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

In the Matter of **OSF Healthcare System, a corporation, and** **Rockford Health System, a corporation.**	**Docket No. 9349** **PUBLIC**

RESPONDENTS OSF HEALTHCARE SYSTEM'S AND ROCKFORD HEALTH SYSTEM'S PRE-TRIAL BRIEF

TABLE OF CONTENTS

TABLE OF CONTENTS
(continued)

Page

TABLE OF AUTHORITIES

Page

Cases

Statutes

Other Authorities

TABLE OF AUTHORITIES
(continued)

Page

INTRODUCTION

Complaint Counsel's Pre-Trial Brief reveals that, other than a "presumption of illegality" based upon market shares and concentration levels, the FTC has no evidence, only unfounded speculation and theory, to support a finding that the affiliation between OSF Healthcare System ("OSF") and Rockford Health System ("RHS") will result in the substantial lessening of competition required to prove a violation of Clayton Act Section 7, 15 U.S.C. § 18. Complaint Counsel impermissibly ignore the unique, Government-created market structure of the U.S. healthcare system, the crisis in spiraling healthcare costs, and the ongoing, dramatic healthcare reform initiatives that are an essential part of the facts surrounding the delivery of healthcare services in Rockford. These market facts must be considered in the application of antitrust law and the 2010 Horizontal Merger Guidelines to the proposed transaction. Complaint Counsel also incorrectly dismiss the substantial and cognizable, merger-specific cost-savings and efficiencies that the affiliation will generate, and which constitute one of the parties' primary motivations for the transaction. (DX0617 (Affiliation Agreement)).

Moreover, Complaint Counsel's focus solely on commercially-insured hospital inpatients, who represent only [redacted] of the inpatients treated in the three Rockford hospitals, is impermissibly myopic. Complaint Counsel's analysis ignores the vast majority of Rockford consumers who will be adversely affected by a prohibition of the proposed merger: the Government-insured (through Medicare or Medicaid) and charity care patients. As a consequence, Complaint Counsel misanalyze the competitive market dynamics that will influence competition in the delivery of healthcare services in Rockford, especially in the wake of healthcare reform.

The evidence will show no basis for concluding that the affiliation of OSF and RHS will enable the combined entity, OSF Northern Region, to unilaterally raise rates in contracts with commercial insurance companies – sophisticated purchasers with substantial market power in their own right – above a competitive level for a sustained time. Nor is there any evidence that the combined entity would engage in anticompetitive, coordinated activity with SwedishAmerican Health System ("SwedishAmerican"), the largest and fastest growing healthcare system in Rockford. Accordingly, Complaint Counsel will be unable to meet their burden of proving that the affiliation may result in a substantial lessening of competition.

After more than a year of intensive investigation and discovery,[1] Complaint Counsel's evidence that the proposed affiliation between OSF and RHS violates Clayton Act Section 7 consists of a single, undisputed fact: three hospitals are more than two.[2] Based upon that fact, and by focusing only on the minority of patients covered by commercial insurance, Complaint Counsel's computation of market shares and HHI concentrations permits the initial presumption that the affiliation will be anticompetitive. But, even assuming *arguendo* that Complaint Counsel's narrow view is correct (which Respondents dispute), Complaint Counsel have no *facts* to add to this presumption. They proffer only economic theory, disconnected from the realities of a rapidly changing healthcare world, and speculation to support their prediction of anticompetitive conduct. Complaint Counsel tortures the documents and testimony so as to construe them to say what they do not truly say. Moreover, Complaint Counsel ignore the substantial cost-savings and quality enhancements that the affiliation will generate. In contrast,

[1] The parties filed their Hart-Scott-Rodino filings with the Federal Trade Commission and the Department of Justice, Antitrust Division on February 11, 2011.

[2] After participating in the FTC's eight-month investigation, the Illinois Attorney General chose not to challenge this affiliation.

Respondents will show that the affiliation is the best way for OSF and RHS to deliver economical, efficient, high-quality healthcare services and benefits to the citizens of Rockford.

The Complaint alleges that the affiliation will substantially lessen competition for commercially insured general acute care inpatient services and primary care physician services in the Rockford area. To the contrary, the evidence at trial will show that the affiliation will provide the Rockford community with substantial procompetitive benefits. The consolidation of OSF and RHS will generate substantial cost savings – more than $114 million in one-time capital cost avoidance and over $37 million in annual recurring operating costs – and efficiencies and improved healthcare delivery services that are only achievable through the affiliation. The cost savings and efficiencies are substantial, cognizable, and merger-specific.[3] (DX1209-006-07, ¶¶ 7-8 (Manning Report)).

Moreover, Complaint Counsel's reliance on a 23-year-old ruling in a prior Rockford hospital merger case that is disconnected from the current regulatory, competitive and economic environment, and on the FTC's recent opinion in *ProMedica*, are misplaced. As Complaint Counsel noted, the Antitrust Division of the U.S. Department of Justice declined to challenge the more analogous proposed merger of OSF and SwedishAmerican in 1997. And, as the Court knows, *ProMedica* involved markedly different facts, competitive landscape and economic environment.

Likewise, the FTC's charge that coordinated interaction will result is pure speculation. Complaint Counsel have no evidence of likely collusion between OSF Northern Region and SwedishAmerican. Their reliance on stale documents highlights a lack of current facts to

[3] Although recognizing that the Court will apply the government's Horizontal Merger Guidelines, and specifically Section 10, Respondents note that from a business perspective, and consumer benefit perspective, the cost savings will be even greater, over $130 million in one-time capital avoidance savings and $42-56 million per year in annual recurring savings. (DX1211-007-08, ¶ 9 (Brown Report)).

support their coordinated effects theory. Their disregard of the testimony of SwedishAmerican's leaders, who consistently testified they will not collude with the merged entity, speaks volumes. Nor is there any evidence that OSF Northern Region will engage in exclusionary conduct with respect to SwedishAmerican. To the contrary, Respondents have agreed to enter into a proposed stipulation to address that FTC concern. Complaint Counsel's inconsistent arguments that the merged entity will both collude with and exclude SwedishAmerican are devoid of credible factual support.

