tr. 3582-3583).

b. Professor Town co-authored the first paper to implement empirical methods that allow economists to simulate the effects of policy changes on market structure in the hospital industry over time. (Town, Tr. 3583).

c. Professor Town co-authored an econometric paper that examined the impact of hospital consolidation in the 1990s and 2000s, finding that hospital consolidation in concentrated markets, consistent with the theory, led to higher rates of uninsurance among racial minorities and low-income populations. (Town, Tr. 3583-3584).

d. Professor Town co-authored an econometric paper that calculated the benefits of competition from private Medicare HMO plans. (Town, Tr. 3584).

e. All of these papers involved empirical work by Professor Town. (Town, Tr. 3584).

<u>Response to Finding No. 1540:</u>

Respondent has no specific response.

1541. Several of these papers have been heavily cited in subsequent research. (Town, Tr. 3584). Indeed, Respondent's economic expert cited some of Professor Town's papers in the report she filed during the preliminary injunction proceeding in Federal Court. (Town, Tr. 3584-3585).

<u>Response to Finding No. 1541:</u>

This proposed finding is misleading to the extent it implies that the subsequent research that supposedly cited his papers were actually presented as proof. Professor Town merely testified that several of the papers on which he has been author have been heavily cited. (Town, Tr. 3584).

1542. Professor Town was retained by the Federal Trade Commission in connection with the current matter in August 2010. (Town, Tr. 3585). The FTC retained him to analyze the competitive impact of ProMedica's acquisition of St. Luke's. (Town, Tr. 3584).

<u>Response to Finding No. 1542:</u>

Respondent has no specific response.

1543. Professor Town concluded that the acquisition of St. Luke's by ProMedica eliminates competition between ProMedica and St. Luke's, increasing their bargaining power, and will result in higher prices at St. Luke's and at ProMedica's legacy hospitals in Lucas County. (Town, Tr. 3600-3601).

Response to Finding No. 1543:

Respondent references back to responses to previous sections which detail Professor Town's analysis.

2. Respondent's Witnesses

a. Bruce Den Uyl

1544. Respondent's expert witness, Bruce Den Uyl, was asked to assess the financial performance of St. Luke's leading up to the Acquisition. (Den Uyl, Tr. 6412).

Response to Finding No. 1544:

Respondent references back to its replies to Complaint Counsel's proposed findings of fact in previous sections which detail Mr. Den Uyl's analysis. (*See supra* Section XVI).

1545. Mr. Den Uyl has never been employed by a hospital or physician practice. (Den Uyl, Tr. 6511).

Response to Finding No. 1545:

Mr. Den Uyl has over 25 years of experience providing valuation and financial consulting and expert testimony to a wide range of healthcare companies, including hospitals. (RX-56 at 000001, *in camera*).

1546. Mr. Den Uyl has never managed the day-to-day finances of a hospital. (Den Uyl, Tr. 6511).

Response to Finding No. 1546:

Mr. Den Uyl has over 25 years of experience providing valuation and financial consulting and expert testimony to a wide range of healthcare companies, including hospitals. (RX-56 at 000001, *in camera*). He has advised healthcare clients on structuring and financing transactions

and have served as a financial advisor to troubled and bankrupt healthcare entities and their creditors. (RX-56 at 000002, *in camera*).

1547. Mr. Den Uyl has never been employed by a health plan and has never directly participated in reimbursement negotiations on behalf of either a health plan or a hospital. (Den Uyl, Tr. 6511-6512).

Response to Finding No. 1547:

Mr. Den Uyl has over 25 years of experience providing valuation and financial consulting and expert testimony to a wide range of healthcare companies, including healthcare companies. (RX-56 at 000001-000002, *in camera*). He has been engaged to provide fairness reviews of transactions involved hospitals and managed care plans on behalf of State Attorneys General throughout the United States. (RX-56 at 000002, *in camera*).

1548. Mr. Den Uyl does not have a degree in accounting, and has never taken an accounting course. (Den Uyl, Tr. 6513-6514). Mr. Den Uyl also has never taught an accounting course. (PX01951 at 009 (Den Uyl, Dep. at 30), *in camera*; Den Uyl, Tr. 6513).

Response to Finding No. 1548:

Mr. Den Uyl has a degree in economics. (RX-56 at 000046, *in camera*). Mr. Den Uyl was a Partner and Director of the Healthcare Valuations group at Price Waterhouse. (RX-56 at 000046, *in camera*). Mr. Den Uyl has over 25 years of experience providing valuation and financial consulting and expert testimony to a wide range of healthcare companies, including hospitals. (RX-56 at 000001, *in camera*). He has advised healthcare clients on structuring and financing transactions and have served as a financial advisor to troubled and bankrupt healthcare entities and their creditors. (RX-56 at 000002, *in camera*).

1549. Mr. Den Uyl does not hold a Certified Public Accountant ("CPA") license. (Den Uyl, Tr. 6513; PX01951 at 009 (Den Uyl, Dep. at 30), *in camera*).

Response to Finding No. 1549:

Mr. Den Uyl was a Partner and Director of the Healthcare Valuations group at Price Waterhouse. (RX-56 at 000046, *in camera*). Mr. Den Uyl has over 25 years of experience providing valuation and financial consulting and expert testimony to a wide range of healthcare companies, including hospitals. (RX-56 at 000001, *in camera*). He has advised healthcare clients on structuring and financing transactions and have served as a financial advisor to troubled and bankrupt healthcare entities and their creditors. (RX-56 at 000002, *in camera*).

1550. Mr. Den Uyl has never signed a company's financial statements. (Den Uyl, Tr. 6514).

Response to Finding No. 1550:

Mr. Den Uyl has over 25 years of experience providing valuation and financial consulting and expert testimony to a wide range of healthcare companies, including hospitals. (RX-56 at 000001, *in camera*). He has advised healthcare clients on structuring and financing transactions and have served as a financial advisor to troubled and bankrupt healthcare entities and their creditors. (RX-56 at 000002, *in camera*).

1551. Prior to this litigation, Mr. Den Uyl never had any involvement with the hospitals in Lucas County. (Den Uyl, 6514). For instance, he has never been retained by either St. Luke's or ProMedica in their ordinary course of business. (Den Uyl, Tr. 6514). Outside of this litigation, Mr. Den Uyl has never done any work related to health care in the Toledo area. (Den Uyl, Tr. 6514).

Response to Finding No. 1551:

Mr. Den Uyl has over 25 years of experience providing valuation and financial consulting and expert testimony to a wide range of healthcare companies, including hospitals. (RX-56 at 000001, *in camera*). He has advised healthcare clients on structuring and financing transactions and have served as a financial advisor to troubled and bankrupt healthcare entities and their creditors. (RX-56 at 000002, *in camera*). Recently, Mr. Den Uyl was retained by the Attorney General of Michigan to advise on Vanguard's acquisition of Detroit Medical Center. (RX-56 at 000002, *in camera*).

1552. Mr. Den Uyl was retained in this litigation by McDermott, Will & Emery, counsel for Respondent. (Den Uyl, Tr. 6506-6507).

Response to Finding No. 1552:

Respondent has no specific response.

1553. Mr. Den Uyl was paid $645 an hour; he and his staff have billed a total of approximately $500,000 as a result of this litigation. (Den Uyl, Tr. 6509-6511).

Response to Finding No. 1553:

Respondent has no specific response.

1554. Despite concluding that "St. Luke's struggled financially during the years up to the joinder," Mr. Den Uyl admitted that St. Luke's financial performance "improved" during the eight months leading up to the Acquisition. (Den Uyl, Tr. 6503-6504, 6523-6524). In particular, Mr. Den Uyl testified that St. Luke's operating income, EBITDA, and overall cost coverage ratio all improved during the first eight months of 2010 compared to 2009. (Den Uyl, Tr. 6590-6591, 6603-6604, *in camera*).

Response to Finding No. 1554:

Respondent references back to responses to previous sections which detail Mr. Den Uyl's analysis.

1555. Mr. Den Uyl also concluded that, going forward, a standalone St. Luke's faced certain "obstacles," such as capital needs and health care reform, that it "*might* not be able to achieve." (Den Uyl, Tr. 6503-6504) (emphasis added).

Response to Finding No. 1555:

Respondent references back to its replies to Complaint Counsel's proposed findings of fact in previous sections which detail Mr. Den Uyl's analysis. (*See supra* Section XVI).

1556. However, Mr. Den Uyl has not concluded that, absent the Acquisition, St. Luke's would fail or become insolvent, be unprofitable, or even that its patient volumes and market shares would decline. (*See supra* Section XVII.B.).

Response to Finding No. 1556:

Respondent references back to its replies to Complaint Counsel's proposed findings of fact in previous sections which detail Mr. Den Uyl's analysis. (*See supra* Section XVI).

1557. In fact, Mr. Den Uyl has provided no expert opinion on how long St. Luke's could have survived absent the Acquisition, and he has not projected a standalone St. Luke's operating performance and reserve fund level in future years. (*See supra* Section XVII. B.).

Response to Finding No. 1557:

Respondent references back to its replies to Complaint Counsel's proposed findings of fact in previous sections which detail Mr. Den Uyl's analysis. (*See supra* Section XVI).

b. Margaret Guerin-Calvert

1558. Ms. Guerin Calvert was hired in February of 2010 by Respondent to assess the competitive effects of ProMedica's acquisition of St. Luke's Hospital. (Guerin-Calvert, Tr. 7576).

Response to Finding No. 1558:

Respondent has no specific response.

1559. Ms. Guerin-Calvert is the Vice-Chairman of Compass Lexecon. (RX-6 at 3 (Guerin-Calvert, Dep. at 5), *in camera*).

Response to Finding No. 1559:

Respondent has no specific response.

1560. Ms. Guerin-Calvert is not a PhD economist. (Guerin-Calvert, Tr. 7591).

Response to Finding No. 1560:

Ms. Guerin-Calvert is trained as an industrial organization economist and has worked as an economist on issues related to competition and competition policy since 1979. (RX-71(A) at 000004, *in camera*).

1561. Ms. Guerin-Calvert is not an econometrician. By her own admission, she is a consumer of econometrics. (PX01954 at 009 (Guerin-Calvert, Dep. at 32), *in camera*). Ms. Guerin-Calvert's educational experience in econometrics consists of a college course in 1977 and attendance at several one-day long seminars at the Department of Justice and Compass Lexecon. (Guerin-Calvert, Tr. 7592-7598).

