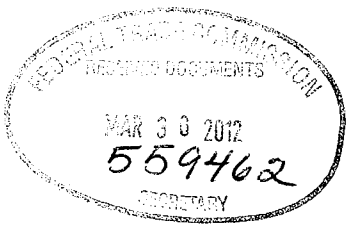
UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES



In the Matter of	)	
	)	
OSF HEALTHCARE SYSTEM, a corporation,	)	Docket No. 9349
	)	
and	)	PUBLIC
	)	
ROCKFORD HEALTH SYSTEM, a corporation.	)	

RESPONDENTS OSF HEALTHCARE SYSTEM'S AND ROCKFORD HEALTH SYSTEM'S MOTION *IN LIMINE* TO PRECLUDE ADMISSION OF UNRELIABLE MATERIALS EXPECTED TO BE OFFERED IN AN ATTEMPT TO SHOW COORDINATED EFFECTS

NOW COME Respondents OSF HEALTHCARE SYSTEM ("OSF") and ROCKFORD HEALTH SYSTEM ("RHS"), and move, *in limine*, to preclude Complaint Counsel from attempting to introduce into evidence the following immaterial, irrelevant, unreliable and misleading materials during the administrative trial: PX0349, PX0350, PX0354, PX0388, PX0462, PX0463, PX0556, PX0630, PX0704, PX1265, PX3151, PX4000 -019 and -024, and PX4626. None of these exhibits is admissible to support Complaint Counsel's expected use of them in connection with its coordinated effects theory. Copies of all of these exhibits are attached hereto as Exhibits A – M, respectively.

Dated: March 30, 2012

Respectfully submitted,

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	)	

STATEMENT REGARDING MEET AND CONFER

On March 27, 2012, Kristin M. Kurczewski and Nicole L. Castle, counsel for Respondents OSF Healthcare System and Rockford Health System, conferred telephonically with Richard Cunningham, Complaint Counsel, regarding Respondents' Motion *in Limine* to Preclude Admission of Unreliable Materials Expected to be Offered in an Attempt to Show Coordinated Activity. Complaint Counsel indicated that they intend to oppose Respondents' motion.

Dated: March 29, 2012

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UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
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	)	
	)	
Respondents.	)	

RESPONDENTS OSF HEALTHCARE SYSTEM'S AND ROCKFORD HEALTH SYSTEM'S MEMORANDUM IN SUPPORT OF THEIR MOTION *IN LIMINE* TO PRECLUDE ADMISSION OF UNRELIABLE MATERIALS EXPECTED TO BE OFFERED IN AN ATTEMPT TO SHOW COORDINATED EFFECTS

To prove the Complaint's allegations that the proposed affiliation will increase the likelihood that the remaining two competitors in Rockford will engage in anticompetitive coordinated action, Complaint Counsel appear to rely only on a limited number of exhibits as evidentiary support.[1] During the parallel federal court preliminary injunction proceeding, where Complaint Counsel presented the same coordinated effects theory, they relied primarily upon the exhibits, which Respondents now seek to exclude from evidence, in a misleading attempt to show the exchange of competitively-sensitive information and/or a history of coordinated activity between Respondents and/or among the three health systems in Rockford. Respondents expect that, in the administrative trial, Complaint Counsel will attempt to introduce the same exhibits into evidence and elicit testimony from their expert witnesses (but, likely not the individuals most knowledgeable about the documents or their contents) in the same misleading way as proof of their coordinated effects theory. None of the exhibits, however, show a history

1 These exhibits, which are the subject of this Motion, are PX0349, PX0350, PX0354, PX0388, PX0462, PX0463, PX0556, PX0630, PX0704, PX1265, PX3151, PX4000 -019 and -024 and PX4626, and are attached hereto as Exhibits A – M. All other exhibits cited and attached are cited as either PX___ or DX___.

of coordinated activity or exchange of competitively sensitive information in the Rockford healthcare market and, therefore, they cannot, individually or collectively, form the basis for any assertion by Complaint Counsel that the proposed affiliation will increase the ability to coordinate among the hospital systems in the Rockford area. Accordingly, this Court should exclude them from evidence.

The documents that are the subject of this motion are irrelevant, immaterial, and unreliable, the type of evidence which the Commission's Rules of Practice say the Court shall exclude. 16 C.F.R. §3.43(b). The ALJ may also bar evidence if it is misleading, results in a waste of time, is needlessly cumulative, or adds nothing to the analysis of the issues. *Id., see also Pagel, Inc. v. S.E.C.*, 803 F.2d 942, 947 (8th Cir. 1986). While the ALJ has the discretion to admit hearsay evidence, the ALJ may only do so if it is relevant, material, and bears satisfactory indicia of reliability so that its use is fair. 16 C.F.R. §3.43(b).

During the preliminary injunction proceeding, when Complaint Counsel cited these documents as support for their coordinated effects allegations, they omitted relevant parts of the record that explained, and even directly and indisputably rebutted, the implications which Complaint Counsel sought to draw. This Court should not allow Complaint Counsel to introduce unreliable and misleading evidence into the record just because they have no relevant, timely, probative evidence to support their claim of coordinated effects.

1) PX 0349, PX0350, PX0462, and PX0463 (Exhibits A – D) are notes prepared by someone at Health Care Futures ("HCF"), an independent consultant hired by OSF, in October and November 2007, which purport to summarize HCF's discussions with Gary Kaatz, CEO of RHS (PX0349), Dr. William Gorski, President and CEO of SwedishAmerican Health System (PX0350), Bruce Peterson and Bill Messer, interim CEO and Board Chair, respectively, of

Rochelle Community Hospital (PX0462) and Darryl Van Vandervort, CEO of KSB Hospital (PX0463)). As David Schertz, President and CEO of OSF Saint Anthony Medical Center ("SAMC") testified, HCF created these notes as part of its management plan building process, which HCF does with all of its clients, based upon interviews of other health care facilities and systems in the broader service area "to confirm that this is the general direction everybody sees the world moving in." Schertz, Tr. 644:4-14.[2] None of the information in these exhibits contains proprietary information – as a simple review of the documents reveals. Schertz, Tr. 644:20-23.

[redacted] DX706-056. Moreover, these exhibits contain at least two layers of hearsay. Nobody from HCF is on Complaint Counsel's witness list, and, even if they were, there would still be a layer of hearsay involved. Exhibits PX0349, PX0350, PX0462, and PX0463 (Exhibits A – D) are hearsay, unreliable, misleading and add nothing to the analysis of the issues before the ALJ. The Court should exclude them.

2) PX0354 (Exhibit E) is an email exchange, on December 18, 2007, between Mary E. Carlis, Director of Revenue Cycle at SAMC, and Michelle A. Carothers at SAMC. Respondents believe Complaint Counsel intend to offer this email to attempt to establish that SAMC and RMH exchanged competitively-sensitive information relating to the charity assistance programs at each hospital. What the email exchange establishes is the opposite, however, and reflects Carothers suggesting that Carlis say only that SAMC is in the process of finalizing its uninsured discount policy. The document does not establish that any details about

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2 Testimony from the preliminary injunction hearing held in U.S. District Court in Rockford, Illinois on February 1-3, 2012, is cited herein as _____, Tr. _____ (which sections of the transcript are also attached hereto).

the program, let alone competitively-sensitive information, were exchanged. Moreover, neither Mary Carlis nor Michelle Carothers are on Complaint Counsel's witness list, nor has either been deposed, so Complaint Counsel will be unable to lay the appropriate evidentiary foundation for the admissibility of this exhibit. The exhibit should be excluded.

3) PX0388 (Exhibit F) is a February 28, 2011 email exchange between [redacted] Neither that language nor the concept appears anywhere in the email. The email which began the exchange between [redacted], as shown in the exhibit, was from [redacted] The document has nothing to do with coordinating activities of the two hospitals as separate entities. Complaint Counsel knows this from Mr. Sehring's responses to their detailed questions regarding PX0388. Mr. Sehring explained repeatedly that the emails relate to potential work by FTI going forward with the merged entity and do not discuss any cost efficiencies each hospital could achieve separately without the affiliation. DX1181-051-055. [redacted] *See* DX716-050-051. Complaint

Counsel's misuse of this exhibit during the preliminary injunction proceeding to suggest coordinated activity between Respondents was misleading, and again would be misleading if allowed in the upcoming administrative trial. The Court should exclude this exhibit.

4) PX0556 and PX0630 (Exhibits G and H) are RHS Finance & Audit Advisory Committee Minutes from October 26, 2005, which Complaint Counsel offered during the preliminary injunction proceeding to suggest that RHS and SwedishAmerican Hospital ("SAH") exchanged information, regarding whether negotiations were ongoing with Blue Cross Blue Shield of Illinois ("BCBS"). In addition to being stale, there is nothing coordinated about RHS learning that it was bidding against itself with BCBS. These documents do not establish that RHS and SAH agreed on anything. Moreover, despite three opportunities to question RHS CEO Gary Kaatz about these documents (Mr. Kaatz has been the RHS CEO for about twelve years), Complaint Counsel never did. *See* DX0698; DX0706; Kaatz, Tr. 707-776. [redacted], both testified unequivocally that [redacted] *See* PX4000-041. The statements in these exhibits that Complaint Counsel misleadingly relied upon are hearsay, and would again be misleading if allowed in the upcoming administrative trial. The Court should exclude them.

5) PX0704 (Exhibit I) is an email chain between RHS CFO Henry Seybold and RHS Director of Managed Care Paula Dillon from July 17, 2008. Complaint Counsel argued during the federal court proceeding that this document shows Mr. Seybold and Ms. Dillon planning a "pick each others [sic] brains meeting[]" with OSF's Director of Managed Care. Complaint Counsel offered no evidence of what this means. More importantly, when they did question the supposed participants to this meeting during their depositions, all three individuals [redacted]. *See* DX0937-044; DX1158-049-050; DX1182-013. Complaint

Counsel's misuse of this exhibit during the preliminary injunction proceeding to suggest coordinated activity between Respondents was misleading, and again would be misleading if allowed in the upcoming administrative trial. The exhibit should be excluded.

6) PX1265 (Exhibit J) is a letter from Epstein Becker & Green, P.C., counsel for SAH, to Paul Brand, Executive Director of Employers' Coalition on Health ("ECOH"), dated September 26, 2008, and PX4000-019 and 024 (Exhibit K) are portions of the deposition transcript of Richard Walsh, COO of SAH, relating to PX1265. Complaint Counsel misleadingly offered this letter during the preliminary injunction proceeding to attempt to show coordinated activity between Respondents to exclude SAH from an ECOH provider network. The so-called "ultimatum" referred to in this letter, allegedly made by "St. Anthony's and Rockford Memorial Hospital," is not attributed to any person or persons at either of those entities and, even assuming it had been, it would still constitute at least two layers of hearsay. Mr. Walsh's testimony (Exhibit K), upon which Complaint Counsel also relied, itself contains two levels of hearsay. [redacted]. Yet, again, Complaint Counsel never asked either CEO about this allegation, despite three chances to ask Gary Kaatz, and four to ask David Schertz. *See* DX0698; DX0706; Kaatz Tr. 707-776; DX0189; DX0394; DX0714; Schertz Tr. 565-651. Moreover, Complaint Counsel's house of cards collapsed when [redacted] was deposed. [redacted] To the contrary, [redacted]

[redacted] *See* DX1151-042-043. [redacted]

[redacted]. *See* DX1157-003, 013, 031 and 035. Both PX 1265 (Exhibit J) and Mr. Walsh's testimony regarding this topic (PX4000-019 and 024) (Exhibit K) are unreliable and misleading, and Complaint Counsel should be precluded from introducing or relying upon them.

7) PX3151 (Exhibit L) is a November 3, 2005 email between Carol Stever and Mary Breeden of OSF. Complaint Counsel offered this document during the preliminary injunction proceeding to suggest an exchange of competitively-sensitive information between Don Vayr, SAMC's Director of Strategic Planning, and Mr. Abrams, his counterpart at RHS. First, the statement in the e-mail that Mr. Vayr was "told ... that RHS [is] terminating ALL BCBS Agreements – including 'Commercial,'" contains at least three layers of hearsay. And second, despite two opportunities to question Mr. Vayr about this exchange of information, Complaint Counsel avoided the topic except for briefly inquiring if Mr. Vayr ever spoke to Mr. Abrams at RHS regarding contracting. Mr. Vayr responded "No." *See* DX0183; DX1185-039. Complaint Counsel misused this exhibit during the federal court proceeding. Any attempt to do so in the administrative trial would again be misleading and should be prevented.

8) PX4626 (Exhibit M) is a December 2, 2010 email exchange between [redacted]

[redacted] Complaint Counsel argued in the federal court proceeding that this email, [redacted], constitutes "coordinated" activity. Despite two opportunities, they never questioned [redacted] about this document. *See* DX0183; DX1185. Complaint Counsel waited to confront [redacted] with PX4626 until her deposition on February 16, 2012. *See* DX1158-049-054 (they did not ask her about PX4626 on August 3, 2011 (*see* DX0183)). When Complaint Counsel did ask [redacted] about PX4626, [redacted]

[redacted] No matter how hard they tried to manipulate PX4626, [redacted]. *See* DX1158-049-054. This exchange between [redacted] and [redacted] does not constitute any sort of coordinated activity, and Complaint Counsel's attempt during the federal court proceeding to suggest it does was misleading. *Id.* It would also be misleading in the administrative trial and thus should be excluded.

CONCLUSION

All of the credible evidence confirms the Rockford hospitals have not previously engaged in coordinated activity or exchanged competitively-sensitive information, and have no intent to do so in the future. Respondents believe Complaint Counsel, as they have in the past, will attempt to rely upon Exhibits A – M to establish that Respondents have engaged in coordinated activity or exchanged competitively-sensitive information. These exhibits are unreliable and misleading. Complaint Counsel previously omitted relevant parts of the record that explained, and even directly and indisputably rebutted, the implications which Complaint Counsel sought to draw from these documents. Given Complaint Counsel's misleading use of these documents during the preliminary injunction proceedings, Respondents ask the Court to find that these exhibits are unreliable and misleading, and cannot be used by Complaint Counsel to support any claim of coordinated effects resulting from the proposed affiliation.

PX0349, PX0350, PX0354, PX0388, PX0462, PX0463, PX0556, PX0630, PX0704, PX1265, PX3151, PX4000 (pages 019 and 024), and PX4626 (Exhibits A – M) do not meet the requirements of Rule 3.43(b). Accordingly, Respondents respectfully request that the Court

enter an order precluding Complaint Counsel from offering them into evidence, or eliciting testimony about them.

Dated: March 28, 2012

Respectfully submitted,

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Attorneys for Defendant Rockford Health System

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

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[PROPOSED] ORDER

On March 28, 2012, Respondents OSF Healthcare System and Rockford Health System moved *in limine* to preclude admission of unreliable materials expected to be offered in an attempt to show coordinated effects.

Accordingly, upon due consideration of the parties' submissions, it is hereby

ORDERED that Respondents' Motion *in Limine* to Preclude Admission of Unreliable Materials Expected to be Offered in an Attempt to Show Coordinated Effects is granted and PX0349, PX0350, PX0354, PX0388, PX0462, PX0463, PX0556, PX0630, PX0704, PX1265, PX3151, PX4000 -019 and -024 and PX4626 shall be excluded from evidence.

ORDERED:

D. Michael Chappell
Chief Administrative Law Judge

Date:

CERTIFICATE OF SERVICE

I hereby certify that on this 30 day of March, 2012, a copy of Respondents' Motion *in Limine* to Preclude Admission of Unreliable Materials Expected to be Offered in Attempt to Show Coordinated Effects and Memorandum in Support was served on the following via electronic mail:

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Secretary
Federal Trade Commission
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Attorney for OSF Healthcare System

EXHIBIT A

Summary of Discussions with Rockford Health System – November 5, 2007

Participant

- **Gary Kaatz** – President and CEO.

Background

- **Gary** – he has been in Rockford since 2000. He spent 20 years @ Rush and then spent six or seven @ Case Western Reserve in Ohio before he came to RHS. They were losing a ton of money when he came on board.

Discussion material

- **Financials** – they have a lot of money in the bank but struggle to break even operationally. They have had a strategy of de-emphasizing the Medicaid market and are letting SWA go after that market.
- **Land on Riverside** – he would not share what they are specifically planning (I waited to ask him until late in our conversation as I had good interaction with him (he knows some other consultants I know) but he did say they have more consensus now than they did six or so months ago (I reminded him we were asked to work with them by his Board Chair and turned it down). See notes below about Advocate and Rockford – he thinks Rockford needs one strong larger tertiary medical center along I-90 with one other community hospital but does not think that will play out unless there is somebody from the outside that makes things change.
  - **Ed Comments** – Only from reading between lines, I don't think they still have the OK or the commitment from the Board to go forward with a new Hospital on Riverside and will move to an ambulatory campus but he also intimated OB could be part of it.

- Advocate – on his own he mentioned his view that Advocate will be a player in the Rockford market. He did not answer my question directly about whether that would be with his organization but again reading between lines it is clear to me that they have talked with Advocate in some manner. He has a personal relationship with Jim Skogsbergh the Advocate CEO from their work together in IHA. He told me that Advocate believes they need to be in this market and wants to partner with someone. Advocate made a play for the Highland Hospital in Belvedere per both CEO's. When I asked about a future successful picture for Rockford (the town not RHS) he said one strong tertiary medical center along I-90 with one other community hospital in town and maybe two. He said Advocate could be a player in some form. I don't think he was misleading me but I don't know him well.
- **Rockford** (the town) health care today – not known for anything in particular. Good but not great reputation in NICU. Peds, Neurosciences, Rehab, Ortho, Trauma and cardiology but cardiology is a declining and probably is over-stated as a good local service line.
- **Strengths of each organization.** Again reading between lines it does not appear that he has much love for SWA right now – as he said very little interaction with Gosnl or Walsh but a fair amount with Dave Schertz.
  - **SAMC** – location, cardiac care, oncology, ortho and trauma.
  - **RMH** – Peds, OB/NICU, ortho and rehab along with trauma
  - **SWA** – Best and largest PCP group – not just size but good providers.

- **Negative for SAMC** – OSFHPs trying to get peds cases down to Peoria and the fact OSFHPs will not contract with RMH. Clearly, this is him complaining which comes with the territory when one does interviews like this.

- **His take on which organization is best positioned** this one was interesting to me (also see the SWA notes as well) in his order.
  - **SAMC** – due to the OSF System and OSF cash.
  - **RMH** – due to their balance sheet and **NICU/Peds** service lines.
  - SWA – as noted above lot a love for SWA but he said SWA has a local flavor in what they do that they play up that works well.

- **Future of Rockford (the city) health care systems**– see his comments above – he would like to see one large medical center along I-90 but he does not think it will happen. So, short of this happening, each of the three will continue to fight among themselves and Rockford as a whole will suffer in terms of health care. Absent fundamental change in how care is delivered he has concerns about how Rockford will be able to support tmo tertiary care with the volume split three ways. He noted health care is a huge business in Rockford. He would like at least two of the systems working together to combine certain service lines. He does not think a merger will work due to past politics but a combination of service lines under some JVs between RMH and SAMC would be good per him. For example, SAMC has the heart and head trauma but they have the peds and OB and OSF works to improve immigration to their NICU under the JV.
- **Physician employment** – this is again something he brought up. He thinks 50 plus percent of his medical staff will be employed by RMH in five plus years and sees the same thing for the other systems. They are, like others, struggling to help MD groups recruit so they will go back to the employment route.
- **Competition** - RHS is not too worried about Janesville but do worry increasingly about Beloit. He understands that Beloit was able to put their new ambulatory care center in Illinois (Roscoe/Rockton I believe) without a CON since they are not an Illinois organization and if they are not an Illinois organization they don't have to comply with CON laws? That is news to me if true. In addition they are starting to worry a bit about Centegra. Per Gary, Centegra has a second tier medical staff but is quickly improving their medical staff (from my understanding his opinion is probably right) and he thinks they will look West to at least Belvidere. He thought Centegra has money as well (I don't know if that is true). Also, they have seen more volume shifting to Good Shepard in Barrington (part of Advocate) as well.
- **Rehab hospital** started something like five years ago. JV with HealthSouth and it has been a good deal for them economically and strategically as they have grown the rehab service line by a fair amount over the past few years.

EXHIBIT B

Summary of Discussions with Swedish American Health System November 5, 2007

Participant

- Bill Gerstl MD – President - Swedish American Health System

Background

- **Bill**– he started out as a IT and has been in Rockford for decades. He has been the President of SAHS for seven years. He grew up in Naperville. My personal sense of the interview is that he was much more guarded than Gary K from RHS but it may have been me or that may be his style. Frankly, I felt like I got much less out of him versus Gary.

Discussion material

- **Financials** – they are doing well and if the proposed Medicaid overhaul that is apparently under discussion in Springfield becomes law they will be in really good shape. Per Bill, they don't have the money that RHS or SAMC/OSF have in the bank.
- **Payor mix** – he is proud of his 25 percent Medicaid load and is OK being the Medicaid site.
- **Market share** – they have gained share over the past five years per Bill in their PSA (Winnebago, Ogle and Boone County) – Stephanie will help us look at that. They have noticed that referral volume from outside those three counties is down.
- **Their focus** primarily in their PSA and they don't worry as much about the SSA, with a few exceptions such as down by Rochelle (which he brought up).
- **Employment of MDs** – he like Gary K thinks 50 – percent of his specialty base will be employed as it will be the best way to recruit MDs. This was something he brought up. He also wanted to know what OSF was thinking. I told him OSF believes there will much more employment across the System and that like many other clients is trying to best figure out how best to manage and operate specialists (he said if we get it figured out let him know how to best manage specialists!). I also told him that the System believes that successfully employing the specialists will in some of its market's create a market advantage for OSF.
- **SWA Heart Hospital** – successful. Volume has not grown but it has not dropped (even though the overall market volume is down so obviously market share is up in their view) so in their view that is a success. Cath volume is down a a tou due to hospitals like Kish and CGH getting new cath labs. They view Midwest Heart as a success story for them and reading between some lines do not view RCA as their future.
- **Regional hospitals** – he was not very supportive of the regional hospitals. He is suspect of their quality of care as they get into more tertiary level care like caths (he is probably right). It was also very clear that SWA had made the rounds with the regional hospitals and did not have luck as he was clearly frustrated by the attitude of at least some of the regional CEOs (he did not name names).
- **Outside competitors** – he is worried about Ceresgra and he mentioned without me asking that Advocate wanted Highland in Belvedere. He said he did not know what Advocate wanted with it or what their plans were in Rockford. He could be deceiving me but I don't think Advocate and SWA have talked. He does view the regional hospitals as competitors as well and increasingly stronger competitors.

Summary of Discussions with Swedish American Health System November 5, 2007

- **Strengths of the three Rockford health systems** – as with RMH there does not appear to be a lot of love between the RMH and SWA.
  - SAMC – OSF System with the cash and possible market power, Dave Schertz (he said a number of times he has a great relationship with Dave and SAMC even though you all are competitors), and location.
  - RMH – two things he came up with – RMH is the old blue blood place in town but he is not sure that is even an advantage anymore and the fact RMH has $200M plus in free cash.
  - SWA – culture was his big one. He feels like they represent the true Rockford and focus on the local market. Medical Group – largest and best. Focus on quality that has been around since the 80s. Great Board.

- **Which of the three are best positioned for success** – in order
  - SWA – due to their culture and their ties to the community along with their quality focus.
  - SAMC – due to OSF System, location and good quality.
  - RMH – will their cash allow them to ride the storm out?

- **Future of Rockford health care** – he thinks the three will continue to slug it out and have good years and bad years. He feels like SWA is more insulated because they focus on the local market but he also said that local market is not the one that is growing and is also the one that is becoming more impacted by negative economic issues which will lead to more Medicaid. Basically, he is banking on success @ the State level to get more money into Medicaid and with his disproportionate share payments believes he will do well.
- **RMH Land** – he thinks RMH will put up ambulatory care. He would fight them big time if they tried to move OB and NICU to that site.

EXHIBIT C

Summary of Discussions with Rochelle Community Hospital – October 30th, 2007

Participants

- Bruce Pedersen – interim CEO.
- Bill Messer (sp) – Board Chair.

Background the participants

- Bruce – interim CEO for about three weeks. He is the former Aledo CEO who has been doing some consulting and interim work. He IS a candidate for the permanent position. They want the CEO slot filled by January and they have had a number of candidates.
- Bill – on the Board for about 8 years. He is the retired President of the Kishwaukee Community College (was there 34 years) and is now the interim President of the Illinois Valley Community College in Peru (or LaSalle). He has lived in Rochelle for 35 years. Bill was just up to SAMC for what sounded like an outpatient procedure and was very happy with the service. The Board has eleven members which per Bill creates some problems finding eleven good people in town. Their Board finance chair is a former College Board member who does not understand why the Hospital needs to keep any cash, nor make money! Per Bill the same guy was on the College Board and did the same thing.

Discussion material

- **Financials** – not a good year this year, nor last. They are close to break even. Basically they (like many other CAH's we know of) are vulnerable to small shifts in volume – 0.5 – ADC difference across the year can be the difference between a good year and a loss. They are not sure if this two year history is the beginning of a trend or a bump in the road. In prior two to three years they had strong performance (I did not ask their definition of strong performance). While we did not get into numbers they don't appear to have much cash to invest in the facility or strategic projects.
- **Independent affiliate agreement with OSF** – they were not sure if that was still in place and if so what it did. Note to all of us – we should find the affiliation agreement and see if that gave OSF any right of first refusal on sale/merger (other affiliation agreements do). Bruce does not feel like SAMC is interested in the region like SFMC is and does not feel like SAMC does enough paying attention to their needs like he had in Aledo.
- **RMH** – not a player in their market.
- **SWA** – at present they have a greater affinity for SWA although SWA has a newer clinic in Davis Junction which is shifting business from them to SWA. Why SWA? They said SAMC created some ill will when it pulled out of the three way JVs (with SWA and RCH) for both primary care clinic ownership and for Emergency Room coverage. Also, SWA comes across as listening more to their needs than SAMC. For some this was an indication that SAMC was interested only in the money SAMC could pull out of the Rochelle market. They are not really happy with SWA right now but need them to be their partner in clinic and ED to save money.
- **View of SAMC** – despite the above, strong views about the clinical care at SAMC and a perception that SAMC provides better quality care.
- **SAMC Strengths** – quality care and good service.
- **SAMC Weaknesses** – did not know other than specific issue for Rochelle with above noted in SWA comments.

Summary of Discussions with Rochelle Community Hospital – October 30th, 2007

- **Rockford as a destination community for health care** – they indicated Rockford is not noted as THE place to go for any one health issue. It is a tertiary center but not one known for any particular distinguishing services. Folks leave and go to Chicago suburbs often. Also, for Rochelle folks Rockford while still the place to go to shop is also the place with crappy schools, high and bad crime and a bad downtown – most folks from Rochelle merely travel off of State Street.
- **Kish/swankee** – it is evident that Kish and RCH have talked. I did not specifically ask but it was pretty evident. Bill was very familiar with the Kish acquisition of Sandwich Hospital in which they kept a local board. They did say they have NOT made any decisions relative to their future and any relationship with Kish and I believe them. It was also evident to me reading between a bunch of lines that they have talked seriously with Kish. Kish is putting a sleep lab in Rochelle within the next few months. They think Kish will be looking west and thus them, since that may be real that is easier to make for their new facility.
    - **Ed comment** – I talked with them a fair amount relative to the benefits and risks of partnering with a very local player like Kish. I warned them that while Kish may know them Kish also will take more volume to their shop (unless they know RCH) since they are so local. I also pointed out that Kish will likely be more reluctant to put money into RCH given they are so close geographically. I tried to play up the fact sometimes distance is a good thing in a consolidation. It appeared to me that they have not thought all of this through.
- **Future for RCH** – they want to wait for their new CEO to get in place and give him/her time to understand the market and the issues and make a recommendation, but they believe within five years they will be looking for a "white knight" that will help them with capital to invest in their facility and to help them with successfully recruiting physicians. They believe they will stay a CAH but need to invest in the plant and in getting physicians to town.
- **Current issues beyond making money** – recruitment of physicians. They need three to four FPs or IM/Peds. In the last year they have lost two PCPs and added two for a net zero gain. They believe there is a ton of outmigration of primary care to DeKalb, Rockford and Chicago suburbs – anecdotal information from them.
- **Hispanic population** – they have a significant Hispanic pod and it is growing – per Bill @ the High School it is nearly 50 percent of the kids.
- **Local economy** – no real changes. They have not seen any real influx of suburban Chicago residents coming to Rochelle for cheaper housing. No material new businesses have come or are coming either. They are getting a new Super Wall-Mart (which in my experience in some other smaller communities is actually a good sign economically as Wall Mart tends to do some good economic research but it could be just an opportunity to stem volume going to Rockford) and Walgreens.
- **Physician Employment** – they employ one MD directly and two via the JV with SWA. They also have the JV with SWA to employ the ED MDs.
- **Advice for SAMC and OSF** – dance with regional players and see if it can lead to marriage but be willing to provide benefit to the regional players while you are dancing.
- **Our conclusions** – not a done deal with Kish and I think they will give the new CEO six + months to figure our a course of action. Kish has a leg up but not a sure thing and again I think I identified some things for them to at least think about. SWA is probably not a long-term partner either given the fact SWA seems to want to compete with them. SAMC is still viewed in the aggregate as a good partner but they have not been sucked up to enough. They need MDs (like everyone else).

EXHIBIT D

Summary of Discussions with KSB Hospital – November 12, 2007

Participant

- **Darryl Van Vandervort- CEO.** Darryl has been @ KSB since 83 (he came as the CFO) and became CEO when Jim Dague (who is now the CEO in Goshen IN and another HCF client) was fired. He is retiring in three years.