The weight of the evidence will show that the proposed affiliation answers the call of a healthcare system in crisis for transformative, economical, efficient delivery of high quality healthcare services that will benefit the citizens of Rockford, while preserving a highly competitive hospital and physician market. An examination of the real world market dynamics in Rockford will show that OSF Northern Region will not have market power sufficient to raise prices to supracompetitive levels with respect to either alleged market. Complaint Counsel, therefore, cannot prove a Section 7 violation.

FACTUAL BACKGROUND

A. Rockford Demographics

Rockford was once the second largest city in Illinois with a thriving manufacturing economy, but that is no longer true. Today, Rockford has slow population growth, a depressed economy, high unemployment, and substantial poverty. (DX1210-034-35, ¶¶ 73-77 (Noether Report)). Between 2001 and 2011, Rockford lost over 12,200, or 31%, of its manufacturing jobs. (DX1210-034, ¶ 74 (Noether Report)). Although some increases in service sector jobs may have offset part of this manufacturing decline, those jobs pay lower wages than manufacturing jobs and offer reduced or no healthcare benefits. (DX1210-035, ¶ 77 (Noether Report)).

From 2000 to 2010, the population in Rockford grew less than 2% and its per capita personal income figures decreased. (DX1210-035, ¶ 77 (Noether Report)). From 2000 to 2010, the city's unemployment rate increased from 7.3% to 16.6%. (DX1210-035, ¶ 78 (Noether Report)). And as a result of the significantly declining economy, the Rockford metropolitan statistical area ("MSA") has (as of January 2010) the highest unemployment rate in Illinois and the fifth-highest in the nation. (DX1210-035, ¶ 78 (Noether Report)). From 2000 to 2010, the city's percentage of population below the poverty level increased by nearly 80% (from 14% to 25%). (DX1210-035, ¶ 84 (Noether Report)). These factors have led to a decrease in the number of Rockford residents with commercial health insurance and a corresponding increase in the number of Government-insured or charity care patients seeking treatment at the Rockford hospitals.

Reductions in government sourced funding for healthcare has become more and more prevalent, and that trend will continue and probably accelerate. Emphasis must be placed on improved, more effective and efficient delivery of healthcare services. The Patient Protection and Affordable Care Act of 2010 ("Affordable Care Act") and other recent health reform-related laws require added emphasis on these issues in any assessment of the competitive environment. In the healthcare world of 2012, Rockford citizens will benefit greatly from the enhanced ability of the consolidated entity to more effectively deliver healthcare services. (DX1406-047-48, ¶ 70 (Sage Report)).

B. Hospitals Located in Rockford

There are three hospital systems – OSF, RHS, and SwedishAmerican – located in Rockford. All of these hospital systems offer the same general acute care inpatient hospital, outpatient, and ancillary services, and employ primary care and specialty physicians. (DX1210-

009, ¶ 11 (Noether Report)). OSF operates Saint Anthony Medical Center ("SAMC"), RHS operates Rockford Memorial Hospital ("RMH"), and SwedishAmerican operates SwedishAmerican Hospital ("SAH") and SwedishAmerican Medical Center in Belvidere.

1. OSF Healthcare System's Saint Anthony Medical Center

OSF is a not-for-profit integrated healthcare system based in Peoria, Illinois. It is owned and governed by the Sisters of the Third Order of Saint Francis. (DX0189-005 (Schertz IHT) at 9:12-22; DX1210-006-08, ¶ 9 (Noether Report)).

OSF operates seven acute care facilities: OSF St. Francis Medical Center & Children's Hospital in Peoria, Illinois; OSF St. James in Pontiac, Illinois; OSF St. Joseph Medical Center in Bloomington, Illinois; OSF St. Mary Medical Center in Galesburg, Illinois; OSF Holy Family Medical Center in Monmouth, Illinois; OSF Saint Anthony Medical Center ("SAMC") in Rockford, Illinois; and OSF St. Francis Hospital in Escanaba, Michigan. (DX0189-005 (Schertz IHT) at 9:12-18; DX1210-006-08, ¶ 9 (Noether Report)). OSF has operated SAMC in Rockford since 1899. (DX0189-005 (Schertz IHT) at 9:12-15; DX1210-006-08, ¶ 9 (Noether Report)).

SAMC is a full-service hospital that offers a broad array of primary, secondary, and tertiary-level services, including one of two Level I trauma centers located in Rockford. SAMC is licensed to be a 254-bed hospital, currently staffs [redacted] beds, currently serves an average daily census of approximately [redacted] patients, and has an occupancy rate of [redacted] (DX1210-006-08, ¶ 9 (Noether Report)). SAMC also operates a physician organization, OSF Medical Group, that is comprised of approximately [redacted] primary care physicians[4] and [redacted] specialists offering care from several locations in the Rockford area. (DX1210-006-08, ¶ 9 (Noether Report)).

[4] In the 30 minute drive geographic area used by Complaint Counsel's expert, Dr. Capps, SAMC has [redacted] primary care physicians.

SAMC also includes a home healthcare agency and a College of Nursing. (DX1210-006-08, ¶ 9 (Noether Report)).

Complaint Counsel attempt to taint the record by alleging that OSF has a [redacted] position in the Peoria market (which is in central, not northern Illinois, and is nowhere close to the geographic market alleged in this case). (Pre-Hearing Brief, at 4). OSF's only hospital in Rockford, SAMC, has an estimated market share of all discharges within its primary service area of approximately [redacted] (DX1210-067, ¶ 177 (Noether Report)). Based on both admissions and discharges, SAMC places third among the three Rockford hospitals. (DX0193-009 (Stenerson IHT) at 31:16-18; DX1210-067, ¶ 177 (Noether Report)).

SAMC receives a substantial portion of its inpatient and outpatient revenues from the Medicare and Medicaid programs. (DX1210-087, ¶ 239 (Noether Report)). In 2010, SAMC's combined Medicare and Medicaid share of inpatient discharges was approximately [redacted] (DX1210-087, ¶ 239 (Noether Report)). SAMC's share of inpatient discharges where the primary payor was a commercial payor declined from [redacted] in 1997 to [redacted] in 2010 (and to [redacted] in the first half of 2011). (DX1210-087, ¶ 239 (Noether Report)). In addition, SAMC's charity care expenses have more than [redacted] since 2008. (DX1210-087, ¶ 239 (Noether Report)).