Response to Finding No. 1561:

Ms. Guerin-Calvert is trained as an industrial organization economist and has worked as an economist on issues related to competition and competition policy since 1979. (RX-71(A) at 000004, *in camera*). Ms. Guerin-Calvert has been employed as an economist at the U.S. Department of Justice, Antitrust Division with a substantial portion of her time spent on mergers. She was eventually appointed to head the analytics group. In 1990, she was appointed Assistant Chief of the Economic Regulatory Section of the Antitrust Division, which she held for four years. (Guerin-Calvert, Tr. 7125-7128; RX-71(A) at 000004, *in camera*). In that position, she was responsible for the supervision of mergers, civil case investigations and regulatory filings. (RX-71(A) at 000004, *in camera*). Ms. Guerin-Calvert has extensive experience, outside the classroom, in economics. (RX-71(A) at 000090-000101, *in camera*). More importantly, Ms. Guerin-Calvert, has been accepted as an economic expert in all cases in which she has testified. (RX-71(A) at 000090-000101, *in camera*).

1562. Ms. Guerin-Calvert has never published a peer-reviewed paper dealing with econometric modeling or analysis. (Guerin-Calvert, Tr. 7600-7601). Ms. Guerin-Calvert does not program in Stata, a statistical computer program used to perform econometric analysis. (Guerin-Calvert, Tr. 7604-7605).

Response to Finding No. 1562:

Ms. Guerin-Calvert has published numerous papers on a variety of matters, including mergers. (RX-71(A) at 000090-000101, *in camera*). Ms. Guerin-Calvert's team programs in Stata, producing information which she then interprets. (Guerin-Calvert, Tr. 7604-7605).

In addition, Ms. Guerin-Calvert has been an invited participant in healthcare hearings conducted by the Federal Trade Commission and Department of Justice. (Guerin-Calvert, Tr. 7148-7149). Further, Ms. Guerin-Calvert authored or co-authored three major studies for the American Hospital Association, providing economic and empirical analyses of trends and factors

driving costs in healthcare, and evaluating whether or not mergers were the source of significant cost increases. (Guerin-Calvert, Tr. 7150-7151).

1563. Prior to testifying in this matter, Ms. Guerin-Calvert has testified in antitrust matters nine times in federal court, and in only one of those instances did she testify for the complainant. (Guerin-Calvert, Tr. 7130-7132).

Response to Finding No. 1563:

Ms. Guerin-Calvert has testified for the plaintiff in state court, arbitration proceedings, and in Canada. (Guerin-Calvert, Tr. 7130-7132; RX-71(A) at 000091, *in camera*).

1564. In antitrust merger matters, Ms. Guerin-Calvert has testified five times, each time for the defense. (Guerin-Calvert, Tr. 7582-7583).

Response to Finding No. 1564:

Respondent has no specific response.

1565. Ms. Guerin-Calvert testified that the 2001 merger of Summit and Alta Bates would not result in anticompetitive price increases. (Guerin-Calvert, Tr. 7606-7610). However, Steven Tenn's paper, *A Case Study of the Sutter Summit Transaction,* found price effects resulting from post-merger market power. (International Journal of the Economics of Business, Vol. 18, No. 2, February 2011, pps 65-82).

Response to Finding No. 1565:

Steven Tenn's paper claimed that after the merger prices increased at Summit Hospital but not at Alta Bates. (Guerin-Calvert, Tr. 7607-7611). The paper analyzed prices after the merger as compared to a control group and concluded that prices at Alta Bates after the merger were competitive relative to the control group. (Guerin-Calvert, Tr. 7607-7611). For Summit, prices after the merger exceeded the rate of growth for several payors in the control group. (Guerin-Calvert, Tr. 7607-7611). The paper did not unequivocally conclude that the price increase at Summit was a result of the merger and did not take into account that Summit was a failing firm. (Guerin-Calvert, Tr. 7607-7611).

1566. Ms. Guerin-Calvert testified that the merger of Long Island Jewish Memorial and North Shore Hospital in 1997 would not result in anticompetitive price increases. (Guerin-

Calvert, Tr. 7611-7613). Florida State University economists Gary Fournier and Yunwei Gai, however, examined the market after the merger and concluded that price increases had occurred in the market. (What does Willingness-to-Pay reveal about hospital market power in merger cases?, Sept. 2006, working paper).

Response to Finding No. 1566:

Fournier and Yunwei, which is not a peer-reviewed paper, concluded that they observed price changes after the merger but they did not say definitely that the merger was the cause of the price changes. (Guerin-Calvert, Tr. 7612-7614).

1567. In the past three years, Ms. Guerin-Calvert has presented analysis in support of mergers before the FTC or DOJ at least twelve times. (Guerin-Calvert, Tr. 7583-7584).

Response to Finding No. 1567:

Respondent has no specific response.

C. Witnesses Who Testified by Deposition and/or Investigational Hearing Only

Gary Akenberger

1568. Mr. Akenberger is the Senior Vice President of Finance and Strategic Business Development at ProMedica Health System. (PX01912 at 005 (Akenberger, IHT at 10), *in camera*; PX01912 at 008 (Akenberger, IHT at 25), *in camera*).

Response to Finding No. 1568:

Mr. Akenberger's current title is Senior Vice President of Finance at ProMedica Health System. (PX01912 (Akenberger, IHT at 10); PX02104 at 001, *in camera*).

1569. Mr. Akenberger is responsible for all accounting within ProMedica and Paramount Health Care. (PX01912 at 009 (Akenberger, IHT at 26-27), *in camera)*. From August 2008 to July 2010, Mr. Akenberger was responsible for mergers and acquisitions undertaken by ProMedica and had oversight responsibilities for the Acquisition. (PX01912 at 009 (Akenberger, IHT at 26-27), *in camera)*.

Response to Finding No. 1569:

Respondent has no specific response.

1570. Mr. Akenberger was one of the lead finance representatives to quantify efficiencies opportunities from the Acquisition and was the lead individual responsible for the

financial analysis behind the efficiencies. (PX01931 (Akenberger, Dep. at 93), *in camera*).

Response to Finding No. 1570:

Respondent has no specific response.

1571. Mr. Akenberger described himself as the lead individual responsible for the financial analysis, substantiation, and verification of Respondent's alleged efficiencies. (PX01931 at 025, 026 (Akenberger, Dep. at 93, 100), *in camera*). He stated that he reviewed every individual efficiency claim alleged by Respondent. (PX01931 at 028 (Akenberger, Dep. at 105), *in camera*).

Response to Finding No. 1571:

Respondent has no specific response.

1572. Since the Acquisition, Mr. Akenberger has been the "lead finance representative" on a steering committee formed to oversee efficiencies analysis of the Acquisition. (PX02104 at 002 (¶ 4) (Akenberger, Decl.), *in camera*). Mr. Akenberger also leads the steering committee with respect to verifying the financial underpinnings of the alleged efficiencies. (PX02104 at 002-003 (¶ 6) (Akenberger, Decl.), *in camera*).

Response to Finding No. 1572:

Respondent has no specific response.

1573. Kathleen Hanley, ProMedica's CFO, testified in court that Mr. Akenberger was one of the key employees familiar with the specifics and details of ProMedica's efficiencies analysis. (Hanley, Tr. 4729, *in camera*).

Response to Finding No. 1573:

Respondent has no specific response.

1574. Mr. Akenberger submitted an affidavit that discussed Respondent's alleged efficiencies. (PX02104 (Akenberger, Decl.), *in camera*; PX02105 (Akenberger, Decl. Exhibits), *in camera*). In his affidavit, Mr. Akenberger withdrew previously-alleged efficiency claims that Respondent had argued would generate many millions of dollars in savings. (*See* PX02104 at 003 (¶ 7) (Akenberger, Decl.), *in camera*; *see also* PX00020 (Respondent's original submission on alleged efficiencies of the Acquisition), *in camera*).

Response to Finding No. 1574:

Mr. Akenberger's affidavit did not withdraw ProMedica's efficiency estimates; rather,

Mr. Akenberger stated that {

} (PX02104

at 003, *in camera*). For example, Mr. Akenberger stated that {

} (PX02104 at 003, *in camera*).

1575. During his depositions, Mr. Akenberger often struggled to provide details necessary to substantiate the efficiency claims contained in his affidavit and Respondent's efficiency submissions. (*See* PX01931 at 028-029, 040, 043, 051, 053 (Akenberger, Dep. at 106-109, 154, 167, 198-199, 207)). His deposition testimony sometimes suggested that Respondent's efficiency claims were calculated incorrectly, or failed to take into account the possibility of negative effects on patient quality of care. (*See* PX01912 at 052, 057, 059 (Akenberger, IHT at 199-200, 219-220, 227)).

Response to Finding No. 1575:

The proposed finding mischaracterizes Mr. Akenberger's testimony. During his depositions Mr. Akenberger did not "struggle" to provide details substantiating ProMedica's expected efficiencies; rather, {

}

(*See* PX01931 (Akenberger, Dep. at 106-109, 154, 167, 198-199, 207, *in camera*)). Further, Mr. Akenberger testified that {

} (PX01912 (Akenberger, IHT at 226-227, *in camera*)).

1576. Respondent did not call Mr. Akenberger to testify. Mr. Akenberger was listed on Respondent's final witness list to potentially testify regarding efficiencies and the rationale for the joinder.

Response to Finding No. 1576:

The proposed finding violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record.

Dr. Stephen Bazeley

1577. Dr. Bazeley is a physician operating a family practice with five other physicians in Waterville, Ohio. His practice was established in 1990 and serves about 10,000 to 20,000 patients. (PX01932 at 004 (Bazeley, Dep. at 11-12), *in camera*).

Response to Finding No. 1577:

Respondent has no specific response.

1578. Dr. Bazeley has practiced medicine in the Toledo metropolitan area since 1977. (PX01932 at 006 (Bazeley, Dep. at 18), *in camera*)

Response to Finding No. 1578:

Respondent has no specific response.

1579. Dr. Bazeley maintains admitting privileges at St. Luke's and Flower hospitals but has not admitted a patient to Flower in 7-8 years. (PX01932 at 022 (Bazeley, Dep. at 81), *in camera*).

Response to Finding No. 1579:

Respondent has no specific response.

1580. Dr. Bazeley has an average daily census of 10-16 patients at St. Luke's Hospital. (PX01932 at 023 (Bazeley, Dep. at 86), *in camera*).

Response to Finding No. 1580:

Respondent has no specific response.

1581. Dr. Bazeley has served on St. Luke's Board of Directors since 2000. (PX01932 at 005 (Bazeley, Dep. at 16), *in camera*)

Response to Finding No. 1581:

Respondent has no specific response.

1582. Respondent did not call Dr. Bazeley to testify. Dr. Bazeley was listed on Respondent's preliminary witness list to potentially testify to the competitive effects of the joinder, the rationale for the joinder with ProMedica, the financial condition of St. Luke's, patient preferences, and physician privileges.

Response to Finding No. 1582:

The proposed finding violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record.