Discussion material

- **Financials** – KSB has a fairly constant three to four percent net margin which correlates to approximately $3 to 4M. He noted there is a fair amount of money in town but they do not get any major donations as folks think the old Shaw trust (the S in KSB) still has money to support the hospital...
- **KSB Physicians** – They are big into employment and have their own IP residency program.
  - **Employed base** - 75 on active staff and 60 are employed. 80 percent of his medical staff are FMG or international medical school graduates. 20 of the 60 are FPs and about half the FPs do deliveries. They also employ IMs, OBs and specialists – they believe in the future nearly all of their MD base will be employed. They employ three cardiologists with two doing interventional work. They have a large J-1 visa contingent. Approximately ten of their employed MDs came through the Rockford residency programs (I am assuming this is the primary care).
  - **FP residency** – they just had their second class complete – they have two a year and they have kept one of four in the area – all of the FP residents are foreign born or international medical school graduates. The residents have their first year @ SWA and their second @ KSB. KSB had 1,100 candidates for the two slots.
- **MD needs** – more PCP and more specialists primarily GI, ENT and neurology. He has two J-1 visa MDs who will leave in the next year (GI, and Cardiology).
- **Cardiology** – two of KSB's cardiologists have some referral relationship with the SWA RCA cardiologists but he does not believe they send much out to Rockford or RCA. By and large however, RCA was historically not very friendly or good with referring MDs from Dixon. He mentioned a Dr Soriano (sp) from Rockford who is a neurologist who has done a great job of working with referring MDs to contest with RCA.
- **Cath lab** – it has been operational for a few years and they had 308 caths @ KSB last year.
- **Future of KSB and partnering with anyone** – Darryl is three years from retirement and KSB has already named his successor (their current COO- David Schreiner). David was just named citizen of the year in Dixon and is a Dixon first kind of person. Darryl flat out told me he will NOT pursue any discussions with any other party (Rockford or Sterling or anyone) in the next three years – he does not want the hassle. He also said his successor is very independent minded as well. This was one of the more direct no ways I have heard regarding future alignment – this was not just with OSF but with anyone.
- **Chicago provider leak into their service area.** They have not seen any influx of Chicago physicians nor Chicago payers into their market. He is aware it is happening in DeKalb. He noted anecdotaly that he has started to see around town a few commuters to Chicago suburbs but at present he believes these are very few.
- **I-88** – I was not aware but per Darryl IDOT is exploring some kind of interstate mile swap with the Illinois Toll Authority for some of the miles between Dixon and the Chicago suburbs (tollways tend to reduce development due to their limited access) and Dixon is the first exit from the West (or the last one from the East). Apparently, the Dixon Chamber of Commerce is pushing for this and believes it will be a huge growth engine if it happens. I had not heard of this before.

- Ills worries –he is not worried about CGH (typical CGH is not good comments) but is worried about how Chicago may influence them in the future. He also worries about the fact most of his home town companies are being bought up by major international companies and how that could impact local loyalty among the business leaders. He also worries about not enough physicians. He relies a fair amount on J-1 and given their location they qualify but per Darryl it is a close call each year to determine if they qualify and if they start to get some influx in population that could eliminate that option which could create some recruiting worries. He thinks they keep about a fifth of the J-1s that come through Dixon.
- Community – some new transportation (trucking) jobs have come in the last few years along I-88 but community is not growing much. Major employer – Rayner – Garage Doors. BX just got the Rayner contract. Also Rayovac (batteries) is in town and they were just bought out by an international company. Other major employer is Rollstoc(sp) which is a Swedish (or Finnish –he was not sure) company that makes most of the hidden bar codes used for tracking goods across the world.
- MD compensation plan for their employed MDs – base set @ 50th percentile of MGMA with bonus on top of that for productivity.
- Rockford Hospitals and referrals – he did not have much to say good or bad about any of the Rockford hospitals (it is clear to me that he nor his organization worry or even pay attention to what is going on in Rockford relative to health care (still a shopping destination) and I don't think he had a good data set on what is leaving the area. He thought NICU goes to RMH.
- Other
  - Pharmacy – KSB is a site where U of I pharmacy students train and they get one every once in while to stay.
  - JCAHO – they are not JCAHO accredited and stopped working with JCAHO years ago and he believes it has not hurt them in any contracting.
  - Parking deck – KSB just opened (the day before I came) a new parking deck.
- Our conclusion –not that this is wrong but at least the CEO @ KSB is fairly internally and very locally focused and it is very clear that they do not want to do anything to dramatically change the landscape until he retires.

EXHIBIT E

From: Carrothers, Michelle A.
Sent: Tuesday, December 18, 2007 11:10:32 AM
Subject: FW: Community questions re prompt pay discount and % above poverty level

[redacted]

I know if Swede's RMH want this information they can find it with the AG's office through our charity policy that is submitted. Do we want to make them work for it or should we be good guys and share? I recommend that we share. I know that our percentage is lower but we have a very generous catastrophic policy that somewhat makes up for that. We can tell them that we are in the process of finalizing our uninsured discount policy. Are you OK with that?

From: Carlis, Mary E.
Sent: Tuesday, December 18, 2007 9:22 AM
To: Carrothers, Michelle A.
Cc: Lassandro, Ida L.
Subject: Community questions re prompt pay discount and % above poverty level

Michele,

Received a phone call from my peer at Swedish American Hospital in Rockford wanting information on what % above the poverty level we calculate charity assistance. Randy left me a message stating that Rockford Memorial had just increased theirs to 300%. Swedes is currently at 200% and looking to re-evaluate that figure. SAMC is currently at 150%. Talked with Dave Stenerson this morning and he recommended emailing you to get your take on sharing this type of information with our competitors. I was also interested in finding out what the other two facilities are offering for prompt pay discount - however, if I ask that question I am sure they will want to know what we are doing as well. What's your take on sharing this info? I would appreciate any guidance you could provide us.

Mary E. Carlis
Director Revenue Cycle CHAM

OSF Saint Anthony Medical Center
5666 E. State St.
Rockford, IL 61108
Phone: 815-395-4515 Pager: 815-227-3451
Mary.Carlis@osfhealthcare.org

EXHIBIT F

SUBMITTED FOR

IN CAMERA REVIEW

EXHIBIT G

ROCKFORD HEALTH SYSTEM

FINANCE AND AUDIT ADVISORY COMMITTEE

Monday, November 14, 2005
4:00 p.m.
Finkenstaedt Board Room

AGENDA

				Est. Time
I.	**Approval of Minutes**		Robert Pickering	1 Min
	A. October 26, 2005*			
II.	**Blue Cross Update**		Joseph Smith	10 Min
III.	**2006 Budget Volume Assumptions**		Suzanne Petru Kerry Hill Dennis Oltz Belinda Muck	45 Min
IV.	**RHS October 2005 Financials**	***To be distributed***	Suzanne Petru	20 Min
V.	**Van Matre HealthSouth Rehabilitation Hospital Financial Report – 3rd Quarter Ending September 30, 2005**	**Exhibit A**	Suzanne Petru	10 Min
VI.	**Other Business**			
	A. Line of Credit		Suzanne Petru	5 Min
	B. Status of Internal Audit Director		Suzanne Petru	5 Min
				96 Min
VII.	**Adjournment**		Robert Pickering	

*Enclosure: Minutes of October 26, 2005

Next Meeting
December 12, 2005
4:00 p.m.
Finkenstaedt Board Room

ROCKFORD HEALTH SYSTEM

FINANCE & AUDIT ADVISORY COMMITTEE
MINUTES

October 26, 2005

PRESENT:	Duane R. Bach	Jack W. Packard
	W. Walter Boothe	Robert A. Pickering
	James W. Breckenridge, M.D.	Jeffrey E. Schauer, M.D.
STAFF SUPPORT:	Tony Kazwell	Suzanne M. Petru
INVITED GUESTS:	John Rhoades	Joseph Smith
	Kevin Ruggles, M.D.	Earl Tamar

Mr. Robert Pickering, Chairman, called the meeting to order at 7:00 a.m.

MINUTES: There being no additions or corrections to the minutes, it was

VOTED: To approve the September 14, 2005 minutes of the Finance & Audit Advisory Committee as presented.

BLUE CROSS UPDATE: Mr. Joe Smith, Corporate Director of Managed Care stated that in September, Rockford Health System presented a proposal to Blue Cross based on a floor of 64% of billed charges. He stated that during a meeting with Blue Cross, he asked what it would take for Rockford Health System to be an in-network PPO provider. Blue Cross responded that the hospital would need to be at 50% of charges. Mr. Smith noted that Blue Cross did give the System an opportunity to remain "out of network" at a 75% of charges reimbursement rate for the next three years. He stated that management feels strongly that based on the System's future growth plans and the surrounding areas which participate in Blue Cross; it would be beneficial to be an "in-network" PPO provider. Therefore, a blended proposal was developed whereby standard services would be at 50% of charges and specialty services at 70% of charges.

Mr. Smith stated that during discussions, Blue Cross insinuated that the hospital is in a bid war and that the other two hospital's rates were so low that if Blue Cross would sign a PPO contract with RHS at a higher rate, RHS would be cannibalizing that business and Blue Cross would be losing money on every case. Mr. Smith noted that this may be true on standard charges, but not on specialty services such as NICU and Peds Specialties that are unique to RHS. With regard to standard services at 50% of charges, RHS indicated to Blue Cross that they would not be losing money on every case due to RHS being at the proposed level that Blue Cross indicated would be acceptable. Blue Cross rejected the System's blended

proposal and indicated that the offer was still too high and then indicated that the other two hospitals are at cost or below cost. Blue Cross's most recent proposal to RHS is to remain out-of-network at 75% of charges for three years and have requested a response from us by October 31, 2005.

Mr. Smith reviewed various assumptions and their impact on several contract models.

Dr. Schauer stated that the market penetration of Blue Cross seems to be increasing and believes that the decrease in volumes in the hospital directly relates to Blue Cross patients. Mr. Pickering questioned the strategy of Blue Cross by offering an increase for the System to remain out-of-network. Mr. Kaatz does not understand what their strategy is, but believes that Blue Cross may have some type of verbal arrangement with the other two hospitals in town. Mr. Pickering stated that Blue Cross was not interested in the System's blended rate proposal of 70/50, therefore, suggested possibly revising the blended rate to 70/40. This blended rate would put RHS under the other hospitals for standard services and would not compromise on the specialized services where there is no competition. In reviewing past data, Mr. Smith stated that according to Blue Cross, not having a contract results in a decline of 10% in admissions, 17% in outpatient cases, and outpatient reimbursement decrease of 5% or $200,000. At the same time, SwedishAmerican Health System and OSF St. Anthony experienced a 12% increase in admissions, a 6% increase in outpatient cases and a 25% increase in combined (in and outpatient) revenues due to their contract with Blue Cross.

Mr. Smith stated that the risks to being preferred in-network provider include:

- Immediate and long-term loss in reimbursement (guaranteed shrinking margins).
- Cannibalization of other better paying plan business.
- Overall erosion of leverage in the market place.
- Not as much leverage due to having a physician contract.

The benefits to being preferred in-network include:

- Increased volume.
- Capture additional collar-county NICU referrals.
- Increase physician other business volume.
- Supports east side growth.
- Take business from SwedishAmerican and OSF.

Mr. Smith stated that he spoke with the Managed Care Director at SwedishAmerican who indicated that they are not in a bid process with Blue Cross, however, Blue Cross has indicated to us that we are in a competitive bid process. Blue Cross has indicated that the System's rates are not acceptable because bids from the other hospitals are less making it appear that the System is actively in the bid process which is untrue. Mr. Pickering asked Mr. Smith if Blue

Cross would accept a two tier arrangement. Mr. Smith stated that all the contracts he negotiated in Chicago for Resurrection Hospital were two tiered whereby the high dollar services were carved out and Blue Cross was willing to accept this if the net impact was where it needed to be. Mr. Pickering believes that the advantage of a two tier arrangement is the ability to use the exclusive services to support the standard services; therefore, the System may be able to reduce a percentage point under the competition for standard services.

Mr. Smith stated that he believes the System has three options:

- Accept Blue Cross proposal for 75% of charges for the next three years.
- Reduce rates to acceptable levels and split rates between standard and high dollar services.
- Indicate to Blue Cross that the System wants a 70/40 contract (or something close to this) or the System will terminate their contract.

Mr. Pickering suggested not giving Blue Cross a specific rate, but indicate that the System is willing to negotiate and if Blue Cross does not want to negotiate, then consider accepting 75% of charges for three years. Dr. Breckenridge recommends presenting an offer to Blue Cross and if not accepted, consider terminating our contract. He believes Blue Cross is offering the System 75% of charges because they do not believe we will accept their proposal for an in-network PPO contract and Blue Cross does not want us to terminate our contract. Mr. Smith will be meeting with management to determine the next steps with Blue Cross. Mr. Pickering stated that this was a very worthwhile discussion and helps the Committee understand the many challenges management is encountering.

PHYSICIAN EMPLOYMENT CONTRACT:

Dr. Ruggles referred to the revised copy of Exhibit A which is a request for approval of an employment contract with James Won, M.D. He stated that Dr. Won is a Neurologist that has worked for Rockford Health System as a locum tenens since January 2005. The Rockford Health System Board has established as a matter of policy and practice that physician compensation at or above the Medical Group Management Association (MGMA) 75th percentile should be reviewed and approved by the Board of Directors. Dr. Ruggles reported that the MGMA compensation for a Neurologist at the 75th percentile for 2005 (using 2004 data) equals $262,676.00. In light of the difficulty in recruiting neurologists to Rockford and the ongoing need for such services at Rockford Health System, Rockford Health Physicians proposes to offer Dr. Won a guaranteed salary of $250,000.00 plus $20,000.00 signing bonus through October 31, 2006.

Dr. Ruggles stated that Rockford Health Physicians requests approval to enter into an agreement with Dr. Won materially consistent with the terms presented in the attached employment contract.

Following discussion, the following Resolution was presented for approval by the Finance & Audit Advisory Committee:

***BE IT RESOLVED,** that the CEO of Rockford Health System and his designees be authorized to enter into an agreement with James Won, M.D. materially consistent with the terms presented in the attached employment contract.*

The Finance & Audit Advisory Committee,

VOTED: To approve the Resolution as presented.

SEPTEMBER 2005 FINANCIALS: Ms. Petru reviewed the September, 2005 Financial Report.

For the month of September, the System budgeted an operating income of $200,000 and actual operating income totaled $100,000, resulting in an unfavorable variance of $100,000. She reviewed the key components of the unfavorable variance.

OTHER BUSINESS: Line of Credit

Ms. Petru stated that as reported to the Committee last month, Rockford Health System Obligated Group borrowed $6.8 million on its line of credit. On October 6, 2005 $5.8 million was repaid with the remaining $1.0 million balance being repaid on October 21, 2005.

ADJOURNMENT: There being no further business to discuss, the meeting was adjourned at 8:15 a.m.

Respectfully submitted,

Lorrie Pierce

Lorrie L. Pierce
Secretary

EXHIBIT H

FINANCE & AUDIT ADVISORY COMMITTEE MINUTES
October 26, 2005

Mr. Robert Pickering, Chairman, called the meeting to order at 7:00 a.m.

MINUTES: There being no additions or corrections to the minutes, it was

VOTED: To approve the September 14, 2005 minutes of the Finance & Audit Advisory Committee as presented.

BLUE CROSS UPDATE

Mr. Joe Smith, Corporate Director of Managed Care stated that in September, Rockford Health System presented a proposal to Blue Cross based on a floor of 64% of charges. He stated that during a meeting with Blue Cross, he asked Blue Cross what it would take to be an in-network PPO provider. Blue Cross responded that the hospital would need to be at 50% of charges. Discussions took place at RHS to determine a way to be accepted into the Blue Cross PPO plan and came up with a blended proposal. Mr. Smith noted that Blue Cross did give the System an opportunity to remain out-of network at 75% of charges for the next three years. He stated that the System felt strongly that based on the System's future growth plans and the surrounding regions that participate in Blue Cross, it makes sense to have a PPO contract. There was a consensus that the hospital could not go down to 64% and then down to 50% of charges over night, therefore, we thought we could offer Blue Cross a blended proposal. Mr. Smith stated that Blue Cross has insulated that the hospital is in a bid war and that the other two hospital's rates are so low that if Blue Cross would sign a PPO contract with RMH at a higher rate, they would be cannibalizing that business and losing money on every case. This may be true on the standard charges, but not on the specialty services such as NICU, Peds Specialities that are unique to RMH. Blue Cross is already paying RMH at 70% of charges for that business so it would not be out of bounds to offer a blended proposal whereby the standard services would be at 50% of charges (which would be status quo with the other hospitals in town) and the specialty services at 70% of charges. With regard to the standard services at 50% of charges, we indicated to Blue Cross that they would not be losing money on every case, because we are maintaining at the level you proposed to us would be acceptable. Following our proposal, Blue Cross rejected our offer and responed that RHS proposal was still too high, and now stating that the other hospitals are at cost or below cost. Blue Cross most recent offer to us is to remain out-of network at 75% of charges for three years and need to receive a response from us by October 31, 2005.

Mr. Smith reviewed a contract model summary of a four year Blue Cross contract with annual discount adjustments. He stated that the current year is at 70% of charges and years 2006 through 2009 are at a blended rate of 70% of charges for NICU, Peds subspecialties, and Neurosciences and 50% of charges for all other services. The total contributions currently total $7.2 million and with the blended rate would total $5.6 in 2006 and ending year 2009 at $5.7. This model would result in an unfavorable impact to

contribution throughout the four years ending with an unfavorable $1.4 million impact to contribution.

In reviewing the Blue Cross contract model assumptions, Mr. Smith stated that a 10% factor is assumed for business captured from OSF St. Anthony and SwedishAmerican Health System (other than NICU and PICU) for the first year only. Natural growth for all business other than NICU and or Neurology would be calculated at 10% for 2006, 15% for 2007, and 10% for 2008 and 2009. Mr. Smith stated that the 10% growth rate is consistent with where Blue Cross has been historically in inpatient business, year to year, even without a contract. He ntoed that there has been a decline in inpatient and outpatient cases, specifically in outpatient cases we have seen 20% decreases year to year on the total outpatient cases. While revenue has increased in inpatients due to increase our charges, increases in the intensity of cases seen. Mr. Smith stated that natural growth for NICU or Neurology would be calculated at %5 in 2006, 9% in 2007, and 5% in 2008 and 2009. Under the blended model the percentage of growth that takes patients from other contracted payors would be 60%, the cost to charge would be 43% and the annual increase to charge master is assumed at 4%.

Mr. Smith stated that it is also relevant to include the physicians in the impact of the Blue Cross proposal. When looking at the impact to the contribution margin at the hospital, we need to also look at what potential could happen when including the physicians in the mix. He reviewd the comparison of the Blue Cross out of network plan offer which includes the physician component. Under Blue Cross's proposed out of network contract which is 75% of charges, the expected revenue for the hospital totals $21.1 million and for the physicians, $7.0 million. The 2006 contribution margin for hospital and physciaisn totals $11.4 This is an extra 5% over the hosptial's current rate which amounts to with current volumes approximately $1.5 million in extra reimbursement if everything remains constant from the current contract. However, we feel that as we go forward with Blue Cross, the trend of reduced cases and reduced reimbursement will continue, therefore we believe we will be reducing business with the 75% contract. Mr. Smith stated that our proposal to have a blended contract would result in a 2006 contribution margin of $8.6 million. The difference between out of network contract and in-PPO contract totals $2.8 million. Given the variation in volumes, it is a much more compelling argument to accept the lower rate from Blue Cross in the PPO than it has been in the past. Year to year through 2009, the contribution margin remains fairly constant between Blue Cross's out of network contract and the System's blended contract proposal.

Mr. Smith stated that the physciaisn currently have an in-network contract, however, Blue Cross will not alter their rates for the physicians. We tried to receive a 6% increase, but Blue Cross indicated that everyone is on the same rate system and program that the RHPH physicians are on which Mr. Smith is true as PPO rates are fairly standard across all providers.

Mr. Smith next reviewed a sample of a four year Blue Cross contract with annual discount adjustments at the estimated Blue Cross acceptable rate of 50% of charges for

all services. He stated that total contribution in 2006 would total $2.7 million and $2.4 million in 2009. He stated that being at 50% of charges would result in not losing money, however, would be losting contribution margin. The unfavorable impact to contribution totals $4.4 million in 2006 and $4.7 million in 2009.

Mr. Smith reviewed the comparison of the Blue Cross out of network offer of 75% of charges to the Blue Cross acceptable rate of 50% of charges to be included in the PPO network. The proposed out of network contract would result in a 2006 contribution margin (hospital and physicians) of $11.4 million as compared to a contribution margin of $5.7 million for the suggested in network contract. The difference between the out of network contract and in network PPP contract totals $5.7 million for 2006. In 2009, the difference between an out of network contract and PPO contract would be $5.9 million. Mr. Smith stated do we take the leap and do what we feel is in our best interest strategically or do we stay with our current contract with reducing volumes year to year as an out of network provider at 75% of charges. Or do we decide to not enter into a contract with Blue Cross.

Dr. Schauer stated that the market penetration of Blue Cross seems to be increasing and believes that the decrease in volumes in the operating room and hospital directly relates to Blue Cross patients. Mr. Kaatz stated that Blue Cross has approximately 20% of market penetration.

Mr. Pickering stated that if Blue Cross does not like us, why is Blue Cross offering us an increase for us to stay out of network and questions what their strategy is. Mr. Kaatz does not understand why they are offering 75% out of network for three years. He stated that in the Rockford market, Rockford Health System is the only three star in terms of patient satisfaction and Blue Cross does pay attention to this. Mr. Kaatz stated that there was some thought that the other two hospitals in town might have an arrangement with Blue Cross to keep RHS out, but can not prove this. Mr. Pickering believes that it might not be an arrangement to keep RHS out, but believes that it might be an arrangement that is predicated that Blue Cross will give you 50% of charges, but only if it is an exclusive with us. He believes that there may be two institutions in town at 50% of charges or below, and RHS for the specialized services at 75% of charges. Mr. Kaatz stated as Dr. Schauer stated, there is excess capacity in Primary Care market and believes that if we include the physicians in our proposal, there is no added leverage because of primary care excess capacity. Mr. Pickering stated that Blue Cross was not interested in our blended proposal of 70/50, and suggested that we blend it to 70/40 and now we will be under everyone else under the standard services and we will not compromise on the specialized services where there is no competition. Mr. Smith stated that at the last discussion, the floor was set at 64% and have moved that floor many times, and if the Committee believes 50% is acceptable, he will bring that back to Blue Cross, but he recommends not going below 50% on a blended proposal.

In reviewing past data, Mr. Smith stated that according to Blue Cross, not having a contract results in a decline of 10% in admissions, 17% in outpatient cases, and outpatient reimbursement decrease of 5% or $200,000. At the same time, SwedishAmerican Health

System and OSF St. Anthony experienced a 12% increase in admissions, a 6% increase in outpatient cases and a 25% increase in combined (in and outpatient) revenues due to their contract with Blue Cross.

In reviewing the risks versus benefits of a Blue Cross PPO contract, Mr. Smith stated that the risks to being preferred in-network include:

- Immediate and long-term loss in reimbursement (guaranteed shrinking margins).
- Cannibalization of other better paying plan business.
- Overall erosion of leverage in the market place.
- Not as much leverage due to having a physician contract.

Mr. Smith stated that the benefits to being preferred in-network include:

- Increased volume.
- Capture additional collar-county NICU referrals
- Increase physician other business volume
- Supports East side growth
- Take business from SwedishAmerican and OSF

Mr. Pickering belives that Blue Cross has a strategy that we have not figured out due to them offering us an increase to not be an in-network provider. He is concerned that if we offer them 50% of charges, they will not accept the proposal. Mr. Smith questions whether we are actually bidding against ourselves. In talking to the Managed Care Director at SwedishAmerican, he stated that they are not in the bid process with Blue Cross and their contract is solid for the next year, however, Blue Cross has told us we are in a competitive bid process. Blue Cross has indicated that the System's rates are not acceptable because bids from other hospitals are less, making it seem that we are actively in the bid process which is not true. Our contract expires at the end of December and typically if you push further towards the deadline, you will get more in concession. He emphasized that we have to be careful not to bid against ourselves, which in some respects, Blue Cross may be setting us up for. Mr. Pickering asked Mr. Smith his opinion on a two tier arrangement – keeping a difference those areas where the Ssytem has exclusivity such as NICU. Would Blue Cross find an acceptable two tier arrangement if the result was the same. Mr. Smith stated that all the contracts he negotiated in Chicago for Resurrection Hospital were two tiered and were able to carve out the high dollar services (NICU, cardiac surgery) and Blue Cross is willing to do this as long as the net impact is where it needs to be. He stated that the System can offer this strategy to Blue Cross. Mr. Pickering blieves that the advantage of a two tier arrangement is that we are using our exclusive areas to support our standard areas and therefore, for standard services we may be able to add in a percentage point or two under the competition. Mr. Smith believes that the tiered approach is a sound strategy. Mr. Pickering stated that if the System is at 50% of charges, what would be the margin be for the hospital compared to Medicare. Ms. Petru stated that Medicare pays approximately between 92% and 96% of cost. Mr. Pickering stated that even at 50% of charges, the hospital would be making more money on Blue Cross than on Medicare. Dr Rugges stated that he likes the two tier

strategy at a lower rate and if the high dollar services can be strategically grown because our whole strategy is about growth, particularly east and we could end up with an overall better balance if the high end services is carved out more and we have more control over where we put our efforts into which service lines we grow. Mr. Pickering believes if going with a two tier arrangement, there should be a lot of thought as to what are we putting on the premium side, not only for where we are today, but where we want to grow.

Mr. Smith stated that he believes we have three options:

1. Accept Blue Cross proposal for 75% of charges for the next three years.
2. Reduce rates where we can get them acceptable and split between standard and high dollar services.
3. Indicate we want a 70/30 contract or something close to this or the System will terminate all contracts (hospital and physician).

Mr. Packard stated that our market share is eroding and our volumes are declining. The most difficult job for administration is to match cost with declining volume. He believes we need to find some strategy to stabilize volumes and then grow them and questions which Blue Cross model would accomplish this.

Mr. Bach is puzzeled as to why Blue Cross would give the System an increase to stay out of network which we did not request. He believes it would have been easier for Blue Cross to keep the System at the current rate of 70% of charges. Mr. Kaatz suspects that Blue Cross has a verbal arrangement with the other two institutions in town. Mr. Pickering commented that Blue Cross may have some type of verbal arrangement with the other two institutions and if this is the case, what is the risk in the System of putting what we would consider a very aggressive offer to Blue Cross. Mr. Kaatz believes the risk we could increase our activity level by having busier physicians, more admissions and more patient visits but lose a lot of money. Mr. Pickering questions whether Blue Cross would even accept an aggressive offer from us due to the possibility of a verbal commitment with the other two institutions. Mr. Kaatz stated that if this happens, we may have to go down a legal avenue because they are not for profit and believes they are obligated to negotiate in good faith.

Mr. Pickering stated that Mr. Smith might want to meet with Blue Cross and tell them that he has met with the Finance Committee and the System is prepared to go below 50% on standard services, however, we need a premium for our specialty services and may be able to blend it close to 50%. Mr Kaatz stated that we may want to discuss with the physicians the possibility of the physicians marketing the hospital with Blue Cross. Mr. Pickering recommends not giving Blue Cross a specific rate, but rather tell them what we are willing to negotiate or if you do not want to negotiate we will accept 75% of charges for three years and remain out of network. Dr. Breckenridge recommended offering Blue Cross an offer and if not accepted the System will terminate the contract at the end of the year and let them come back with an offer. Mr. Pickering questioned why Blue Cross is offering the System 75% of charges and Dr. Breckenridge's position is that Bloue Cross

is offering the System 75% of charges becsue they do not believe we will accept proposals for an in network provider, but they do not want us to terminate our contract. Mr. Pickering thought this was a very worthwhile discussion and helps the Committee understand the challenges management has.

PHYSICIAN EMPLOYMENT CONTRACT

Dr. Ruggles referred to the revised copy of Exhibit A which is a request for approval of an employment contract with James Won, M.D. He stated that Dr. Won is a Neurologist that has worked for Rockford Health System as a locum tenens since January 2005. The Rockford Health System Board has established as a matter of policy and practice that physician compensation at or above the Medical Group Management Association (MGMA) 75th percentile should be reviewed and approved by the Board of Directors. Dr. Ruggles reported that the MGMA compensation for a Neurologist at the 7th percentile for 2005 (using 2004 data) equals $262,676.00. In light of the difficulty in recruiting Neurologists to Rockford and the ongoing need for such services at Rockford Health System, Rockford Health Physicians proposes to offer Dr Won a guaranteed salary of $250,000.00 plus $ 20,000.00 signing bonus through October 31, 2006.

Dr. Ruggles stated that Rockford Health Physicians request approval to enter into an agreement with Dr. Won materially consistent with the terms presented in the attached employment contract.

Following discussion, the following Resolution was presented for approval by the Finance & Audit Advisory Committee:

> ***BE IT RESOLVED**, that the CEO of Rockford Health System and his designees be authorized to enter into an agreement with James Won, M.D. materially consistent with the terms presented in the attached employment contract.*

The Finance & Audit Advisory Committee,

VOTED: To approve the Resolution as presented.

RHS SEPTEMBER 2005 FINANCIALS

Ms. Petru reported that year-to-date, discharges were 5% below prior year and 6% under budget. She referred to the hospital census report for January through October 23, 2005 which shows the significant variation in census which is a staffing challenge to the hospital. Surgery cases were 8% below prior year and 10% under budget. She noted that the budget assumed an increase in inpatient neurosurgery cases beginning in August 2005 due to the hiring of a third neurosurgeon. This physician has not yet been hired. All surgery categories were under budget with the exception of ortho spine which was up 8%. Total ER visits were 3% over prior year and 3% over budget. Total outpatient ER visits were 5% over prior year and 4% over budget. Admissions from ER year-to-date were 2% below prior year and 3.5% under budget.

Ms. Petru reported that Rockford Health Physicians provider encounters year-to-date were 17% under budget. She stated that the variance is due to budgeted recruits for ENT, Plastic Surgery, Psychiatry, Dermatology, Neurology, Maternal Fetal Medicine and Neurosurgery who are not expected to begin until 2006. In addition, one Neurologist and and one Material Fetal Medicine physician are not expected to begin until 2007. Mr. Pickering stated that from month to month, it indicates that the physicians have not been hired, however, if we added all nineteen physicians, the numbers of encounters would not change significantly. Is it the fact that the volume is not being captured or the fact that we have not hired physicians. Ms. Petru stated that it is a combination of both not hiring physicians as well as production from other areas. Ms. Petru reported that ancillary encounters year-to-date were 8.5% under budget which relates to outsourcing physical therapy to Enduracare.

Ms. Petru reported that year-to-date, VNA home health visits were 2% over prior year and 3% under budget. Hospice days were 19% under budget.