OSF is one of the original 32 Pioneer Accountable Care Organizations ("ACOs") selected by the Center of Medicare & Medicaid Services ("CMS"). The Pioneer ACO initiative was born of the Affordable Care Act and will reward ACOs based on how well they are able to improve the health of Medicare patients while lowering their healthcare costs through coordinated care, while ACOs bear the financial risk if they do not meet the program's goals. (DX0904-001 (OSF ACO News Release); DX0550-001-07 (CMS Press Release: Pioneer Accountable Care

Organization Model: General Fact Sheet); DX0551-001 (US Department of Health and Human Services Press Release: Affordable Care Act Helps 32 Health Systems Improve Care for Patients); DX0902-001-038 (OSF ACO Presentation); DX0905-001-02 (Memo from K. Schoeplein re: ACO selection); DX1202-048 (Romano PI Tr.) at 182:1-185:9). ACOs are groups of doctors, hospitals and other healthcare providers who collaborate together to share responsibility for healthcare costs and improved quality of care. (DX0904-001 (OSF ACO News Release); DX1201-048 (Romano PI Tr.) at 184:1-185:9). OSF was selected based on its commitment to be a leader in reducing healthcare delivery costs while improving quality of care. As a Pioneer ACO, OSF was recognized as a "nation's leader [] in health systems innovation, providing highly coordinated care for patients at lower costs." (DX0904-001 (OSF ACO News Release); DX1201-048 (Romano PI Tr.) at 184:1-185:9; DX1202-069 (Schertz PI Tr.) at 588:11-24). With the consummation of the affiliation, both of the OSF Northern Region's hospitals, SAMC and RMH, will be able to participate in the Pioneer ACO program, extending the benefits of this program to the Rockford area. (DX0904-001 (OSF ACO News Release); DX1201-048 (Romano PI Tr.) at 184:1-185:9; DX1202-069 (Schertz PI Tr.) at 588:11-24).

2. Rockford Health System

RHS is a community-based, non-profit healthcare system and the oldest healthcare organization in Rockford. (DX1210-006-08, ¶ 9 (Noether Report)). RHS consists of four entities: RMH, Rockford Health Physicians, the Visiting Nurses Association of Rockford, and the Rockford Memorial Development Foundation. (DX1210-006-08, ¶ 9 (Noether Report); DX0183-009 (Dillon IHT) at 32:10-13).

RMH is the flagship facility of RHS and has been serving the Rockford region since 1885. (DX1210-006-08, ¶ 9 (Noether Report)); DX0183-009 (Dillon IHT) at 32:16-17). RMH is

located on the west side of Rockford in an area of town characterized by a more elderly and indigent population. (DX0185-007 (Schrieber, IHT at 21:2-7)). RMH offers a broad array of primary, secondary, and tertiary-level services, including one of two Level I trauma centers located in Rockford and a Level III neonatal intensive care unit. RMH has [redacted] licensed beds, of which [redacted] are staffed, and an average daily census of 188, translating into an average occupancy rate of [redacted] (DX1210-006-08, ¶ 9 (Noether Report)). RMH has an estimated share of all discharges within its primary service area of approximately [redacted] (DX1210-067, ¶ 177 (Noether Report)). Based on both admissions and discharges, RMH places second among the three Rockford hospitals. (DX1210-067, ¶ 177 (Noether Report)).

Rockford Health Physicians is the employed physician group within RHS. Rockford Health Physicians employs approximately [redacted] primary care and specialty physicians. Approximately 46 of these physicians are designated primary care physicians (including internal medicine, family practice and pediatrics), and approximately [redacted] are specialty physicians offering service from several locations throughout the region. (DX1210-006-08, ¶ 9 (Noether Report)).

RMH is a disproportionate share hospital for both Medicare and Medicaid patients. (DX1210-087-88, ¶ 238 (Noether Report)). Combined, Medicare and Medicaid represented approximately [redacted] of RMH's inpatient discharges in 2010. (DX1210-0087-88, ¶ 238 (Noether Report)). The percentage of RMH's inpatient discharges from commercial patients has declined from [redacted] in the first half of 2011. (DX1210-0087-88, ¶ 238 (Noether Report)).

3. SwedishAmerican Health System

SwedishAmerican has the largest and most centrally located hospital in Rockford. (DX1210-006-08, ¶ 9 (Noether Report)). SwedishAmerican is comprised of two hospitals, SAH in Rockford and SwedishAmerican Medical Center in Belvidere. The health system also operates SwedishAmerican Medical Group, SwedishAmerican Home Health Care and the SwedishAmerican Foundation. (DX1210-006-08, ¶ 9 (Noether Report)).

SAH is a not-for-profit, general acute care hospital that has served the Rockford Region since 1912 and provides primary, secondary, and tertiary services, including a Level II trauma center. SAH is licensed for 333 beds, of which approximately [redacted] are staffed. (DX1210-006-08, ¶ 9 (Noether Report)).

In 2009, SwedishAmerican opened its Belvidere facility, just east of Rockford, becoming the most eastern emergency room among the three hospital systems. (DX0717-004 (Walsh Dep.) at 11:23-12:1). This development has resulted in a significant decrease in patients from the eastern counties treated at SAMC from when SAMC was the facility located the farthest east. SwedishAmerican's Belvidere facility provides inpatient services, emergency medicine, outpatient therapy, imaging, sleep disorder, pharmacy and lab services. (DX1210-070, ¶ 185 (Noether Report)). SwedishAmerican Medical Center at Belvidere is licensed for 55 beds, but currently staffs only [redacted] beds. (DX1210-008, 070, ¶¶ 9, 185 (Noether Report)). Across both facilities, SAH operates an average daily census of [redacted] translating into an average occupancy rate of approximately [redacted] across both campuses. (DX1210-006-08, ¶ 9 (Noether Report)).

SwedishAmerican Medical Group, SwedishAmerican's multi-specialty physician group practice, employs [redacted] physicians, including [redacted] primary care physicians and [redacted] specialists. (DX1210-006-08, ¶ 9 (Noether Report)). SwedishAmerican also operates the University of

Illinois College of Medicine family practice residency program. This is the only residency program in Rockford. (DX0714-028 (Schertz Dep.) at 107:24-108:15; DX0192-006 (Benink IHT) at 17:14-18:21).