Douglas Deacon

1583. Mr. Deacon is the Vice President of Professional Services at St. Luke's Hospital. (PX01908 at 007 (Deacon, IHT at 19-20), *in camera*). He is also the President of Care Enterprises. (PX01908 at 013 (Deacon, IHT at 43), *in camera*).

Response to Finding No. 1583:

Respondent has no specific response.

1584. Mr. Deacon oversees departments which include ancillary services such as laboratory, radiology and rehab, as well as coordination between those departments and other departments at St. Luke's Hospital. (PX01908 at 013 (Deacon, IHT at 42), *in camera;* PX01908 at 015 (Deacon, IHT at 50), in camera).

Response to Finding No. 1584:

Respondent has no specific response.

David Dewey

1585. Mr. Dewey is the Vice President of Business Development at St. Luke's Hospital and the President of the WellCare Physicians Group. (PX01909 at 003, 005 (Dewey, IHT at 8, 15), *in camera*). As the Vice President of Business Development, Mr. Dewey's responsibilities include strategic planning, product development and public relations. (PX01015 at 001 (Resume of David M. Dewey)).

Response to Finding No. 1585:

Respondent has no specific response.

1586. Mr. Dewey has also served as Marketing Director, and Vice President of Information and Marketing Services at St. Luke's. (PX01909 at 004 (Dewey, IHT at 11), *in camera*).

Response to Finding No. 1586:

Respondent has no specific response.

Dr. Lee William Hammerling

1587. Dr. Hammerling is the Chief Medical Officer and President of ProMedica Physician and Continuum Services. (PX01913 at 004 (Hammerling, IHT at 7), *in camera)*.

Response to Finding No. 1587:

Respondent has no specific response.

1588. Dr. Hammerling is responsible for developing and implementing the performance improvement plan which monitors quality, patient safety and service at ProMedica. (PX00146 at 002).

Response to Finding No. 1588:

Respondent has no specific response.

1589. Dr. Hammerling is also responsible for the recruitment, operations and integration strategy of the employed physician network at ProMedica. (PX00146 at 002).

Response to Finding No. 1589:

Respondent has no specific response.

1590. Respondent did not call Dr. Hammerling to testify. Dr. Hammerling was listed on Respondent's final witness list to potentially testify to the competitive effects of the joinder, patient preferences, and physician privileges.

Response to Finding No. 1590:

The proposed finding violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record.

Barbara Machin

1591. Ms. Machin has been a member of the St. Luke's Hospital Board of Directors since 1994. (PX01001 at 002; PX01907 at 006 (Machin, IHT at 16), *in camera*).

Response to Finding No. 1591:

Respondent has no specific response.

1592. Ms. Machin served as Chairman of the Board from March 2008 until March 2010. (PX01001 at 002).

Response to Finding No. 1592:

Respondent has no specific response.

Steve Marcus

1593. Mr. Marcus is the Vice President of Clinical Financial Analytics and Integration for ProMedica Health System. (PX01936 at 010 (Marcus, Dep. at 32), *in camera*). He has been in this position since October of 2010. (PX01936 at 010 (Marcus, Dep. at 33), *in camera*).

Response to Finding No. 1593:

Respondent has no specific response.

1594. As the Vice President of Clinical Financial Analytics and Integration, Mr. Marcus is responsible for developing ProMedica's capability to serve as an accountable care organization. (PX01936 at 010 (Marcus, Dep. at 33), *in camera*).

Response to Finding No. 1594:

Respondent has no specific response.

1595. Prior to becoming the Vice President of Clinical Financial Analytics and Integration, Mr. Marcus was Director of Managed Care for ProMedica. (PX01936 at 010 (Marcus, Dep. at 30), *in camera*). As Director of Managed Care, Mr. Marcus was accountable for approximately 50 employees. (PX01936 at 010 (Marcus, Dep. at 31), *in camera*). Mr. Marcus reported directly to the Vice President of Managed Care Revenue Cycle and Reimbursement. (PX01936 at 010 (Marcus, Dep. at 31), *in camera*).

Response to Finding No. 1595:

Respondent has no specific response.

1596. Mr. Marcus has a Bachelor's degree in biology and a Master's degree in economics, both from Bowling Green State University. (PX01936 at 004 (Marcus, Dep. at 7), *in camera*).

Response to Finding No. 1596:

Respondent has no specific response.

Nancy Mullins

1597. Ms. Mullins is the Director of Contracting for CIGNA Healthcare responsible for northeast and northwest Ohio. (PX01900 at 003 (Mullins, IHT at 6)). Ms. Mullins has held this position for almost 10 years. (PX01900 at 003 (Mullins, IHT at 7)).

Response to Finding No. 1597:

Respondent has no specific response.

1598. As Director of Contracting, Ms. Mullins is responsible for developing and maintaining the healthcare provider network in northeast and northwest Ohio. (PX01900 at 003 (Mullins, IHT at 7)).

Response to Finding No. 1598:

Respondent has no specific response.

1599. Ms. Mullins works with sales and marketing teams to understand the needs and preferences of CIGNA customers in northern Ohio. (PX01900 at 003 (Mullins, IHT at 7-8)).

Response to Finding No. 1599:

Respondent has no specific response.

David Oppenlander

1600. Mr. Oppenlander is the former Vice President and Treasurer of St. Luke's Hospital. (Wakeman, Tr. 2652, *in camera*). Mr. Oppenlander was effectively St. Luke's Chief Financial Officer—although St. Luke's did not use that title. (Black, Tr. 5557).

Response to Finding No. 1600:

Respondent has no specific response.

1601. Mr. Oppenlander joined St. Luke's Hospital in September of 2003. (PX01933 at 013 (Oppenlander, Dep. at 42), *in camera*). Mr. Oppenlander left St. Luke's in 2009. (RX-11 at 53-54 (Oppenlander, Dep. at 205-206), *in camera*).

Response to Finding No. 1601:

Respondent has no specific response.

1602. Mr. Oppenlander was responsible for negotiating St. Luke's contracts with health plans, among other matters. (RX-11 at 6 (Oppenlander, Dep. at 16), *in camera*).

Response to Finding No. 1602:

Respondent has no specific response.

Dr. Salvador Peron

1603. Dr. Peron is a urologist at the Toledo Clinic. (PX01948 at 003 (Peron, Dep. at 3)).

Response to Finding No. 1603:

Respondent has no specific response.

1604. Dr. Peron is the chairman of the division of urology at St. Luke's. (PX01948 at 028 (Peron, Dep. at 104)).

Response to Finding No. 1604:

Respondent has no specific response.

1605. Dr. Peron is the medical director of Surgi+Care, an outpatient surgery center on the campus of St. Luke's Hospital. (PX01948 at 006, 008 (Peron, Dep. at 16, 23).

Response to Finding No. 1605:

Respondent has no specific response.

1606. In March 2010, Dr. Peron opened a new office in Bowling Green, Ohio, on the campus of Wood County Hospital. (PX01948 at 006, 024 (Peron, Dep. at 14, 88-89)).

Response to Finding No. 1606:

Respondent has no specific response.

Eric Perron

1607. Mr. Perron was appointed the Computer Information Systems ("CIS") Director at St. Luke's Hospital in February 2006. (PX01928 at 004 (Perron, Dep. at 7), *in camera*).

Response to Finding No. 1607:

Respondent has no specific response.

1608. As CIS director, Mr. Perron is responsible for technology operations and strategic development for technology. (PX01928 at 005 (Perron, Dep. at 10), in camera).

Response to Finding No. 1608:

Respondent has no specific response.

1609. In December 2009, Mr. Perron recommended St. Luke's move forward on an EMR contract. (PX01928 at 021 (Perron, Dep. at 75), *in camera*). This decision was not opposed by Mr. Wakeman or any other St. Luke's executive. (PX01928 at 023 (Perron, Dep. at 85), *in camera*).

Response to Finding No. 1609:

Respondent has no specific response.

1610. ProMedica did not consult with Mr. Perron regarding IT or EMR efficiencies calculations in conjunction with the efficiencies analysis of the Acquisition presented by Compass Lexecon. (PX01928 at 040 (Perron, Dep. at 150-152), *in camera*).

Response to Finding No. 1610:

The proposed finding cites testimony that lacks foundation.

Larry Peterson

1611. Mr. Peterson is the Chairman of the ProMedica Health System Board of Trustees, and obtained this position in January of 2009. (PX01901 at 035 (Peterson, IHT at 132), *in camera*).

Response to Finding No. 1611:

Respondent has no specific response.

1612. Mr. Peterson is also the Chairman of the Executive, Compensation and Board Development Committees at ProMedica Health System. (PX01901 at 021 (Peterson, IHT at 77), *in camera*).

Response to Finding No. 1612:

Respondent has no specific response.

1613. Mr. Peterson has been a member of a committee of the ProMedica Health System Board since 2000. (PX01901 at 035 (Peterson, IHT at 133), *in camera*).

Response to Finding No. 1613:

Respondent has no specific response.

Dr. Robert Reiter

1614. Dr. Reiter was the associate chief medical officer and senior vice president for quality and clinical performance improvement for ProMedica. (PX01930 at 004 (Reiter, Dep. at 8)).

Response to Finding No. 1614:

Respondent has no specific response.

1615. Dr. Reiter led and directed ProMedica's system-wide quality and performance efforts in three major areas: quality goals, patient safety, and clinical best practices. (PX01930 at 005 (Reiter, Dep. at 12-13)).

Response to Finding No. 1615:

Respondent has no specific response.

1616. Dr. Reiter did not participate in any merger discussions between ProMedica and St. Luke's. (PX01930 at 014 (Reiter, Dep. at 47)).

Response to Finding No. 1616:

Respondent has no specific response.

1617. During weekly meetings with his direct reports, Dr. Reiter had conversations about the steps it would take to bring St. Luke's into ProMedica's quality efforts. (PX01930 at 016 (Reiter, Dep. at 56)).

Response to Finding No. 1617:

Respondent has no specific response.

1618. Dr. Reiter made a presentation to St. Luke's medical executive committee on ProMedica's system-wide best practice initiative in January 2011. (PX01930 at 014 (Reiter, Dep. at 48)).

Response to Finding No. 1618:

Respondent has no specific response.

1619. Dr. Reiter was listed on Respondent's final witness list to testify regarding quality, but was not called to testify.

Response to Finding No. 1619:

The proposed finding violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record.

1620. Dr. Reiter recently left ProMedica after Mr. Oostra expressed displeasure about his ability to take ProMedica's quality "to the next level" in terms of publishing data and standardizing clinical protocols. (Oostra, Tr. 5939, *in camera*).

Response to Finding No. 1620:

This proposed finding is misleading. Mr. Oostra also testified that "with respect to everything Bob [Reiter] did for us, he did a great job, definitely improved quality. I think all our metrics and scores show that. I think we're very pleased with that. However, as far as now going to the next level and looking at some new things and changing how we wanted to do things on a much more participative fashion with our board, it was just a good time for Bob to leave." (Oostra, Tr. 5939). Further, Mr. Oostra explained that Dr. Reiter left ProMedica voluntarily to accept a teaching position at a medical school in Oregon. (Oostra, Tr. 6026-6027).