For the month of September, the System budgeted an operating income of $200,000 and actual operating income totaled $100,000, resulting in an unfavorable variance of $100,000. In reviewing the key components of the unfavorable variance, Ms. Petru stated that hospital net patient revenue was impacted by inpatient census which was below budget in al departments except PICU and NICU. Outpatient revenue was favorable to budget for the month which was attributed to above budget volumes in all major ancillary departments with strong volumes in Cath Lab and CT. Ms. Petru reported that Medicare payer mix was 39.5% versus a budget of 39.7% and Medicaid's payer mix was 18.6% vers budget of 17.4%. Other operating revenue for the month totaled $600,000 which was primarily driven by a contribution/transfer from the Foundation to fund the lobby renovations and a favorable variance in Van Matre's operations. Labor and professional fees expenses were unfavorable to budgety by $100,000 which is due to the continuation of above budget orientation time, overtime, and incentive bonuses for staffing clinical departments with open positions. Supplies were unfavorable to budget by $400,0000 which is related to above budget volumes in the CAth Lab utilizing high cost stents and defibrillators and higher than expected costs in pharmacy and lab.

Rockford Health Physicians gross revenue variance for September consists of lower than budgeted production which represents 45% of the variance. Budgeted providers not yet starting represents 42% of the variance, 8% consists of unbudgeted time off and physical therapy represents 5% of the variance. Purchased Services and insurance were favorable to budget by $300,000 due to lower billing fees tied to lower net revenues and lower transctiption costs due to lower than budgeted encounters. Salaries and professional fees were favorable to budget by $200,000 due to support staff positions for new physician recuits not yet hired nad less than expected amounts in pension expenses.

Ms. Petru stated that the System is at break even and we are forecasting a $2.5 million loss at the end of the year. Forecast numbers do not include the provider tax benefit. Mr. Pickering asked if the current performance is offering additional challenges as we are

working on next year's budget. Mr. Tamar stated that we continue to see volume decreases. He stated that aggressive measures are being taken in relation to supplies and labor. There are teams that are starting on process improvements due to if we want to decrease labor costs we need to change processes.

OTHER BUSINESS

Line of Credit

Ms. Petru stated that as reported to the Committee last month, Rockford Health System Obligated Group borrowed $6.8 million on its line of credit. On October 6, 2005 $5.8 million was repaid with the remaining $1.0 million balance being repaid on October 21, 2005.

ADJOURNMENT: There being no further business to discuss, the meeting was adjourned at 8:15 a.m.

EXHIBIT I

From: Seybold, Henry
Sent: Thursday, July 17, 2008 12:30 PM
To: Dillon, Paula </O=ROCKFORD HEALTH SYSTEM/OU=RHS/CN=RECIPIENTS/CN=PDillion>
Subject: RE: Followup

Midway would like a truck stop.....no we probably should talk about meeting them either here (preferred), in Peoria (probably their preference) or on common ground (if they are in Chicago anytime soon).

It is much more of a get to pick each others brains meetings. If you (or they) do not see the value should we meet at all?

Henry M. Seybold Jr.
Senior Vice President, Finance & CFO
Rockford Health System
815-971-6796 (office)
815-968-4908 (fax)

From: Dillon, Paula
Sent: Thursday, July 17, 2008 12:23 PM
To: Seybold, Henry
Subject: Followup

First, thanks for allowing me to vent.....doesn't occur very often....

Second, please reclarify – you wanted me to contact Mary Breeden, OSF Director of Managed Care, to set up a meeting perhaps midway between Peoria and here...

P

Paula R. Dillon
Director of Managed Care
Rockford Health System
2400 N. Rockton Avenue
North Office Building
Rockford, IL 61103
815-971-5871
pdillon@rhsnet.org

EXHIBIT J

EXHIBIT A

EPSTEIN BECKER & GREEN, P.C.
ATTORNEYS AT LAW
1227 25TH STREET, NW, SUITE 700
WASHINGTON, DC 20037-1175
202.861.0900
FAX: 202.296.2882
EBGLAW.COM

MARK E. LUTES
TEL: 202.861.1824
FAX: 202.296.2882
MLUTES@EBGLAW.COM

September 26, 2006

VIA FACSIMILE

Paul W. Brand
Executive Director
Employers' Coalition on Health
1639 North Alpine Road
Rockford, IL 61107-1449

Re: Contracting with Hospitals in the Rockford Area

Dear Mr. Brand:

Our client, SwedishAmerican Health System, has asked us to write this letter regarding certain conduct related to hospital contracting in the Rockford area. Our client has been informed that two of the three hospitals in Rockford, St. Anthony's and Rockford Memorial Hospital, have approached you with an ultimatum related to contracting for hospital services. It is our understanding that the ultimatum proffered is that in order to contract with either Rockford Memorial Hospital or St. Anthony's, you must contract with both of them to participate in a single hospital network, and you must agree not to contract with SwedishAmerican to participate in that same network.

As you may be aware, an agreement by competitors (such as Rockford Memorial and St. Anthony's) to refuse to deal unless a purchaser excludes another competitor in this market can be deemed *per se* illegal under the antitrust laws as a group boycott. Group boycotts have consistently and recently been condemned by the courts.

A "classic boycott involves concerted action with a purpose either to exclude a person or group from the market, or to accomplish some other anticompetitive object, or both." *Armstrong Surgical Ctr.*, 185 F.3d 154, 157 (3d Cir. 1999). "[C]ommercially motivated group boycotts, or concerted refusals to deal, generally are considered illegal per se under section 1." *See Fed. Trade Comm'n v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411, 431-32 (1990); *Weiss v. York Hosp.*, 745 F.2d 786, 818 (3d Cir. 1984). "The per se rules can result in erroneous conclusions in some cases, but '[f]or the sake of business certainty and litigation efficiency, we

have tolerated the invalidation of some agreements that a fullblown inquiry might have proved to be reasonable.'" *North Texas Specialty Physicians v. F.T.C.*, 528 F.3d 346, 360 (5th Cir. 2008) (quoting *Arizona v. Maricopa County Med. Soc.*, 457 U.S. 332, 344 (1982).

There are two elements to a *per se* illegal boycott under section 1 of the Sherman Act, "(1) at least some of the boycotters were competitors of each other and the target, and (2) the boycott was designed to protect the boycotters from competition with the target." *Cathedral Trading, LLC v. Chicago Bd. Options Exchange*, 199 F. Supp. 2d 851, 859 (N.D. Ill. 2002). It is likely a court or antitrust enforcement agency would find both elements present in this situation. St. Anthony's and Rockford Memorial Hospital are competitors of each other and of the target, SwedishAmerican. In addition, it would appear that the boycott is designed to protect St. Anthony's and Rockford Memorial Hospital from competition from SwedishAmerican.

Under that standard, the fact that you, as a purchaser of services, are involved would not remove the agreement from *per se* illegality. "[T]he [Supreme Court] described the cases that had condemned boycotts as *'per se'* illegal as those involving 'joint efforts by a firm or firms to disadvantage competitors by either directly denying or persuading or coercing suppliers or customers to deny relationships the competitors need in the competitive struggle.'" *Toys "R" Us, Inc., v. Fed. Trade Comm'n*, 221 F.3d 928, 936 (7th Cir. 2000) (quoting *Nw. Wholesale Stationers, Inc. v. Pac. Stationary & Printing Co.*, 472 U.S. 284, 294 (1985)).

However, even if the boycott were not *per se* illegal, it appears that in this case, its effects are blatantly anticompetitive; therefore it is likely it would be condemned by any court. Courts have held that a reduction in consumer choice itself can result in a sufficient anticompetitive effect to raise antitrust concerns, even in the health care arena.[1] As described to us, there can be no question that the agreement restricts options for purchasers of hospital services, such as your group. The request implicitly admits that viable networks can exist with two of the three hospitals in the area—and then proceeds to dictate to purchasers what two hospitals must be included. It is difficult to imagine what procompetitive justifications St. Anthony's and Rockford Memorial Hospital would attempt to proffer for their conduct; and we would assume that you would have any such procompetitive justification carefully scrutinized by competent antitrust counsel prior to agreeing to such a scheme.

Finally, it is important for you to recognize that your agreement to such an arrangement could implicate you in this illegal conduct. As the Supreme Court noted, "acquiescence in an illegal scheme is as much a violation of the Sherman Act as the creation and promotion of one." *United States v. Paramount Pictures, Inc.*, 334 U.S. 131, 161 (1948). The cases are legion, that the "'combination or conspiracy' element of a section 1 violation is not negated by the fact that one or more of the co-conspirators acted unwillingly, reluctantly, or only in response to coercion." *MCM Partners, Inc. v. Andrews-Bartlett & Assocs.*, 62 F.3d 967, 973-74 (7th Cir. 1995); *see also Flintkote Co. v. Lysfjord*, 246 F.2d 368, 375 (9th Cir.) ("Because one is coerced by economic threats to participate in or aid and abet an illegal scheme does not excuse

[1] *Key Enterprise of Delaware, Inc. v. Venice Hospital*, 919 F.2d 1550, 1558-59 (11th Cir. 1990), *vacated in part on other grounds*, 9 F.3d 893 (11th Cir. 1993).

the actor."), cert. denied, 355 U.S. 835 (1957); *Olin v. St. Peter's Community Hosp.*, 656 F. Supp. 760, 763 (D. Mont. 1987) ("the fact that the hospital was coerced by economic threats" was not sufficient to remove the hospital from liability), aff'd, 861 F.2d 1440, 1451 (9th Cir. 1988).

For the reasons outlined above, we believe that the conduct described is anticompetitive and would likely be deemed to violate the antitrust laws. Therefore, we ask that you refuse to participate in the arrangement being proposed by Rockford Memorial Hospital and St. Anthony's.

Very truly yours,

Mark H. Lutes

EXHIBIT K

SUBMITTED FOR

IN CAMERA REVIEW

EXHIBIT L

From: Breeden, Mary E.
Sent: Thursday, November 3, 2005 04:57:12 PM
To: Harbaugh, Ken J.
Subject: FW: BCBS "Hot" issue in Rockford - FYI

FYI..

—Original Message—
From: Stever, Carol A.
Sent: Thursday, November 03, 2005 3:10 PM
To: Breeden, Mary E.
Subject: BCBS "Hot" issue in Rockford - FYI

Mary
Since I'm not sure we're going to be able to touch bases this afternoon...wanted to apprise you of a BC Rockford development...

When Kevin was talking with Phil Lumpkin regarding SMMC Commercial Agreement, Phil mentioned he thought Kevin's call might be regarding the Rockford "hot" issue that's going on...Kevin asked me to see if I could find out what Phil meant by that...Called Don Vayr and he contacted his RMH counterpart (Abrams) who is pretty straight with him...

His counterpart told him that RMH was terminating ALL BCBS Agreements – including "Commercial" and had given them verbal notice, though not public just yet...Don Vayr will be watching situation closely...This might mean that BCBS will want/need to send more babies to SFMC...might actually help our negotiations –

You can share with Ken Harbaugh, but reserve others for now until made 'public'.

Carol Stever
Manager, Corporate Managed Care

EXHIBIT M

SUBMITTED FOR

IN CAMERA REVIEW

KAATZ TESTIMONY
PI HEARING

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
WESTERN DIVISION

FEDERAL TRADE COMMISSION	)	Docket No. 11 C 50344
	)	
Plaintiff,	)	Rockford, Illinois
	)	Friday, February 3, 2012
v.	)	9:00 o'clock a.m.
	)	
OSF HEALTHCARE SYSTEM and ROCKFORD HEALTHCARE SYSTEM,	)	
	)	
Defendants.	)	

VOLUME 3
TRANSCRIPT OF PROCEEDINGS
BEFORE THE HONORABLE FREDERICK J. KAPALA

APPEARANCES:

For the Plaintiff:
U.S. FEDERAL TRADE COMMISSION
(600 Pennsylvania Avenue, NW,
Washington, D.C. 20580) by
MR. MATTHEW J. REILLY
MR. JEFFREY H. PERRY
MR. RICHARD CUNNINGHAM

For Defendant OSF:
HINSHAW & CULBERTSON
(100 Park Avenue,
Rockford, IL 61101) by
MR. MICHAEL F. IASPARRO

HINSHAW & CULBERTSON
(222 N. LaSalle Street,
Suite 300,
Chicago, IL 60601) by
MR. MATTHEW J. O'HARA
MR. ALAN I. GREENE
MS. KRISTIN M. KURCZEWSKI

For Defendant RHS:
MC DERMOTT WILL & EMERY LLP
(227 W. Monroe Street, Suite 4400,
Chicago, IL 60606) by
MR. DAVID MARX
MR. WILLIAM P. SCHUMAN

because you hoped that your relationship with Mr. Schertz and Saint Anthony's would grow in the future; isn't that true?
A. Yes. We just entered a new business relationship with them, and we've got high expectations for that business relationship, and they're our friends, and, yeah, we want that relationship to grow.
MR. CUNNINGHAM: I don't have anything further. Thank you very much for your time, Mr. Olson.
MR. O'HARA: I have no questions on redirect, your Honor. Thank you.
THE COURT: You may step down, Mr. Olson. Thank you for your help.
THE WITNESS: Thank you, sir.
(Witness excused.)
THE COURT: Before going on to the next witness, I want to address a motion that was filed here that I'll provide all of you with a copy. Will Cecile Kohrs step forward, please? Good morning.
MS. KOHRS: Good morning.
THE COURT: Did I pronounce your last name right?
MS. KOHRS: It's Kohrs, like the beer.
THE COURT: Ms. Kohrs, first of all, I'd ask you not to argue the motion until we've established your right to bring the motion. But initially you made a bare bones request to address the court regarding sealed documents, and I received that from

the court security officer. I advised him that I'd like you to put your request in the form of a motion, and you did so, and I provided copies to the parties. But it's not much more than your first request.
When I suggested that you put it in the form of a motion, I had in mind the motions that were filed by the parties and the intervenors, and they filed comprehensive motions citing authority to establish that they were entitled to the relief that they were requesting, and you just said essentially that you wanted to address the court.
And your motion presents an interesting situation on a couple levels. First of all, I don't know who you represent.
MS. KOHRS: I'm sorry. MLex US is a business incorporated in Delaware, and we're fully accredited by the United States Senate Press Gallery in Washington D.C. We're an antitrust news organization, and our subscribers are business people and law firms with an interest in regulatory risk, and we specialize in antitrust.
THE COURT: Okay. Now, the first question is do you have a right to intervene in this case? Do you have a right to present evidence or present argument?
MS. KOHRS: Your Honor, it's a First Amendment issue, and as a journalist, I believe that the public has a right to know what's going on in the courtroom, and I'd applaud your comments at the beginning of this trial when you said that

that's an important issue.
So, I'd ask you to just consider a few issues. I've made similar requests in other trials. I cover antitrust trials around the country in many other courts.
THE COURT: I don't know whether you have standing to make arguments in this proceeding.
MS. KOHRS: Well, I'd argue, your Honor, that I do have standing because I am a member of the press, and journalists have widely been recognized as being able to appeal to courts to request that documents be made public in order that the public interest can be served. And the public interest, your Honor, in this matter --
THE COURT: Okay. I think you're arguing the motion.
MS. KOHRS: I'm sorry.
THE COURT: Let's establish whether you can talk about it, and then let's go forward --
MS. KOHRS: Sorry.
THE COURT: -- with what you want to say.
But the second level concerns the authority for your allegations. You don't explain anywhere in the motion why my order is in violation of the First Amendment. We all know that First Amendment rights are not unlimited.
MS. KOHRS: Yes, your Honor.
THE COURT: But I'd like in your motion some statutes or decisions that address those issues. I've considered the

motions of the parties and the intervenors regarding confidentiality, and I certainly want to hear from you if you have a right to argue in this proceeding, and if you do have a right to argue, I'd like to know what the basis is for your arguments for your positions before you come up and present them.
So, I'm going to ask you to do those two things. I'd like you to present a supplemental motion that explains and argues for the rights of MLex US, the intervenor in this case, whether MLex has standing to present the issues that you want to bring out, and then I need some supporting authority to buttress the position you're taking on those issues.
MS. KOHRS: Okay.
THE COURT: Please do that, and can you please provide copies for the parties here, and we'll take it up later.
MS. KOHRS: Okay. Thank you.
THE COURT: You're very welcome. Nice to talk to you.
Let's take a midmorning break. Let's resume again at 20 to 11:00.
(Brief recess.)
THE COURT: All right. The defense may call its next witness.
MR. MARX: Thank you, your Honor. The defendants call Mr. Gary Kaatz, please.
(Witness duly sworn.)

THE COURT: Please take a seat at the witness stand. Please proceed, Mr. Marx.

MR. MARX: Thank you, your Honor.

GARY EMMETT KAATZ, DEFENDANTS' WITNESS, SWORN

DIRECT EXAMINATION

BY MR. MARX:

Q. Mr. Kaatz, would you state your full name, spelling your last name for the record, please?

A. My name is Gary Emmett Kaatz, K-a-a-t-z.

Q. By whom are you currently employed?

A. Rockford Health System.

Q. What is your current position at Rockford Health System?

A. I am the president and chief executive officer.

Q. How long have you held that position?

A. Approximately twelve years.

Q. Can you describe for us generally your duties and responsibilities as the president and chief executive officer?

A. I am responsible ultimately for all aspects of the organization, making sure that it performs within all guidelines necessary. I am responsible for looking out to the future and making sure that the organization is properly positioned as it should be enforcing the mission statement and our value statement and providing a significant link to the community, the greater community of Rockford, Illinois.

Q. Do you have any involvement in Rockford Health System's strategic planning?

A. I do.

Q. Can you tell us generally what that entails?

A. Typically select a management consultant, if we decide to employ one. I work with the planning committee, the executive committee, the full board. We are responsible for putting together data as necessary. We put together scenarios for some scenario planning. And we typically have a board retreat or two along the way as we conclude.

Q. Are you responsible for Rockford Health System's financial performance?

A. I am ultimately responsible for their financial performance.

Q. Do you have any help in that regard?

A. I have a ton of help.

Q. What about the operational and clinical performance of Rockford Health System? Do you have any responsibility with respect to those areas?

A. I am responsible for both of those.

Q. You do that by yourself?

A. I have staff, a highly talented staff, that I rely on for that.

Q. Prior to today's testimony, have you given any testimony connected to the FTC's investigation of the proposed affiliation of Rockford Health System and OSF?

A. I have been deposed twice.

Q. Twice. Let's talk for a few minutes about your educational background. From what university did you receive your undergraduate degree?

A. Pennsylvania State University.

Q. And what was your degree in?

A. Bachelor of Science in biological health.

Q. When did you receive that degree?

A. 1973.

Q. Have you undertaken any graduate study since then?

A. I have.

Q. Can you tell us what you've done?

A. I have received a Master of Business Administration in finance and healthcare management from the Graduate School of Business at the University of Chicago.

Q. And when did you receive that degree?

A. 1976.

Q. Before you came to Rockford Health System, where did you work?

A. I spent 18 years at Rush Presbyterian St. Luke's Medical Center in Chicago, going from assistant to the president to being responsible for the management of all medical sciences and services. I went to Youngstown, Ohio, for eight years, first as the executive vice president of the Western Reserve Healthcare Corporation and then lastly as the president of Forum Health. Then I moved to Rockford in 2000 to take the position that I

currently have.

Q. What was Forum Health?

A. Forum Health was a multi-hospital integrated delivery system in northeastern Ohio.

Q. Do you know about what the annual revenues were for Forum Health about the time you left?

A. Approximately north of half a million a year.

Q. In total, how long have you worked in the hospital field?

A. More than 35 years.

Q. Do you belong to any community or civic organizations?

A. I do.

Q. Which ones?

A. I am on the board of Easter Seals. I am very involved with the March of Dimes. I am the past chair of the Illinois Hospital Association and remain on the executive committee. I am a past member of the American Hospital Association's Regional Five Board. I am a past board member of the YMCA in Rockford. I am a past board member of the symphony in Rockford. I am currently on the board of the Rockford Area Economic Development Council.

Q. And did you hold any leadership positions in the Illinois Hospital Association within the last five years?

A. Yes.

Q. What position and when?

A. I was the chair of the association in 2011.

Q. You were the chair or the president?
A. The chair.
Q. Okay. The court's heard a lot about Rockford Health System, SwedishAmerican, and OSF, but can you briefly describe for us Rockford Health System?
A. Rockford Health System is the oldest hospital, the oldest healthcare organization in Rockford, going back well over a hundred years. It is not-for-profit. It is governed by the board of directors that represents the community. The board size can range anywhere from 13 to 21 members.

And the institution itself is comprised of the Rockford Memorial Hospital, the Rockford Health Physicians Group, the Visiting Nurses Association, the Rockford Memorial Foundation, and Van Matre Rehabilitation Hospital, which is a joint venture for-profit rehab hospital that we own with Health South.

Q. The Rockford Health Physicians, do you know what types of physicians Rockford Health Physicians employees?
A. Yes.
Q. What kind?
A. We employ from primary care all the way up to the most subspecialty areas, such as neurosurgery and pediatric surgery.
Q. Do you have a sense of about how many physicians Rockford Health Physicians employees?
A. Yes.
Q. How many is that?

A. About 150.
Q. You're making me work pretty hard.
A. Sorry.
Q. That's okay. The Visiting Nurses Association, can you tell the court what that is, please?
A. Visiting Nurses Association is also -- it goes back -- it was founded in 1910, the oldest VNA in the area. It is responsible for all aspects of home care for a variety of patients, from elder abuse to the need for continued care for somebody that has coronary heart failure, to a family that might be in the middle of a tough transition from being discharged from a hospital to the home setting. It runs the gamut. It is also very much involved in hospice care and palliative care, so that a lot of patients are in that end-of-life period.
Q. I think you mentioned the Rockford Memorial Development Foundation. What is that?
A. That is our philanthropic arm. It typically raises anywhere between two and four million dollars a year for us, and it really is actively supporting initiatives throughout the health system.
Q. Now, does Rockford Health System have a women's center?
A. We do. We just opened one.
Q. Can you describe what that is, please?
A. I think we opened it in the past April. We decided that we would form a program that was designed after one or two that we had seen outside of Rockford that better addressed the way we had been managing certain female populations in town. And so, we have advanced digital mammography. We have the capability to do ultrasound. I should say screening, as well as diagnostic mammography.

We have a multidisciplinary approach to women that are presenting with cancer, for example, among other things, that involves radiology, surgery, oncology, and pathology. We pride ourselves with the goal of having results given back at the end of the day. And we pride ourselves on the fact that we bring those specialty programs to the patient rather than have the patient take their time to do multiple scheduling. So, one stop shopping.
Q. And where is that women's center located?
A. It's located on Perryville, as well as Rockton Avenue. We have two locations for it.
Q. I think you said Rockford Health System has a board of directors that's comprised of between 13 and 21 members?
A. Correct.
Q. Can you tell us generally who sits on that board?
A. In addition to five physicians, they are community members. They have been linked to the community through their employment. Some have run large organizations. We have the president of the junior college in town. We have an attorney. We have a marketing expert. We have the individual who runs one of the TV

stations.

We really look for a pretty comprehensive skill set across the board, but, most importantly, we have very, very, very deep roots in the community and we really look for board members who will provide an active venue, an active link between Rockford Health System and its entities and the communities that we serve.
Q. Why is it that you want community members on Rockford Health System's board of directors?
A. We exist to serve our community. We are a community-based organization. We're rich in that. We have a rich history of tentacles throughout the community.

Another organization that we have that I didn't mention is our Ambassador Program, which is an additional link that we have into the community for new people that come into Rockford in the area. So, our entire history goes back to the importance of the link, and as the community goes, so goes Rockford Health System.
Q. Who do you consider to be Rockford Health System's competitors?
A. We are a complex regional tertiary care center. So, in the area of -- we have a Level III neonatal intensive care unit. We're one of ten perinatal centers in the Level III perinatal centers throughout the state of Illinois. So, we would compete with Lutheran General, in some cases Children's Memorial, in

some cases one or two of the institutions that are in Wisconsin.
We are a Level I trauma center, which means that we are prepared and adequately resourced to cover the most critically injured ill patients, if you will. And in that case we do compete with Saint Anthony's, but we also compete with outlying Level I trauma centers, again such as Lutheran General in Chicago.
We are the only pediatric critical care unit in the region, and sometimes we collaborate, sometimes we compete with Children's Memorial and perhaps Christ Hospital and again institutions in Milwaukee.
And besides that, I think our primary competition would be between our institution, SwedishAmerican Hospital, our institution, Saint Anthony's Medical Center.
Q. From your perspective as the president and chief executive officer of Rockford Health System, how does SwedishAmerican's affiliation with the University of Wisconsin Health at Madison affect competition between health systems here in the Rockford area?
A. Two different points on that. We have had business relations with the University of Wisconsin going back to my first couple of years here, and we're frustrated by a couple of the arrangements where there was a desire to see patients and have them transported to Madison for additional care.
The second point, though, they are an academic

institution, well resourced, strong in some clinical areas. And so, I think that they would provide formidable competition in some of those clinical service lines where they are strong.
Q. By they you're referring to the University of Wisconsin?
A. Yes.
Q. How does that relationship with SwedishAmerican affect your competition with SwedishAmerican?
A. I think it takes it up a couple notches. I think, yeah, it adds to that challenge.
Q. How so?
A. Because they'll be able to bring resources, such as drug trials, perhaps subspecialty care, perhaps alternative treatment patterns that they are resourced to do that we are not able to do at this point in time.
Q. Is it your view that -- do you have a view as to whether or not SwedishAmerican's affiliation with the University of Wisconsin at Madison will affect SwedishAmerican's attractiveness to patients and employers here in Rockford?
A. I think in some cases it will very much do that.
Q. How so?
A. By adding to the clinical portfolio of services that they'll have, as well as the cache of an academic institution such as the University of Wisconsin in an attempt to differentiate itself in the market.
Q. Can you briefly describe how the economic situation in

Rockford has changed over the eleven, I guess almost twelve years now that you've been here?
A. This have been a lot of plant closings. When I came here, there was a lot more small manufacturing. There was more large manufacturing. There have been significant plant closings. There have been a significant downsizing of the working population.
And I think that overall in the time that I've been in Rockford, I think that that slope has been on the negative. Less employment, less employers, less stability from the manufacturing sector, less from the small manufacturing sector, and hopes that perhaps the larger manufacturers could grow at some point to pull that out.
Q. Has that economic situation had any effect on Rockford Health System?
A. Yes.
Q. How so?
A. We have seen a significant increase in the number of patients that present that have no coverage whatsoever. We've seen our bad debts rise. We've seen it rise in our Medicaid component. And so, yes, we have seen that pronounced in our payor mix.
Q. What effect has it had on Rockford Health System's financial situation?
A. It's made it more challenging.

Q. How so?
A. Well, with those payor groups, whether you're getting zero payment to a payment that's significantly below cost, you have to be incredibly innovative and creative in this environment to offset those cost differences in the equation. So, it has presented an element that we've had to really challenge ourselves with with regard to the financial stewardship of the organization.
Q. Can you briefly tell the court how the passage of healthcare reform legislation is going to affect Rockford Health System's operations?
A. We view the component parts of healthcare reform, the Patient Care Accountability Act, to be improvements for individuals around the country. However, it's going to completely force us to look at our business model. It is going to turn the business model that we've become so comfortable with over the last 40, 50, 60 years of fee-for-service, one doctor, one patient, one facility to the need for a payment system that is evolving that's going to be fee-for-value, it's going to require organizations such as hospitals to work in a different collaborative vein with their physicians, with nursing homes, with visiting nurses association, with rehab hospitals. Instead of competing, they're going to have to collaborate more along a longitudinal basis, and I think that there is going to have to be a complete redo in terms of the functioning of the team

around the fact that there will be this fee-for-value.
Q. How do you expect your compensation to change when healthcare reform is implemented relative to what it has been up until now?
A. Clinical outcomes. Clinical outcomes to me personally is the only driver for success going forward. If you can document excellence, whether it's in infection rates or an effective change in your readmission policy or you can institute a surgical procedure or a technology that takes care that used to be in the inpatient arena to the outpatient arena and you can have good patient satisfaction added onto that, you're going to get paid and perhaps even receive a bonus payment if you do it really well. More importantly, if you don't, you're going to receive a penalty payment. So, I view clinical outcomes as the driver and the only driver as we transform this archaic 50-year old business model into a new one.
Q. As a provider both of inpatient hospital services, outpatient hospital services, ancillary services, and physician services, what do you do to try and meet the challenge that healthcare reform poses?
A. Oh, you study it, first of all, right? You challenge yourself. You try to get your arms around as much literature as possible. You try to talk to the organizations in the country that are leading the charge, such as the American Hospital Association, for resourcefulness, try to identify any states

around the country that have attempted a couple of those initiatives themselves, and you form a multidisciplinary group that really gets together and talks about what we're going to have to change.
So, for example, in our institution the past year, one of the key variables to be attacked in the readmission work behind the new act, if you will, is a significant reduction in the readmission rates for patients that have congestive heart failure. And we have found that when we discharge a patient, if that patient is seen by a cardiologist within seven days of that discharge, the likelihood of he or she being readmitted to our institution is about 70 percent less. So, things of that nature become paramount.
Q. Internally at Rockford Health System, with whom are you working to try and prepare for what I guess is now the advent of healthcare reform?
A. Within the organization?
Q. Yes.
A. We are working with -- as I said, we start with the multidisciplinary team. Our medical staff is intimately involved. Our nursing staff is intimately involved. Our environmental services staff is ultimately involved. Our board, we are responsible for educating our board and having them challenge us with regard to whether we're on top of it or not. So, it is a full court press, if you will, throughout the entire

organization in that spirit of teamwork.
Q. Now, before you had any affiliation talks -- and we'll talk in a minute about your discussions with Advocate and then ultimately with OSF -- did Rockford Health System try to position itself to deal independently with the declining economics in Rockford and healthcare reform?
A. We have.
Q. What did you do?
A. We have aggressively attacked our cost structure, and I think we've had some success with that, as seen in some of the fiscal years of '09 and '10 and mostly variable expenses. We have not been able to do a lot with fixed expenses, but we were able to significantly decrease our variable expenses through a series of probably 300 to 500 different decision points and initiatives.
Q. Has Rockford Health System been approached or discussed possible affiliations with other healthcare systems?
A. We have.
Q. Which ones?
A. We've talked with Advocate Healthcare out of Chicago. We've talked with Northwestern Memorial out of Chicago. We've talked with Aurora Health out of Milwaukee. We've talked with OSF Healthcare out of Peoria.
Q. Which of those institutions that you've mentioned, Advocate, Northwestern Memorial, Aurora Health, and OSF, did you speak

with first?
A. Advocate.
Q. Who initiated those discussions?
A. Advocate approached us through a third-party that they had employed.
Q. When did those discussions occur, do you recall?
A. I believe the summer or the spring of 2008.
Q. Did Rockford Health System and Advocate reach any agreement?
A. We did a letter of intent.
Q. Did you ultimately enter into an affiliation agreement with Advocate?
A. We did not.
Q. What happened?
A. Well, in the time period covered by the letter of intent, we studied them, as they studied us. Our number one desire requirement was that there must be an active, responsible, involved local board. We spent time talking with their board members. We spent time talking to some of the board members from their institutions and found that they did not have the governance model that we were looking for. It was more of an advisory capacity with decision-making solely centralized in Oakbrook.
Q. And why was the governance such an issue for Rockford Health System?
A. Our history, our tentacles to the community. It's a must to

have local governance. We are a locally governed institution. We are part of this community, have been longer than anybody else.
Q. Were there any other concerns that Rockford Health System had about a potential affiliation with Advocate?
A. We were. We were concerned that their model was not focused on maximizing what happens in Rockford. Their model was a little more focused on what patients we could refer into the Chicago marketplace. That was probably our second biggest concern after the governance issue.
Q. So, how did your discussions with Advocate end?
A. It also happened at a time when the market went south and Advocate lost an enormous amount of money off their balance sheet. We agreed to be amicable friends. We still are. We talk often. But we agreed to not go along with that decision at that time.
Q. Did you speak with Northwestern Memorial or Aurora Health next?
A. I can't remember.
Q. How long did the discussion with either last?
A. I spoke once with Northwestern Memorial, once with Aurora Health.
Q. I take it those discussions didn't go very far?
A. They did not. Northwestern Memorial at that time had never ventured into an acquisition merger of another institution, and

Aurora Health in Milwaukee just built two brand new hospitals and had very, very little cash on their balance sheet.
Q. So, when did your discussions with OSF begin?
A. I think they began approximately the summer of 2009.
Q. Who approached who?
A. Dave and I got together, talked about if the Advocate deal didn't work out, would we be open to talking with OSF. We spent a lot of time with our board leadership on that and decided that it was worthwhile to pursue.
Q. How did you pursue those discussions?
A. We had several meetings with our board leadership and their board leadership to talk in general at a very high level of why it was important, how it could be done, what we wanted to accomplish, what the goals would be, how it would fit as we read the future of healthcare, and compared our mission statements and got to know each other a little bit better.
Q. You mentioned you had certain concerns about the possible affiliation with Advocate. Did you have any concerns about a possible affiliation with OSF Healthcare?
A. We did.
Q. Can you tell us what those were?
A. First one out of the blocks, local governance, local governance, local governance.
Q. Why was that a concern to you?
A. The history of our organization. We exist to benefit the

residents of the greater Rockford area. We are a not-for-profit community asset governed by our board. Local governance is in our blood.
Q. OSF healthcare is a not-for-profit. Do they have the same kind of local governance structure, do you know, as Rockford Health System does?
A. To my knowledge, they had more of an advisory board. So, they had not had that type of local governance, no.
Q. Were there any other concerns that you had besides the local governance issue as you approached your discussions or pursued your discussions with OSF?
A. Yes.
Q. What other concern did you have?
A. I think we were very intrigued by their culture. We were very intrigued about them as a faith-based organization. We were very intrigued about how they operated with their multiple sites. We wanted to get a gauge on how innovative they were. We wanted to gauge on their responsibilities to not only their employees, but their patients. We had to learn a little bit more about where they were with graduate medical education and their relationship with the University of Illinois. So, yes, we had some work to do.
Q. Were the questions that you were raising ultimately alleviated?
A. Yes.