In March of 2010, SwedishAmerican announced an exclusive affiliation with the University of Wisconsin at Madison ("UW-Madison"). (DX0717-036 (Walsh Dep.) at 138:12-138:13). The stated goal of the affiliation is to provide access to highly sophisticated sub-specialty healthcare for the residents of the Rockford area. (DX1210-006-08, ¶ 9 (Noether Report)). SwedishAmerican pursued this affiliation with UW-Madison in part to increase service line offerings in Rockford that it would be unable to provide absent the affiliation. (DX0717-035 (Walsh Dep.) at 135:24-136:14). As a result of its affiliation with UW-Madison, SwedishAmerican announced in December 2011 its intention to open a new $40 million cancer facility in Rockford. (DX0203-001 (Register-Star Article); DX0202-001 (Register-Star Article).

SAH's market share within its primary service area, based upon total discharges, is approximately [redacted] (DX1210-067-68, ¶ 177 (Noether Report)). Over the last five years, SAH has been the most successful of the three Rockford hospitals in attracting patients to its facilities, and it has grown at the expense of RMH and SAMC. (DX1210-068-69, ¶ 179 (Noether Report)). SAH has also been investing in new technology, facility upgrades, and expansions much more extensively than either of the other two Rockford hospitals. For example, since 1997, SAH has invested over [redacted] million in renovating its campus, including the construction of a [redacted] 92-bed, heart hospital that opened in 2006. (DX0717-011-34 (Walsh Dep.) at 38:6-18, 128:19-25, 129:1-18; DX1210-070-71, ¶ 185 (Noether Report)).

C. Hospital Reimbursement

Hospitals receive reimbursement for their services from various sources, including government insurance (Medicare and Medicaid), private commercial insurance, and self-pay, as well as providing charity or indigent care for which they do not receive any reimbursement. (DX1210-087, ¶ 23 (Noether Report)).

1. Government Health Insurers

The two methods of government payment are Medicare and Medicaid, both of which are recognized not to cover the costs of treating their patients in full. (DX1210-087, ¶ 23 (Noether Report)). For SAMC, Medicare reimburses only [redacted] of the costs incurred treating the programs' patients, and Medicaid covers only [redacted] of its enrollees' costs. (DX1210-087, ¶ 23 (Noether Report)). Medicare and Medicaid do not cover RMH's patient care costs either. (DX1210-087, ¶ 23 (Noether Report)). To make matters worse, the State of Illinois, which already provides a very low Medicaid reimbursement rate in comparison to other states and has not increased its inpatient rates in over 20 years, has slowed substantially its Medicaid payments, and has announced budget cuts of $2.7 billion to the Medicaid program. (DX1210-087, ¶ 23 (Noether Report)). The State of Illinois has targeted Medicaid for substantial cuts in light of the close to worst-in-the-nation budget deficit. (DX1422-007 (Bloomberg Business Article: "'Toughest' Illinois Budget")).

The declining Rockford economy and increase in unemployment has caused the percentage of commercially-insured in the Rockford MSA to decline from approximately 72% in 2000 to about 48% in 2011. (DX1210-038, ¶ 85 (Noether Report)). At the same time, the percentage of the MSA that is insured by Medicaid has increased from 7% in 2000 to approximately 20% in 2011, while Medicare coverage has increased from 10% of the population

in 2000 to 17% in 2010. (DX1210-038, ¶ 85 (Noether Report)). Moreover, 16% of the population is currently uninsured, and likely to be charity care consumers of healthcare services, almost a 50% increase from 2000. (DX1210-038, ¶ 85 (Noether Report)).

2. Managed Care Organizations

There are a limited and decreasing number of commercial insurers, or managed care organizations ("MCOs"), that contract with one or some combination of the Rockford hospital systems to provide the full range of healthcare services to their commercially-insured members. Blue Cross Blue Shield of Illinois ("BCBS-IL") is the largest MCO by a substantial margin, serving approximately [redacted] of the commercially-insured covered lives in the Rockford area. (DX0712-015, 46 (Pocklington Dep.) at 55:19-25, 179:6-10). Other prominent MCOs in the region include Aetna, Cigna, Coventry, Humana, UnitedHealthcare ("United"), the Employers' Coalition on Health ("ECOH"), and The Alliance. (DX1210-013-19, ¶¶ 25-42 (Noether Report)).

The Rockford healthcare systems offer MCOs an integrated, coordinated system of care for their insureds (or patients), and the contract negotiations between hospitals and MCOs cover the entire array of services that the healthcare systems provide. Accordingly, inpatient and outpatient hospital services are negotiated concurrently, with trade-offs occurring on rates between those services, and the focus placed on total healthcare costs. (DX0183-009 (Dillon IHT) at 30:24-31:20; DX0197-006-07, 39-40 (Breeden IHT) at 20:22-22:24, 152:18-154:6; DX0699-15 (Arango Dep.) at 56:8-20). These negotiations focus on the "total healthcare cost" of treating an MCO's insured population, not just one type of service, because patients often require treatment from more than one provider within a hospital system. (DX0712-028 (Pocklington Dep.) at 105:21-25; DX0703-020 (Hall Dep.) at 74:13-20; DX0699-015, 32 (Arango Dep.) at 55:21-56:20, 123:14-20). Non-price terms, such as prompt payment, claim

submission and review procedures, and provider manual obligations are an important part of the contract negotiations because they impact the system's actual reimbursement from the MCO (and the insured patient). (DX0183-021 (Dillon Dep.) at 79:2-80:14). MCOs negotiate to achieve the lowest total cost of healthcare services provided to their insureds. On the other hand, healthcare providers seek to negotiate fair and reasonable rates that will generate net revenues greater than their total cost of treating the MCOs' patients, thereby allowing them to recover the losses they incur in treating Medicare, Medicaid, charity care and self-pay patients. (DX0717-014-15 (Walsh Dep.) at 52:23-53:3; DX0197-017 (Breeden IHT) at 62:1-63:4).