Dr. Christopher Riordan

1621. Dr. Riordan is a cardiothoracic surgeon who joined ProMedica Physician Group ("PPG") in October 2009. (PX01949 at 004 (Riordan, Dep. at 7)).

Response to Finding No. 1621:

Respondent has no specific response.

1622. Prior to joining PPG in 2009, Dr. Riordan was a self-employed physician in Toledo since 1997. (PX01949 at 004 (Riordan, Dep. at 7)).

Response to Finding No. 1622:

Respondent has no specific response.

1623. Dr. Riordan has been St. Luke's medical director of cardiovascular services since the program's inception. (PX01949 at 006 (Riordan, Dep. at 14)).

Response to Finding No. 1623:

Respondent has no specific response.

1624. Dr. Riordan also served as medical director for cardiovascular surgery at St. Vincent until August 2009. (PX01949 at 014 (Riordan, Dep. at 49)).

Response to Finding No. 1624:

Respondent has no specific response.

Barbara Steele

1625. Ms. Steele is the Acute Care President of ProMedica Health System. As Acute Care President, Ms. Steele is responsible for strategic planning, operations and performance for all of the ProMedica Health System hospitals. (PX01904 at 009 (Steele, IHT at 26, 29), *in camera)*.

Response to Finding No. 1625:

Respondent has no specific response.

1626. Ms. Steele has been employed by ProMedica Health System since 1995. Prior to becoming the President of Acute Care, Ms. Steele was the Chief Operating Officer of The Toledo Hospital and the Regional President for the South and Central Regions of ProMedica Health System. Ms. Steele is also a registered nurse. (PX01904 at 009 (Steele, IHT at 26), *in camera)*.

Response to Finding No. 1626:

Respondent has no specific response.

1627. Respondent did not call Ms. Steele to testify. Ms. Steele was listed on Respondent's preliminary witness list to testify regarding the competitive effects of the joinder, market definition, hospital/health plan contract negotiations, efficiencies, quality, and the financial condition of St. Luke's.

Response to Finding No. 1627:

The proposed finding violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record.

Dennis Wagner

1628. Mr. Wagner is the Finance Director at St. Luke's Hospital. (PX01041 at 001). Mr. Wagner has been employed by St. Luke's since 1985. He has also served as Managed Care and Reimbursement Director, Revenue Cycle Director, and Acting Treasurer. (PX01915 at 004 (Wagner, IHT at 10-11), *in camera;* PX01041 at 001).

Response to Finding No. 1628:

Respondent has no specific response.

1629. Mr. Wagner has a Bachelor of Science in Economics from the University of Toledo and is a Certified Public Accountant. (PX01041 at 002).

Response to Finding No. 1629:

Respondent has no specific response.

1630. As Managed Care and Reimbursement Director and Revenue Cycle Director, Mr. Wagner reviewed managed care contract proposals, and analyzed reimbursement rates before forwarding them to legal counsel for review. (PX01915 at 004 (Wagner, IHT at 11-12), *in camera*).

Response to Finding No. 1630:

Respondent has no specific response.

1631. As Acting Treasurer, Mr. Wagner was also responsible for St. Luke's financial statements and reporting to the finance committee. (PX01915 at 021 (Wagner, IHT at 78-79), *in camera*).

Response to Finding No. 1631:

Respondent has no specific response.

1632. As Finance Director, he no longer reports to the finance committee directly or is ultimately responsible for the financial functions at St. Luke's. (PX01915 at 021-022 (Wagner, IHT at 80-81), *in camera*). However, Mr. Wagner retains the responsibilities of Managed Care and Reimbursement Director and Revenue Cycle Director for St. Luke's. (PX01915 at 021-22 (Wagner, IHT at 80-81), *in camera*).

Response to Finding No. 1632:

Respondent has no specific response.

1633. Respondent did not call Mr. Wagner to testify. Mr. Wagner was listed on Respondent's final witness list to testify regarding the competitive effects of the joinder, product and geographic market definition, hospital/health plan contract negotiations, efficiencies, quality, the financial condition of St. Luke's, rationale for the joinder with ProMedica and negotiations with other potential merger partners.

Response to Finding No. 1633:

The proposed finding violates the ALJ's Order on Post-Trial Briefs by failing to contain specific references to the evidentiary record.

XX. PROPOSED CONCLUSIONS OF LAW

A. Nature of the Action and Jurisdiction

1. This is a civil action arising under Acts of Congress protecting trade and commerce against restraints and monopolies, and is brought by an agency of the United States authorized by an Act of Congress to bring this action. (Joint Stipulations of Law and Fact, JX00002A ¶ 52).

Response to Conclusion No. 1:

Respondent has no specific response.

2. The Federal Trade Commission ("FTC") has jurisdiction over Respondent ProMedica Health System, Inc. ("Respondent" or "ProMedica") and the subject matter of this proceeding pursuant to Section 5 of the Federal Trade Commission Act ("FTC Act"), 15 U.S.C. § 45, and Sections 7 and 11 of the Clayton Act, 15 U.S.C. §§ 18, 21(b).

Response to Conclusion No. 2:

Respondent has no specific response.

3. The FTC is an administrative agency of the U.S. Government established, organized, and existing pursuant to the FTC Act, 15 U.S.C. § 41 *et seq.* (2006). The FTC is vested with authority and responsibility for enforcing, *inter alia*, Section 7 of the Clayton Act, 15 U.S.C. § 18. (Joint Stipulations of Law and Fact, JX00002A ¶ 54).

Response to Conclusion No. 3:

Respondent has no specific response.

4. Respondent, including its relevant operating subsidiaries, is, and at all relevant times has been, engaged in activities in or affecting "commerce" as defined in Section 4 of the FTC Act, 15 U.S.C. § 44 (2006), and Section 1 of the Clayton Act, 15 U.S.C. § 12 (2006). (Joint Stipulations of Law and Fact, JX00002A ¶ 53).

Response to Conclusion No. 4:

Respondent has no specific response.

B. Clayton Act Section 7 Standard and Conclusions

5. Section 7 of the Clayton Act, as amended, bars acquisitions "where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly." (15 U.S.C. § 18 (2006); Joint Stipulations of Law and Fact, JX00002A ¶ 55).

Response to Conclusion No. 5:

Respondent has no specific response.

6. "Congress used the words 'may be' . . . to indicate that its concern was with probabilities, not certainties" and to "arrest restraints of trade in their incipiency and before they develop into full-fledged restraints." (*Brown Shoe Co., Inc. v. United States*, 370 U.S. 294, 323 & n.39 (1962) ("requirement of certainty . . . of injury to competition is

incompatible" with Congress' intent of "reaching incipient restraints."); *see also United States v. Phila. Nat'l Bank*, 374 U.S. 321, 355, 367 (1963) (a "fundamental purpose of amending § 7 was to arrest the trend toward concentration, the tendency to monopoly, before the consumer's alternatives disappeared through merger . . . ."); *Chicago Bridge & Iron Co. N.V. v. FTC,* 534 F.3d 410, 423 (5th Cir. 2008); *FTC v. CCC Holdings Inc.*, 605 F. Supp. 2d 26, 35 (D.D.C. 2009)).

Response to Conclusion No. 6:

Respondent has no specific response.

7. ProMedica's acquisition of St. Luke's constitutes an acquisition under Section 7 of the Clayton Act. (Answer at ¶ 10; *United States v. Columbia Pictures Corp.,* 189 F. Supp. 153, 182 (S.D.N.Y. 1960) (Section 7 is "pragmatic" and "primarily concerned with the end result of a transfer of a sufficient part of the bundle of legal rights and privileges . . . to give the transfer economic significance and the proscribed adverse 'effect.'")). As another court stated in applying Section 7 to the merger of two non-profit hospitals, "the inquiry is whether the resulting corporation(s) owns or controls, however that is manifested, the economic power of the prior corporations." (*United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1256 (N.D. Ill. 1989), *aff'd* 898 F.2d 1278 (7th Cir. 1990); *see also United States v. Dairy Farmers of Am., Inc.*, 426 F.3d 850, 858 (6th Cir. 2005) (citing with approval those Section 7 cases that "focus on the degree to which the defendant controls the decision-making processes that cause anticompetitive effects, rather than the nature or extent of the acquisition.")).

Response to Conclusion No. 7:

Respondent has no specific response.

8. Congress' intent in enacting Section 7 was to prevent unlawful mergers or acquisitions before they created competitive harm. (*Brown Shoe*, 370 U.S. at 318 n.32; *see also FTC v. Procter & Gamble*, 386 U.S. 568, 577 (1967) (Section 7 "was intended to arrest the anticompetitive effects of market power in their incipiency.")).

Response to Conclusion No. 8:

Respondent has no specific response.

9. The purpose of the antitrust laws is to protect competition, not competitors. (*Brown Shoe*, 370 U.S. at 320; Joint Stipulations of Law and Fact, JX00002A ¶ 56).

Response to Conclusion No. 9:

Respondent has no specific response.

C. Burden of Proof

10. Courts generally analyze Section 7 cases under a burden-shifting framework. (*See, e.g., Chicago Bridge*, 534 F.3d at 423; *FTC v. H.J. Heinz, Co.*, 246 F.3d 708, 715 (D.C. Cir. 2001); *United States v. Baker Hughes Inc.*, 908 F.2d 981, 982-83 (D.C. Cir. 1990); *In re Polypore Int'l, Inc.*, 2010 FTC LEXIS 97, at *25 (Dec. 13, 2010)). Under this framework, Complaint Counsel establishes a *prima facie* Section 7 violation by showing that the transaction will result in undue concentration in the relevant market(s). (*Chicago Bridge*, 534 F.3d at 423; *Baker Hughes*, 908 F.2d at 982-83; *Polypore*, 2010 FTC LEXIS 97, at *25).

Response to Conclusion No. 10:

Respondent has no specific response.

11. Undue concentration in a relevant market gives rise to a presumption that the transaction substantially lessens competition. (*Phila. Nat'l Bank*, 374 U.S. at 363; *Chicago Bridge*, 534 F.3d at 423; *Dairy Farmers of Am.*, 426 F.3d at 858; *United States v. Citizens & S. Nat'l Bank*, 422 U.S. 86, 120-121 (1975)).

Response to Conclusion No. 11:

Respondent has no specific response.