Q. Let's talk about the governance first. How were your concerns about local governance addressed?
A. A lot of discussion. In my take, that was a very big leap of faith for OSF Healthcare to agree to.
Q. What was the leap of faith that they took in the form of the agreement?
A. That if we were going to come into their organization that there would have to be a locally governed board for the OSF Northern Region.
Q. Is that the way that OSF Northern Region will be governed?
A. Yes.
Q. How will the OSF Northern Region board be composed, do you know?
A. It will be a community board, self-governed, therefore, having responsibility to identify, select, orient new board members to the board, educate board members. They will be selected locally and approved in Peoria.
Q. Now, what about your concerns about affiliation with a faith-based system? How were those issues resolved?
A. We had to learn a lot about Catholic healthcare and how it interfaced. We also had been a faith-based institution over time. We have a robust program in healthcare chaplaincy and religion and health. But we needed to study in more detail the implications of the Catholic Church and study the implications on healthcare.

Q. Did you do that?
A. We did. We spent a lot of time on that.
Q. And you satisfied those concerns, those questions?
A. Yes, we did.
Q. Ultimately what did the board of Rockford Health System decide about joining with OSF?
A. We decided to join OSF Healthcare.
Q. Why did you do that? Why did you make that decision?
A. We are convinced that there are no price increases in the future. We are convinced, as we're already seeing, Medicare's paying us less. We already know that not only is Medicaid going to be paying us less, but they're not paying us at all. We have not been paid since September.

We are of the design that future success of a healthcare organization includes economies of scale similar to the utility approach, if you will, as well as a very aggressive ingredient of innovative care that can offer enhanced results to patients in a cheaper setting.

Q. And you think you can achieve those objectives through an affiliation with OSF?
A. Convinced of it.
Q. When did OSF and Rockford Health System enter into the affiliation agreement?
A. I believe it was the end of January 2011.
Q. As a result of the affiliation, did OSF, do you recall,

pledge to make any capital contributions to Rockford Health System?
A. They did.
Q. Do you know what that pledge was?
A. I believe the pledge was 35 million -- approximately $35 million a year for the first several years. I can't remember the number of years off the top of my head.
Q. How do you expect as the -- well, let me ask a question first. If the affiliation goes forward and OSF Northern Region is formed, do you expect to hold a position in that organization?
A. I do.
Q. What position do you expect to hold?
A. I expect to be the president and CEO of the OSF Northern Region.
Q. Okay. So, if the affiliation goes forward, do you know how it is that OSF Northern Region would expect to use that $35 million contribution that you'll be receiving from OSF healthcare each year?
A. No. I think that we would probably match it with our integration plan. So, when we get to the point of finishing up the work that we've begun with regard to consolidation, future clinical expansion, I think the plan would be for that capital budget to mirror those decision points.
Q. Will there be any restrictions that you're aware of on the

use -- of OSF Northern Region's use of that $35 million per year capital contribution?
A. Not that I'm aware of.
Q. I think you said there would be a local board of OSF Northern Region; is that right?
A. Yes.
Q. Which entity following the affiliation -- is there water in there for you?
A. Yes.
Q. Which entity following the affiliation, Rockford Health System or OSF Saint Anthony Medical Center, will be responsible for managing OSF Northern Region?
A. Could you repeat that question?
Q. Who will be responsible for managing OSF Northern Region after the affiliation?
A. I will be, with a community board and with reserve powers to Peoria on certain pre-identified items.
Q. Has the term of your tenure as the chief executive officer of OSF Northern Region been set?
A. Yes.
Q. How long do you expect to start out as the chief executive officer?
A. Three years.
Q. Do you plan on serving as the chief executive officer of OSF Northern Region for those three years?

A. Yes.
Q. Let's talk for a couple of minutes about the benefits of the transaction that you perceive. Do you believe that the creation of OSF Northern Region will benefit the Rockford community?
A. Yes.
Q. How?
A. I think, first of all, one of the more exciting things we can do is get graduate medical education to Rockford. Rockford is the fourth largest city, I believe, in Illinois, and, interestingly enough, outside of a very small family practice residency from the medical school here, is totally devoid of any kind of graduate medical education as you see in other towns, whether they be Springfield or -- and I think the opportunity to bring residency programs into Rockford will, number one, enhance the level of medicine practiced; number two, provide a pipeline for future recruitment as we look at tough subspecialty physician labor markets. So, I think, number one, it's exciting about graduate medical education.

Number two, I think it gives us a platform to expand access. We have multiple campuses throughout the area. I think it gives us an opportunity to really take a look at the proper redesign of those campuses with an eye towards how we can actually access and demonstrate access to the community.

Third --
Q. No, go ahead. I'll come back.

A. Third, I think by bringing the institutions together, not only is scale important, but so is nucleus size. So, if we have two orthopedic hand surgeons, we can go to the region and say, boy, we're a hand center. Send your patients to us. But boy, you know, with our two hand surgeons, there might be times when they're out of town, and, therefore, sorry. We're going to have to send you elsewhere. I think that it gives us a nucleus to solidify the fact that, yes, we would be a regional referral center on a 24/7 basis.

Instead of having one pediatric surgeon, we would perhaps have the nucleus to have two so that when one pediatric surgeon is not available or out of town or doing another case, the other pediatric surgeon could provide coverage. So, I think that opportunity presents itself as a regional destination center in a very significant way.

Q. And you mentioned, I think, as the second of the major benefits, the access and the redesigning of the capabilities of the organizations. What do you mean by that?

A. Well, I think that every healthcare organization today -- now, there are different points on the continuum -- has to essentially change their delivery model. One physician, as I said, is no longer going to be one physician taking care of one patient in one place. I think you're looking at the necessity of a physician with advanced practice nursing, perhaps physician assistants that can do a much better job of managing a

population, a population that might be highly diabetic, a population that might have a lot of high blood pressure, a population that may have multiple chronic conditions.

We are going through a process, whether we like it or not, and I think the more successful organizations and healthcare are running with this, to get into that mode of multidisciplinary teamwork that can establish effective management of populations, and that's the real benefit of things such as the electronic medical record.

Q. Why can't you do that yourself now?

A. It's expensive. It's a base. You can't do that with just five patients. You need to have a significant cohort to keep a team very busy. When you try to bring in new physicians and new subspecialty physicians, the first thing they ask is how busy am I going to be. You need to have a nucleus to keep them busy, and you need to have enough patients to make it cost-effective to advance and afford that new model of care.

Q. Do you anticipate following the consummation of this affiliation any consolidation of clinical services that are presently being offered by the two health systems here in Rockford?

A. Yes.

Q. What do you anticipate?

A. We anticipate -- the minute that this is approved, we anticipate taking the work that we've done up to this point with

FTI and really putting a plan together that will be done no later than twelve months after the approval.

Now, we can't share sensitive information. I think we've worked diligently to the point where we can't take it any further. I'm not going to advance any of those clinical consolidations without a lot of input from physicians, a lot of input from our leadership team and the board, a lot of input from nursing, etc., and even patients.

And so, we've decided to not waste their time now because what if we're not able to merge. That would be a waste of money, a waste of individuals' time. But the minute -- the minute that we -- the minute that there would be a decision in the affirmative on this, in no less than twelve months would we have our plan, and I suspect that we would be able to do some clinical consolidations well in advance of that.

Q. Are there particular service lines or areas that you know represent the best opportunities for consolidation or at least a review?

A. Yes.

Q. Can you tell us what those are?

A. I think out of the blocks, pediatrics is one. Obstetrics and gynecology is one. I think the more challenging one will be trauma. And I think that in between we'll probably have some opportunities with regard to oncology, some of the other surgical subspecialty areas.

Q. You mentioned quality. I think you heard -- I think you were here for some of Dr. Romano's testimony earlier this week?

A. I was.

Q. And you may have heard him say that mergers typically do not increase quality, and there's spotty evidence that increased volumes result in higher quality. What makes you as the future CEO of OSF Northern Region think that OSF Northern Region will do better?

A. I thought Dr. Romano did a nice job of reviewing and summarizing the salient points in the literature. I was impressed with his presentation. However, I think his thoughts fell short on the relationship between size and outcomes, and I'll give a couple examples on that.

In our children's medical center, we have 16 pediatric subspecialty services. It's not just the clinical care given to a child. We have extensive developments in child-life therapy, in pre and post child education and care, interfaces with the family. We have pediatric anesthesiologists. There's an entire spectrum. And so, when you take an institution that has a relatively small pediatric department and are able to blend them into a much larger one with that infrastructure, you are going to enhance emotional outcome, as well as clinical outcome.

In obstetrics and gynecology. A lot of high risk babies are born to mothers that believe that they're going to have a normal delivery. When you can have those individuals

deliver at a Level III perinatal center that has anesthesiology 24/7, perinatology, neonatology, and the gamut of surgical and nonsurgical specialists in the case that anything could happen, you are considerably going to enhance it. And I'll be brief because I could go on and on and on on this topic.

Our rehab hospital. We take patients that have had amputations, closed head trauma, spinal cord injury. We put them together. We have outcomes. And the physical medicine rehabilitation community, if you will, has been measuring outcomes earlier than anybody else, going back to the early '70s. We can show the ability to discharge effectively a patient back to home without having to go through a nursing home, etc.

In cardiac surgery, the Society of Thoracic Surgeons has done an enormous amount of work relating the outcomes of atrial and mitral valve replacement and repair surgery to outcomes. Centers that do a lot have a significantly higher outcome.

Our own case, where you look at robotic surgery for patients that have prostate cancer. My goodness gracious. A very difficult surgical procedure to do, but when you do it robotically, you're not only able to send the patient home the next day, but you send them home on Tylenol III with a complication rate of less than 1 percent. It used to be about 4 percent.

And you're talking about not just the doctor. You're talking about the team. You have a team of nurses. You have a team of anesthesiologists. You have a special way to place the patient. There is enormous opportunity to maximize clinical outcomes, to make them better, based on education around coming to a standard of care and minimizing your deviation from that.

Q. And again with respect to the da Vinci robot that you mentioned, Rockford Health System has it, you developed that in Rockford yourself. Why can't you achieve these other quality improvements that you've just described without joining with OSF Healthcare?

A. Well, we've taken them far. We feel very good about what we've accomplished. We've needed to do that, and we're not comfortable with where we are. We feel we're at a point right now where we need to take it up another plane, if you will. Because of size nucleus, number of patients, ease with which we'll recruit physicians will only allow us to take that to the next plane.

Q. How will the affiliation improve cost efficiency?

A. I think that along a couple dimensions. You know, the argument on how scale will impact fixed cost is there, number one. Number two, the advent of subspecialization. And a hospital is going through a transformation that people don't talk about. Hospitals, the typical hospital in the United States, is becoming a mini intensive care unit. You're seeing

cardiac patients of great complexity, neuro patients of great complexity, children of great complexity, neonatals of great complexity. So, you're seeing this whole transformation to the hospital and this point of subspecialization of labor.

So, if I recruit one pediatric neurologist to Rockford and he or she is busy, busy to the point that they're having a hard time keeping up with the patient demands, and we recruit a second one, and there's just not enough work for two of them, we get into some issues. If we could create a setting, if you will, that allows patient activity to be enhanced, we can further stabilize our subspecialty coverage and care in this town.

Q. If Rockford Health System did not affiliate with OSF, would you still have taken steps to try and reduce your capital and operating costs?

A. Yes. If I could provide another example on your previous question.

Q. Sure.

A. I think on the cost thing the real -- the real variable that will significantly affect cost will be the ability of an organization to introduce new techniques, new thinking, new ways of providing care with a patient outcome driving it.

Another example. When a patient at our place years ago had been diagnosed with breast cancer, it was typical for a patient to have 20, 25, 30 radiation treatments in the course of

that, and there may or may not have been surgery along the way. There is new technology that's IORT, intraoperative radiation therapy, where we can take a patient in the operating room, and by means of radiation cones that we have, we can offer that patient a one-time intervention for that breast cancer. Instead of paying $80,000 over the course of 30 treatments, that patient will end up paying 20 or $25,000.

I think that the example we used on the prostatectomy, I think the beating heart surgery, open heart surgery, if you can offer innovative ways to shift that curve, that innovation curve, if you will, there will be the most significant opportunities for cost savings.

Q. And you think you have the opportunity to do that with OSF?

A. I think that we will have the nucleus to do that and have that as part of our culture, yes.

Q. Why is OSF such a good partner for Rockford Health System, as opposed to the others that you've considered?

A. We admire them. We admire their board. We admire the Sisters' focus on the individual, whether it be the employee or the patient, their mission, the whole human being, the whole human spirit. Not to get too far along with it, but anybody that has been a patient knows that there is a role for some form of spiritualty along the course of the stay.

We think that they are an incredibly innovative organization. The fact that they have been selected as one of

the 32 pioneer accountable care organizations, which will be the organization of the future because as Medicare and Medicaid and other payors shift risk to the providers, that will be the foundation, the type of organization that will be emerging in healthcare in my opinion.

They have been advanced in terms of their electronic ICU, their electronic medical record. They have one of the most advanced intensive care units that I have ever seen. They have a very good physician group. They've got excellent training programs. We thought their leadership team was very compatible with ours. So, we thought there was a very nice fit between the two of us.

Q. Is the geographic proximity, the existence of Saint Anthony Medical Center being in the community, as opposed to Advocate, for example, which is not in the community, did that play any role in your decision to affiliate with OSF?

A. It did. Advocate was not going to give us the opportunity to consolidate as much. We probably could have done some back room things, some, in a limited way, but not to the extent that we can with Saint Anthony's being right in our city.

And secondly the concern was -- and our focus is going to be adding to the portfolio of medical services in this community. Advocate was more of the opinion that we should identify certain tertiary care areas and be comfortable having those patients transferred to them.

Q. We talked a little bit earlier, Mr. Kaatz, about the economic environment here in Rockford. My question to you is would you still believe that Rockford Health System would need to merge with or affiliate with OSF even if the economy in Rockford hadn't taken the negative turn that it has?

A. Yes.

Q. Why?

A. Well, you can look at our financial performance. We had a banner year in 2010, and we lost money in 2011. And in the state of Illinois with the state of things, things can change, and they can change quicker than I've ever seen before in my career.

We are absolutely convinced that the successful healthcare organization of the future has the right size, it partners with a physician group, it employs effective IT, it can demonstrate measurable benefits to the community and the patients that it serves, it has a responsible initiative with regard to population healthcare, and overall, significantly, not necessarily just by a unit here, a unit there, but it can significantly lower the cost with a nice increase, if you will, with regard to clinical outcomes.

Q. As a member of this community, what's your impression of how the community is reacting to the proposed affiliation?

A. I think overall I've been impressed with how the community has taken it. There's been a lot of uncertainty, and, yes, there have been people that are very concerned about it and probably not in favor of it, but overall in my circles they have been impressed, very inquisitive about it, what do we want to accomplish. It's been a little difficult to handle that because, again, we're competitors as we sit here today. We're not able to share sensitive information. And so, we're unable to really go out and tell them we plan to do X, Y, and Z in that order.

But there is I think a great deal of interest. I think that there is a great deal of interest to learn more about, and I think there are some people on the fence that would like to know more about what's going on, and I think there's some people that are opposed to it because they think -- for a variety of reasons they think that it might have some economic disadvantage to them.

Q. Let me talk for a couple minutes about the future of OSF Northern Region. As the future chief executive officer, can you tell us whether OSF Northern Region will require managed care organizations' health plans that want to contract with OSF Northern Region to contract only with OSF Northern Region in Rockford? Will you attempt to exclude SwedishAmerican from those health plans' contracts?

A. No.

Q. We talked a little bit about the fact that Rockford Health System competes with SwedishAmerican and presently with Saint Anthony Medical Center. Does Rockford Health System monitor what the other hospitals in Rockford are doing in terms of their service line offerings?

A. Yes.

Q. What do you do?

A. Well, we monitor from a high level. Our medical staffs talk. We get a generally high level of information on what some different initiatives might be. We don't go into -- we don't go into detail on that, but, as I said, it's at a very high level.

Q. How does Rockford Health System decide what capital investments you're going to make in your facilities?

A. Well, we do it off of our strategic plan. We look at the community. We look at where there are opportunities to better address need in the community. We take a look at things that have been fully depreciated. We look at new technologies that we feel are important to introduce.

So, we break it up by clinical areas. We break it up by infrastructure, IT, etc. And we make sure that it reflects the thinking behind our strategic plan and then present it to our board for discussion and approval.

Q. To your knowledge, have representatives from the hospital systems in Rockford exchanged any competitively sensitive information regarding their strategic initiatives before they became public?

A. Not to my knowledge.

Q. To your knowledge, have representatives from the hospital systems in Rockford exchanged any competitively sensitive information regarding their negotiations with health plans?
A. No.
Q. To your knowledge, have representatives from the hospital systems in Rockford agreed with each other on any aspect of their negotiations with health plans?
A. No.
Q. As the future CEO of OSF Northern Region, do you plan for OSF Northern Region and SwedishAmerican to enter into any agreements to defer competition between them?
A. No.
Q. As the future CEO of OSF Northern Region, do you plan for OSF Northern Region and SwedishAmerican to enter into any agreements as it relates to their negotiations with health plans?
A. No.
Q. How can you assure the court that OSF Northern Region will not coordinate its efforts, competitive efforts, with SwedishAmerican after the affiliation is consummated?
A. We're going to remain a community organization, governed, stewardship provided through our board, and the last thing that we're going to do is try to manipulate price to the detriment of our community.
Secondly, I'm accountable for the tone and the command

of the organization through my boss and ultimately the board, and I am going to be directed to operate within proper standards.
Q. Mr. Kaatz, I thank you. I have no further questions.
THE COURT: Cross.
MR. REILLY: Thank you, your Honor.
CROSS EXAMINATION
BY MR. REILLY:
Q. Good morning, Mr. Katz.
A. Good morning, Mr. Reilly.
Q. I'm not sure if I've met you. I might have met you in the hallway. My name's Matt Reilly, and it's a pleasure to meet you.
A. Likewise.
Q. I want to take care of a couple of housekeeping items before I ask you a few questions. Did you meet with your attorneys to prepare for your testimony today?
A. I did.
Q. How long? How many hours?
A. Oh, I think I met with them for a couple hours on Wednesday, and I had breakfast with them this morning.
Q. And that's it. A couple hours on Wednesday and breakfast this morning?
A. Correct.
Q. You reviewed your deposition in the investigational hearings

shortly after they were taken; is that right?
A. I did.
Q. And you reviewed them for accuracy and signed them?
A. I reviewed them for content. A lot of material was in there. Studied the language, studied what was reflected, and then when I was comfortable with it, I signed it.
Q. You told the truth at these depositions, of course?
A. Yes.
Q. Let me ask you about the TV advertising that we've noticed this week in our visit to Rockford. How much did that TV advertising cost?
A. I have no idea.
Q. Did you approve the budget that paid for these TV commercials?
A. I approved the initiative. I didn't approve the exact dollar amount.
Q. So, you have no idea how much these TV commercials cost?
A. I can't tell you that, no.
Q. I want to start with the proposed stipulation Mr. Marx asked you about that's been entered as a proposed order in this court. Is price mentioned anywhere in that proposed stipulation?
A. I'm sorry. Could you clarify the stipulation?
Q. You want to see a copy of it? It's DX938 in your binder, the first binder. It's up on the screen, as well, Mr. Kaatz.
A. And could you please repeat your question?

Q. Is price mentioned, in terms of how much the combined entity will charge health plans if this merger is consummated?
A. I don't see that, no.
Q. So, you can't point me to the section -- any section in the stipulation indicating that OSF Northern Region will not raise rates significantly following the merger; is that right?
A. I'm looking at my screen, and I don't see that.
Q. Let me ask you something. Is there anything in this proposed stipulation that would give a promise to a health plan that only wanted to contract with RMH and not Saint Anthony's? Is there a promise in that stipulation that that would be allowed?
A. Not to my knowledge, no.
Q. And if I asked the other question, if a health plan wanted to contract with just Saint Anthony's, but not RMH, would there be any promise of protection in the stipulation?
A. Not to my knowledge.
Q. Turning to what the merged entity will look like, no final decisions have been made about which, if any, clinical service lines may be consolidated following the merger; is that right?
A. Correct.
Q. In fact, no decision has been made regarding whether any particular service line will be terminated at either Saint Anthony or Rockford Memorial; is that correct?
A. That's correct.

Q. And no decision has been made regarding where any service line would be consolidated, if they're consolidated at all; is that right?
A. That's correct.
Q. In fact, it's possible that the merger goes through, no service lines will be consolidated within the next year; isn't that right?
A. No. There will be a plan over twelve months from the closing of the deal, and the plan will reflect decision points, and it may very well be -- and, again, because we've not been able to go beyond the point we're at now, after we've looked at the details, involved experts in those fields, gotten more familiar with sensitive information that we can share, it may very well be the case that we do begin a course of consolidations prior to the close of that first year.
Q. I understand. I'm going to ask the question again, and I'm trying to track your deposition testimony.
It's possible that if the merger goes through, no service lines will be consolidated within the next year; isn't that right?
A. It's possible.
Q. In fact, it's possible that the merger goes through, no service lines will be consolidated within the next two years; isn't that correct?
A. It's possible.

Q. In fact, no decisions have been made on what actions the merged entity will take in consolidating service lines, and you really can't commit to a timeline for when they will occur; isn't that right?
A. At this point we can't.
Q. So, it's possible -- I'm not asking likely. It's possible that no service lines will ever be consolidated after the merger between Saint Anthony and Rockford; isn't that correct?
A. It's possible.
Q. The merging parties have identified Deloitte as a potential integration team lead that would, if the merger is approved, lead the integration efforts going forward; is that right?
A. Correct.
Q. But you don't know whether Deloitte has actually been retained to provide those services, right?
A. I don't believe they have been retained. At the time of my deposition, I did not know.
Q. And do you believe they've been retained today?
A. I understand they have not been.
Q. So, I probably shouldn't ask the question has Deloitte done any work because I assume consulting firms don't work if they're not retained?
A. Correct.
Q. Did you review Deloitte's integration plan timeline that was given to OSF and Rockford?

A. Yes.
Q. And Deloitte laid out its plan to the OSF Northern Region in response to an RP from the merging parties?
A. Yes.
Q. And that plan included numerous action items that Deloitte suggested should be taken before the merger closes. Do you remember seeing that, Mr. Kaatz?
A. Not specifically.
Q. So, you don't recall any of the action items that Deloitte said should have been taken prior to the merger closing?
A. Not specifically, no.
Q. Do you remember seeing whether they suggested doing a business case verification of the efficiencies prior to the closing of the transaction? Do you recall seeing that?
A. I can't recall that specifically.
Q. Let me just ask you. Would agree that there would be no issue with Rockford Memorial and OSF giving sensitive information to Deloitte, right?
A. If it's done through advice and guidance of our counsel.
Q. Deloitte receiving information from both hospital systems wouldn't be an issue in terms of sharing of confidential information, right?
A. As long as it was guarded under confidentiality, I presume so.
Q. In fact, your litigation efficiency consulting firm, FTI,

did indeed get information from both hospitals, didn't they?
A. I understand they did.
Q. So, is it your understanding that Deloitte could have -- could have, if it was approved by the two hospitals, begin working and doing work prior to the closing if you gave them data?
A. Could you repeat that question?
Q. Sure. There is no limitation on Deloitte entering into a contract, getting information and data, and starting the integration planning process. That was possible to do, wasn't it?
A. Possible.
Q. And you didn't do it because of money?
A. Correct.
Q. Not because of any other restrictions that you're aware of?
A. Well, yes. Yes, there were other restrictions. We did not want to engage a lot of individuals that are high priced and take them away from their responsibilities, whether they are patient care or whatever. We did not want to waste their time. So, yes, money and the employment of human capital are probably the two biggest issues.
Q. Understood. I appreciate that clarification.
You expect that the integration planning process will be a substantial undertaking, correct?
A. Yes.

Q. And you don't expect to get an integration plan until twelve months after the arrangement with Deloitte is agreed upon; is that correct?
A. Agree upon that, and we'll certainly get a lot of work prior to the end of that.
Q. And that plan will determine, for example, whether clinical consolidations will occur, right?
A. It will assist us in making that decision, yes.
Q. And you receive those recommendations and then decide which clinical consolidations, if any, to implement, right?
A. Hopefully it will be done in a parallel process.
Q. And then you'll decide where, where to move clinical services if consolidated; is that right?
A. Yes.
Q. None of that analysis has been done to date?
A. No.
Q. Do you remember sending a memo on joint -- from Rockford Memorial Health System and OSF on November 22nd, 2011, saying the merging -- and this is going to all employees. The merging parties have not even begun to identify opportunities or efficiencies across nonclinical and clinical services currently provided on both campuses. Do you remember that?
A. Vaguely.
Q. And, of course, that was not sent because it was going to be sent if you could -- if this deal was approved; is that right?

A. Correct.
Q. And you were prepared on a joint letterhead to tell the employees that now once it's approved you'll begin to identify opportunities for efficiencies. Do you recall that?
A. I do vaguely.
Q. The merging parties will need to apply for a certificate of exemption to consolidate service lines; is that right?
A. We would investigate the State of Illinois' requirements for certificate of exemption by area which we had planned to consolidate, correct.
Q. But at this point no one at RHS has even studied how the certificate of exemption rules may impact the timing or the ability of the merging parties to consolidate clinical services, right?
A. Not until we know what we're consolidating can we make that COE decision.
Q. Let's return to the role that physicians will play in the consolidation. You're concerned about physician resistance in the community to clinical consolidations if the merger goes through, right?
A. Yes.
Q. You believe that the physicians are the key to consolidating service lines and that their ideas and criticisms are important to the success of a consolidation, right?
A. Yes.

Q. And you plan to have a physician advisory group involved in any clinical consolidations, correct?
A. Yes.
Q. But you haven't even formed any physician advisory groups yet, have you?
A. I have not.
Q. And you will not do that before any clinical consolidations occur; is that correct?
A. I won't because I can't afford to have those individuals commit to something where there is uncertainty about whether it's going to proceed.
Q. You have not set up any physician advisory groups yet because it's a daunting piece of work, right?
A. I have not because I don't want to waste their time.
Q. Because it would be a very, very complex set of things that will need to be worked out right; is that correct?
A. Yes.
Q. It's not something that can be done quickly; is that correct?
A. Some areas quicker than others. Some I think will be able to be done relatively quickly. I think other areas will be very complex.
Q. You haven't provided physicians with a copy of your litigation consultant's efficiencies work yet, have you?
A. I don't understand the question.