Although MCOs often contract with two of the three hospital systems in Rockford to be part of the provider network, the evidence shows that as healthcare costs have increased, payors and employers have been willing to compromise access and choice for lower cost. The fact that insurers in Rockford have been able to offer a hospital network that was attractive to area employers that included only one of the hospital systems provides confirmation that one-hospital networks are viable in the future. For example, prior to 2010, ECOH offered a product that only included RMH. (DX0183-013 (Dillon IHT) at 47:1-24). Between 2000 and 2010, this one hospital product from ECOH successfully attracted approximately [redacted] of ECOH's total enrollee population. (DX0712-024 (Pocklington Dep.) at 91:4-13). BCBS-IL offers an HMO product that has SAH as the sole in-network hospital. (DX0717-017 (Walsh Dep.) at 62:12-18; DX0710-042 (Noether Dep.) at 161:15-20). That HMO product has membership of [redacted] covered lives, which makes the product the [redacted] largest of those sold in Rockford. (DX0699-037 (Arango Dep.) at 142:20-22). Recently, United has also launched a single-hospital product. In 2009, United introduced its "Core" product that includes SAH as the sole in-network hospital. (DX0710-042 (Noether Dep.) at 161:15-20). This product was introduced as a pilot program,

marketed solely to United's fully insured members. The Core product now represents approximately [redacted] percent of United's membership in the Chicago area. United plans to expand the Core product to administrative services-only business in Rockford, where it expects the product to continue to grow. (DX1210-019 ¶¶ 41-42 (Noether Report); DX0707-013 (Lobe Dep.) at 47:19-48:5).

This evidence shows that narrow provider networks are becoming more popular amid current pressures to control healthcare costs, and even more so in a struggling economy. (DX1210-020-21 ¶¶ 47-52 (Noether Report)). A PPO-model plan with only one Rockford in-network hospital is a practical and marketable alternative for Rockford area employers and their employees. Single hospital networks are especially attractive to employers who are price-sensitive and looking for low-cost options in healthcare benefits. (DX0197-028 (Breeden IHT) at 106:18-107:14; DX0710-042 (Noether Dep.) at 163:1-9). For example, one local employer recently contracted with a one-hospital network offered by OSF. (DX1203-007-08 (Olsen PI Tr.) at 679:1-81:7). Under healthcare reform, this trend will accelerate, and efficiency and quality maximizing hybrids will proliferate to arrest the unsustainable spiral in healthcare costs. (DX1406-029-30, 35 ¶¶ 47, 58 (Sage Report)).

D. History of Merger Efforts in Rockford

In 1989, RHS and SAH – who were then the two largest hospital systems in Rockford – attempted to merge. *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251 (N.D. Ill. 1989). The record included real evidence of collusion, and the transaction was enjoined. *Id.* at 1286. More recently, in 1997, SAH and SAMC – then the second and third largest facilities (as RHS and OSF are today) – decided to combine. (DX0132-001 (Register-Star Article)). The parties' objectives in 1997 were similar to those of OSF and RHS here – to achieve critical cost savings

and efficiencies in a declining economic environment that neither could achieve on its own, for the community's benefit. (DX1246-004-05 (Memo in Support of Proposed Acquisition of SAH by OSF)). The Antitrust Division of the U.S. Department of Justice, the same agency that challenged the 1989 transaction, reviewed and approved the proposed merger in 1997. (DX0189-010, (Schertz IHT) at 31:7-20; DX0133-001-02 (Register-Star Article)). The hospitals ultimately decided not to proceed for "cultural reasons." (DX0189-010, (Schertz IHT) at 31:7-20; DX0133-001-02 (Register-Star Article)).

E. The Affiliation of OSF and RHS

1. Rationale for the Affiliation

Spurred by recession that began in 2008, the deterioration of economic conditions in Rockford, and the spiraling costs of providing healthcare services, RHS decided that it must seek an affiliation with another hospital system. RHS determined that it needed to "actively pursue partnerships to optimize the use of limited resources in a market that cannot afford 3 health systems long-term." (DX0041-014 (RHS: Partnership Evaluation Roadmap Presentation)). At this time, SAMC was also suffering from the recession and skyrocketing costs of providing healthcare to the growing population of Medicare, Medicaid and charity care patients. (DX1210-085, ¶ 231 (Noether Report)).

In December 2008, RHS tentatively agreed to affiliate with Advocate Health Care – a Chicago-area system of ten general acute-care hospitals, specialty hospitals and ancillary services – but both organizations ultimately concluded that a transaction was not in either system's best interest. (DX0698-038 (Kaatz IHT) at 147:8-16). An Advocate executive testified that RHS' capital needs were substantial, recalling that they ranged from [redacted] in 2008-09. (DX1173-016-17, 21-22 (Nakis Dep.) at 60:2-61:5, 80:5-81:17). As a means to best improve the quality of services in Rockford while attempting to manage the increasing costs of

healthcare, OSF and RHS then began discussing a potential partnership. (DX0698-038 (Kaatz IHT) at 148:8-16; DX0189-008 (Schertz IHT) at 22:9-23:18). OSF and RHS executed their Affiliation Agreement on January 31, 2011. (DX0617 (Affiliation Agreement)).

Prior to executing the Affiliation Agreement, OSF and RHS reviewed a business efficiencies case developed by FTI Healthcare ("FTI") in order to determine whether significant operational business efficiencies would be generated by the merger of SAMC and RHS into one healthcare system. (DX0049 (FTI Business Efficiencies Study)). As David Schertz, the CEO of SAMC, explained, the parties needed an independent consultant such as FTI to make the business case for the affiliation, so that each party could make a business decision as to whether or not to go forward with the affiliation. (DX1202-084 (Schertz Tr.) at 650:9-16). The FTI business efficiencies study validated both hospitals' prior beliefs that there are substantial savings that can be achieved as a result of the merger, and only as a result of the merger. (DX0049 (FTI Business Efficiencies Study); DX1209-016-11, ¶¶ 7-12 (Manning Report)).

2. Terms of the Affiliation Agreement

If consummated, OSF will become the sole corporate member of RHS, which will manage the affiliated entity, OSF Northern Region. (DX0617 (Affiliation Agreement) § 2.5)). As part of the affiliation agreement, OSF committed to creating a local fiduciary board, the OSF Northern Region Board, to govern the Northern Region. It will be responsible for running the Northern Region, granting physician privileges for RMH and SAMC, handling the budget process for the Northern Region, and approving large contracts for the Northern Region. (DX0184-015 (Seybold IHT) at 55:4-56:24; DX0698-042-43 (Kaatz IHT) at 162:15-167:25).