12. Complaint Counsel may establish a *prima facie* case quantitatively or qualitatively, and may further support its *prima facie* case with evidence that anticompetitive effects are likely. (*See FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1289 (W.D. Mich. 1996), *aff'd*, No. 96-2440, 1997 U.S. App. LEXIS 17422 (6th Cir. July 8, 1997) (FTC may make a *prima facie* case with statistical showing of post-merger control of "undue percentage" of relevant market and a "significant increase in [ ] concentration"); *Polypore*, 2010 FTC LEXIS 97, at *25-26 ("qualitative evidence regarding pre-acquisition competition between the merging parties can in some cases be sufficient to create a *prima facie* case . . .") (citing *In re Chicago Bridge & Iron Co.*, 138 F.T.C. 1024, 1053 (2004)).

Response to Conclusion No. 12:

Market shares and market concentration statistics are only the beginning, not the end of the analysis of whether a transaction might lead to anticompetitive effects. *United States v. Gen. Dynamics, Corp.*, 415 U.S. 486, 498 (1974) (ruling market concentration statistics "were not conclusive indicators of anticompetitive effects"); *United States v. Baker Hughes,* 908 F.2d 981, 984 (D.C. Cir. 1990) ("Evidence of market concentration simply provides a convenient starting

point for a broader inquiry into future competitiveness."); *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1111 (N.D. Cal. 2004) ("determining the existence or threat of anticompetitive effects has not stopped at calculation of market shares."). Indeed, the Government's own *Horizontal Merger Guidelines* caution that "[m]arket shares may not fully reflect the competitive significance of firms in the market or the impact of a merger." Dep't of Justice and Fed. Trade Comm'n, *Horizontal Merger Guidelines*, § 5.3 (2010).

Also, this Court must proceed cautiously when relying on market shares to presume a transaction will likely lead to anticompetitive effects when the transaction involves differentiated products, like general acute-care inpatient services. *Oracle Corp.*, 331 F. Supp. 2d at 1122 ("a strong presumption of anticompetitive effects based on market concentration is especially problematic in a differentiated products unilateral effects context."). This is because "in differentiated product markets, some measure of market power is inherent," in part due to "the many nonprice dimensions in which sellers in such markets compete." *Oracle Corp.*, 331 F. Supp. 2d at 1121. Moreover, merger analysis is concerned primarily with "determining whether the merger would enhance market power, not whether market power currently exists." *Id.*

13. Once a *prima facie* case is established, the burden shifts to Respondent to rebut the presumption of illegality by producing sufficient evidence to demonstrate that Complaint Counsel's evidence inaccurately predicts the likely competitive effects of the transaction. (*United States v. Marine Bancorporation*, 418 U.S. 602, 631 (1974); *Chicago Bridge*, 534 F.3d at 423; *FTC v. Univ. Health Inc.*, 938 F.2d 1206, 1218-19 (11th Cir. 1991); *Polypore*, 2010 FTC LEXIS 97, at *26).

Response to Conclusion No. 13:

Respondent has no specific response.

14. The stronger the *prima facie* case, the greater the Respondent's burden of production on rebuttal. (*Polypore*, 2010 FTC LEXIS 97, at *26 (citing *Heinz*, 246 F.3d at 725; *Baker Hughes*, 908 F.2d at 991)).

Response to Conclusion No. 14:

A strong presumption of anticompetitive effects based on market concentration is especially problematic in a differentiated products unilateral effects context. *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1122 (N.D. Cal. 2004).

15. If the Respondent meets its burden, the burden of production shifts back to Complaint Counsel, who also retains the ultimate burden of persuasion. (*Chicago Bridge*, 534 F.3d at 423 (citations omitted); *Polypore*, 2010 FTC LEXIS 97, at *27).

Response to Conclusion No. 15:

Respondent has no specific response.

D. General Acute Care Inpatient Hospital Services Sold to Commercial Health Plans Constitute a Relevant Market

16. A relevant product market is one in which a hypothetical monopolist could increase prices profitably by a "small but significant" amount for a meaningful period of time. (U.S. Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines* § 4.1.1 (2010) [hereinafter *Merger Guidelines*]).

Response to Conclusion No. 16:

Respondent has no specific response.

17. Defining the product market generally focuses on "demand substitution factors, *i.e.*, on customers' ability and willingness to substitute away from one product to another in response to a price increase or . . . reduction in product quality or service." (*Merger Guidelines* § 4).

Response to Conclusion No. 17:

It is well established that product market definition "focuses *solely* on demand substitution factors." United States Dep't of Justice and Fed. Trade Comm'n, *Horizontal Merger Guidelines* § 4 (2010) (emphasis added) (defining a market by "customers' ability and willingness to substitute away from one product to another in response to a price increase or a corresponding non-price change"); *Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962) (stating the "outer boundaries of a product market are determined by the reasonable

interchangeability of use or the cross-elasticity of demand between the product itself and substitutes for it").

18. Courts frequently have relied on the *Merger Guidelines* framework to assess how acquisitions impact competition. (*See, e.g., Butterworth*, 946 F. Supp. at 1294; *Chicago Bridge* , 534 F.3d at 432 n.11; *Heinz*, 246 F.3d at 716 n.9; *FTC v. Univ. Health Inc.*, 938 F.2d at 1211).

Response to Conclusion No. 18:

Respondent has no specific response.

19. Evidence that predicts a price increase for a group of products "can itself establish that those products form a relevant [product] market." (*Merger Guidelines* § 4; *see also FTC v. Whole Foods Mkt., Inc.*, 548 F.3d 1028, 1046-47 (D.C. Cir. 2008) (Tatel, J., concurring) (CEO's statement that it was buying company to "avoid nasty price wars" was relevant evidence of market definition); *In re Evanston Nw. Healthcare*, No. 9315, 2007 WL 2286195, at *60-61 (FTC Aug. 6, 2007)).

Response to Conclusion No. 19:

Intent is not an element of a Clayton Act Section 7 violation. *United States v. Baker Hughes, Inc.*, 731 F. Supp. 3, 12, n.8 (D.D.C.), aff'd, 908 F.2d 981 (9990) (citing *United States v. E.I. Du Pont de Nemours & Co.*, 353 U.S. 586, 607 (1957).

20. The first relevant product market in this case is general acute-care inpatient services ("GAC") sold to commercial health plans. This is a "cluster market" of services that courts consistently have found when analyzing hospital mergers. (*See, e.g., Butterworth*, No. 96-2440, 1997 U.S. App. LEXIS 17422, at *5; *Univ. Health Inc.*, 938 F.2d at 1210-11; *Rockford Mem'l Corp.*, 898 F.2d at 1284; *Evanston*, 2007 WL 2286195, at *45-47).

Response to Conclusion No. 20:

Respondent has no specific response.

21. The inpatient services included in the cluster market are not substitutes for one another (*i.e.*, appendectomies and knee surgery are not interchangeable). However, the cluster market is used "as a matter of analytical convenience [because] there is no need to define separate markets for a large number of individual hospital services . . . when market shares and entry conditions are similar for each." (*Emigra Group v. Fragomen*, 612 F. Supp. 2d 330, 353 (S.D.N.Y. 2009) (citing Jonathan B. Baker, *Market Definition: An Analytical Overview*, 74 Antitrust L.J. 129, 157-59 (2007)); Joint Stipulations of Law and Fact, JX00002A ¶ 57).

Response to Conclusion No. 21:

Emigra Group is not a case in which the court defined an inpatient OB services market separate from other general acute care inpatient hospital services; rather, it is a case analyzing immigration services and an alleged submarket for corporate immigration services. *Emigra Group*, 612 F. Supp. 2d at 337.

22. The specific inpatient services included in the cluster market are those that both ProMedica and St. Luke's offer, and therefore those for which competition will be affected by the Acquisition. (*FTC v. ProMedica Health Sys.*, No. 3:11 CV 47, 2011 U.S. Dist. LEXIS 33434 at * 23-24, *146-147 (N.D. Ohio March 29, 2011); *see Little Rock Cardiology Clinic v. Baptist Health*, 573 F. Supp. 2d 1125, 1146 (E.D. Ar. 2008) (excluding cardiologists' services from market definition because "[defendant] does not compete in the cardiologists' service market; it has no market share and therefore no market power in [that market].")).

Response to Conclusion No. 22:

Complaint Counsel's reliance on and serial citation of Judge Katz's decision on the Commission's request for a preliminary injunction is misplaced because that ruling has no precedential effect in this proceeding. *See In re R.R. Donnelley & Sons Co.*, 1995 FTC LEXIS 215, at *17 (July 21, 1995) (citing *Univ. of Tex. v. Camenisch*, 451 U.S. 390, 394-95 (1981)). Further, *Little Rock Cardiology Clinic v. Baptist Health*, 573 F. Supp. 2d 1125 (E.D. Ark. 2008), which did not involve a hospital merger, is distinguishable. In that case, the court disregarded plaintiffs' alleged relevant product market because the services plaintiff sought to include were not substitutes for one another. *Id.* at 1144. It also improper to focus on only the services offered by both ProMedica and St. Luke's in common. 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). For purposes of defining a relevant product market, the number of other

competitors providing the service is irrelevant, because, for market the purpose of market definition, one must determine substitute services demanded by consumers, not the number of suppliers. (Guerin-Calvert, Tr. 7221). Indeed, product market definition "focuses *solely* on demand substitution factors." United States Dep't of Justice and Fed. Trade Comm'n, *Horizontal Merger Guidelines* ¶ 4 (2010) (emphasis added) (defining a market by "customers' ability and willingness to substitute away from one product to another in response to a price increase or a corresponding non-price change"); *Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962) (stating the "outer boundaries of a product market are determined by the reasonable interchangeability of use or the cross-elasticity of demand between the product itself and substitutes for it").

23. Outpatient services are excluded from the GAC market because they are not substitutes for inpatient services and because they are subject to different competitive conditions (including a different set of providers and different entry conditions) than are inpatient services. (*See Rockford Mem'l Hosp.*, 898 F.2d at 1284 (excluding outpatient services from a GAC product market)).

Response to Conclusion No. 23:

Respondent has no specific response.

E. Inpatient Obstetrical Services Sold to Commercial Health Plans Constitute a Relevant Product Market

24. Inpatient obstetrical services sold to commercial health plans constitute a separate relevant product market in which the competitive effects of the Acquisition must be analyzed. A separate product market for this service line is necessary because "market shares and entry conditions" are different for obstetrics than for the overall cluster of GAC services. In particular, UTMC and Mercy St. Anne do not offer obstetrical services. (*ProMedica*, 2011 U.S. Dist. LEXIS 33434 at * 24-25, * 148-149; *see Emigra Group*, 612 F. Supp. 2d at 353 (citation omitted)).