Q. Have you provided physicians with a copy of the FTI report?
A. Oh, we have had physicians involved in the presentation from FTI. Yes, we have.
Q. Have you provided the physicians with a summary of their efficiencies work, all physicians?
A. Not all physicians, but some physicians of our leadership, yes.
Q. What percentage of physicians would you guess have seen the FTI report?
A. A small number. I can't come up with a percentage, but a relatively small number.
Q. And you haven't had a general meeting with physicians to give them an overview of the potential clinical consolidations that might result from the merger, have you?
A. Not yet, no.
Q. In fact, physicians have yet to provide meaningful input on any aspect of the affiliation; isn't that right?
A. No. We have had physicians provide very meaningful input to date, but we have decided until we know that this is a yes or no to not take it to the full medical staff.
Q. And once you take it to the full medical staff -- or I should say until you take it to the full medical staff, you really won't know what the physician resistance and other issues will look like on any suggested consolidation; isn't that right?
A. We'll know some of it prior to that, and we'll also know

some of the ideas that they have on how best we can do it.
Q. But taking it to the medical group will allow you to identify any physician issues or concerns; isn't that right?
A. Well, if we do our job right, we'll have a lot of those identified before it goes en masse to the group.
Q. On your direct exam you talked about trauma services, and let's focus on those for a moment. No final decisions or plans have been made with respect to consolidating trauma services, right?
A. Correct.
Q. So, in two years it's possible that there will still be two Level I trauma centers at RMH and SAMC, right?
A. Please repeat your question.
Q. Is it possible that there will still be two Level I trauma centers at Rockford and Saint Anthony's after two years?
A. It's possible.
Q. Consolidation of the two hospital trauma units will be the most complex of all service line consolidations, right?
A. In my opinion, yes.
Q. And you view potential consolidation of trauma as a politically charged issue with Saint Anthony's, correct?
A. Yes.
Q. And the level of cost savings from consolidating trauma depends on what level of trauma services are maintained at the other facility; is that right?

A. It has a lot to do with that.
Q. And you don't have any confidence in putting a specific number on the recurring annual savings that you expect to achieve through trauma consolidation, right?
A. We do 1100 visits in our trauma center, and Saint Anthony's does approximately the same number, I believe.
Q. My question -- sorry, Mr. Kaatz.
A. I'm trying to answer your question.
If I have to take an extra couple of months to make sure that we don't make a mistake on something as complex an area of savings lives, I will comfortably do that.
Q. And so, the answer is you do not feel confident putting a specific number on the recurring annual savings you would expect from consolidating trauma right here, do you?
A. Correct.
Q. And you don't have the information to base that estimate at this point, do you?
A. No.
Q. And even if trauma consolidation ultimately occurs, it would take 24 to 36 months from the date the merger is consummated before any such actual consolidation would occur. Do you remember testifying to that?
A. Vaguely.
Q. Is that a true statement?
A. Approximately, right.

Q. Cardiology. Let's talk about cardiology services. You mentioned that; I think, on your direct. And there's no final plan on whether or where to consolidate cardiology or cardiac services following the merger, correct?
A. Correct.
Q. Additional analysis will have to be done post-merger?
A. Yes.
Q. Pediatrics. No final decisions or plans have been made with regard to consolidating general pediatrics, correct?
A. Correct.
Q. Women and children's. No plans or decisions have been made with regard to consolidating women and children's services; is that correct?
A. Correct.
Q. And if women and children's services are consolidated at Rockford Memorial, you would need to hire additional staff, right?
A. Yes.
Q. But that's something that at least will have to be studied in greater detail, correct?
A. Yes.
Q. Your litigation consultant, FTI, assumed that as part of its analysis the women and children's would be located to RHS. Do you remember that?
A. I do.

Q. And that's not correct sitting here today, is that? Or you don't know if it's correct. No decision has been made.
A. No decision has been made.
Q. Thank you. That was a bad question. I appreciate you helping me.
So, FTI was wrong about that when it said that women and children's would be located at RHS. Or may have been wrong.
A. I think we paid FTI to give us an analytical set of recommendations that made sense for them. Again, we have not made any decisions on the relocation or location of our clinical areas.
Q. And consolidations of cardiology and women and children's services were a part of FTI's efficiencies report; is that correct?
A. Yes, I believe so.
Q. And, again, for those services no final decisions have been made about whether or when or even if any of those services will be consolidated; isn't that right?
A. Correct.
Q. You have no plans or have made no decisions to lower the rates you charge health plans after this merger, have you?
A. I have not nor do I know of any discussions that have dealt with rates.
Q. There have been no internal discussions at Rockford, as you said, about maybe lowering the rates to health plans after this

merger, has there?
A. No, not to my knowledge.
Q. And there are no plans to freeze rates or have rates only go up as much as inflation if this acquisition goes through, is there?
A. There have been no decisions to that effect.
Q. Not any internal decisions about whether to freeze rates or raise them only so much; is that true?
A. Not to my knowledge.
Q. You've been employed by RHS for almost twelve years?
A. Yes.
Q. You've never worked with FTI before this transaction, right?
A. No.
Q. In all these years, RHS never hired FTI for any purpose; is that correct?
A. I don't believe so.
Q. And FTI's role in this proposed merger has been to do an efficiencies report; is that correct?
A. Correct.
Q. And you reviewed FTI's conclusions at a high level; is that right?
A. Yes.
Q. And you haven't reviewed the underlying data or methodology in that FTI report?
A. I have not.

Q. And RHS has not done its own efficiencies analysis for this transaction, have they?
A. No.
Q. You've only reviewed FTI's recommendations; is that right?
A. Correct.
Q. And FTI completed its analysis towards the end of 2010, correct?
A. Correct.
Q. To your knowledge, FTI has done no further analysis since then?
A. To my knowledge, they have not.
Q. And to your knowledge, FTI's collected no new data to re-run their analysis; is that correct?
A. I am unaware of that.
Q. And no one at RHS or OSF has re-run FTI's analysis using more recent data, have they?
A. I don't know that.
Q. And the data that FTI used in its efficiencies report is now at least 18 months old; isn't that right?
A. I don't know.
Q. Do you know what data they used to run the efficiencies analysis?
A. I can't recall specifically.
Q. And despite FTI's knowledge about both OSF and Rockford Health System, you have no plans to retain FTI for any purposes

going forward; isn't that right?
A. That's correct.
Q. In fact, FTI was one of the bids to get the integration planning contract, and instead you chose Deloitte; isn't that true?
A. I was unaware of that.
Q. Who made the decision to hire FTI?
A. It was -- well, let's see. It was a group of both individuals from OSF Healthcare and Rockford Health System.
Q. You're not the one who retained FTI, are you?
A. No.
Q. You didn't recommend that FTI be retained, correct?
A. I can't recall that specifically.
Q. Mr. Kaatz, outside counsel hired FTI, didn't they?
A. They did.
Q. Not OSF, not Rockford Health System; isn't that correct?
A. Correct.
Q. Are you aware that FTI provided Rockford Health System with a performance report that estimated that RHS could achieve -- I won't say the number -- several million dollars in annual recurring savings without a merger? Are you aware of that?
A. Could you rephrase that question?
Q. Sure. Are you aware that FTI presented a report to Rockford Health Systems that estimated that RHS without a merger -- without a merger -- could achieve several million dollars in

annual recurring savings? Are you aware of that?
A. A separate report.
Q. Yes.
A. No, I'm not.
Q. You didn't sit in on a presentation that FTI made that talked about all efficiencies that RHS could achieve without a merger?
A. No.
Q. Have you heard about the FTI performance report from anyone except for counsel?
A. No.
Q. You testified in your direct about the merger discussions RHS had with Advocate in 2009, correct?
A. Yes.
Q. And you would agree that a merger with Advocate would have given RHS the prospect of reducing costs, correct?
A. Correct.
Q. A merger with Advocate would have given RHS the opportunity to improve quality; is that right?
A. Correct.
Q. And the quality improvement would have come from sharing best practices with Advocate, right?
A. Correct.
Q. An affiliation with Advocate could have improved how RHS allocates resources, correct?

A. Could have.
Q. And there was a possibility to improve graduate medical education in Rockford through an affiliation with Advocate, right?
A. Correct.
Q. And an affiliation with Advocate could have helped with physician recruitment, right?
A. Correct.
Q. And an acquisition or merger with Advocate could have helped in recruiting more subspecialists to the Rockford area; is that right?
A. Correct.
Q. Let me understand the terms that RHS offered to Advocate. RHS did not offer Advocate the same terms it offered to OSF; is that correct?
A. I can't recall the specific terms.
Q. Do you recall, in fact, that RHS insisted that Advocate provide hundreds of millions of dollars in capital commitment as part of the deal terms? Do you remember that?
A. I remember that that came about because Advocate was very interested in developing the land that we had on our Riverside property. Yes, I do.
Q. And when RHS was talking with OSF, they did not insist on having a new hospital on the Riverside property as part of the OSF merger deal?

A. They did not bring that up. Advocate brought that up. OSF did not bring that up.
Q. Did you ever go back to Advocate and say, hey, there's no need for a new hospital to be built. Just make a certain capital commitment to RHS. Did you ever go back and talk to Advocate?
A. Yes, we did.
Q. And they said no?
A. Correct. They had just lost millions in the downturn of the '08, '09 market. And so, they took the entire capital play off the table as a result.
Q. So, after you began discussions with OSF -- and this is after and they're progressing -- you then went back to Advocate and said would they be interested in doing a deal?
A. Not after discussions with OSF, no.
Q. You would agree that the proposed merger with OSF is not the only way RHS can address healthcare reform going forward, correct?
A. Not the only way, but in our estimation the best way.
Q. And the proposed merger with OSF is not the only way RHS can reduce costs going forward, right?
A. Not the only way, but again the desirable maximum way.
Q. And the proposed merger with OSF is not the only way RHS can improve quality; isn't that right?
A. Not the only way, but the best way.

Q. And the proposed merger with OSF is not the only way RHS can attract or recruit subspecialists or specialist physicians, right?
A. Not the only way, but in our estimation the best way.
Q. And the proposed merger with OSF is not the only way RHS could take steps to stem out-migration; is that correct?
A. Correct.
Q. RMH has also taken steps to improve quality in the recent years, hasn't it?
A. Yes.
Q. RHS has had significant success in improving quality in recent years, correct?
A. Yes.
Q. RHS has set very, very aggressive goals for continuing to improve its quality regardless of this merger; isn't that right?
A. Correct.
Q. And I'm sure this is something you're proud of, Mr. Kaatz. RHS won a distinguished hospital award for clinical excellence and a distinguished hospital award for patient safety, right?
A. You're kind with your compliment of me. I had very little to do with it. It was our board that set the direction and our clinicians that really worked hard on that. And that award only is proof that we're in the right direction, nothing more.
Q. My team at this table will tell you I take all the credit for their good work. So, I'm glad you're better than me,

Mr. Kaatz.
And if RHS were to remain independent, it is your expectation that it would be able to continue to improve quality of care at RMH, right?
A. Yes.
Q. And RHS has undertaken initiatives to improve its level of coordination of care; is that correct?
A. Correct.
Q. And these initiatives have helped improve patient outcomes, right?
A. Correct.
Q. And if RMH were to remain independent, you'd expect to continue implementing best practices, right?
A. Correct.
Q. And that would include efforts to improve patient outcomes, correct?
A. Correct.
Q. And that would include efforts to reduce costs, correct?
A. Yes.
Q. Based on health grades information that you've seen, how does the quality of care at SAMC compare with RMH?
A. Could you repeat that question?
Q. Based on the health grades information that you have seen, how does the quality of care at Saint Anthony compare with Rockford Memorial Hospital?

A. I think that, as best as I could recall, the health grades data that I saw included an analysis of Rockford Memorial Hospital, Saint Anthony, and SwedishAmerican, and it gave scores of one star as the lowest, three stars as middle range, and five stars as the highest. And as I recall, and I have not looked at that for more than a year, I believe Rockford Memorial came in with the highest number of five stars, Saint Anthony's came in second, and SwedishAmerican came in third.
Q. You would agree that you would still need a lot of information before you would make the conclusion on whether quality of care is superior at Rockford Memorial or Saint Anthony's, right?
A. Yes.
Q. And to make that comparison, you would need a specific by-category comparison of clinical outcomes observed or expected, right?
A. Correct.
Q. And no one at RHS has compared clinical outcomes between Rockford Memorial and Saint Anthony's, right?
A. Correct.
Q. The same is true for individual service lines, right?
A. Correct.
Q. And overall clinical outcomes, right?
A. Correct.
Q. And you also don't know whether the quality of care is

comparable across all of OSF's hospitals, right?
A. Correct.
Q. And it would concern you -- it would concern you if you saw unequal levels of quality across OSF's existing hospitals, right?
A. It would get my attention.
Q. Is there a difference between concern and get your attention, Mr. Kaatz?
A. I don't know. It would concern me.
Q. In fact, very little, if anything, has been done to analyze the quality implications of this merger; isn't that right?
A. That's correct.
Q. You made the decision not to undertake that analysis yet, correct?
A. Yes. A lot of sensitive information at hand there.
Q. RHS has implemented hundreds of cost savings initiatives over the last several years, right?
A. Yes.
Q. Over the last few years, RMH has been able to independently reduce labor costs, correct?
A. Correct.
Q. Improve productivity, right?
A. Yes.
Q. Reduce supply costs, correct?
A. Correct.

Q. Improve patient safety programs, right?
A. Yes.
Q. And refinance its debt at a lower interest rate?
A. Correct.
Q. And that's not an all inclusive list of RHS's successful cost saving initiatives, is it?
A. It's not.
Q. And you testified that there's no magic whatsoever to achieving these savings, right?
A. I believe I did.
Q. And you're familiar with RHS's Lean projects, right?
A. I am.
Q. Lean is a large project at RHS to look at processes and to identify which steps in each process can be removed in an effort to make RHS more efficient, right?
A. Yes.
Q. And Lean is an initiative RHS undertook around 2009 to improve efficiency, quality, and cost, right?
A. Yes.
Q. And the Lean program has been a success, hasn't it, Mr. Kaatz?
A. So far it has, yes.
Q. For example, RHS has successfully improved cost and quality in its emergency department by improving throughput, right?
A. That's correct.

Q. And that improvement continues to this day?
A. Right.
Q. And that improvement will continue even if RHS remains independent, right?
A. That's the plan, yes.
Q. And if RMH were to remain an independent hospital, it will continue attacking costs through further cost-cutting initiatives, right?
A. We will continue attacking cost in the most creative and innovative ways possible.
Q. And RMH would continue to make some improvement in its average length of stay if it were to remain independent, right?
A. Yes.
Q. And RMH would also continue to improve, reduce its readmission rates if it were to remain independent, right?
A. Yes.
Q. RMH will continue with initiatives to further improve ER throughput if it were to remain independent, correct?
A. Yes.
Q. Involving physicians in cost-cutting initiatives makes it more successful, right?
A. Yes.
Q. And you don't believe you could successfully implement cost-cutting initiatives without physician involvement, right?
A. I believe that.

Q. And the same is true for quality initiatives?
A. I believe that.
Q. And that's because physicians have knowledge you and other hospital executives don't have, right?
A. It goes beyond that.
Q. Why else?
A. They bring in a different dimension that we don't provide, and they are a significant input into a multifaceted set of issues.
Q. And you haven't involved physicians in any of the post-merger plans for cost savings, have you?
A. We have involved a couple physicians to be part of the FTI presentation.
Q. Right. And besides those couple of physicians, you haven't involved physicians in any of the post-merger planning for quality improvements, have you?
A. No, we have not.
Q. In October 2009 you believed that RHS was not approaching the partnership discussions with OSF out of weakness, right?
A. Correct.
Q. That's because you felt that Rockford Health System had a strong balance sheet at the time, right?
A. Correct.
Q. In 2010 RHS had a strong year financially, right?
A. Yes.

Q. And despite difficult economic struggles in Rockford, RHS exceeded financial projections in 2010, right?
A. Yes.
Q. And you told the RHS board of directors that financially 2010 was a stellar year for Rockford Health System, right?
A. Yes.
Q. And, in fact, you told the RHS board of directors that RHS was entering 2011 a much stronger, more viable healthcare system. You told the board that, right?
A. Yes.
Q. And you told the board that RHS's 2010 quality, growth, and financial accomplishments were huge, right?
A. Correct.
Q. In 2010 RHS had positive operating income of approximately $26 million, right?
A. Approximately, correct.
Q. In 2011 RHS still had positive operating income, right?
A. No.
Q. What did they have in 2011?
A. I believe -- although the audit is not complete, I believe it was in the negative number.
Q. That audit is not complete?
A. It's not.
Q. You testified on direct that the three Rockford hospitals compete with one another; is that right?

A. Yes.
Q. They compete for inpatient services, as well as primary care physician services; is that right?
A. Correct.
Q. RMH seeks to maintain and improve its quality in part to compete against the other two Rockford hospitals; is that correct?
A. It's not the primary driver, but yes, it is correct.
Q. And RMH also seeks to maintain and improve its image in part to get patients that might otherwise go to Swedish or Saint Anthony's, right?
A. Correct.
Q. And for general inpatient care for all patients in and around Rockford, Saint Anthony's and SwedishAmerican are RHS's only meaningful competitors; is that right?
A. Would you please repeat that question?
Q. For general inpatient care for all patients in and around Rockford, Saint Anthony's and SwedishAmerican are RHS's only meaningful competitors; is that correct?
A. Correct.
Q. And patients in the Rockford area want to get their medical care close to home, right?
A. Yes.
Q. And competition with Saint Anthony's sometimes spurs Rockford to offer new programs; is that right?

A. Not necessarily.
Q. Sometimes spurs RHS to offer new programs?
A. Just competition with Saint Anthony's?
Q. Yes.
A. Not necessarily.
Q. I won't go to the deposition. Let me ask it this way.
Competition with Saint Anthony's and SwedishAmerican sometimes spurs RHS to offer new programs?
A. Correct.
Q. You believe that competition on patient outcomes is beneficial to patients; isn't that right?
A. I do.
Q. And you agree that there's emerging quality competition among the three Rockford hospitals; is that right?
A. I do.
Q. Absent a merger, you think that the three Rockford hospitals will compete on quality and outcomes, right?
A. I think absent a merger, the three institutions will continue to compete on quality, but will not be at the point of where the Chicago suburbs are or where Springfield, Illinois, is or where Champaign, Illinois, is.
Q. I understand the comparison to those areas, but absent a merger, you think the three Rockford hospitals will compete on quality and outcomes, correct?
A. I do, yes.

Q. And you believe that competition on outcomes will always benefit patients, right?
A. Always.
Q. And that's true for the three Rockford hospitals and their patients, right?
A. As well as others, correct.
Q. And after the merger, there's no dispute in this court that RMH will no longer compete with Saint Anthony's; isn't that correct?
A. That's correct.
Q. And it's true that Saint Anthony's and RMH's primary care physicians will no longer compete, will they?
A. That's not an absolute. Our physician group at Rockford Health System has healthy internal competition. And so, we actually do see patients go from one of our docs in the physician group to others based on some of their desires.
Q. In terms of contracting with managed care plans, the primary care physicians employed by the merged entity won't be competing. Is that a fair statement?
A. If I understand your question correctly, it's along the lines of competition just based on managed care contracting?
Q. Yes.
A. No, they won't be.
Q. There's no dispute that OSF Northern Region would be the largest hospital system in Rockford, right?

A. Correct.
Q. Based on beds, correct?
A. Correct.
Q. Discharges, revenue, and patient days, right?
A. Correct.
Q. There's no measure by which OSF Northern Region wouldn't be the larger hospital system in Rockford, right?
A. In the aggregate, that's correct.
Q. You have concerns that the merger could negatively impact the culture at RMH; is that right?
A. Yes.
Q. You think about that a lot, don't you?
A. I do.
Q. And you're very proud of the culture that RHS has and would not want this merger to impact that, right?
A. Correct.
MR. REILLY: I have nothing further, your Honor.
MR. MARX: Your Honor, I have no further questions. Thank you.
THE COURT: I have just two questions. Dr. Kaatz, if I denied the motion for a preliminary injunction, how long would it take for the parties to sign the documents finalizing the merger?
THE WITNESS: Your Honor, I think that could be done within two to four weeks.

THE COURT: And if I denied the motion for preliminary injunction, how long would it take Saint Anthony and Rockford Health System to start exchanging sensitive and confidential documents?
THE WITNESS: We could begin that right away.
THE COURT: Okay. Do the parties have any questions in consequence of my questions?
MR. REILLY: No, your Honor.
MR. MARX: No, your Honor.
THE COURT: You may step down. Thank you for your help.
THE WITNESS: Thank you, your Honor.
(Witness excused.)
THE COURT: We'll break for lunch. Let's meet again at 1:45.
(Whereupon, the within hearing was recessed to 1:45 o'clock p.m. of the same day.)

FOR THE NORTHERN DISTRICT OF ILLINOIS
WESTERN DIVISION

FEDERAL TRADE COMMISSION,)Docket No. 11 C 50344
)
Plaintiff,)Rockford, Illinois
)Friday, February 3, 2012
v.)1:45 o'clock p.m.
)
OSF HEALTHCARE SYSTEM)
and ROCKFORD HEALTHCARE)
SYSTEM,)
)
Defendants.)

VOLUME 3
TRANSCRIPT OF PROCEEDINGS
BEFORE THE HONORABLE FREDERICK J. KAPALA

APPEARANCES:
For the Plaintiff: U.S. FEDERAL TRADE COMMISSION
(600 Pennsylvania Avenue, NW,
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MR. JEFFREY H. PERRY
MR. RICHARD CUNNINGHAM

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MR. MICHAEL F. IASPARRO
Hinshaw & Culbertson
(222 N. LaSalle Street,
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MR. MATTHEW J. O'HARA
MR. ALAN I. GREENE
MS. KRISTIN M. KURCZEWSKI

For Defendant RHS: MC DERMOTT WILL & EMERY LLP
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Suite 4400,
Chicago, IL 60606) By
MR. DAVID MARX
MR. WILLIAM P. SCHUMAN

For Defendant RHS (cont.): MC DERMOTT WILL & EMERY LLP
(600 13th Street NW,

SCHERTZ TESTIMONY
PI HEARING

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
WESTERN DIVISION

FEDERAL TRADE COMMISSION,	)Docket No. 11 C 50344
	)
Plaintiff,	)Rockford, Illinois
	)Thursday, February 2, 2012
v.	)9:00 o'clock a.m.
	)
OSF HEALTHCARE SYSTEM	)
and ROCKFORD HEALTHCARE,	)
	)
Defendants.	)

VOLUME 2
TRANSCRIPT OF PROCEEDINGS
BEFORE THE HONORABLE FREDERICK J. KAPALA

APPEARANCES:

For the Plaintiff:
U.S. FEDERAL TRADE COMMISSION
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MR. DAVID MARX
MR. WILLIAM P. SCHUMAN

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competition, not a negative.
Q. Did you do an analysis whether either Saint Anthony's or Rockford Memorial are likely to fail absent this merger?
A. Again, I concluded that they're financially viable, and that reflects their own projections moving forward, as well as their own testimony.

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Q. Mr. Marx also asked you whether you had predicted a precise increase that may result from this merger. Do you remember that?
A. Yes, I do.
Q. Precise to you meant 23.4 percent or some number?
A. Yes.
Q. Mr. Marx also asked you whether you made a precise estimate of cost changes, increases or decreases in costs that may result from this merger. Do you remember that?
A. Yes.
Q. And you had not?
A. That's correct.
Q. On your direct you talked about your summary of conclusions in this matter. So, I'm going to ask you, Dr. Capps. Did your lack of a precise estimate on price increase resulting from this merger --
THE COURT: This is Page 49 of the demonstrative packet?
MR. REILLY: Yes.
BY MR. REILLY:
Q. Did the fact that you did not do or estimate a precise price increase resulting from this merger or that you did not estimate a precise change in how cost may result from this merger, has that in any way shaken your confidence in your conclusions that you testified about earlier?

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A. No. When I formed those conclusion, I certainly knew that I had not generated those precise numbers. Instead what I took was a comparison of the magnitude of the current competition, which is the competition that will be eliminated. They are close competitors. There's substantial competition between them. The merger will eliminate that and create a strong likelihood of higher prices.
Against that, many of the -- a substantial portion, as we talked about earlier, of the claimed efficiencies are either not merger-specific or are speculative in nature. And with respect to quality, you know, I'll note that we heard from Dr. Romano on that account yesterday.
MR. REILLY: Nothing further, your Honor.
THE WITNESS: I think that was seven minutes.
THE COURT: Mr. Marx.
MR. MARX: Nothing further. Thank you, your Honor.
THE COURT: You may step down, Dr. Capps.
THE WITNESS: Thank you.
THE COURT: Thank you for you help.
(Witness excused.)
THE COURT: We'll take a 15-minute recess. Let's reconvene at quarter to 4:00.
(Brief recess.)
THE COURT: All right. Mr. Reilly.
MR. REILLY: We hit the four witnesses that you

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allowed, your Honor, and so we rest.
THE COURT: Mr. Greene, are you ready for the defendants' case?
MR. GREENE: Yes, we're ready to proceed. The first witness is David Schertz.
(Brief pause.)
THE COURT: Raise your right hand.
(Witness duly sworn.)
THE COURT: Please take a seat at the witness stand.
DAVID SCHERTZ, DEFENDANTS' WITNESS, SWORN
DIRECT EXAMINATION
BY MR. GREENE:
Q. Would you please state your name, please?
A. David Schertz.
Q. And by whom are you employed, Mr. Schertz?
A. OSF Healthcare System at Saint Anthony Medical Center in Rockford.
Q. What is your position?
A. I'm president and CEO.
Q. And how long have you held that position?
A. Since December of 1995.
Q. Generally what are your duties as president and CEO of Saint Anthony?
A. I'm responsible for the overall operation and performance of the hospital. That includes supervision and interaction of an

executive team. It involves a great deal of medical staff interaction, community interaction, and I'm a primary liaison to our corporate office.
Q. You said you came to Rockford in 1996; is that right?
A. '95.
Q. '95. Can you briefly summarize your employment in the hospital industry before you came to Rockford?
A. Prior to Rockford, I was the president and CEO of Progressive Health Systems in Pekin, Illinois, from April 1991 until November 1995. Prior to that I was the CEO of Stuart Circle Hospital in Richmond, Virginia, a proprietary institution. That was from February of '88 through beginning of April of '91.
Prior to that I was part of BroMenn Healthcare in Bloomington, Illinois, serving as vice president-administrator of our Mennonite Hospital campus from 1985 to 1988. Prior to that I was the administrator of Eureka Community Hospital in Eureka, Illinois, from 1982 to 1985. Then prior to that I was the assistant administrator of that same facility from 1978 to 1982. And prior to that I was a unit manager at Saint Francis Medical Center in Peoria from March of '78 to August of '78.
Q. And with all of that, how long have you been active in the hospital industry?
A. 34 years total. 33 and a half in administrative responsibility.

Q. Okay. You mentioned BroMenn in Bloomington. When you were there, how many campuses were there?
A. Well, initially I was part of the Mennonite Hospital Association from '78 to '85, and then that became BroMenn Healthcare. That was the merger of Mennonite Hospital Association and Brokaw Hospital.
Q. Did you have involvement in the integration of BroMenn after the merger?
A. I did.
Q. What involvement did you have?
A. Campus redesign of the Mennonite campus, certainly ongoing discussions at an executive level about plan implementation, service consolidation, etc.
Q. Do you belong to any community or civic organizations here in Rockford?
A. I'm on the executive committee of the Rockford Area Economic Development Council. I'm also on the board of the Rockford Health Council.
Q. What is the Rockford Area Economic Development Council?
A. That's a coalition of businesses in the greater Rockford area and northern Illinois that work on the issues surrounding business growth in Rockford and recruitment of new businesses to Rockford.
Q. And you mentioned you're on the executive committee now; is that correct?

A. Correct.
Q. Have you held other leadership positions with that organization?
A. Yes. I've served as secretary, treasurer, vice president, and president of the Economic Development Council.
Q. What is the Rockford Health Council?
A. That is a coalition of area businesses and social service agencies. It includes the College of Medicine, it includes Rosecrance, which is a large chemical dependency management program, and the three medical centers in Rockford.
Q. Have you held leadership positions with Illinois Health Council?
A. Yes. I'm a past president and also past chair of their legislative agenda committee.
Q. Have you been involved or are you involved in any statewide organizations?
A. I'm involved with the Illinois Hospital Association. I'm a past member of the board of trustees. I served six years in that capacity.
Q. Would you describe for us what OSF Healthcare System is?
A. OSF Healthcare System is an organization of more than 13,000 individuals. It's comprised of seven hospitals and a very large medical group with hundreds of employed positions in all of its venues. We have a foundation. We have our own proprietary company, Saint Francis, Inc. We have a college of nursing in

Peoria, as well as Rockford.
A large company. I've got to remember all the entities. We have a number of clinical product lines organized around cardiac medicine, neurosciences, etc. So, a very large organization covering parts of Illinois and Michigan.
Q. What is OSF Medical Group?
A. OSF Medical Group is the organizational name of our -- what had been our employed primary physician group and is now expanding into a multi-specialty physician group.
Q. And are some of those employed physicians located at Saint Anthony?
A. Yes.
Q. Are those physicians allowed to admit patients to hospitals other than Saint Anthony?
A. Yes.
Q. Do you know do they?
A. Yes. Our cardiac group admits to SwedishAmerican. I know they've each done some work at Rockford Memorial. I know they do work at DeKalb Hospital.
Q. Who are the owners of OSF Healthcare System?
A. The Sisters of the Third Order of Saint Francis.
Q. And is there a mission that the OSF Healthcare System has?
A. The mission is to serve persons with the greatest care and love in a community that celebrates the gift of life.
Q. Does that mission apply to Saint Anthony as one part of OSF?

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A. Yes.
Q. And how is the mission transmitted to employees of your hospital?
A. It's transmitted through a number of different venues and medium. Each morning the work of the hospital starts at 8:00 a.m. with a prayer over the intercom. We are all educated on an annual basis on topics related to the mission and our objectives in terms of service to others.
Executives go through focus training annually. Part of our management plans calls for a mission integration strategy for that current year where all of our employees receive additional education about how they can better understand the mission and also represent and execute the mission.
Q. Who do you consider to be Saint Anthony's competitors?
A. It depends on which product line. Locally immediately in Rockford we compete against Rockford Health System, we compete against SwedishAmerican Health System.
But beyond that, we're a Level I trauma center, tertiary center. If you look at the data, we don't generate excess income in our local market to cover all of our costs. Much of that comes from the services that we provide to a surrounding tertiary region. In other words, as Level I trauma, we do high end, complex trauma. We do -- we're the number one heart surgery program in the area. We do a lot of complex neurosurgery, a lot of complex orthopedics. More of that will

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come from a wider range. We cover a wider geography. That's where we tend to make a greater margin to help cover much of our cost of operation.
Competition in that level is more focused on Madison, Milwaukee, the Chicago suburbs, the Quad Cities west of us. They are encroaching into our tertiary market now. So, a critical element of what keeps Saint Anthony's operating is that tertiary business.
Q. And could you tell us briefly about the service lines and the structure of SwedishAmerican Healthcare System?
A. SwedishAmerican. Both hospitals or just the one in Rockford?
Q. The whole system. What elements are there in the system?
A. Well, SwedishAmerican is the largest provider in the marketplace, now north of 40 percent of the market, moving towards 45. They have a very large obstetrics program. They have a cardiac program. In fact, built a heart hospital a few years back dedicated to that. They have orthopedics. In fact, they have pretty much all the same product lines that we would have at Saint Anthony's.
They do also have mental health services, a hospital located in Belvidere. So, we're kind of bracketed by their campuses. And recently, a rather strategic move, they have aligned with the University of Wisconsin in Madison. So, that's going to be quite a challenge for us going forward.