The OSF Northern Region board will be a self-governed community board. (DX0617 (Affiliation Agreement) § 2.5). The affiliation agreement requires that seven of the board members be residents of the Rockford community. The balance of board members will be

comprised of two representatives appointed by OSF, two representatives appointed by Rockford Memorial Development Foundation, and four locally-based physicians. (DX0184-015 (Seybold IHT) at 55:22-56:18; DX0190-037 (Sehring IHT) at 143:11-144:23). This community board was critical to RHS in the structure of this affiliation and provides local governance far more independent of OSF than is the case for any other OSF operated hospital. (DX1203-019 (Kaatz PI Tr.) at 725:22-727:17). The purpose of this board is to assure that the best interests of the Rockford community are at the forefront of all OSF Northern Region decisions. (DX1203-019 (Kaatz PI Tr.) at 725:22-727:17).

OSF has committed to provide a minimum of $35 million per year for eight years in capital investment to the OSF Northern Region as part of the Affiliation Agreement. (DX0184-026 (Seybold IHT) at 100:13-101:17; DX0698-043 (Kaatz IHT) at 165:23-166:17). This commitment is guaranteed even though capital budgets ordinarily are subject to annual review by the OSF Board. (DX0191-012-013 (Sister McGrew IHT) at 43:11-46:9; DX0190-021, 44-45 (Sehring IHT) at 77:14-25, 172:11-173:15). OSF has also committed to maintain RMH as a general acute care hospital for at least ten years to best assure that the Rockford community on the west side of the river maintains sufficient access to healthcare. (DX0184-027 (Seybold IHT) at 103:5-9). Under the agreement, SAMC and RHS will maintain current medical staff status and privileges. (DX0190-048 (Sehring IHT) at 185:5-12).

Post-closing, Gary Kaatz, the current CEO of RHS, will serve as CEO of the OSF Northern Region. (DX0706-003-04 (Kaatz Dep.) at 5:13-12:16). David Schertz, the current CEO of SAMC, will serve as the Chief Operating Officer for OSF Northern Region. (DX0714-003 (Schertz Dep.) at 6:14-19).

ARGUMENT

I. COMPLAINT COUNSEL CANNOT PROVE THAT THE AFFILIATION VIOLATES SECTION 7

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

To establish anticompetitive effects, Complaint Counsel must show more than some impact on competition. Instead, Complaint Counsel have "the burden of showing that the acquisition is reasonably likely to have 'demonstrable and substantial anticompetitive effects.'" *New York v. Kraft Gen. Foods, Inc.*, 926 F. Supp. 321, 358 (S.D.N.Y. 1995) (*quoting United States v. Atl. Richfield Co.*, 297 F. Supp. 1061, 1066 (S.D.N.Y. 1969), *aff'd*, 401 U.S. 986 (1971)). "[E]phemeral possibilities" of anticompetitive effects are not sufficient. *United States v. Marine Bancorp., Inc.*, 418 U.S. 602, 623 (1974); *see also FTC v. Tenet Health Care, Inc.*, 186 F.3d 1045, 1051 (8th Cir. 1999). Rather, there "must be 'the reasonable probability' of a substantial impairment of competition by an increase in prices above competitive levels to render a merger illegal under §7. A 'mere possibility' will not suffice." *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 136-37 (E.D.N.Y. 1997) (*citing Fruehauf Corp. v. FTC*, 603 F.2d 345, 351 (2d Cir. 1979)).

The Complaint alleges that the affiliation between RHS and OSF violates Clayton Act Section 7 based on two theories of anticompetitive harm – unilateral effects and coordinated interaction. Complaint Counsel can prove neither. Unilateral effects are not likely because SAH is a closer substitute to SAMC and RMH, respectively, than SAMC and RMH are to each other, and because the rivalry between SAH and OSF Northern Region will empower MCOs to negotiate competitive rates no matter the network configuration at issue. Coordinated interaction is not likely because general acute-care inpatient services are highly differentiated, because MCOs are sophisticated, well-informed negotiators, and because MCO-hospital contracts contain a complex array of price and non-price terms that make coordination virtually impossible to achieve, police and maintain. As a result, the evidence presented at trial will demonstrate that Complaint Counsel cannot prove a Section 7 violation.

A. The Relevant Market Allegations

Complaint Counsel allege two relevant product markets: (1) general acute-care inpatient hospital services sold to commercial health plans and (2) primary care physician services sold to commercial health plans. (PX2504-006 (Complaint) at ¶¶ 23, 26).

1. General Acute-Care Inpatient Hospital Services

Although the use of a "cluster" market of all inpatient hospital services, rather than looking at each discrete service, generally has been recognized, *see In re Evanston Nw. Healthcare Corp.*, Dkt. No. 9315, 2007 WL 2286195 (F.T.C Aug. 6, 2007); *FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir. 1995); *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1211-12 (11th Cir. 1991); *Long Island Jewish Med Ctr.*, 983 F. Supp. at 138-40; *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1290-91 (W.D. Mich. 1996), by focusing on this alleged product market, Complaint Counsel ignore the vast majority of patients served by the two

hospitals who are not commercially insured and the increasing substitution of outpatient services for those previously provided only on an inpatient basis.

In alleging that the market is limited only to these services provided to the minority of the hospital systems' patients who are covered by a commercial health plan, Complaint Counsel ignore the majority of the hospital systems' patients who – along with the commercially insured – would benefit from the proposed affiliation. In particular, the alleged product market excludes inpatient care to patients who are covered by Medicare or Medicaid, or who are uninsured. The result is that Complaint Counsel consider only [redacted] of the inpatients treated in the three Rockford hospitals and exclude the rest. (DX1210-038, 41 ¶¶ 85, 93 (Noether Report)). Focusing only on commercially insured patients does not provide the correct framework for assessing the transaction's competitive effects. The quality enhancements and efficiencies resulting from the merger will directly and positively affect the care delivered to all patients, regardless of whether they are commercially insured. (DX1210-041-42 ¶ 93 (Noether Report); DX1427-058 (Sage Dep.) at 226:10-228:12). Hospital systems and their medical staffs do not apply their resources and services differently for commercially insured patients than they do for government pay, self-pay, or charity care patients. Complaint Counsel's alleged market analysis therefore incorrectly fails to take into account the positive effects that the merger will have on the majority of Rockford citizens who are unaffected by MCO negotiations. (DX1210-041-42 ¶ 93 (Noether Report)).