Response to Conclusion No. 24:

Complaint Counsel's reliance on and serial citation to Judge Katz's decision on the Commission's request for a preliminary injunction is misplaced because that ruling has no

precedential effect in this proceeding. *See In re R.R. Donnelley & Sons Co.*, 1995 FTC LEXIS 215, at *17 (July 21, 1995) (citing *Univ. of Tex. v. Camenisch*, 451 U.S. 390, 394-95 (1981)). Further, *Emigra Group* is not a case in which the court defined an inpatient hospital OB services market separate from other general acute care inpatient hospital services; rather, it is a case analyzing immigration services and an alleged submarket for corporate immigration services. *Emigra Group*, 612 F. Supp. 2d at 337. Therefore, no legal authority supports carving inpatient OB services out from the general acute care inpatient hospital services cluster market. Complaint Counsel did not cite a single case in which the court defined an inpatient hospital OB services market separate from other general acute care inpatient hospital services. Moreover, Complaint Counsel's assertion that inpatient OB services are not substitutable for other general acute care inpatient services is equally applicable to inpatient knee surgery and inpatient gastro-intestinal services, both of which Complaint Counsel include in their general acute care inpatient services market. *See California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1119 (N.D. Cal. 2001).

25. Inpatient obstetrical services need not – and should not – be included in the overall general acute-care inpatient services market simply because they are offered within the same facilities as the other services. (*Rockford Mem'l Hosp.*, 898 F.2d at 1284 (Posner, J.) ("Hospitals can and do distinguish between the patient who wants a coronary bypass and the patient who wants a wart removed from his foot; these services are not in the same product market merely because they have a common provider.")).

Response to Conclusion No. 25:

Complaint Counsel's reliance on *United States. v. Rockford Mem'l Corp.*, 898 F.2d 1278 (7th Cir. 1990), is misplaced, as it does not present any legal authority to support carving inpatient OB services out from the general acute care inpatient hospital services cluster market; rather, *Rockford Mem'l Corp.* analyzes the lack of interchangeability between inpatient and outpatient hospital services. *Id.* at 1284. Also. Complaint Counsel's assertion that inpatient OB

services are not substitutable for other general acute care inpatient services is equally applicable to inpatient knee surgery and inpatient gastro-intestinal services, both of which Complaint Counsel include in their general acute care inpatient services market. *See California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1119 (N.D. Cal. 2001).

F. The Relevant Geographic Market is Lucas County

26. Section 7 of the Clayton Act prohibits acquisitions that are likely to lessen competition in "any section of the country," otherwise known as a geographic market. (*Phila. Nat'l Bank*, 374 U.S. at 355-356; Joint Stipulations of Law and Fact, JX00002A ¶ 58).

<u>Response to Conclusion No. 26:</u>

Respondent has no specific response.

27. The relevant geographic market within which to analyze the competitive effects of the Acquisition is no broader than Lucas County. Under the case law and *Merger Guidelines*, the relevant question to define the geographic market is whether a hypothetical monopolist controlling *all* Lucas County hospitals could profitably implement a small but significant non-transitory increase in price ("SSNIP"). (*Merger Guidelines* § 4.2; *ProMedica*, 2011 U.S. Dist. LEXIS 33434 at * 25-26, *149).

<u>Response to Conclusion No. 27:</u>

Respondent does not disagree that that the proper relevant geographic market is Lucas County, Ohio because that is where ProMedica and St. Luke's provide general acute care inpatient hospital services. However, Complaint Counsel's reliance on and serial citation to Judge Katz's decision on the Commission's request for a preliminary injunction is misplaced because that ruling has no precedential effect in this proceeding. *See In re R.R. Donnelley & Sons Co.*, 1995 FTC LEXIS 215, at *17 (July 21, 1995) (citing *Univ. of Tex. v. Camenisch*, 451 U.S. 390, 394-95 (1981)).

28. Defining the geographic market is a "pragmatic" undertaking and Complaint Counsel must "present evidence of practical alternative sources to which consumers . . . would turn if the merger were consummated." (*Butterworth*, 946 F. Supp. at 1291; *see generally Phila. Nat'l Bank*, 374 U.S. at 358-62).

<u>Response to Conclusion No. 28:</u>

Respondent has no specific response.

G. The Acquisition is Presumed Unlawful in Two Relevant Product Markets Based on Concentration Thresholds

29. "A transaction resulting in a high concentration of market power and creating, enhancing, or facilitating a potential that such market power could be exercised in anticompetitive ways is presumptively unlawful." (*Butterworth*, 946 F. Supp. at 1294 (citations omitted); *see also Phila. Nat'l Bank*, 374 U.S. at 363; *Baker Hughes*, 908 F.2d at 982-83).

Response to Conclusion No. 29:

Market shares and market concentration statistics are only the beginning, not the end, of the analysis of whether a transaction might lead to anticompetitive effects. *United States v. Gen. Dynamics, Corp.*, 415 U.S. at 498 (ruling market concentration statistics "were not conclusive indicators of anticompetitive effects"); *United States v. Baker Hughes,* 908 F.2d 981, 984 (D.C. Cir. 1990) ("Evidence of market concentration simply provides a convenient starting point for a broader inquiry into future competitiveness."); *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1111 (N.D. Cal. 2004) ("determining the existence or threat of anticompetitive effects has not stopped at calculation of market shares."). Indeed, the Government's own *Horizontal Merger Guidelines* caution that "[m]arket shares may not fully reflect the competitive significance of firms in the market or the impact of a merger." Dep't of Justice and Fed. Trade Comm'n, *Horizontal Merger Guidelines*, § 5.3.

Likewise, this Court must proceed cautiously when relying on market shares to presume a transaction will likely lead to anticompetitive effects when the transaction involves differentiated products, like general acute-care inpatient services. *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1122 (N.D. Cal. 2004) ("a strong presumption of anticompetitive effects based on market concentration is especially problematic in a differentiated products unilateral effects context."). This is because "in differentiated product markets, some measure of market power is inherent," in part due to "the many nonprice dimensions in which sellers in such markets

compete." *Id.* at 1121. Moreover, merger analysis is concerned primarily with "determining whether the merger would enhance market power, not whether market power currently exists." *Id.*

30. Market concentration can be measured using the Herfindahl-Hirschman Index ("HHI"), as adopted by the federal antitrust enforcement agencies. (*Merger Guidelines* § 5.3).

Response to Conclusion No. 30:

Respondent has no specific response.

31. Courts have likewise adopted and relied on the HHI as a measure of market concentration. (*See, e.g., Univ. Health Inc.*, 938 F.2d at 1211 n.12 (HHI is the "most prominent method" of measuring market concentration); *FTC v. PPG Indus., Inc.*, 798 F.2d 1500, 1503 (D.C. Cir. 1986); *FTC v. Cardinal Health*, 12 F. Supp. 2d 34, 53-54 (D.D.C. 1998); *FTC v. Staples*, 970 F. Supp. 1066, 1081-82 (D.D.C. 1997); *In re Evanston Nw. Healthcare Corp.*, D-9315, Initial Decision at 150 (Oct. 20, 2005) (McGuire, J.) ("The HHI is the most prominent method of measuring market concentration, commonly used by the Department of Justice, the FTC, and the courts in evaluating proposed mergers.") (citing *Butterworth*, 946 F. Supp. at 1294)).

Response to Conclusion No. 31:

Respondent has no specific response.

32. The HHI is calculated by summing the squares of the market shares of all firms in the market. A transaction that increases concentration by 200 points or more and results in a highly-concentrated market (HHI over 2,500) is presumed likely to enhance market power. (*Merger Guidelines* § 5.3).

Response to Conclusion No. 32:

Respondent has no specific response.

33. Sufficiently large HHI figures establish the FTC's *prima facie* case that a merger is anti-competitive. (*Heinz*, 246 F.3d at 716 (citing *Baker Hughes*, 908 F.2d at 982-83 & n.3)).

Response to Conclusion No. 33:

Market shares and market concentration statistics are only the beginning, not the end, of the analysis of whether a transaction might lead to anticompetitive effects. *United States v. Gen. Dynamics, Corp.*, 415 U.S. at 498 (ruling market concentration statistics "were not conclusive

indicators of anticompetitive effects"); *United States v. Baker Hughes,* 908 F.2d 981, 984 (D.C. Cir. 1990) ("Evidence of market concentration simply provides a convenient starting point for a broader inquiry into future competitiveness."); *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1111 (N.D. Cal. 2004) ("determining the existence or threat of anticompetitive effects has not stopped at calculation of market shares."). Indeed, the Government's own *Horizontal Merger Guidelines* caution that "[m]arket shares may not fully reflect the competitive significance of firms in the market or the impact of a merger." Dep't of Justice and Fed. Trade Comm'n, *Horizontal Merger Guidelines,* § 5.3.

34. The market shares and HHI levels here far exceed levels found to be unlawful by the Supreme Court and other courts. In *Philadelphia National Bank,* the Supreme Court found that a combined market share of 30 percent, with many remaining competitors, violated the Clayton Act. (*Phila. Nat'l Bank,* 374 U.S. at 364). In *University Health Inc.*, the court found that the FTC had "clearly established a *prima facie* case of anticompetitive effect" when it proved that a merger of two nonprofit hospitals would have reduced the number of competitors from five to four and resulted in a combined share of about 43 percent, an increase in HHI of over 630, and a post-merger HHI of 3200. (*Univ. Health Inc.*, 938 F.2d at 1211 & n.12, 1219; *see also FTC v. Bass Bros. Enters., Inc.*, No. C84-1304, 1984 U.S. Dist. LEXIS 16122, at *65 (N.D. Ohio June 6, 1984) (enjoining two mergers that would have resulted in 200 and 300 point increases in HHI); *Cardinal Health,* 12 F. Supp. at 52-53 (enjoining two mergers that would have resulted in 600 and 800 point increases in HHI)).

Response to Conclusion No. 34:

Market shares and market concentration statistics are only the beginning, not the end, of the analysis of whether a transaction might lead to anticompetitive effects. *United States v. Gen. Dynamics, Corp.*, 415 U.S. at 498 (ruling market concentration statistics "were not conclusive indicators of anticompetitive effects"); *United States v. Baker Hughes,* 908 F.2d 981, 984 (D.C. Cir. 1990) ("Evidence of market concentration simply provides a convenient starting point for a broader inquiry into future competitiveness."); *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1111 (N.D. Cal. 2004) ("determining the existence or threat of anticompetitive effects has not stopped at calculation of market shares."). Indeed, the Government's own *Horizontal*

Merger Guidelines caution that "[m]arket shares may not fully reflect the competitive significance of firms in the market or the impact of a merger." Dep't of Justice and Fed. Trade Comm'n, *Horizontal Merger Guidelines*, § 5.3.