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Q. Have you seen any announcements of the scope of that alignment that SwedishAmerican has with UW?
A. There was a big article in the paper that they were going to build a multi-million dollar cancer center at the intersection of I-90 and Riverside, which is just northeast of our location.
They've also in their announcement of the affiliation a couple years ago talked about expanding IT presence in the northern region. I know currently or recently University of Wisconsin Madison established an EICU in Freeport, which is about 30 miles west of us, and our concern is that going forward that kind of connectivity pushed down through the University of Wisconsin to hospitals that currently refer a significant amount of business to us that those patterns will be altered.
Q. What is an EICU?
A. Electronic intensive care unit. In other words, physicians at the University of Wisconsin Madison monitor patients in Freeport. If a problem arises there, they're connected through telecommunications to nurses or doctors at Freeport and then provide oversight direction on patient management.
Q. From your perspective, has the opening of the hospital by SwedishAmerican in Belvidere affected your hospital?
A. Yes. That facility, I believe, opened up in the spring of '09. Prior to that we were averaging about 1500 admissions from that ZIP code area annually. Our most recent report I think shows we are now getting about 1150 from that market.

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Q. Can you explain how that change comes about? We've heard there's just a very few staffed beds at that hospital at Belvidere?
A. Well, it is still a licensed hospital, and the way the state regulations work, if somebody's in a medical distress condition, ambulances are instructed to go to the nearest hospital. So, in that marketplace, their emergency room would be the nearest emergency room.
Once stabilized, the nearest hospital rule no longer applies. So, patients can then be transferred to any higher level of care. So, historically, where folks from that location would come to Saint Anthony's, about eight miles away, if they go to that hospital now, they can be transferred to SwedishAmerican, which is another three or four miles beyond us.
Q. How can you know that those patients would have come to Saint Anthony if the hospital weren't open in Belvidere?
A. I can't know that, but I can know that the opening of that hospital created a 350 admission drop per year. We were the nearest hospital. If there was a problem, they would come to us.
Q. Because you were the farthest east of the three hospitals in Rockford?
A. Yes.
Q. From your perspective as president and CEO of Saint Anthony how effective a competitor is SwedishAmerican?

A. Very effective.
Q. And how has that affected your ability to compete?
A. Well, certainly it's very challenging. They have an alignment with the College of Medicine in Rockford for a family practice residency program, which allows them to have a much closer working relationship with future primary care doctors to be recruited from that program.

They also have a somewhat symbiotic relationship with a local fairly qualified health clinic, Crusader Clinic. The vast majority of the Crusader babies are delivered there at SwedishAmerican. So, it's hard for us to compete against that. That, coupled with now the alignment with the University of Wisconsin, that poses some great challenges for us.
Q. You were here during the testimony by Dr. Capps?
A. Yes.
Q. And you saw that map that went up that showed various hospitals and the distance?
A. Yes.
Q. Do the existence of those hospitals outside of Rockford have an effect on the operations of Saint Anthony?
A. Yes, they do. Immediately north of Rockford is the community of Beloit, about 14 miles north. Beloit Memorial Hospital located there is not a small community hospital. In fact, they performed 70 open heart procedures this past year.

About four years ago, I believe, they established a

rather large ambulatory care center in northern Winnebago County, about ten miles north of Saint Anthony's. They're using that presence and rotating primary care and specialists through that setting to help pull patients back out of northern Illinois to their hospital in Wisconsin. So, there is competition there.

Over time, the ring of hospitals you saw around Rockford, there was a point in time a decade ago when all cardiac cath activity in that region would go upstream to one of the hospitals primarily in Rockford. Since that time almost every hospital in the region has had their own cardiac cath lab. So, that business no longer goes to Rockford. It stays there, and that's had an impact on operations, also.
Q. And did you have other types of referrals or do you have other types of referrals from those hospitals in the ring that you referred to?
A. Yes. Another impact over the last several years is the encroachment of Chicago systems, Wisconsin reaching into our tertiary market to redirect referrals for stroke, for example. Freeport Memorial has an affiliation with Alexian Brothers in the Chicago suburbs. They send stroke activity there.

Rochelle Community Hospital, a small critical access south of us, has a relationship now with Central DuPage Hospital for stroke referral. Kishwaukee Medical Center in DeKalb has a relationship with Loyola for cancer referrals. And over in Sterling-Rock Falls, there's a relationship now between CGH and

Genesis Health System in Davenport for cardiac referral.
Q. How many staff beds does Saint Anthony have?
A. We currently report 238.
Q. And do you know what the other two hospitals based in Rockford, how many staffed beds they report?
A. Ball park I think RMH is around 300, and I know SwedishAmerican is 325, 330.
Q. Do you keep track of the occupancy of beds at Saint Anthony?
A. In an oversight fashion, yeah. Reports are generated on a regular basis.
Q. Are you aware of the State of Illinois monitoring the occupancy of hospital beds?
A. Yes. Every hospital files an annual hospital questionnaire that you have to submit utilization information, and they calculate percentage occupancy from that.
Q. And to whom or to what agency is that information reported?
A. Illinois Department of Public Health.
Q. And does the department publish that information periodically?
A. Yes.
Q. I'm going to hand you a document, which may be easier. This is DX0694. I've handed you the cover and Page 68, and I'd like to ask you to take a look at Page 68, if you would. First of all, what date does this document bear at the top of that page?
A. Looks like 28 July 2011.

Q. Okay. As far as you know, is this the most recent such report issued by the IDPH?
A. As far as I know.
Q. And based on the cover, this is Inventory of Healthcare Facilities and Services and Need Determinations; is that correct?
A. That's correct.
Q. On the top of the page, what year of information is being reported?
A. 2008 admissions.
Q. Okay. And then if we go down to the second half of the page, you see a heading medical surgical/pediatrics planning area totals?
A. Yes.
Q. Are you with me?
A. Yeah, I think so. Medical surgical total?
Q. Yes. Okay. And if you go down to the very last column on the page to the far right, do you see two columns, one called existing beds and one called excess beds?
A. At the very bottom on the right-hand corner, yes.
Q. Yes. And what does this report for existing beds?
A. 745.
Q. And what does it report for excess beds?
A. 237.
Q. And if we go back up to the top of the page, which

hospitals, which geographic area is this page reporting on?
A. It appears to be the Rockford MSA, which would include Winnebago and Boone County.
Q. And so, that would be Rockford Memorial --
A. Rockford Memorial, Saint Anthony Medical Center, and SwedishAmerican Hospital and SwedishAmerican Medical Center.
Q. And SwedishAmerican Medical Center is the name of the facility in Belvidere?
A. I'm not sure. It's one or the other.
Q. Okay. Now, you see the columns labeled 2008 population and 2018 population on the right-hand side of the page just above where you mentioned the existing beds and the excess beds?
A. Yes.
Q. From what you can see here, is the IDPH projecting a larger population in 2018 than in 2008?
A. Yeah. There appears to be a slight increase, yes.
Q. And is your understanding of the bottom part, which shows the existing beds and excess beds, the projection for 2018?
A. That appears to be what they're trying to do.
Q. And the 745 existing beds is the same number as currently or at least in 2008, right?
A. Correct.
Q. And so, if the excess beds are projected to be 237 on a larger population, slightly larger population, would it be your belief that the excess beds right now are at least as much as

237?
A. At least as much as that.
Q. Okay. Thank you. We're done with that exhibit.
How does the economy of Rockford compare to what it was when you arrived here 16 years ago?
A. It's much worse than it was 16 years ago. A number of factors. When I came to town, I became involved with economic development fairly early on, and from time to time they would share reports with us about the current economic state of Rockford. I believe in 1996 -- '95, '96, that time period, if you looked at the average household income and compared it to average household income nationwide, you develop a score, with 1.0 being the median household income in the country. Where your community scored relative to that would say something about the economic condition.
In '95, '96 I believe the median income in Rockford scored out at 1.0 or slightly above. Most recently, I think in 2010, the median income in Rockford scored out at .82, which means it's 18 percent below median household income in the United States. That's a dramatic change.
Q. We've heard talk during the hearing, and you were here, about the unemployment in Rockford?
A. Yes.
Q. Has the unemployment and the general economic situation had an effect on Saint Anthony?

A. Yes.
Q. And what has been that effect?
A. It's a rather dramatic impact over the last three years. With the precipitous drop in employment, certainly the condition not only of Rockford, but the state of Illinois and the country, we've had rather severe financial setbacks in 2009, 2010, and 2011. It's a function of the fact that our charity care during that window of time on a cost basis has tripled. That's about an eight million dollar reduction to bottom line performance just for charity care.
Q. What do you mean by on a cost basis?
A. The cost of providing the care.
Q. That doesn't build in a reference to a ChargeMaster or anything the hospital might charge for?
A. No. They require that you report charity care on the cost that you incur providing the care. There's so many different price structures, somebody could be charging twice as much for something. If you reported charity on price, it would be inflated. Cost is cost.
Q. Have you seen evidence elsewise than the charity care of the effect on the economy?
A. Our Medicaid as a percentage of our activity at Saint Anthony's has increased more than twofold. Medicaid is funded by the State of Illinois, which at the current time is not funded by the State of Illinois.

Q. What do you mean it's not funded by the State of Illinois?
A. Illinois is eight billion dollars in debt. It's ranked 50th in the nation in terms of economic performance, and what it's causing are delays in payment for Medicaid patients and State of Illinois patients. Not only is Medicaid paid at a very low rate, but they're not paying on time. So, it creates not only an income problem for the hospitals, it creates a time value of money problem, also.
Q. What is the approximate percentage of your total cost that Medicaid does pay to Saint Anthony?
A. Of total cost?
Q. Yes.
A. That Medicaid pays?
Q. Yes. The total cost of caring for those Medicaid patients.
A. It's somewhere around 60, 65 percent.
Q. You also receive Medicare payments; is that correct?
A. Correct.
Q. And do those payments cover the total cost of your serving the Medicare patients?
A. No. They cover -- it's a range sometimes 73 to 80 percent, somewhere in there.
Q. Does the fact that Medicare pays less than the total cost of serving those patients, is that separate and apart from the current economic situation in Rockford and Illinois?
A. Yes.

Q. And that's generally throughout the country; is that correct?
A. Yes.
Q. And do you expect that situation to continue?
A. No. I expect it to get worse.
Q. Why?
A. Well, the Healthcare Reform Act takes a half a billion dollars out of Medicare to fund other parts of the plan. The Illinois Hospital Association has run analyses, just initial analyses, showing that by full implementation our reimbursement for Medicare will decrease another eleven to twelve million dollars a year.

And that initial analysis does not have a good estimate of the impact of some of the initiatives that are rolling out currently. For example, 30-day readmission. Increasingly, Medicare will not be paying for any readmission inside of 30 days of a patient's previous discharge. There's no way to know just how severe that might be.

Secondly, recovery audits. Those are accelerating in terms of an outside contractor hired by the government going in to audit Medicare records, primarily looking for inconsistencies in documentation. There's no question service was provided, but if it's not documented accurately, then that payment can be denied. We have no way of estimating what that impact's going to be. So, I would see it getting worse.

Q. What is the effect of these and perhaps other factors, what have they had on the bottom line of Saint Anthony in recent years?
A. 2009 for hospital and physician group operations, we posted a ten million dollar loss. In 2010 for hospital and physician group operations, we posted nearly a seven million dollar loss. And during the past year we posted a loss in excess of two million dollars for physician and hospital operations.
Q. Did you hear Dr. Capps testify that for 2011 you had forecast in your management plan to have a profit?
A. Yes.
Q. And was that true?
A. No.
Q. Was it true that it was in your --
A. Oh, it was in the management plan, but that was developed -- the plan I believe he was speaking to was submitted in the summer of 2012, developed with numbers from the summer of 2011 developed from numbers from the spring of 2011. Let's see. April, May, June, July, August the bottom fell out. In two months alone we were $2.7 million over budget for charity care. So, it just goes to show you that financial projections sometimes aren't accurate.
Q. Do you have confidence that the financial projections in your most recent, that is, your 2012 management plan can be fulfilled?

A. Once again, given all the change ongoing presently, it's very difficult for us to know the true impact of reimbursement. We try to get a better handle on our costs. It's one of the reasons for pursuing the merger. The future is about being able to reduce your cost for a service, and the merger provides us with a best solution that doesn't diminish access to care.

If we have to do it on our own, to reduce our costs at equivalent levels, current knowledge in healthcare says you're going to have to learn how to break even on Medicare. Right now we'd have to cut about 20 percent of our costs to break even on Medicare as it's paid now, not how it will be paid in the future at lower rates. So, the challenge is cost.
Q. Can't you make that up by getting higher rates from the commercial health plans?
A. The way this is evolving, currently 70 percent of everything we do is either Medicare, Medicaid, or charity. The remainder half of that is Blue Cross/Blue Shield. We currently take rates from them for our physicians, and, as they grow stronger, I assume at some point in time we'll be taking rates for the hospital.

The remainder, the smaller core of business, in 2014 the insurance exchanges start across the country. We try to monitor what the potential impact of that is. Literature says at the present time that as much as 30 to 50 percent of all small business owners rather than continue to try and provide

insurance coverage, it will be cheaper for them to pay the federal penalty per employee and then write a check to their employees to go buy their coverage on the exchange.

Okay. The only problem with that is the only model we have out there to look at as to how this might progress is in Massachusetts. As a member of the IHA board, we interacted with members of the Massachusetts Hospital Association, and they did warn us. It started out okay, but the exchanges are now moving down towards Massachusetts state Medicaid rates. So, we'll be price-takers at that kind of a rate going forward for an even larger portion of our what had been commercially insured population.
Q. Okay. You were here yesterday when Dr. Romano testified, weren't you?
A. Yes.
Q. And do you recall that he talked about the Epic electronic medical records system?
A. Yes.
Q. And Saint Anthony is fully implemented with Epic, correct?
A. Yes.
Q. And as far as you know, Rockford Memorial is moving toward implementation?
A. Yes.

MR. REILLY: Your Honor, he's leading his witness. Objection to leading questions.

THE COURT: Sustained. I'll sustain the objection to the last question.
BY MR. GREENE:
Q. Do you know whether Rockford Memorial has an electronic medical records system?
A. They are currently replacing it, or they are currently installing or planning to install the Epic medical record.
Q. Once those two systems are installed, will they be compatible? In other words, will they be able to talk with one another?
A. If we are able to get the merger done in the very near future, they will be able to work with us to design their platform around one patient repository, patient record repository.
If, in fact, this doesn't happen very soon, they'll have to go ahead and implement their own patient base. So, in other words, they'll have Epic at their location, we will have Epic at our location, but, no, the two will not talk to each other.
Q. Did you hear Dr. Romano testify that there can simply be some sort of cooperation agreement between the two hospitals and that they could share the Epic information without merging?
A. I did hear that.
Q. Is there any reason that you couldn't do that?
A. You could do that. The only problem is we go from -- if the

merger happens, we can save about four million dollars building their platform on our platform. If you have to hire the appropriate expertise to build the interface engine so the two systems can talk in the future, you're talking about expensive, millions of dollars.
Q. To your knowledge is every Epic system the same as every other Epic system?
A. They start out in a basic configuration, but they build their own patient base. There tends to be customization of most platforms.
Q. You are familiar with the term pioneer accountable care organization?
A. Yes.
Q. Just briefly what is OSF's involvement in the pioneer ACO?
A. OSF healthcare is one of 32 systems nationwide that have been named by CMS as part of the pioneer ACO project, which is to begin to experiment, understand, and participate in a model that provides a more coordinated globalized model towards patient care. This is where healthcare is going, and we're fortunate that we were selected, fortunate that the quality of care and the organization of OSF was deemed one of the best in the country.
Q. Is Saint Anthony as part of the OSF system part of pioneer ACO?
A. We are not.

Q. Do you know why not?
A. Two reasons come to mind. Number one, we have got some subspecialty gaps that would not allow us to participate. We still need to fill those. And, secondly, given the burden of this ongoing process, it was felt that we should probably get this out of the way before we take on the process of implementing the ACO model in the Rockford area.
Q. If the affiliation were to go through with Rockford Memorial, what is your understanding as to whether that would fill the gap of specialties?
A. Our gaps are in obstetrics and pediatric medicine. They are a Level III center. So, yes, that would fill those gaps.
Q. Okay. Do you know -- assuming for the moment that sometime in the year 2012 the affiliation were to go forward, would the OSF Northern Region, as it would then be called, would it be able to join in the preexisting OSF pioneer ACO?
A. Yes, we'd be able to be added to that, the affiliation, as you say, if it went through this year. Probably not until January 1 of 2014.
Q. You've used a specific date, January 1. Why did you say that?
A. Because anybody participating in the project currently, the pioneer ACO, they can amend their contract with CMS on January 1st of each year.
Q. Will it require more than amending of the contract, as far

as you know, to add the northern region?
A. No.
Q. No further application would be required?
A. No.
Q. Thank you.
Prior to this affiliation that you want to enter into with Rockford Memorial, was there a previous time in which you were at Saint Anthony when there was an attempted affiliation with another hospital in Rockford?
A. Yes. 1997, '98.
Q. And that was with who?
A. SwedishAmerican Health System.
Q. At the time of that proposed transaction, what was Saint Anthony's position in the market among the three hospitals?
A. On the basis of discharges, we were in third place.
Q. What about SwedishAmerican at that time?
A. They were in second place.
Q. Do you know if the affiliation was investigated by the federal government?
A. Yes, it was.
Q. And which agency?
A. It would be the Department of Justice.
Q. And what was the conclusion -- what was the result of that investigation?
A. They chose to let the merger go forward.

Q. But it didn't go forward?
A. No.
Q. Why?
A. I'll just use the term cultural differences.
Q. Now, you're aware at the time that Saint Anthony and SwedishAmerican presented to the government a forecast of efficiencies and cost savings?
A. Um-hm.
Q. Are there differences today as to the need to achieve efficiencies and cost savings, as opposed to the situation 15 years ago?
A. Yeah.
MR. REILLY: Objection. Vague, your Honor.
THE COURT: Do you understand the question?
THE WITNESS: Yeah, I think so.
THE COURT: I'll overrule the objection.
BY THE WITNESS:
A. Well, in 1997 I think the national debt was around four trillion. Today it's 15 trillion and going up. Why do I say that. That's going to have an impact on what we have to pay for healthcare in the future.
Number two, the economic condition of Rockford in 1997 was much stronger than it is today. In '97 we didn't have encroachment the way we do now from regional competitors like Chicago, Madison, Milwaukee, Quad Cities.

In '97 we didn't employ nearly as many specialists as we do now. Why do I bring that up. It's very costly. Illinois, the state of Illinois, was in much better financial condition in 1997. But Illinois is also a very litigious state. It's very hard to get specialists to Illinois unless you pay their way to employ them and insure them. It's a very expensive proposition and one that we did not experience to any great extent in 1997.
Q. Let's talk about the proposed affiliation that brings us to this courtroom today. What was the genesis of the affiliation?
A. The genesis. Well, certainly the economic conditions, and, quite frankly, the realization -- I've been here over 15, 16 years, and knowing what's coming or seeing what's coming, the best way to deal with it would be to try and find a way to bring two institutions in Rockford together.
At that time, spring of 2009, Rockford Health Systems was in discussions with Advocate Healthcare about possible affiliation. Those discussions concluded in April of 2009. I had known Gary Kaatz about nine years by then, and he and I, interacting in many community forums -- we were both on the IHA board of trustees -- we kind of looked at the circumstance of the economic environment in Rockford and kind of saw things the same way. He and I have both worked in a number of other healthcare markets outside of Rockford. So, we brought those perspectives also.

But I had asked him would you like to go have lunch. We had lunch, and I put forward the thought that now that you're done with Advocate, would you consider maybe aligning with OSF Healthcare. We came to a point of mutual agreement that was worth investigating. We took it back to our respective boards, and that started a small discussion group composed of a small group from Rockford Health Systems, a small group from OSF. Those discussions went on and were successfully completed in May of 2010, at which time we announced a letter of intent had been executed.
From then through the summer of 2010, fall, winter, and early part of 2011, we performed intensive due diligence, and that led to our announcement about this time last year that we had come to agreement, an affiliation agreement.
Q. You mentioned in the course of your answer that you saw what was coming. Were you referring to the economy, something else? What were you referring to?
A. I think that was about the time that the Accountable Care Act was being debated nationwide, but you could also see the debt building, and you knew that actually whether it was a Democratic administration or a Republican administration, there were going to be reductions in Medicare. There are going to have to be reductions in Medicare reimbursement.
Q. You mentioned a series of steps. Before the letter of intent was signed, did Saint Anthony take any steps to

investigate what sort of benefits it might achieve by the affiliation?
A. We utilized a consultant that works frequently with OSF, Health Care Futures, and using what they knew about OSF and publicly available data, they put together a 30,000 foot analysis about potential benefits of Rockford Health Systems joining OSF.
Q. And what did that show?
A. It showed it was worth pursuing.
Q. Okay. Subsequently after you signed the letter of intent, did you have further analysis made of efficiencies and cost savings?
A. Yes. The due diligence phase required that we bring in -- that a third-party be brought in, a consultant, to do a more in-depth analysis of both organizations. Obviously, OSF couldn't look at proprietary data of Rockford Health Systems and vice versa. So, the third-party was responsible for investigating, analyzing, interviewing, and developing a set of findings that would be shared with both parties.
Q. Did those findings -- by the way, what was the organization that you brought in?
A. FTI was the consulting firm that conducted the work.
Q. Did FTI's findings play any role in the decision of OSF to want to move forward?
A. They provided confirmation of what we thought was there or

was there.
Q. And when you say confirmation of what you thought was there, what do you mean?
A. Well, they found an estimated annual savings from operations ranging from 42 million annually to 56 million, that range. They also found capital savings of over a hundred million dollars.
Now, why do we think that is there? Well, quite frankly, two reasons. 42 million at the low end of the range, that's 5 percent of the operating costs of the combined entity. More importantly, we're going to have to probably cut 20 percent, given what's coming in Medicare. So, it confirmed what we thought was there.
Q. And as the CEO and president of Saint Anthony, do you believe that the efficiencies and savings forecast by FTI are achievable?
A. Yes, they are achievable. I believe they're conservative. We have to go far beyond that.
Q. By the way, when Dr. Romano testified, did you hear him say that rather than merging, hospitals can just close down some service lines?
A. Yeah, I do remember hearing that.
Q. What's your response to that testimony as it applies to Saint Anthony?
A. Well, I mean, we're here today because there's opposition

saying that our merger could decrease access. That's one of the factors. Yet, the consultant is telling us that, well, you can just close something and decrease access to take care of it. No. The best way to do this is to merge the two entities in a way that allows you to continue to provide a full service platform that can compete in this marketplace.
Q. What do you believe -- if you did close some service lines, what effect do you believe that would have on your ability to compete?
A. That would lead to the end of our organization because if you're not a full service institution in this marketplace, you can't compete on negotiation for prices, and, quite frankly, in this community if you start to eliminate services, the credibility of your institution is brought into question, and that leads to further decline.
Q. Do you recall hearing Dr. Romano also testify that mergers do not necessarily lead to an increase in quality and patient outcomes?
A. Yes.
Q. What is your response to that testimony?
A. Well, his testimony also was -- I mean, one of the tenets of greater quality is to create greater volume through -- greater through-put creates greater quality. His recommendation when he said, well, just go ahead and close it and refer it to a larger center, a larger center to me implies higher volume. Okay?

We believe and there is literature that demonstrates in many of the complex procedures -- and we are a Level I trauma center and do a lot of complex procedures -- that there is benefit through greater volume. I've gotten that feedback from doctors on our medical staff, and it's in the literature, and we believe that to be true.
Q. By the way, have you had feedback from doctors on your medical staff as far as their views of moving forward with the affiliation?
A. The doctors I've interacted with on our medical staff are very positive about it.
Q. I want to you ask about one other piece of testimony. You were here when Mr. Petersen testified yesterday?
A. Yes.
Q. And one of the things he said was that rarely, if ever, do hospitals achieve predicted cost savings from a merger. What is your response as far as your belief specifically with respect to Saint Anthony's ability along with Rockford Memorial to achieve savings?
A. Not only can it be achieved, but, as I said earlier, they must be achieved. And this is a platform on which we can better achieve those cost reductions than trying to do it independently. So, I believe that savings will be made and then some.
Q. Should this transaction go through and the Northern Region

be set up, what will be your position?
A. My position will be chief operating officer of the Northern Region.
Q. And who will be the chief executive officer?
A. That will be Gary Kaatz.
Q. And what type, if any, of a local board will there be?
A. Well, actually, there will be a local board, a governing board, charged with overseeing the operations of all the OSF assets in the northern region.
Q. And in today's structure with Saint Anthony, is there a local governing board?
A. No, there is no governing board in Rockford.
Q. Is there another type of board?
A. We have an advisory board that meets usually quarterly. It's more of a community interaction model.
Q. Is it your view that the affiliation will benefit this community?
A. I believe it will greatly benefit this community.
Q. Can you explain how and why you believe that?
A. Well, our own chamber of commerce has talked about Rockford as a healthcare destination. We believe that by coming together, building larger centers of excellence, we can accomplish that. We can start to stop some of the out-migration from the service area. It creates a more stable platform going forward for employment.

Quite frankly, the things that we can do in terms of freeing up money from the costs we currently incur through duplication can be reinvested. One example would be we'd like to start an internal medicine residency program at the College of Medicine. We'd also like to start a surgical residency program at the College of Medicine. That creates additional employment, that creates another way to make Rockford a destination, and it benefits the community.

Q. And what is the plan as far as how to achieve the cost savings that will allow to happen what you just described?

A. Well, that plan is yet to be developed in detail. We have not proceeded until we know where we stand with this process. It's going to be expensive, more consultants engaged, but we believe that the initial work done by FTI shows there are opportunities. We still have to develop a plan that will say how do we consolidate, where do we consolidate, and then proceed.

Q. Why haven't the two organizations started that process within the last year?

A. Well, first of all, in order to put together a functional and effective plan, we are going to have to look at a lot of proprietary data that we currently can't look at. And, quite frankly, why do we start to spend the money not knowing where we're at with this process with the FTC.

Q. You heard the testimony of both Mr. Petersen and Ms. Lobe

yesterday; is that correct?

A. Yes.

Q. And you heard some concerns expressed by them about their ability to have enough leverage to contract with the Northern Region if the merger goes through; is that correct?

A. Yeah.

Q. Have you also heard concerns expressed by SwedishAmerican along those lines?

A. I've been told about them, yes.

Q. Do the health plans or SwedishAmerican in your view have a reason to be concerned?

A. No.

Q. Have steps already been taken to alleviate any concerns that they have expressed they have?

A. Yes.

Q. And there's been some talk about a proposed stipulation. I'd like to show you that. It's DX938. For ease, I'll hand you a paper copy. You get your choice of screen or paper.

A. This is fine.

Q. Okay. Mr. Schertz, did you participate in the decision to enter into this proposed stipulation?

A. Yes.

Q. Are you supportive of the proposed stipulation?

A. Yes.

Q. Let's talk about item number one. What will item number one

do to alleviate the express concern?

A. Well, why don't I just read it. It's probably easier.

Q. That's great.

A. Upon consummation of the affiliation of OSF and RHS pursuant to the affiliation agreement dated January 31st, 2011, and the creation of the OSF Northern Region, OSF Northern Region will not require any managed care organization to exclude SwedishAmerican Health System from its provider network as a condition for a contract with the OSF Northern Region.

Q. And if this merger goes through and you are the COO of the OSF Northern Region, do you intend to comply and live up to this stipulation?

A. Yes.

Q. Have you been informed by OSF leadership that the system is behind the stipulation?

A. Yes.

Q. Let's take a look at the second paragraph. Why don't you read that into the record, also.

A. Following consummation of the affiliation of OSF and RHS pursuant to the affiliation agreement dated January 31st, 2011, and the creation OSF Northern Region, neither OSF nor OSF Northern Region will require a managed care organization to contract with OSF on a systemwide basis or any other individual OSF hospital outside of the OSF Northern Region as a condition for obtaining a contract with the OSF Northern Region hospitals.

Q. And in your own words, what is that part of the stipulation intended to achieve?

A. It will allow health plans to contract directly with the Northern Region without having to contract with the rest of the OSF system. That's consistent with the level of autonomy that's being granted to the board of directors here in Rockford.

Q. Does OSF Saint Anthony monitor what other hospitals in Rockford are doing in terms of their service offerings?

A. Yes.

Q. How do you do that?

A. I usually turn on the TV or read the newspaper. You can see it in many media outlets. You can also find out -- medical staffs travel between hospitals, and they will talk to each other, and they will say, well, they're going to be trying to do this. So, yeah, we try to monitor that because we have to maintain a competitive posture based upon what the competition's doing.

Q. During the 16 years that you've lead Saint Anthony, have you personally been involved with discussions with either of the other two hospitals located in Rockford as to dividing up service lines among the hospitals?

A. No.

Q. Have you had discussions about the prices you will charge for your services?

A. No.

Q. Have you had discussions about the rates that you will charge to health plans?
A. No.
Q. Have you had any discussions about boycotting any health plan?
A. No.
Q. Have you authorized anyone else at Saint Anthony to have discussions on any of those topics with the other two hospitals in Rockford?
A. No.
Q. Do you know of any such discussions?
A. No.
Q. Do you know of any collaborative action that has been carried on by Saint Anthony with Rockford Memorial in the 16 years you've headed the organization?
A. No.
Q. Similarly, has there been any such activity with SwedishAmerican?
A. Outside of the merger, no.
Q. If and when this transaction closes and you are the Northern Region, do you contemplate coordinating pricing with SwedishAmerican?
A. No.
Q. Coordinating negotiations with health plans?
A. No.