Respondents do not dispute that prices are determined differently for commercially insured patients than for most government-insured patients, but the two sets of patients are inter-related. For example, a growing number of publicly insured patients are enrolled in managed care plans such as Medicare Advantage, the rates for which commercial insurers negotiate with

hospitals. (DX1210-041-42 ¶93 (Noether Report)). Also, hospital systems generally do not cover their costs in treating Medicare and Medicaid patients and must recoup the shortfall with the generally higher payments received for services to commercially insured patients. In addition, MCOs currently apply aspects of healthcare reform that hold hospital systems accountable for their performance and cost-effectiveness, through mechanisms such as pay-for-performance, shared-savings plans, and bundled payment options for all services provided in a particular episode of care. Complaint Counsel's narrow focus on MCOs and their enrollees ignores these market dynamics, which are significant to a proper assessment of the competitive effects of the transaction.

2. Primary Care Physician Services

From day one, Complaint Counsel alleged in their Complaint that the primary care physician ("PCP") services market consisted of services offered by physicians practicing internal medicine, family medicine, and general practice, but excluding physician services provided by pediatricians and OB-GYNs. (PX2504-006, ¶ 26 (Complaint)). Now, however, in their Pre-Trial Brief, Complaint Counsel put forth a different definition fostered by one of their expert witnesses, Dr. Capps, which can only be seen as an effort to inflate applicable market shares and concentration measures in the PCP market. (Pre-Hearing Br., at 32-35).

Inexplicably, and for the first time in these proceedings, Complaint Counsel's economic expert, Dr. Capps, has included what he calls "PCP-related" physicians within the relevant PCP market. (DX1210-100, ¶ 275 (Noether Report)). The invented "PCP-related" label itself defeats the argument that the physicians within that category should be included in the relevant market. Dr. Capps' attempt to inflate the market shares and market concentration in the PCP market, beyond those which he has previously defined and testified to, impugns his credibility.

In particular, Dr. Capps incorrectly includes in his PCP market share calculations hospitalists and urgent care facility physicians. Hospitalists are not PCPs – they monitor and coordinate care of hospitalized patients in a general acute inpatient care setting, but do not provide primary care services. (DX1210-100, ¶ 276 (Noether Report)). Similarly, physicians who practice at urgent care clinics provide only urgent care, not primary care services. (DX1210-100, ¶ 276 (Noether Report). Patients do not seek regular primary care services from hospitalists or urgent care physicians, and hospitalists and urgent care physicians are not substitutes for PCPs. They should be excluded from the calculation of PCP market share and concentration.

At the same time Dr. Capps is inflating the numerator in his market share calculations (*i.e.*, the number of PCPs employed by OSF Medical Group and Rockford Health Physicians), Dr. Capps has incorrectly excluded many actual PCPs in the geographic market from the denominator (the total number of PCPs). In particular, Dr. Capps incorrectly excluded all of the PCPs employed by the Crusader Clinic in Rockford, on the ground that – contrary to the evidence – they serve only uninsured and under-insured patients. (DX1210-100, ¶ 277 (Noether Report)). Dr. Capps also downweights the full 25 family practice physicians employed by the University of Illinois College of Medicine at Rockford ("UIC") to only 13.4 fulltime equivalents, even though he makes no similar adjustment for other physicians in the marketplace, including those employed by RHS and OSF, who may practice part-time. (DX1210-098-099, ¶271 (Noether Report)). Unlike hospitalists and urgent care physicians, PCPs at Crusader Clinic and

UIC do provide typical primary care services to their patients. The PCPs at Crusader Clinic and UIC must be included in the totality of PCPs practicing in the Rockford area.[5]

The effect of Dr. Capps' manipulation of the number of PCPs in the relevant market is to artificially, and improperly, inflate the combined market share resulting from the affiliation. It is only through this baseless manipulation that Dr. Capps finds that the PCP market would become not just moderately concentrated, but possibly highly concentrated, under the Merger Guidelines.

The analysis of Dr. Noether more accurately reflects the evenly dispersed tri-county PCP market. (DX1210-099-100, ¶ 274 (Noether Report)). And, unlike Dr. Capps, Dr. Noether did not manipulate the data by including "PCP-related" physicians; she included only physicians who actually are PCPs in her analysis. (DX1210-100, ¶¶ 275-276 (Noether Report)). Nor did Dr. Noether seek to exclude physicians who are actually providing primary care in the market – she correctly included all of the PCPs at Crusader Clinic and UIC in her analysis. (DX1210-100-101, ¶¶ 277-279 (Noether Report)). As a result, Dr. Noether's analysis shows that OSF Northern Region's share of primary care physician services would be approximately [redacted] – not [redacted] percent, as Dr. Capps erroneously calculates. (DX1210-101, ¶ 279 (Noether Report)). Moreover, Dr. Noether's analysis accurately reflects a post-acquisition HHI of 1,517 (with a change of 432), barely over the "moderately concentrated" threshold under the Merger Guidelines. (DX1210-101-102, ¶¶ 279-284 and Exhibit 22 (Noether Report)).

[5] The nature of the payor for patients treated by Crusader Clinic or physicians does not change the fact that those physicians provide primary care services. If, as Dr. Capps suggests, PCPs who treat patients covered by government payors should be excluded from the PCP market share calculations, then Dr. Capps would also have to determine the percentage of Medicare and Medicaid patients treated by OSF and RHS PCPs and exclude the FTE equivalent of those OSF and RHS PCPs from his PCP market share calculations – something Dr. Capps did not do. Nor did Dr. Capps modify the number of OSF or RHS PCPs to account for those who do not spend all of their time with patients, as he did for the UIC PCPs.

3. The Geographic Market

Complaint Counsel has the burden to prove a proper geographic market. *United States v. Conn. Nat'l Bank*, 418 U.S. 656, 669 (1974). Complaint Counsel allege that the "relevant geographic market in which to analyze the effects of the affiliation in the general acute-care inpatient hospital services sold to commercial health plans market is no broader than the geographic market defined by the District Court in its 1989 opinion: an area encompassing all of Winnebago County, essentially all of Boone County, the northeast portion of Ogle county, and single zip codes in McHenry, DeKalb, and Stephenson counties (referred to by the District Court as the "Winnebago-Ogle-Boone" market)." (PX2504-006, ¶ 27 (Complaint)). Complaint Counsel's economic expert, however, analyzed competitive effects in a considerably smaller area defined by a Google Maps assessment of a 30-minute drive from Rockford City Hall. That putative market includes most, but not all, of Winnebago County, less than half of Boone County, and very small portions (single zip codes or less) of Stephenson and Ogle Counties. (DX1210-043, ¶ 94 (Noether Report)). Complaint Counsel attempt to have it both ways by including in its Pre-Trial Brief both of the geographic market concepts without telling Respondents or the Court which concept they intend to use at trial.