This Court must proceed cautiously when relying on market shares to presume a transaction will likely lead to anticompetitive effects when the transaction involves differentiated products, like general acute-care inpatient services. *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1122 (N.D. Cal. 2004) ("a strong presumption of anticompetitive effects based on market concentration is especially problematic in a differentiated products unilateral effects context."). This is because "in differentiated product markets, some measure of market power is inherent," in part due to "the many nonprice dimensions in which sellers in such markets compete." *United States v. Oracle Corp.*, 331 F.Supp.2d 1098, 1121 (N.D. Cal. 2004). Moreover, merger analysis is concerned primarily with "determining whether the merger would enhance market power, not whether market power currently exists." *Id.*

35. A duopoly, as in the inpatient obstetrical services market here, is presumptively unlawful in and of itself. There is "by a wide margin, a presumption that [a three-to-two] merger will lessen competition . . . ." (*Heinz*, 246 F.3d at 716).

Response to Conclusion No. 35:

Complaint Counsel proclaim a duopoly where none exists. In fact, no legal authority supports carving inpatient OB services out from the general acute care inpatient hospital services cluster market. Complaint Counsel did not cite a single case in which the court defined an inpatient hospital OB services market separate from other general acute care inpatient hospital services. Moreover, Complaint Counsel's assertion that inpatient OB services are not substitutable for other general acute care inpatient services is equally applicable to inpatient knee surgery and inpatient gastro-intestinal services, both of which Complaint Counsel include in their

general acute care inpatient services market. *See California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1119 (N.D. Cal. 2001).

FTC v. Heinz Co., 246 F.3d 708 (D.D.C. 2001), is also distinguishable from the instant case. There, the court analyzed the merger of two baby food manufacturers, not hospitals. *Id.* at 711. Here, negotiations between hospitals and MCOs cover the full range of inpatient services that MCOs' members need, including inpatient OB services. (RPF 1020). It is also uncontested that St. Luke's does not offer high-risk inpatient OB services; only ProMedica and Mercy do. (RPF 1022). Nevertheless, no evidence exists showing that hospitals can or do price discriminate for inpatient OB services, and prices for high-risk OB services have been competitive, even though only two competitors provide them. (RPF 1021, 1022).

H. Respondent Has Failed to Rebut the Presumption of Likely Harm

36. Proof that an acquisition will increase concentration in one or more relevant markets with significant barriers to entry establishes a *prima facie* case that a merger is anticompetitive. (*Heinz*, 246 F.3d at 716 (likelihood of success demonstrated by showing that market concentration would increase substantially)).

Response to Conclusion No. 36:

Respondent has no specific response.

37. The burden shifts to the Respondent to rebut the *prima facie* case by attempting to show that market-share statistics do not accurately reflect the market. (*Heinz.* 246 F.3d at 715; *Baker Hughes*, 908 F.2d at 982-83). "The more compelling the *prima facie* case, the more evidence the defendant must present to rebut it successfully." (*Heinz*, 246 F.3d at 725 (quoting *Baker Hughes*, 908 F.2d at 991)).

Response to Conclusion No. 37:

Respondent has no specific response.

38. Section 7 of the Clayton Act does not ask whether any competitor remains, but whether competition is substantially lessened. (*See Evanston*, No. 9315, 2007 WL 2286195, at *14 ("The issue is not whether other hospitals competed with the merging parties, but whether they did so to a sufficient degree to offset the loss of competition caused by the merger.")).

Response to Conclusion No. 38:

Complaint Counsel are required to prove 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 OB services, in Lucas County. *See United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 135 (E.D.N.Y 1997); *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1122 (N.D. Cal. 2004) (stating that merger analysis is concerned primarily with "determining whether the merger would enhance market power, not whether market power currently exists."). To prove anticompetitive effects, 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." *Id.* "[A]ntitrust theory and speculation cannot trump facts." *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 116-17 (D.D.C. 2004).

1. There Will Be No Timely, Likely, or Sufficient Entry or Expansion in the Relevant Markets

39. Entry must be "timely, likely, and sufficient in its magnitude, character and scope to deter or counteract the competitive effects" of a proposed transaction. (*Merger Guidelines* § 9; *United States v. Visa U.S.A., Inc.*, 163 F. Supp. 2d 322, 342 (S.D.N.Y. 2001), *aff'd*, 344 F.3d 229, 240 (2d Cir. 2003); *Cardinal Health*, 12 F. Supp. 2d at 55-58).

Response to Conclusion No. 39:

Respondent has no specific response.

40. Respondent must show both that entry is *likely* – meaning both technically possible and economically sensible – and that it will *replace* the competition that existed in both relevant markets prior to the merger. (*See Cardinal Health*, 12 F. Supp. 2d at 56 (quotation omitted); *In re Chicago Bridge*, 138 F.T.C. at 1147 (noting "new entrants and fringe competitors" might not replace lost competition), *aff'd sub nom. Chicago Bridge,* 534 F.3d 410).

Response to Conclusion No. 40:

The antitrust laws do not require new entry or a bricks and mortar addition. *Cardinal Health*, 12 F. Supp. 2d at 55. Rather, the *Horizontal Merger Guidelines* make clear that repositioning by rivals can suffice to defeat anticompetitive effects. *See United States v. Baker Hughes, Inc.*, 908 F.2d 981, 988-989 (D.C. Cir. 1991) (noting the presence of existing firms "poised for future expansion" supported the conclusion that the merger at issue there would not likely cause anticompetitive effects). The *Horizontal Merger Guidelines* state "[r]epositioning is a supply-side response that is evaluated much like entry." United States Dep't of Justice and Fed. Trade Comm'n, *Horizontal Merger Guidelines*, § 6.1 (2010). Further, the *Horizontal Merger Guidelines* recognize that "non-merging parties may be able to reposition their products to offer close substitutes for the products offered by the merging firms." United States Dep't of Justice and Fed. Trade Comm'n, *Horizontal Merger Guidelines*, § 6.1 (2010).

41. The higher the barriers to entry, the less likely it is that the "timely, likely, and sufficient" test can be met. (*Visa U.S.A.*, 163 F. Supp. 2d at 342).

Response to Conclusion No. 41:

A showing that a non-merging party may be able to reposition its products to offer close substitutes for the products offered by the merging firms satisfies the *Horizontal Merger Guidelines*' requirements that the entry or repositioning be timely, likely, and sufficient. United States Dep't of Justice and Fed. Trade Comm'n, *Horizontal Merger Guidelines*, §§ 9.1-9.3 (2010).

42. The history of entry "is a central factor in assessing the likelihood of entry in the future." (*Cardinal Health*, 12 F. Supp. 2d at 56; *Polypore*, 2010 FTC Lexis 97, at *86; *Merger Guidelines* § 9).

Response to Conclusion No. 42:

Even "the threat of entry can stimulate competition in a concentrated market, regardless of whether entry ever occurs." *United States v. Baker Hughes, Inc.*, 908 F.2d 981, 988 (D.C. Cir. 1991).

2. Respondent's Efficiencies Claims Fail

43. Under the *Merger Guidelines* and related case law, efficiencies claimed by a defendant are not to be credited unless they are merger-specific (*i.e.*, likely to be achievable only by this transaction), substantiated, and of such a character and magnitude that the transaction is not likely to be anticompetitive in any relevant market. (*Merger Guidelines* § 10; *see also Univ. Health Inc.*, 938 F.2d at 1223 ("defendant [cannot] overcome a presumption of illegality based solely on speculative, self-serving assertions"); *Staples*, 970 F. Supp. at 1089).

Response to Conclusion No. 43:

Respondent has no specific response.

44. Respondent must prove the Acquisition results in "significant economies and that these economies ultimately would benefit competition and, hence, consumers." (*Univ. Health*, 938 F.2d at 1223, see also *Butterworth*, 946 F. Supp. at 1300).

Response to Conclusion No. 44:

Respondent has no specific response.

45. A defendant's "proof of extraordinary efficiencies" must be "more than mere speculation and promises about post-merger behavior." (*Heinz*, 246 F.3d at 720-21).

Response to Conclusion No. 45:

Respondent has no specific response.

3. St. Luke's is Not a Failing Firm

46. At the time of the Acquisition, St. Luke's was not a "failing firm" as defined under the *Horizontal Merger Guidelines* and U.S. Supreme Court precedent. (Joint Stipulations of Law and Fact, JX00002A ¶ 21).

Response to Conclusion No. 46:

Respondent has no specific response.

4. St. Luke's is Not a Flailing Firm

47. The so-called flailing firm defense requires a "substantial showing that the acquired firm's weakness, which cannot be resolved by any competitive means, would cause that firm's market share to reduce to a level that would undermine the government's *prima facie* case." (*FTC v. Tenet Healthcare Corp.*, 17 F. Supp. 2d 937, 947 (E.D. Mo. 1998), *rev'd on other grounds,* 186 F.3d 1045 (8th Cir. 1999) (citing *Univ. Health*, 938 F.2d at 1221)). Thus, to succeed, Respondent must make a "substantial showing" of an imminent, steep plummet in St. Luke's market share (from 11.5 percent to less than 2 percent for GAC services and from 9.3 percent to less than 1.3 percent for OB services) such that market concentration falls below levels that trigger the presumption of anticompetitive harm. If Respondent cannot make "the requisite showing that [its] financial weakness would reduce its market share to a level that would undermine the government's *prima facie* case . . . the "flailing firm" defense does not apply." (*FTC v. Tenet Healthcare Corp.*, 17 F. Supp. 2d 937. 947 (E.D. Mo. 1998), *rev'd on other grounds,* 186 F.3d 1045 (8th Cir. 1999).

Response to Conclusion No. 47:

Complaint Counsel do not dispute that St. Luke's alleged market share must be discounted by its financial weakness, which, absent the joinder with ProMedica, would have limited its ability to continue to compete effectively in the market. *See United States v. Int'l Harvester Co.*, 564 F.2d 769, 773-74 (7th Cir. 1997); *FTC v. FTC v. Arch Coal, Inc.* 329 F. Supp. 2d. 109, 155-157 (D.D.C. 2004); *Lektro-Vend Corp. v. Vendo Co.*, 660 F.2d 255, 275-76 (7th Cir. 1981). The Court must consider St. Luke's likely competitive significance in the absence of the transaction. *Arch Coal,* 329 F. Supp. 2d at 157 (analyzing acquired entity's financial condition as part of competitive effects analysis).

48. To qualify as a "flailing" firm, a competitor must be so compromised that its future competitive significance is overstated by current market shares. (*See FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 153 (D.D.C. 2004) (citing *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 506-08 (1974)); Joint Stipulations of Law and Fact, JX00002A ¶ 59).

Response to Conclusion No. 48:

The Court must consider St. Luke's likely competitive significance in the absence of the transaction. *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004) (analyzing

acquired entity's financial condition as part of competitive effects analysis). Here, in lieu of an affiliation, St. Luke's considered *eliminating* money-losing core hospital services, including

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} which

would have reduced its share to zero for those services. (RPF 1962, 1963-1965, *in camera*).