Q. Coordinating pricing?
A. No.
Q. Coordinating anything else which would involve exchange of competitively sensitive information?
A. No.
Q. If you were to do so, would that be consistent with the mission of the Sisters of the Third Order of Saint Francis?
A. No.
Q. Thank you. That's all I have.
THE COURT: Mr. Reilly, you may cross.
MR. REILLY: You. .
CROSS EXAMINATION
BY MR. REILLY:
Q. Mr. Schertz, you don't have to read what's in the binder. I'm going to ask you questions, and I'll refer to each of the documents when I'm ready.
A. Sure.
Q. Thank you.
Good afternoon, Mr. Schertz.
A. Good afternoon.
Q. Did you meet with your attorneys to prepare for your testimony today?
A. Yes.
Q. When did you meet with your attorneys?
A. Yesterday and this morning.

Q. And how about Tuesday?
A. Tuesday?
Q. At Hinshaw? Tuesday?
A. It could have been. The week's kind of running together.
Q. So, you met with the attorneys to prepare for your testimony on Tuesday, Wednesday, and this morning?
A. Yes.
Q. How long did you meet with your attorneys in total to prepare for your testimony today?
A. Half hour this morning, about an hour last night, probably two hours on Tuesday.
Q. And how many hours on Wednesday at Hinshaw?
A. It wasn't more than two hours.
Q. Do you know how much OSF spent on the television advertising that's been playing this week involving the merger?
A. No.
Q. Do you have any idea?
A. Nope.
Q. More than a million dollars?
A. I don't know.
Q. If this merger is consummated, Mr. Schertz, you will receive a bonus of approximately $80,000, won't you?
A. Yes.
Q. Is that a lot of money to you, Mr. Schertz?
A. Yes.

Q. And so, if your testimony today helps convince Judge Kapala to let this merger go through, you will receive $80,000; is that correct?
A. If the merger is successfully completed, there's a bonus payment.
Q. If the merger is consummated, you get a bonus payment?
A. Right.
Q. You expect to remain with the combined firm post-merger; is that correct?
A. I believe that will depend upon my performance.
Q. You expect that you will remain --
MR. GREENE: Excuse me, Mr. Reilly. Mr. Schertz, could you speak up? I'm having trouble hearing.
THE WITNESS: Sorry.
THE COURT: Stay about three inches from the microphone, and everybody will be able to pick up what you say.
BY MR. REILLY:
Q. The affiliation agreement contemplates that you will be COO of the Northern Region; isn't that right?
A. That's correct.
Q. And Mr. Kaatz, I think you testified, will be the CEO of the Northern Region?
A. That's correct.
Q. And so, you'll report out to Mr. Kaatz?
A. Yes.

Q. In fact, both you and Mr. Kaatz have positions secured under the affiliation agreement; is that right?
A. That is correct.
Q. And while you expect to be COO of the Northern Region, you also expect that the Northern Region, the combined entity, will be able to reduce its total number of employees after the merger; isn't that right?
A. Yes.
Q. But you won't be one of those employees laid off, will you, Mr. Schertz?
A. That will be a function of my performance.
Q. You can only be laid off due to performance; is that correct?
A. Yes, that's the standard.
Q. And the FTI report, the efficiency report, recommended layoffs not because of performance, but because of efficiency; isn't that right?
A. Layoffs is not the only way to accomplish that.
Q. The FTI efficiency report, Mr. Schertz, contemplated laying off employees not because of performance at all; isn't that right?
A. Because of excess capacity.
Q. Talking about the FTI, I think you testified that OSF brought them in. FTI wasn't hired by OSF, were they?
A. No. I didn't say OSF brought them in. I said --

Q. I'm sorry. Go ahead.
A. I said a consultant was retained. I didn't say who by. I said --
Q. And your consultant FTI was retained by your antitrust lawyers, weren't they?
A. By legal counsel.
Q. By your antitrust counsel.
A. Legal counsel. I'll use that term.
Q. And FTI --
THE COURT: Mr. Schertz, I'm having trouble picking up what you're saying.
THE WITNESS: I'm sorry.
THE COURT: I need you to use the amplification system. It's a big room. Your voice can get lost. And the longer you talk, the softer you get.
THE WITNESS: Right.
THE COURT: So, pretend you're talking to somebody in the back of the courtroom, and we'll be able to hear you much better.
THE WITNESS: Yes, sir.
BY MR. REILLY:
Q. And your legal counsel hired FTI to do the efficiency report in anticipation of the FTC investigation; isn't that correct?
A. No. FTI was hired to confirm what we believed was there in potential savings.

Q. FTI was hired because of the FTC process, weren't they?
A. Well, we have to demonstrate that there is savings that result from the merger.
Q. And you had to demonstrate it to the FTC or this court; isn't that correct?
A. Yes.
Q. Because if OSF had hired FTI to do an evaluation of the efficiencies, Hinshaw wouldn't have been involved at all; isn't that right?
A. Something of this magnitude I believe legal counsel would be involved regardless.
Q. Legal counsel's not going to hire a consulting firm to look at efficiencies for you, are they, absent an antitrust investigation?
A. I don't know. I'll have to -- give me another circumstance.
Q. Sure, I will. Has Hinshaw been involved in your looking at who is going to be your integration consultants? For example, hiring Deloitte?
A. Yes, they have.
Q. They've been involved in the contracting, but what about the actual decision to hire Deloitte? Who is hiring Deloitte, OSF or Hinshaw?
A. Well, since they haven't been hired yet, I'm not sure which entity is going to take care of that.
Q. OSF is going to hire Deloitte, aren't they, Mr. Schertz?

A. I'll let you know when they're hired.
Q. Is there any chance that Hinshaw is going to hire Deloitte to do the integration planning?
MR. GREENE: Objection. Argumentative.
THE COURT: I don't believe so. I'll allow the question to stand.
BY THE WITNESS:
A. Do you want to repeat the question?
MR. REILLY: Could you read it, please?
(The pending question was read by the reporter.)
BY THE WITNESS:
A. I guess that would depend on what time that occurs.
BY MR. REILLY:
Q. So, there is a chance that your antitrust counsel may hire the consulting firm to do integration planning following the merged entity?
A. I'm sure there's some possibility that might happen.
Q. Mr. Greene also asked you about whether OSF and SwedishAmerican presented efficiencies to the Department of Justice in 1997; is that right?
A. I believe so, yes.
Q. And you answered yes?
A. Yes.
Q. Did OSF and SwedishAmerican also present to DOJ a prediction that one or both of those hospitals would likely fail if that

merger didn't happen? Do you recall that?
A. I believe it was in previous testimony.
Q. And so, you presented efficiencies to DOJ, but you also presented a prediction that either or both SwedishAmerican or Saint Anthony would fail if the 1997 merger didn't go through; is that right?
A. Right.
Q. Did SwedishAmerican fail when that merger didn't go through in 1997?
A. No.
Q. Did Saint Anthony's fail when that merger didn't go through in 1997?
A. No.
Q. And SwedishAmerican has done very well since 1997, haven't they?
A. Yes.
Q. And who did they merge with to have such a strong financial performance?
A. I'm not aware of any merger other than their affiliation with the University of Wisconsin.
Q. Which was recent. Which was a recent affiliation.
A. Several years ago.
Q. And since 1997 Saint Anthony's has been profitable for many of the years to date; isn't that true?
A. I'd have to go back and look. There were some slim years.

Q. You don't know if you're profitable for the vast majority of those years from 1997?
A. What's your definition of vast majority?
Q. Just tell me your best understanding, Mr. Schertz, of how many years from 1997 to date Saint Anthony was profitable.
A. I know it hasn't been any of the last three.
Q. Well, what about the 15, if my math is right, before that?
A. I remember at least a couple years we were close to losing money.
Q. You just remember a couple years of profitability since 1997, Mr. Schertz?
A. No. A couple of years that we were close to losing money.
Q. And who did Saint Anthony's merge with after 1997 and after telling the DOJ that it's likely that Saint Anthony's or SwedishAmerican would fail?
A. We didn't merge with anybody.
Q. Do you know whether DOJ made the decision based on OSF's and SwedishAmerican's prediction of failure in the next year or two in 1997?
A. I don't know.
Q. You have no idea why DOJ closed that investigation, do you?
A. I do not know.
Q. You talked about in your direct, Mr. Schertz, negotiations with health plans and leverage; isn't that right?
A. I believe so, yeah.

Q. Contract negotiations for Saint Anthony with health plans are handled by OSF corporate; isn't that right?
A. Correct.
Q. By the managed care office in OSF corporate?
A. Correct.
Q. In fact, you have no involvement negotiating contracts with health plans for SAMC; isn't that correct?
A. The only involvement I would have is on those contracts that might be negotiated locally by our chief financial officer.
Q. You don't even review draft contracts between health plans and SAMC, do you?
A. No.
Q. You don't know how long a typical negotiation between OSF and health plans takes, do you?
A. No.
Q. In fact, you've never negotiated a contract with a health plan for SAMC, have you?
A. That's correct.
Q. You don't read the contracts that OSF enters into with health plans, do you?
A. No.
Q. And isn't it true that you do not approve SAMC's contracts with health plans?
A. That's correct. They're approved by our board of directors.
Q. You submit the proposed health plan contract to the board,

and the board either approves it or doesn't, right?
A. Yes.
Q. You've never sought a provider network in Rockford, have you, Mr. Schertz?
A. Well, the only thing we have currently is our Direct Access Network.
Q. In the last five years, how many health plans have you sold to an employer in Rockford at Saint Anthony's?
A. Well, if you're talking about OSF --
Q. No, I'm talking about Saint Anthony's.
A. Okay. Well, Direct Access Network originates out of OSF Healthcare.
Q. Have you ever sold a CEO of SAMC, a provider network, to an employer in Rockford?
A. I have not.
Q. Have you ever created or developed a hospital network in Rockford?
A. I mean, all that would be handled through our managed care or through our CFO. So, no.
Q. Health plan contracting is not your business responsibility, is it, sir?
A. No, not the terms and language, none of that.
Q. So, in terms of the negotiating leverage between health plans and hospitals, you have no involvement whatsoever in hospital health plan contracting; isn't that true?

A. In terms of details and language, no.
Q. You don't read draft contracts or even the final contracts, do you, Mr. Schertz?
A. No, I do not.
Q. You don't sit in negotiation sessions, do you?
A. No.
Q. You really have no knowledge, since you're not at the negotiating sessions, you don't read the draft contracts, you don't read the final contracts, how negotiations occur between health plans and hospitals in Rockford; isn't that true?
A. I don't know the details, no.
Q. You believe that two hospital systems would be better than three hospital systems in Rockford; isn't that correct?
A. I believe two hospital systems could provide an excellent level of service to the residents of the Rockford area.
Q. So, it would be better, correct?
A. Yes.
Q. You have no plans to close Rockford Memorial Hospital or SAMC after the merger closes, do you?
A. No.
Q. In fact, the affiliation agreement says both hospitals must stay open for five years at least?
A. Without 75 percent approval of the board, yes.
Q. So, post-merger, the number of hospitals in Rockford doesn't decrease, just the number of health systems operating the

hospitals in Rockford; isn't that right?
A. That's correct.
Q. So, it's competition between health systems that will decrease post-merger, not the number of hospitals in Rockford; is that right?
A. Well, if you want to talk about the intensity of competition, there will be plenty of it.
Q. But you testified in your deposition you don't even know if competition among the three health systems in Rockford allows employers and employees to get lower rates. You don't even know that, do you? You didn't have an opinion on that in your deposition.
A. If you say it's in my deposition, that's what I said.
Q. You don't know if competition among the three health systems in Rockford has resulted in SAMC getting paid less by commercial health plans, do you?
A. Because I don't know what the other two are getting paid.
Q. That wasn't my question, sir. You don't know if competition among the three health systems in Rockford has resulted in SAMC getting paid less by commercial health plans, do you?
A. I don't know.
Q. Isn't it true that if a health plan pays SAMC less, that will allow the health plan to offer lower rates to employers and employees in Rockford?
A. Or have higher profits.

Q. Were you here for the testimony of Ms. Lobe and Mr. Petersen?
A. Yes.
Q. Did they, in fact, testify in this court that lower reimbursement rates from the three Rockford hospitals allows them to provide lower healthcare costs for employers and employees? Isn't that right?
A. They said that.
Q. There's no debate for the self-insured employers who are paying the bills directly that lower rates from SAMC means lower rates for employees and employers in Rockford, right?
A. If they are paying the direct cost, yes.
Q. And so, that is true for self-insured employers?
A. Depending on the terms of the contract.
Q. You talked just a little bit ago about the Direct Access Network, DAN?
A. Yes.
Q. Employers can purchase the DAN product directly from OSF by going online and signing up; isn't that right?
A. I believe so, yes.
Q. And if a Rockford employer within the last five years was interested in signing up to DAN, they could have done that; isn't that right?
A. I'd have to check with the administrator of the DAN network.
Q. But during your deposition, you knew that it was available

at least since 2008; is that right?
A. That was my guess, yes.
Q. And DAN is a single hospital network in Rockford; is that right? As it applies to Rockford.
A. As it applies to be Rockford.
Q. And that single hospital network would be a hospital network of Saint Anthony's, right?
A. Correct.
Q. In 2008 how many Rockford employers signed up for this single hospital network?
A. We weren't promoting it.
Q. But it was available.
A. I don't know if there was that much awareness of it.
Q. I'm not asking about the awareness. My question is in 2008 how many Rockford area employers signed up for DAN?
A. None.
Q. In 2009 how many Rockford area employers signed up for DAN?
A. None.
Q. In 2010 how many Rockford area employers signed up for the single hospital network in Rockford through DAN?
A. None.
Q. In 2011 how many Rockford employers signed up for the single hospital network of Saint Anthony through DAN?
A. One.
Q. One. November 2011 that started?

A. Yes.
Q. Do you know how many employees that one employer has?
A. Employees, covered lives, probably slightly over a hundred.
Q. Less than a hundred employees, maybe more covered lives? Does that sound, right?
A. That sounds about right.
Q. So, let me see if I have this right. Since 2008 to date, even though a single hospital network was available directly through Saint Anthony's, one Rockford area employer of about 80 people signed up for it. Is that a true statement?
A. I would say it's accurate.
Q. Do you know how many employers or covered lives there are in Rockford, sir?
A. No.
Q. Do you know if it's more than a hundred thousand?
A. No.
Q. You agree that health plans seek the lowest rates possible from SAMC; isn't that right?
A. I'm sorry. Repeat that.
Q. You would agree that health plans seek the lowest rates possible from Saint Anthony's?
A. Yes.
Q. You're never aware of a health plan in your 16 or 17 years saying, "Hey, we'll pay a little bit more than we have to"?
A. I'm not aware.

Q. At the same time, OSF tries to get the highest reimbursement rates they can from a health plan; is that right?
A. Well, we would attempt to get adequate reimbursement, yes.
Q. And adequate reimbursements include higher reimbursements; isn't that correct?
A. Adequate.
Q. Has OSF or Saint Anthony's ever said to any health plan, "Hey, don't give us a 12 percent rate increase," for example, "we'll take six"?
A. Well, in a recent year, we had planned to go back to ECOH and negotiate for higher rates, and they asked us for a rate freeze, and we said okay, we'll freeze them.
Q. And you've subsequently increased ECOH's rates since then, haven't you, sir?
A. Froze them for a year.
Q. Was your answer yes to that?
A. Yes.
Q. SAMC seeks the best rates it can from health plans; isn't that true, sir?
A. Yeah, we seek what we deem to be adequate reimbursement.
Q. Getting the highest rates from commercial health plans allows Saint Anthony's to fund some of its other activities; isn't that right?
A. Some of them, yeah.
Q. High rates for Saint Anthony's is a good thing from your perspective as CEO; isn't that right?

A. Not if they're so high they alienate us from the payor.
Q. Have Saint Anthony's rates ever been so high that it alienated people, sir?
A. No. Actually, the increases have been rather small for a number of years.
Q. You talked on your direct testimony about who Saint Anthony's competes with, and you mentioned besides the two Rockford hospitals, a bunch of other hospitals; is that correct?
A. Yes.
Q. You are aware, sir, that OSF Saint Anthony's has in its contract that the health plan will not contract with more than one hospital who is located within seven miles of Saint Anthony's? You've heard of those exclusivity provisions, right?
A. Not that level of specificity.
Q. You were here when Dr. Capps testified, weren't you?
A. I was, but I must have missed that.
Q. You didn't see a slide on the seven-mile exclusivity provision in Saint Anthony's contracts?
A. No. I might have been outside of the courtroom at that time.
Q. So, sitting here today you have no knowledge of whether Saint Anthony's has in its health plan contracts restrictions that does not allow a health plan to add two additional hospitals to its network?

A. Not at that level of detail.
Q. Have you ever heard of a seven-mile exclusivity provision in Saint Anthony's health plan contracts?
A. No.
Q. Have you ever heard whether a health plan who has Saint Anthony's in its network cannot add the two other Rockford area hospitals by contract with Saint Anthony's?
A. I am aware of historic restrictions on having more than two of the three Rockford hospitals in a contract.
Q. So, let me ask you about your knowledge of those historical restrictions. Have these restrictions ever extended beyond Rockford, say, to exclude some of the outlying hospitals, like Beloit?
A. I'm not aware of any.
Q. In fact, Saint Anthony's has never had a clause, at least in the last ten years, in a health plan contract that excludes or prohibits any health plan from contracting with anyone other than the Rockford area hospitals; isn't that right?
A. If you say so.
Q. Let me ask you. Since you're talking about the Belvidere facility, has Saint Anthony's now, in fact, changed its contracting that prevents a health plan from contracting with that Belvidere facility, say twelve miles away?
A. I'm not aware of that change.
Q. Because that Belvidere facility, sir, has six beds; isn't

that right?
A. Well, that's what they testified to today. It has a capacity for 55.
Q. Do you believe that any employer in Rockford if they asked the health plan to get me a two-hospital network, if that health plan showed up with SwedishAmerican Hospital and the Belvidere facility, that employer would be happy? Do you think there's a chance that employer would be happy with that selection of two hospitals?
A. I can't make a judgment for the employer. That's their decision.
Q. Sir, do you think any employer in Rockford views a six-bed facility as a substitute for either Saint Anthony's or Rockford Memorial Hospital?
A. I don't know.
Q. It's possible that an employer in Rockford could consider a six-bed facility in Belvidere as a substitute for a 200-bed plus Saint Anthony and almost 300-bed Rockford Memorial Hospital. Is that your testimony?
A. If the employer wanted to have a SwedishAmerican only product, it would include the medical center and the hospital in Belvidere.
Q. Yeah, right. But if they wanted a two-hospital network, would the Belvidere facility be adequate to an employer?
A. I don't know.

Q. It's true that today, Mr. Schertz, that a health plan who wants to offer a two-hospital network can offer one without reaching agreement with Saint Anthony; isn't that true?
A. Yes.
Q. Because if a health plan didn't reach an agreement with OSF, they could still have Rockford Memorial Hospital and SwedishAmerican in their network, right?
A. Yes.
Q. If this merger goes through, a health plan could not offer a two-hospital network in Rockford without reaching an agreement with OSF; isn't that correct?
A. Yes.
Q. And does the fact that now OSF controls whether a health plan can offer a two-hospital network, doesn't that give Saint Anthony's at least some additional leverage with health plans?
A. Well, a large organization, you could argue that, but the bottom line is the leverage of the payor is much greater than the hospital's.
Q. I understand that. I'm asking what this merger changes. You agree that this merger, if consummated, does give the combined entity at least some additional leverage with health plans. You agree with that, don't you?
A. I believe in my deposition in Washington D.C. I used an illustration. Here's how much leverage we have now, here's how much leverage we have after the merger, and here's how much

leverage somebody like Blue Cross has. I agree.
Q. I understand. I'm asking just what this merger changes. And when you testified about some additional leverage, that meant higher rates, didn't it, sir?
A. It could, yes.
Q. Do you recall having testified that OSF is a very dominant healthcare system in central Illinois? Do you remember that testimony?
A. Yes.
Q. And you believe that OSF is dominant in central Illinois because OSF owns OSF Saint Francis in Peoria, as well as surrounding hospitals, right?
A. Yes.
Q. And you testified that larger organizations tend to have more negotiating leverage with health plans, correct?
A. Yes.
Q. And you'd also agree that OSF's market leverage in the northern region is not nearly as great as it is in the central region, correct?
A. That's correct.
Q. And the northern region includes Rockford; isn't that right?
A. Yes.
Q. And if the merger is consummated, OSF-RHS will become the largest provider of health care by discharges in the Rockford area, correct?

A. Correct.
Q. And discharges is how market share is usually calculated according to you; is that correct?
A. Yes.
Q. And the combined system would be the largest in Rockford area by bed count, as well, right?
A. Right.
Q. By revenue, as well?
A. I haven't seen Swedes' revenue lately.
Q. The combined OSF-RHS would have roughly 60 percent of market share based on discharges in the Rockford area; isn't that right?
A. It's somewhere under 60 percent.
Q. And you'd agree that in terms of rate negotiation, larger entities do better with health plans, right?
A. Without knowing what they're actually being paid, I can't validate that.
Q. But all things being equal, larger providers do better in negotiations with health plans than smaller providers?
A. That's the theory.
Q. And you also in your affidavit describe Blue Cross as being dominant; is that right?
A. Yes.
Q. And Blue Cross' market share is 60 percent in Illinois; isn't that right, Mr. Schertz?

A. It sure is.
Q. So, Blue Cross is dominant with a 60 percent market share. That's the same market share as a combined entity if this merger is approved; isn't that right?
A. Yes.
Q. Well, the --
A. Slightly less.
Q. Will the combined entity be dominant in Rockford, Mr. Schertz?
A. It will be the largest player in the Rockford area.
Q. Will the combined entity be dominant in Rockford, Mr. Schertz?
A. Dominant is defined by a number of different factors.
Q. Please use the same definition of dominant as you did when you described Blue Cross as dominant.
A. Because they aren't measured by the same factors.
Q. Let's turn to the stipulation.
MR. REILLY: Can we put it up on the screen? Your Honor, you're okay with us continuing past 5:00? I'll try to make it as quick --
THE COURT: That's fine with me. I can stay as long as you want. I'm worried about everybody else.
MR. REILLY: Okay. I appreciate your patience. This won't take that much longer, I don't think.

BY MR. REILLY:
Q. You recognize the document that's up on the screen, Mr. Schertz?
A. Yes.
Q. That's the stipulation that you were testifying about earlier in your direct?
A. Yes.
Q. Who drafted this stipulation, Mr. Schertz?
A. I believe it was drafted by our legal counsel.
Q. This stipulation was drafted to try to get this deal approved by this court; isn't that correct?
A. I think it was drafted to alleviate concerns that had been expressed.
Q. It was drafted on the eve of the PI hearing, the preliminary injunction hearing, wasn't it, Mr. Schertz?
A. Yes.
Q. And it was submitted to this court just a few days ago, right?
A. Friday, I think.
Q. It was drafted, at least in part, to convince this court to allow this merger to go through; isn't that right?
A. It's irrelevant. It's binding if it goes through.
Q. I don't care if you think my question's irrelevant, sir. I want you to answer it. Wasn't this proposed stipulation drafted in part to try to convince this court to let this merger go

through?
A. It was drafted to alleviate concerns that we had been made aware of.
Q. Alleviate concerns by potentially a federal district court?
A. No. Actually, I believe they were expressed by payors and SwedishAmerican.
Q. Was this part of a litigation strategy to get this deal through?
A. I'm not a litigator.
MR. GREENE: Objection.
MR. REILLY: I'll withdraw the question.
BY MR. REILLY:
Q. Can you point me to the section of the stipulation indicating that OSF Northern Region will not raise rates following the merger?
A. There's no such stipulation.
Q. This stipulation says nothing about what the combined entity will charge if this merger is consummated; is that correct?
A. That is correct.
Q. And so, if a health plan wanted to add SwedishAmerican to its network and also have the two other Rockford hospitals, this stipulation does not prevent OSF from charging any rate to that health plan; is that right?
A. It does not prevent, but it doesn't make sense.
Q. I understand. I'm just talking about this stipulation.

You would agree that Saint Anthony's has implemented a number of procedures and practices to improve its cost of delivering care, correct?
A. That is correct.
Q. Saint Anthony's has implemented practices to discharge patients on time; is that right?
A. That is correct.
Q. And you have seen some impact from those procedures on length of stay and cost per case data; is that correct?
A. That's correct.
Q. And SAMC recently implemented processes to improve readmission rates, as well?
A. That is correct.
Q. And SAMC has made progress in more efficiently staffing its clinical department in the last year and a half?
A. That's correct.
Q. And it has reduced the labor costs by eliminating 70 FTEs, 70 positions?
A. That is correct. Please, for the record, not layoffs.
Q. What was that?
A. They were not layoffs. They were positions.
Q. I just said reducing labor costs. I'm sorry if I said layoffs.
SAMC has also implemented protocols to lower its supply costs with some success in some areas?

A. With some success.
Q. And SAMC, you already testified, has implemented Epic electronic medical records; is that correct?
A. That's correct.
Q. And many of these programs targeting improved readmissions, supply costs, and lengths of stay that you have implemented at Saint Anthony's are starting to improve Saint Anthony's costs; is that right?
A. That is correct.
Q. And you expect to continue implementing programs aimed at reducing Saint Anthony's costs regardless of whether this merger is consummated; isn't that right?
A. That is correct.
Q. You wrote in your affidavit that Chrysler's manufacturing plant in Belvidere employed only 1700 of the 2700 employees that it once employed; is that correct?
A. That's correct.
Q. Do you know -- I think you testified on direct that you read the newspapers quite a bit, watch TV. Do you know Chrysler is hiring significantly more people in that Rockford plant?
A. Yes, recently they announced that.
Q. And they said that they will add up to 2700 more jobs in the future?
A. Didn't see that number.
Q. The CEO of Chrysler came to town to do a press conference

there. Did you see that?
A. No. I was -- I think I was here, but --
Q. The governor of Illinois came to visit the plant?
A. Good.
Q. Mr. Schertz, you wouldn't disagree that the Rockford area economy has improved since 2009, would you?
A. I would agree it has improved.
Q. You would agree that unemployment is down from its peaks?
A. Down, but still the highest in Illinois.
Q. Down from a high of over 15 to under 12; is that correct?
A. I haven't seen under 12.
Q. I want to talk about the projections, and I want to put them on the screen, but, obviously, these are confidential. So, we'll get a cap on that. This is PX371.
MR. REILLY: It's in your binder we just handed to you, your Honor.
BY MR. REILLY:
Q. And it's in your binder, as well. Titled Management Plan FY 2012.
Before I ask about this management plan, I just wanted to ask is it true that OSF has reserves of over a billion dollars?
A. I'm not aware we've got a billion.
Q. How much do you think the reserves are?
A. Probably not a billion.

Q. Close to a billion?
A. I have no idea.
Q. You recognize this document, don't you, Mr. Schertz?
A. Now, be careful. I've got competitors in the room.
Q. That's why I've got it --
A. I'm just saying our dialogue.
Q. Do you recognize this document, Mr. Schertz?
A. Yes, I do.
Q. This is a document that was sent by you and the Saint Anthony's executives to the OSF board of directors?
A. That's correct.
Q. And the numbers that you present to the OSF board are, of course, your best estimates and projections that you can give; isn't that right?
A. Yes.
Q. In fact, you're under a duty to be as accurate and truthful as possible in your reports to the board; is that right?
A. Yes.
Q. And you presented this to the board in August of 2011, right?
A. Right.
Q. And not only did you send this document, you gave a separate presentation to the board of directors, right, that had some subset of this document?
A. Management plan, yes.

Q. And this document, PX371, is the most recent management plan sent to the OSF board, right?
A. That's correct.
Q. Healthcare reform was passed around January 2010; is that right?
A. In early 2010.
Q. And the healthcare reforms are actually discussed in the management report. There's a little section on health care reform?
A. Right.
Q. And the healthcare reform in the at least projected impact is considered by Saint Anthony's executives when putting these projections together?
A. These to the best of our knowledge. Some of these projections don't have any real impact built in.
Q. I understand. But to the best of your ability, when you sent these projections to the board recently, you and other Saint Anthony's executives were considering the impact of healthcare reform; isn't that right?
A. Yes.
Q. And you also when you sent these projections to the board considered the state of the Rockford economy?
A. Yes.
Q. And when you sent these projections to the board very recently, were you also considering population growth and

projected population growth in Rockford?
A. To the best of our ability to estimate.
Q. And just so we're clear, because I think you testified about service cuts, the projections you have going out to 2015 or so, there are no service cuts built into those projections, are there, sir?
A. No, because we don't know how bad it's going to get yet.
Q. But you were sending projections to the board, and these projections did not incorporate any expected service cuts, were there, sir?
A. No, and I also reported to the board when I met with them for the management plan, I said this is probably good for about six months.
Q. So, I want to look at some of the projections. Again, obviously, you know better than me that these are sensitive. So, I'm going to talk very generally about them.
Could you please turn to PX371, Page 31? Do you see excess of revenues over expenses?
A. Yes.
Q. Is that another word for profit?
A. Yes.
Q. And these profit projections were presented recently to the OSF board by you; is that true?
A. Actually, they were presented by my chief financial officer. He presents the budget.

Q. Presented under your direction as CEO?
A. Correct.
Q. And without talking about any specific numbers, it's fair to say –
MR. REILLY: And we're looking at Page 31, your Honor.
BY MR. REILLY:
Q. (Continuing) – that from 2011, 2012, 2013 through 2016 you and other Saint Anthony senior executives projected significant increases in profit through 2016; isn't that correct?
A. Projected.
Q. Projected. Estimated.
A. Well, just for clarity's sake, we also projected – as you can see, projected for year-to-date and through 2011, projected a pretty good profit there.
Q. My question –
A. Take 10 million off of that, and that's where we wound up.
Q. My question is, sir, that in the profit projections you sent to the board in the most recent financial management plan, you and other Saint Anthony executives projected dramatic increases in profits through 2015. Is that a fair statement?
A. Projected, yes.
Q. And since you presented and sent these projections to the OSF board, have you sent new projections that captured some factors that you didn't consider before?
A. No. We presented a bottom line that was ten million dollars

less than what you see projected.
Q. These are the most recent current projections that in the ordinary course of business you sent to the OSF board; is that correct?
A. Projections are about as good as the last three months of activity.
Q. But they must reportsomething. You present them to the board. You're not wasting the OSF board's time, are you, sir?
A. They understand the volatility of healthcare in the Rockford region.
Q. There must be some usefulness to presenting projections going forward if you present them to the board and the OSF board wants to see them. Is that a fair statement?
A. It helps with the dialogue, yes.
Q. And turning to PX – you're still on 31. Turning to the same page, 31. 32. I'm sorry. Turning to 32. PX371, 32. Looking at admissions and patient days?
A. Yes.
Q. Saint Anthony's executives, including you, projected to the board that both admissions and patient days at Saint Anthony's would increase every year from 2010 to 2016; isn't that correct?
A. Yes, and that projection is already wrong.
Q. And just so we're clear again, these projections incorporated you and other Saint Anthony's executives' best estimate of healthcare reform impact; isn't that right?