49. "[F]inancial weakness . . . is probably the weakest ground of all for justifying a merger [and it] certainly cannot be the primary justification of a merger." (*Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324, 1339 (7th Cir. 1981)); *see also FTC v. Warner Commc'ns, Inc.*, 742 F.2d 1156, 1164-1165 (9th Cir. 1984)).

Response to Conclusion No. 49:

The financial weakness of an acquired firm is relevant to the assessment of the competitive dynamics of a market. *See United States v. Int'l Harvester Co.*, 564 F.2d 769, 773-74 (7th Cir. 1997) The Court must consider St. Luke's likely competitive significance in the absence of the transaction. *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004) (analyzing acquired entity's financial condition as part of competitive effects analysis).

50. Courts have strongly disfavored "a weak company defense" because it "would expand the failing company doctrine, a defense which has strict limits." (*Warner Commc'ns*, 742 F.2d at 1164 (internal quotations omitted)).

Response to Conclusion No. 50:

The financial weakness of an acquired firm is relevant to the assessment of the competitive dynamics of a market. *See United States v. Int'l Harvester Co.*, 564 F.2d 769, 773-74 (7th Cir. 1997). The Court must consider St. Luke's likely competitive significance in the absence of the transaction. *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004) (analyzing acquired entity's financial condition as part of competitive effects analysis).

I. Divestiture is Necessary to Remedy Harm

51. Once Complaint Counsel has established a violation of Section 7, "all doubts as to the remedy are to be resolved in its favor." (*United States v. E.I. du Pont de Nemours & Co.*, 366 U.S. 316, 334 (1961)).

Response to Conclusion No. 51:

The Commission's remedy is subject to judicial review and should be overturned if the "remedy selected has no reasonable relation to the unlawful practices found to exist." *N. Tex. Specialty Physicians v. FTC*, 528 F.3d 346, 371 (5th Cir. 2006) (remanding the proceeding to the FTC after holding portions of the FTC's remedy were overly broad and internally inconsistent). *In re The Raymond Lee Org.*, 1978 FTC LEXIS 124, at *227-28, *337-352 (F.T.C. Nov. 1, 1978) (eliminating provisions of a proposed order that were overbroad and unnecessary to remedy the abuse found and stating that the order "must not be punitive, but must assure correction of those practices found to be unlawful and prevent their reoccurrence in the future.").

52. The Commission has broad discretion to select a remedy so long as it bears a "reasonable relation to the unlawful practice found to exist." (*Jacob Siegel Co. v. FTC*, 327 U.S. 608, 611-13 (1946)).

Response to Conclusion No. 52:

Respondent has no specific response.

53. The "principal purpose of relief is to restore competition to the state in which it existed prior to, and would have continued to exist but for, the illegal merger." (*In re B.F. Goodrich Co.*, 110 F.T.C. 207, 345 (1988) (internal quotation omitted)).

Response to Conclusion No. 53:

Respondent has no specific response.

54. "[D]ivestiture is the usual and proper remedy where a violation of Section 7 has been found." (*In re. Polypore Int'l, Inc.*, D-9327, initial decision at 329 (FTC March 1, 2010) (Chappell, J.) (citing *E.I. du Pont*, 366 U.S. at 329 ("the very words of § 7 suggest than an undoing of the acquisition is a natural remedy."); *Ford Motor Co. v. United States*, 405 U.S. 562, 573 (1972) ("Complete divestiture is particularly appropriate where asset or stock acquisitions violate the antitrust laws."); *California v. American Stores Co.*, 495 U.S. 271, 285 n.11 (1990) (noting that a person who is allowed to continue holding

ownership over stock or assets that created a Section 7 violation would be engaging in a perpetual violation, and thus, divestiture is the only effective remedy)).

Response to Conclusion No. 54:

This Court must "craft a remedy that will create a competitive environment that would have existed in the absence of the violations." *In re Evanston Nw. Healthcare Corp.*, 2007 FTC LEXIS 210, at *244 (F.T.C. Aug. 6, 2007). In seeking to achieve that pre-joinder competitive environment, the Court has access to the "complete array" of equitable remedies to cure the illegal conduct. *In re Ekco Prods. Co.*, 1964 FTC LEXIS 115, at *117, 122 (F.T.C. June 30, 1964). Divestiture is only one possible remedy a court may impose, and it is not an "automatic sanction, mechanically invoked in merger cases." *In re Retail Credit Co.*, 1978 FTC LEXIS 246, at *260 (F.T.C. July 7, 1978); *see also Ekco Prods. Co.*, 1964 FTC LEXIS 115, at *117 (stating the Commission's remedies include "divestiture *and other remedies*") (emphasis added). Indeed, divestiture is "an extremely harsh remedy." *Reynolds Metals Co. v. FTC*, 309 F.2d 223, 231 (D.C.C 1962). Where equally effective remedies other than divestiture are available, "due regard should be given to the preservation of substantial efficiencies or important benefits to the consumer in the choice of an appropriate remedy." *Retail Credit Co.*, 1978 FTC LEXIS 246, at *260-61, *341; *see also Ekco Prods. Co.*, 1964 FTC LEXIS 115, at *136-37 (stating "the Commission's powers are broad and flexible" and should be "exercised in accordance with principles of fairness and equitable treatment.").

55. Section 11(b) of the Clayton Act's Section 7 provides that the Commission "shall" order a divestiture of "the stock, or other share, capital, or assets, held" in violation of Section 7. (15 U.S.C. § 21(b)).

Response to Conclusion No. 55:

This Court must "craft a remedy that will create a competitive environment that would have existed in the absence of the violations." *In re Evanston Nw. Healthcare Corp.*, 2007 FTC

LEXIS 210, at *244 (F.T.C. Aug. 6, 2007). In seeking to achieve that pre-joinder competitive environment, the Court has access to the "complete array" of equitable remedies to cure the illegal conduct. *In re Ekco Prods. Co.*, 1964 FTC LEXIS 115, at *117, 122 (F.T.C. June 30, 1964). Divestiture is only one possible remedy a court may impose, and it is not an "automatic sanction, mechanically invoked in merger cases." *In re Retail Credit Co.*, 1978 FTC LEXIS 246, at *260 (F.T.C. July 7, 1978); *see also Ekco Prods. Co.*, 1964 FTC LEXIS 115, at *117 (stating the Commission's remedies include "divestiture *and other remedies*") (emphasis added). Indeed, divestiture is "an extremely harsh remedy." *Reynolds Metals Co. v. FTC*, 309 F.2d 223, 231 (D.C.C 1962). Where equally effective remedies other than divestiture are available, "due regard should be given to the preservation of substantial efficiencies or important benefits to the consumer in the choice of an appropriate remedy." *Retail Credit Co.*, 1978 FTC LEXIS 246, at *260-61, *341; *see also Ekco Prods. Co.*, 1964 FTC LEXIS 115, at *136-37 (stating "the Commission's powers are broad and flexible" and should be "exercised in accordance with principles of fairness and equitable treatment.").

56. The Supreme Court noted that divestiture is "simple, relatively easy to administer, and sure. It should always be in the forefront of a court's mind when a violation of § 7 has been found." (*E. I. Du Pont*, 366 U.S. at 330-31).

<u>Response to Conclusion No. 56:</u>

This Court must "craft a remedy that will create a competitive environment that would have existed in the absence of the violations." *Id.* In seeking to achieve that pre-joinder competitive environment, the Court has access to the "complete array" of equitable remedies to cure the illegal conduct. *In re Ekco Prods. Co.*, 1964 FTC LEXIS 115, at *117, 122 (F.T.C. June 30, 1964). Divestiture is only one possible remedy a court may impose, and it is not an "automatic sanction, mechanically invoked in merger cases." *In re Retail Credit Co.*, 1978 FTC LEXIS 246, at *260 (F.T.C. July 7, 1978); *see also Ekco Prods. Co.*, 1964 FTC LEXIS 115, at

*117 (stating the Commission's remedies include "divestiture *and other remedies*") (emphasis added). Indeed, divestiture is "an extremely harsh remedy." *Reynolds Metals Co. v. FTC*, 309 F.2d 223, 231 (D.C.C 1962). Where equally effective remedies other than divestiture are available, "due regard should be given to the preservation of substantial efficiencies or important benefits to the consumer in the choice of an appropriate remedy." *Retail Credit Co.*, 1978 FTC LEXIS 246, at *260-61, *341; *see also Ekco Prods. Co.*, 1964 FTC LEXIS 115, at *136-37 (stating "the Commission's powers are broad and flexible" and should be "exercised in accordance with principles of fairness and equitable treatment.").

57. "It is axiomatic that the normal remedy specified in Section 7 cases is the divestiture of what was unlawfully acquired." (*In re Olin Corporation*, 113 F.T.C. 400, 584 (1990)).

Response to Conclusion No. 57:

This Court must "craft a remedy that will create a competitive environment that would have existed in the absence of the violations." *Id.* In seeking to achieve that pre-joinder competitive environment, the Court has access to the "complete array" of equitable remedies to cure the illegal conduct. *In re Ekco Prods. Co.*, 1964 FTC LEXIS 115, at *117, 122 (F.T.C. June 30, 1964). Divestiture is only one possible remedy a court may impose, and it is not an "automatic sanction, mechanically invoked in merger cases." *In re Retail Credit Co.*, 1978 FTC LEXIS 246, at *260 (F.T.C. July 7, 1978); *see also Ekco Prods. Co.*, 1964 FTC LEXIS 115, at *117 (stating the Commission's remedies include "divestiture *and other remedies*") (emphasis added). Indeed, divestiture is "an extremely harsh remedy." *Reynolds Metals Co. v. FTC*, 309 F.2d 223, 231 (D.C.C 1962). Where equally effective remedies other than divestiture are available, "due regard should be given to the preservation of substantial efficiencies or important benefits to the consumer in the choice of an appropriate remedy." *Retail Credit Co.*, 1978 FTC LEXIS 246, at *260-61, *341; *see also Ekco Prods. Co.*, 1964 FTC LEXIS 115, at *136-37

(stating "the Commission's powers are broad and flexible" and should be "exercised in accordance with principles of fairness and equitable treatment.").

Dated: September 29, 2011

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FEDERAL TRADE COMMISSION
2011 SEP 29 PM 12: 24
DOCUMENT PROCESSING

I, Christine Devlin, hereby certify that I served a true and correct copy of the foregoing Respondent's Replies to Complaint Counsel's Proposed Findings of Fact and Conclusions of Law, Public Version, upon the following individuals by hand on September 29, 2011.

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

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

I, Christine Devlin, hereby certify that I served a true and correct copy of the foregoing Respondent's Replies to Complaint Counsel's Proposed Findings of Fact and Conclusions of Law, Public Version, upon the following individuals by electronic mail:

Matthew J. Reilly
Jeffrey H. Perry
Sara Y. Razi
Jeanne H. Liu
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