A. Actually, no, it did not.
Q. Sir, you just testified at your deposition that these projections to the best of your ability incorporate healthcare reform.
A. It incorporates what we see going forward without a good sense of what the impact will be.
Q. I understand that predictions on healthcare reform isn't perfect, but you did incorporate to the best of your ability the impact of healthcare reform; isn't that true?
A. Actually, very limited incorporation.
Q. In 2009 SwedishAmerican opened a facility in Belvidere; is that correct?
A. That's correct.
Q. And Mr. Greene asked you about communications with your other two rivals or competitors in Rockford. Do you remember that?
A. I believe so, yeah.
Q. And you said there are no communications about managed plan contracting, right?
A. Managed care contracting?
Q. Um-hm.
A. Right. Okay.
Q. But let me ask you about what you did when you heard that SwedishAmerican was going to open up a facility in Belvidere. You were concerned because that Belvidere facility would be

competing against Saint Anthony's; isn't that correct?
A. Actually, I was upset because we had been trying to work on several projects for an oncology center of excellence, trying to maintain positive relationships.
Q. And when SwedishAmerican opened that facility in Belvidere you thought that there would be an impact to Saint Anthony's business; isn't that correct?
A. Yes, and there has been.
Q. And that facility, as you testified, competes with Saint Anthony's; isn't that correct?
A. It competes through its parent.
Q. And when you heard about SwedishAmerican opening that facility, you called Dr. Gorski and said to him let's do a joint venture and incorporate rather than compete on that facility; isn't that correct?
A. Yes, I did.
Q. And because he said no, that facility now competes with Saint Anthony's, correct?
A. That's correct.
Q. And if he said yes to your phone call and your conversation with him, then that facility would not compete with Saint Anthony; is that correct?
A. Well, no, it would.
Q. If it was a joint venture between Saint Anthony --
A. If there's a joint venture, it's providing service that is

now not being provided at Saint Anthony's.
Q. I want to talk now about Health Care Futures. Who is Health Care Futures?
A. They are a healthcare consulting firm.
Q. I'm sorry. Did I not say Dr. Gorski is Swedes' CEO? I'm sorry. Who is Dr. Gorski?
A. He is the president and CEO of SwedishAmerican Health System.
Q. So, to close a loop on that, that conversation we just had, you called Dr. Gorski, the CEO of SwedishAmerican, when you heard that SwedishAmerican was going to be opening up a competitive facility in Belvidere?
A. They were contemplating purchasing it, yes.
Q. And you suggested to doing a joint venture rather than have SwedishAmerican compete against you; is that right?
A. No. It was about trying to maintain a positive working relationship.
Q. Did you hire Health Care Futures to talk and interview your competitors, sir?
A. No. I hired Health Care Futures to help us develop a five-year strategic plan.
Q. And Health Care Futures, to help you develop a five-year plan, went and interviewed the CEOs of your two competitors; is that correct?
A. He interviewed CEOs of the entire region.

Q. Including the CEOs of your two competitors?
A. The two other hospitals in Rockford.
Q. Yes, the two hospitals in Rockford.
And some of the information that Health Care Futures provided to Saint Anthony's about your two Rockford competitors included physician employment strategies; isn't that right?
A. What page are you referring me to?
Q. PX350.
A. Okay. Which page is that?
Q. Page 1.
A. Okay.
Q. Employment of MDs. PX351 is a summary of an interview that Health Care Futures had with Dr. Gorski; is that correct?
A. Yes.
Q. And in this interview summary that Health Care Futures gave to Saint Anthony, Dr. Gorski is discussing SwedishAmerican's strategy for employment of physicians; isn't that correct?
A. I'm not sure what you're specifically referencing. What statement of Dr. Gorski?
Q. Employment of MDs. Do you see that sub-bullet?
A. All right.
Q. Dr. Gorski talked with your consultant about SwedishAmerican strategy on employment of MDs. Was that public information, sir?
A. No, but a lot of it's common knowledge. It's talked about

through the IHA. It's talked about through the country about how to deal with the changing nature of the healthcare delivery.
Q. Do you know if Health Care Futures told Dr. Gorski when they were interviewing him that the information he was providing would get back to you and other Saint Anthony's executives?
A. Well, he had to ask their permission to do the interview.
Q. And so, SwedishAmerican willingly interviewed with your consultant knowing that that information will be passed back to Saint Anthony?
A. Well, it was done in the light of just basic confirming what's the marketplace look like, where's things going to the future. You want to have a general sense that what you're thinking about is in line with where the world's going.
Q. You want to get a sense for the marketplace and make sure your two competitors saw the marketplace the same way; is that correct?
A. No. The entire region.
Q. Including your two Rockford competitors?
A. I'm sorry. There's nothing in here that's proprietary.
Q. Is SwedishAmerican's strategy on the future employment of doctors public information?
A. That's not a strategy. That's a general direction.
Q. So, you knew what Dr. Gorski was thinking when it came to whether SwedishAmerican was going to hire 25 or 50 more physicians?

A. He says 50 percent. He doesn't say anything about any --
THE COURT: Is this a sealed document? Is this confidential or not?
MR. REILLY: It is under seal.
THE COURT: Well, then --
THE WITNESS: Well, it's going to be hard to debate it.
MR. REILLY: That's all right, your Honor. We won't go through the specific details in there. You have the document. You can review it.
BY MR. REILLY:
Q. Since you hired Health Care Futures to interview your --
THE COURT: Are you leaving this document?
MR. REILLY: I'm leaving it, yes.
BY MR. REILLY:
Q. Since you hired Health Care Futures, Mr. Schertz, to interview your two rivals in Rockford, have you hired any additional consultants to interview other executives at the other hospitals?
A. I'm not aware of any.
Q. So, since Health Care Futures interviewed the CEOs of your two rival hospitals, you're aware of no other use of consultants?
A. I have to go back and look at records.
MR. REILLY: I have nothing further, your Honor.
REDIRECT EXAMINATION

BY MR. GREENE:
Q. Let's start at the end.
A. Okay.
Q. What was the reason that you hired Health Care Futures in 2007?
A. To develop a five-year strategic plan for OSF Saint Anthony Medical Center.
Q. Did you direct them to interview anyone at SwedishAmerican or at Rockford Memorial?
A. We did not direct them, per se. Part of their management plan building process, which they do with all of their clients, is to interview other facilities and systems in their broader service area to confirm that this is the general direction everybody sees the world moving in.
Q. Did you personally ask Dr. Gorski to speak with Health Care Futures?
A. I don't know if I asked him. We had to contact him. I can't remember if the consultant did it or I did it as a courtesy.
Q. You said, if I heard you correctly, that none of the information that was on Exhibit 350 was proprietary information; is that correct?
A. Correct.
Q. In fact, you said the information was common knowledge?
A. Yeah. Well, I remember hearing the consultant earlier

talking about the Advocate thing. Everybody knew Advocate was out sniffing around the entire region.
Q. After you received Exhibit 350 from Health Care Futures, did you have any conversations with Dr. Gorski about that information?
A. No.
Q. Did you enter into any plan of action with Dr. Gorski?
A. No.
Q. Did you enter into any plan of action with Rockford Memorial based on that interview?
A. No.
Q. Did you intend to before they were interviewed?
A. No.
Q. You were asked about some new hires at Chrysler. Is it your position that OSF Saint Anthony needs the affiliation with Rockford Memorial irrespective of the changing state of the economy in Rockford?
A. Yes.
Q. And is that for the reasons you stated earlier?
A. Yes.
Q. You recall Mr. Reilly asked you some questions about the combined two hospitals having 60 percent of the Rockford market and you said not quite that high?
A. Correct.
Q. And he also referred to the fact of Blue Cross having

60 percent of the market in Rockford in its industry?
A. Two different industries.
Q. Yes. Two different industries. In the case of the hospitals, if the hospitals combined, what percentage of the market will your single competitor based in Rockford have?
A. Our single competitor, close to 45 percent.
Q. And do you know what percent of the market the nearest competitor to Blue Cross has in Rockford?
A. I don't know, but it's going to be in the low double digits.
Q. Did you hear Ms. Lobe testify yesterday that United was number two?
A. Yes.
Q. And do you remember what percentage she used?
A. I thought she used 15.
Q. So, what you have in the hospitals are two fairly equal competitors, correct?
A. Correct.
MR. REILLY: Your Honor, he's leading the witness. He's testifying. Objection.
MR. GREENE: All right. Let's move on.
BY MR. GREENE:
Q. From the fact of if there is the merger, will OSF Saint Anthony automatically receive higher rates from the Blue Crosses, Humanas, and Uniteds?
A. No.

Q. If as a result of the stipulation there is a network which includes both the OSF Northern Region and SwedishAmerican, what effect, if any, on rates will the presence of SwedishAmerican in the same network have?
A. It won't have effect. I mean, in terms of how we negotiate going forward?
Q. Yes.
A. There's been these assertions that, you know, we won't give good rates if there are two hospitals in the system. It's in our best interests to give our best rate to keep those payors satisfied because you can see by the financial condition we need to keep every one of them we can.
Q. And let me ask you a related question. Mr. Reilly asked you about the ability of OSF Northern Region to seek whatever rates it wants, and you said it didn't make sense. Can you explain why you said it didn't make sense?
A. Well, once again, we have to keep the payors happy, too. Therefore, we have to negotiate in good faith. We have to make sure that they're satisfied with the outcome. It is not in our interests to alienate any payor in the northern region.
Q. Is there in your view any difference between the ability of Saint Anthony to reduce its cost on its own and the ability of the combined entity with Rockford Memorial to reduce its costs?
A. Yes.
Q. And what is the difference?

A. Well, we don't duplicate costs at Saint Anthony's. Between the two entities, there are many duplicative costs that can be part of the cost reduction equation. You can't do that as a single entity.
Q. Can you give an example of when you talk about duplication?
A. I mean, we run two of everything. I mean, that leads to inherent inefficiency. You can't keep something running all the time or at a high levels of productivity in many circumstances. If you're able to combine certain aspects of operation, you create greater efficiency, and that reduces your cost per unit of service.
Q. What is your view as to whether the combined OSF Northern Region will be a stronger, weaker, or equal competitor to what the two hospitals are individually today vis-a-vis SwedishAmerican?
A. Well, it will be a stronger competitor.
Q. Has DAN been actively marketed in the Rockford area?
A. No.
Q. With respect to managed care contracting, do you delegate responsibility for involvement in what corporate is doing to anyone on your staff?
A. My chief financial officer.
Q. Okay. And do you know yourself what input he has to the corporate managed contracting people?
A. Well, he provides input on the conditions on the ground in

Rockford, where our cost picture is at, what we hope to see out of a contract negotiation as it affects Saint Anthony Medical Center, but in most cases that then becomes the function of the corporate managed care office.
Q. Let me ask you a couple questions about FTI.
A. Sure.
Q. Was FTI the only consultant that was looked at for that project?
A. There were several consultants looked at.
Q. And what was the process to choose FTI?
A. Much of it was based upon the presentation they made, what they brought to the table, and, most importantly, checking on references of organizations that had used them in the past.
Q. You referred to presentations. What were these presentations?
A. Basically they showed their methodology, and they showed their track record. They showed results. They presented themselves as an incredibly credible organization in terms of this type of analysis.
Q. Are you talking from personal knowledge of the presentations?
A. In terms of the selection process?
Q. You referred to some presentations. Were you there?
A. I was there for some of them.
Q. Were other people from OSF Healthcare System there?

A. Yes.
Q. Were representatives of Rockford Memorial there?
A. At some point, yes.
Q. And those presentations were made to executives of both organizations?
A. Yes.
Q. And there were also some attorneys present?
A. Yes.
Q. And was FTI hired only because of the threat of possible action by the FTC?
A. No, they were hired because we needed somebody to show us the business case for doing this.
Q. And did you, in fact, take what FTI showed you into account in making the business decision to proceed with the definitive agreement?
A. Yes.
Q. One last – well, two last questions. Prior to testifying under oath today, did you testify under oath previously in connection with the investigation?
A. I've had three depositions where I've had to testify under oath.
Q. And in those three prior testimonies and in your testimony today, was anything you said affected by the fact that you would receive a bonus if this deal goes through?
A. No. I've been here for 16 years, and I see what a mess this

town is. I want to do this.
Q. That's all I have. Thank you.
MR. REILLY: Nothing further, your Honor.
THE COURT: You may step down, sir. Thank you.
THE WITNESS: Thank you.
(Witness excused.)
THE COURT: All right. We're adjourned. 9:00 o'clock. Before we leave, are we on track for finishing up tomorrow?
MR. REILLY: Absolutely. We appreciate your generosity in giving us some more time. They have three more witnesses.
MR. MARX: Yes. We've got three more witnesses tomorrow, your Honor. We'll run a total on the time to see how we're allocated, and we'll work it out so that we can be done tomorrow.
THE COURT: All right. Good.
MR. MARX: Thank you.
MR. REILLY: Thank you, your Honor.
THE COURT: Have a good night.
(Whereupon, the within trial was adjourned to Friday, February 3, 2012, at 9:00 o'clock a.m.)

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DX1181

In the Matter of:

OSF Healthcare System and Rockford Health System

February 7, 2012
Robert Sehring (Confidential)

Condensed Transcript with Word Index

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DX1181-001

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Q. You can put that to the side.
I'm going to show you another exhibit that's been previously marked. It's a two-page exhibit marked PX0388, begin Bates Stamp OSF00027752.
It's an e-mail chain. The last e-mail in the chain is from Mr. Seybold to Mr. Sehring, Mr. Baker, Gary Kaatz, Mr. Schertz, Michelle Conger, and Mr. Stenerson dated February 28th, 2011.
A. Okay.
MR. HERRICK: Alan, do you need more time?
MR. GREENE: I guess I'm a slow reader.
Okay. Thank you.
BY MR. HERRICK:
Q. Mr. Sehring, just focusing on the next-to-last e-mail in the chain, the one that's from you dated February 28th, 2011, at 8:24 a.m.
Do you see that?
A. I do.
Q. I'll just read that paragraph in its entirety into the record very briefly.
"As part of a follow-up conversation with FTI, I requested that they provide a proposal to update the data in their analysis. Even just looking at their proposed Phase I, it was more comprehensive than I was expecting as is the price tag. I know through various

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conversations, no one was very enamored with the work of FTI. However, their proposal does provide a basis for comparison with other alternatives we may discuss."
Did I read that correctly?
A. You did.
MR. GREENE: Actually, I don't think it matters, but in the first sentence it says, "To update the data" -- I think you left out the word "used" -- "in their analysis."
MR. HERRICK: Okay. Thank you.
MR. GREENE: It doesn't change the content.
MR. HERRICK: Thank you.
BY MR. HERRICK:
Q. Just to make the record clear, I'll reread that first sentence.
"As part of a follow-up conversation with FTI, I requested that they provide a proposal to update the data used in their analysis."
Did I read that one correctly?
A. I believe so.
Q. Okay. Am I understanding this correctly that you asked FTI to provide a proposal for a data update following their merger report?
A. In reading this, I believe that was a piece of it.

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Q. So this is dated February 28th, 2011.
Do you know whether the data update you're referring to there is for the December 2010 merger report or the report that we discussed earlier from earlier in February?
A. Yeah. I suspect it could be either one of them. I'm not sure which one it was -- which one their update was referring to.
Q. Why did you want a proposal from FTI for an update in their analysis?
A. Well, I think at some point we will need to do that, whether it was at that area or sometime in the future. As we get closer to the ability to merge, we'll need to look at an update or a refresh of that data.
I suspect at that point -- perhaps it was undue hope that it wouldn't be as long a process as it has been, and so subsequently, perhaps it became clearer we never proceeded with that.
Q. Why do you think there will need to be an update on the data used in FTI's analysis?
A. Well, at some point, the information that was analyzed is based on data that is in the past, and while we certainly have not seen anything that fundamentally changes the data at Saint Anthony's, there's always the need to look at more recent data, just as we look at

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more recent financial data and see how that is evolving. So at some point, that would seem to be an appropriate step.
Q. At what point do you think that would be an appropriate step?
A. When the timeline becomes clearer as to whether and when we can merge.
Q. Is there a point at which the data underlying FTI's analysis becomes too stale to be reliable?
A. Not that I think of, again, because I haven't noted any fundamental changes at least on Saint Anthony's of the operations of Saint Anthony's save for financial deterioration of financial results, and so I have no reason to believe that at this point that data is stale.
Q. Do you think 10 years from now you could still be using the same data that FTI relied on?
A. Off the record, if we're still talking 10 years from now, I want to find another line of work but --
Q. Technically, that was on the record.
A. Okay. Fine.
I think it's fair to say that 10 years from now with the changes that are anticipated due to health care reform, that that information would be stale at that point.

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Q. What about five years from now?
A. I would provide the same reason.
Q. Three years from now?
A. Not as sure.
Q. One year from now?
A. I don't believe so.
Q. Do you know when the data that was used in the FTI report was collected?
A. I believe much of it was collected in '09 and perhaps early '10.
Q. So approximately two years ago was when the data was fully collected?
A. That sounds about right.
Q. It's your view at this point that that data would still be reliable after three years, if you add another year; is that right?
A. From my perspective, yes.
Q. Continuing on this e-mail, the next sentence reads, "Even just looking at their prepared Phase I, it is more comprehensive than I was expecting as is the price tag."
Did I read that correctly?
A. You did.
Q. What is the proposed Phase I that you're referring to there?

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A. I don't recall their proposal specifically, but from reading this, it would have included some update of the data, but obviously, it was more than that since my comment is that it was more comprehensive than I expected, but I don't recall specifically what was included.
Q. When you say or when you wrote, I should say, "as is the price tag," what is that in reference to?
A. I would say it was higher than I expected.
Q. Was that a consideration, in your view, as to whether to have FTI provide the updated data used in their analysis?
A. It would have been a consideration. I'm not sure it would have been the primary consideration.
Q. What was the primary consideration?
A. Ultimately, it was the value of starting that process, again, without having a good understanding of the timeline in which the merger could proceed.
Q. Looking at the next sentence, it reads, "I know through various conversations, no one was very enamored with the work of FTI."
Did I read that correctly?
A. You did.
Q. What's that in reference to?
A. I believe it was in reference to the

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presentations that were made by FTI in February relative to working with each individual organization, I believe.
Q. Does it say anywhere in your e-mail that you're referring to the one from earlier in February?
A. It does not, but you asked me what my recollection was.
Q. Is it clear from context, in your mind, that you're not referring to the merger report from December 2010?
A. It's clear from my recollection.
Q. Okay. Anything in the e-mail say that, though?
A. No.
Q. Looking at Mr. Seybold's response, which was from 1:21 p.m. the same day, February 28th. That first sentence reads "Bob, I would agree that the RHS staff were less than enthusiastic with the depth of the FTI analysis."
Did I read that correctly?
A. You did.
Q. Do you know what Mr. Seybold is referring to there?
A. I couldn't be specific as to what his reference or recollection is now.
Q. But your read on this e-mail chain you believe is that this was in reference to the individual reports

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that FTI did for RHS and SAMC on potential cost savings?
A. That's my recollection on what I wrote, and my presumption or I assume -- my assumption would be that he was responding in the same context, but I don't know that.
Q. Do you know who those various conversations were with, the ones that you referred to in your e-mail?
A. Mine would have been with folks such as Dave Schertz and Dave Stenerson relative to the presentations in February.
Q. Did SAMC ever provide RHS with a copy of the February reports we have been discussing?
A. I would seriously doubt that.
Q. Did SAMC ever get a copy of the counterpart for RHS?
A. Not that I'm aware of.
Q. Why not?
A. Because I would presume that it would include confidential information that shouldn't be shared between the parties.
Q. I believe you testified earlier -- I don't want to misstate your testimony -- that RHS didn't attend the SAMC meeting in February of 2011 with FTI; is that right?
A. No. I testified that I didn't know.

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Q. Okay. I'm glad I clarified.
If neither side, RHS or OSF, shared this work with each other, why are you discussing the contents of that work with Mr. Seybold in the e-mail chain?
MR. GREENE: Objection. Misstates the very document you've got in front of him.
A. I did not discuss the contents of the reports with Henry Seybold.
BY MR. HERRICK:
Q. You did not write that you're not very enamored with their work; is that right?
A. What I said was I heard from others that they were not enamored with the work, and, again, my recollection is it was referring to the presentations that were made in February.
Q. And those presentations were with regard to cost savings that could be achieved independently without respect to the merger; right?
A. From the report you showed me earlier, I would presume that those were that. Again, I didn't review the whole report, nor was I at the presentation.
Q. But that's your understanding; right?
A. That is my understanding.
Q. So if there were no merger being considered, is this the kind of e-mail discussion you would have with

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a competitor?
A. Is what the type of?
Q. The e-mails set forth in PX0388.
MR. GREENE: Objection. Vague.
A. I'm not sure that absent a merger, we would be discussing jointly contracting with someone like FTI as we have now. So I would say that wouldn't be a conversation that would be had because the circumstances would be very different.
BY MR. HERRICK:
Q. But here we're not talking about jointly contracting with FTI, are we, in your e-mails?
A. I believe the proposal was for a joint contract, and actually, it would have been through counsel had we gone forward with it, but it was for a joint engagement of FTI for these activities, including the refresh of the data. So, yes, it would have been a joint effort.
Q. And the cost savings of that you say -- you're referring to -- strike that.
The February 2011 FTI analysis that you say you're referring to here, would that have been something that you would ordinarily discuss with a competitor?
MR. GREENE: Objection. Asked and answered.
A. What you referred to before was the data portion of the contract, which would have been a joint effort.

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So with respect to the activities of FTI and the presentation in the context of judging FTI as an integration consultant for someone who would be jointly contracted going forward, yes, I would think that that would be a conversation that I would have with someone like Rockford Health System where we have a planned merger.
BY MR. HERRICK:
Q. Where does it talk about, in your e-mail, hiring them as a integration consultant? I don't see that in there.
A. It does not refer specifically to an integration consultant.
Q. Okay. So I'm just trying to make sure I understand your testimony.
You requested that FTI provide a proposal to update the data they used in their analysis; is that right?
A. I did.
Q. Is it your testimony that that is in reference to updating the data used in their merger analysis or the February 2011 analysis that we discussed earlier?
A. I already stated that I wasn't sure which one it was specifically referring to.
Q. So continuing on in this paragraph --

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MR. GREENE: Which paragraph?
MR. HERRICK: The paragraph in Mr. Sehring's e-mail.
BY MR. HERRICK:
Q. Continuing on in that paragraph, how can we tell whether you're referring to the December 2010 report or the February 2011 report when you're saying, "I know through various conversations, no one was very enamored with the work of FTI?
MR. GREENE: Objection. Asked and answered.
A. From the plain reading of the document, you cannot, but you asked for my recollection, and my recollection is that it was more in reference to the February meeting than it was to the original work of FTI.
BY MR. HERRICK:
Q. Okay. Let's assume for the moment that it was in reference to the February 2011 meeting just for purposes of this question.
Why are you telling a competitor what your company thinks about work that FTI has done concerning cost savings that can be achieved by your company without the merger?
A. I was not --
MR. GREENE: Objection. Asked and answered.

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A. (Continuing.) I did not discuss any of that. I did not discuss the content because I wasn't familiar with the content of either of those reports.

The conversation was or the comments were relating to the performance of FTI, and, again, I believe in conjunction with the presentations that they made in February.

I did not discuss nor did I provide any information regarding the cost efficiencies that were identified as part of those meetings to the extent that they were identified because I didn't participate and I'm not familiar with them.

BY MR. HERRICK:

Q. But aren't you telling a competitor that you're sort of rejecting this work that FTI has done by saying you've heard through various sources that no one was very enamored with FTI's work?

MR. GREENE: Objection. Argumentative.

A. No.

BY MR. HERRICK:

Q. No. Why are you commenting on FTI's work for SAMC at all --

MR. GREENE: Objection.

BY MR. HERRICK:

Q. -- in an e-mail with a competitor?

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MR. GREENE: Excuse me. I thought you were done earlier.

I object. I think the horse is very well dead. You should stop beating him.

THE WITNESS: Sorry, could you --

MR. HERRICK: I'm trying to get an answer.

MR. GREENE: You have gotten a straight answer from him to every question. You don't need the smirk on your face. That doesn't add anything to the deposition.

MR. HERRICK: Nor does raising your voice, Alan.

MR. GREENE: Just because you don't like the answer doesn't mean you haven't gotten a straight answer.

I am offended, and I hope you withdrew that comment.

MR. HERRICK: Raising your voice is unnecessary, Alan. We can be civil.

MR. GREENE: We are being civil. If I speak a little louder, I'm trying to get through the smirk.

BY MR. HERRICK:

Q. All right.

I believe there is a question pending.

(The record was read by the Reporter.)

A. The comment was relating to the hiring or the potential hiring of FTI going forward. It was not

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relating, again, to the specific work that they did or presented at those two meetings.

So it was more an evaluation or comments heard regarding the evaluation of their efforts. It had nothing do with the information that was shared at those meetings.

Q. I'm really struggling understanding that answer.

You're saying that in your written e-mail to Mr. Seybold that no one was very enamored with the work of FTI had nothing to do with the content of what was presented at that meeting?

A. I think it was a --

MR. GREENE: Excuse me. This is pure harassment. Just because you either don't understand or probably because you don't like the answer, which is why you made the inappropriate comment, and actually the reason I raised my voice is because you offended the witness and me.

Asked and answered so many times you are harassing the witness. Move on.

MR. HERRICK: There is a question pending.

THE WITNESS: Which is.

MR. HERRICK: Can you read it back, please.

(The record was read by the Reporter.)

A. It certainly would have nothing to do with the

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information that was presented to Saint Anthony's at that meeting that would be considered confidential.

BY MR. HERRICK:

Q. If you told SwedishAmerican that you were not going to pursue certain cost-saving initiatives, would that be inappropriate, in your view?

MR. GREENE: Objection. Vague. Indefinite. No definition of what you mean by "inappropriate."

A. I'll ask a question about what do you mean about not going to pursue cost efficiencies? Because I'm not sure that that is what this letter -- e-mail says at all.

BY MR. HERRICK:

Q. Focusing for the moment on the cost savings that FTI believed to be achievable as set forth in the February 2011 meeting.

MR. GREENE: Objection.

BY MR. HERRICK:

Q. Do you understand what I'm referring to at this point?

MR. GREENE: Objection. That's a mischaracterization. You have no factual evidence for your statement of what FTI said or didn't say. Misleading question.

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BY MR. HERRICK:
Q. Is it your understanding that the analysis set forth by FTI in February 2011 concerns cost savings that SAMC could achieve without the merger?
A. From looking at the report that you showed me before, that appears to be what the report says. I can only presume that's what was discussed at the meeting, but I don't know.
Q. When you wrote that no one was very enamored with the work of FTI, which you have now testified was in reference to that February 2011 meeting, did you have an understanding then of what the content of that meeting was?
A. Not of the content, but, again, of the general sense in discussions with at the time it would have been, I would assume, Dave Schertz and/or Dave Stenerson that they viewed that presentation as a sales call and neither one of them viewed it as terribly helpful, but not of the specific content.
Q. Did you have an understanding of whether SAMC -- strike that.
Did you have an understanding of whether FTI was making a sales call based on savings, if believed, SAMC could achieve without the merger?
A. I don't know.

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Q. But you're reading from the document we discussed earlier that that was the purpose of the way you have categorized it as a sales call?
A. At least that one page we discussed in reviewing it, it appeared to be savings that were possible in comparing Saint Anthony's Medical Center to benchmarks -- their benchmarks.
It did not indicate whether or not FTI believed that those were achievable. It really identified opportunities that are out there. Whether or not FTI -- or whether or not FTI believes Saint Anthony's could achieve those or whether Saint Anthony's believed they could achieve those, I have no idea.
Q. Assuming you're understanding is correct, would you have concerns about telling SwedishAmerican that you didn't think that pursuing those cost savings was worthwhile?
MR. GREENE: Objection. Vague.
A. And I didn't say that, nor does this e-mail say that that is the case. So I don't see how that is a hypothetical that really would come about and certainly is not --
BY MR. HERRICK:
Q. I'm sorry. Go ahead.
A. -- certainly is not here in my e-mail.

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Q. Okay. Let me rephrase the question.
Let's assume for the moment that everything that you believe to be the case about the February 2011 report that we looked at earlier is accurate.
Would it be appropriate for you to tell an executive at SwedishAmerican that no one at OSF was very enamored with that work?
MR. GREENE: Objection. Vague. Asked and answered.
A. I would say oftentimes -- not just specific to that, but oftentimes there are conversations amongst health care systems in the use of various outside consultants.
I'll use especially Epic as an example. Oftentimes we have dialogue with organizations who are considering using Epic as their electronic health medical record. We already use Epic, and so do we have as an organization conversations with other organizations regarding our experiences with using Epic with the implementation of Epic, absolutely; and, no, I don't view that as necessarily troublesome.
BY MR. HERRICK:
Q. Well, Epic is a little different, isn't it?
Epic is an electronic medical record system; correct?

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A. It's an outside vendor no different than FTI.
Q. Except that FTI was doing calculations -- operating under an assumption that, you know, what you believe about the February 2011 report is accurate, FTI was making calculations about cost savings that SAMC could achieve on its own.
MR. GREENE: Is there question there now that you've finished your monologue?
BY MR. HERRICK:
Q. Correct?
A. I don't believe that that -- at least on the page that you showed me, that's not what I could draw from that, that those are efficiencies that either FTI or Saint Anthony's believed were achievable.
It identified opportunities that were out there in comparing Saint Anthony Medical Center's performance to FTI's benchmarks. That in no way speaks to whether or not those savings -- those efficiencies were achievable.
Q. And your understanding is that those calculations that were set forth in the February 2011 report were based on internal data from SAMC; is that right?
A. I believe, again, from reading the report that you provided me; it was a comparison between FTI

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