Complaint Counsel's and Dr. Capps' putative geographic markets each contain the three hospital systems in Rockford. Complaint Counsel do not contend that the market in which to assess the transaction contains hospital systems other than RHS, SAMC, and SwedishAmerican. Still, in Complaint Counsel's alleged market, a larger proportion of its residents have reasonable access to other facilities, especially for outpatient services that constitute a substantial portion of hospital system revenues. (DX1210-044 ¶ 95 (Noether Report)). Complaint Counsel also ignore the increasing penetration into the Rockford area by hospitals located elsewhere in Illinois and in Wisconsin. The outmigration of Rockford area residents for hospital services has had a

significant impact on SAMC's and RMH's ability to effectively compete. Regardless, Complaint Counsel cannot prove that the affiliation violates Section 7, because they cannot show that, as a result of the affiliation, there is a "reasonable probability" of a substantial lessening of competition in the future. *See Long Island Jewish*, 983 F. Supp. at 135 ("To meet the requirements of Section 7, the Government must show a reasonable probability that the proposed merger would substantially lessen competition in the future.").

B. Complaint Counsel Cannot Prove that the Affiliation Will Result in Anticompetitive Effects

1. Complaint Counsel Cannot Meet Their Burden Solely with Market Concentration Data

Complaint Counsel argue that the affiliation is a "merger to duopoly" and the computation of market shares and HHI levels create a "presumption of illegality." (PX2504-001, 02, 08, ¶¶ 2, 5, 33-35 (Complaint); Pre-Hearing Brief, at 1-2, 27-29). However, the essence of Complaint Counsel's evidence reduces to a single, undisputed fact: three independent hospital systems currently compete in Rockford, and after the affiliation two will remain. That fact, without more, does not meet Complaint Counsel's burden under Section 7. And as we will show, there is no more.

The calculation of market shares and market concentration is the beginning, not the end, of the analysis of whether a transaction is likely to substantially lessen competition. *FTC v. CCC Holdings, Inc.*, 605 F. Supp. 2d 26, 46 (D.D.C. 2009); *Baker Hughes, Inc.*, 908 F.2d at 992 (explaining that "[e]vidence of market concentration simply provides a convenient starting point for a broader inquiry into future competitiveness" because the HHI "cannot guarantee litigation victories"). The Supreme Court has cautioned that "statistics concerning market share and concentration are 'not conclusive indicators of anticompetitive effects.'" *Arch Coal*, 329 F. Supp. 2d at 130 (*citing United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 498 (1974)). Likewise,

the Horizontal Merger Guidelines recognize that "[m]arket shares may not fully reflect the competitive significance of firms in the market or the impact of a merger." *See Horizontal Merger Guidelines* at § 5.3. As a result, courts recognize that "determining the existence or threat of anticompetitive effects has not stopped at a calculation of market shares" and, therefore, "[a] finding of market shares and consideration of [the presumption created by market shares] should not end the court's inquiry." *United States v. Oracle*, 331 F. Supp. 2d 1098, 1111 (N.D. Cal. 2004); *see also Baker Hughes*, 908 F.2d at 992 (noting, "the Herfindahl-Hirschman Index cannot guarantee litigation victories").

Instead, Respondents may produce "nonstatistical evidence which casts doubt on the persuasive quality of the statistics to predict future anticompetitive consequences." *Univ. Health*, 938 F.2d at 1218 (citation omitted). The court must examine the "structure, history and probable future" of the market to determine whether market shares are indicative of likely anticompetitive effects from the affiliation. *Gen. Dynamics*, 415 U.S. at 498. "Hence, antitrust theory and speculation cannot trump facts." *Arch Coal*, 329 F. Supp. 2d at 116. If Respondents successfully rebut the presumption, then "the burden of producing additional evidence of anticompetitive effect shifts to the government, and merges with the ultimate burden of persuasion which remains with the government at all times." *Arch Coal*, 329 F. Supp. 2d at 116 (citation omitted). Where, as here, market shares are not an accurate predictor of future competitive effects, they are no substitute for a rigorous analysis of actual market dynamics. *See Baker Hughes*, 908 F.2d at 983-85.

Here, the record evidence of the market realities rebuts the presumption that high market shares may cause anticompetitive effects post-affiliation. A review of the "structure, history and probable future" of the general acute care inpatient services market in Rockford (even assuming

Complaint Counsel's definition) establishes that market shares should not be construed to reflect the power to obtain supracompetitive prices. *Gen. Dynamics*, 415 U.S. at 498. Instead, the evidence will show that MCOs wield significant leverage over the Rockford hospitals, and can reject any attempt by OSF Northern Region to increase prices above competitive levels. RHS and SAMC are not each other's closest competitors. Moreover, SAH – Rockford's largest and fastest growing hospital – is a viable, marketable alternative to OSF Northern Region that will constrain any attempt by OSF Northern Region to raise its rates above competitive levels. Still further, Complaint Counsel's application of traditional concentration theory to a healthcare system that is subject to non-traditional forces imposed by decades of government regulation and impossible-to-sustain cost growth is a square peg in a round hole. (DX1406-008-10, 44 ¶ 69 (Sage Report); DX1427-032, 39 (Sage Dep.) at 121:7-122:14, 149:9-150:24). As a consequence, the operative facts here belie the notion that the affiliation will result in a substantial lessening of competition. To the contrary, the combination of RHS and SAMC will inure to the great benefit of Rockford consumers.

2. The Structure, History, and Probable Future of the Market Demonstrate that Anticompetitive Effects Will Not Result from the Affiliation

Complaint Counsel cannot prove that the affiliation is likely to result in anticompetitive effects or a substantial lessening of competition in the future. In their Pre-Hearing Brief, Complaint Counsel characterize the economic conditions in the Rockford area and the imperatives of healthcare reform as not "relevant." This is incorrect. They are critical parts of the operative factual landscape and provide the essential background which this Court must consider in its analysis of the "structure, history and probable future" of the market. Complaint Counsel are living in the healthcare world of 1989. But the courts tell us that is the wrong lens through which to view and analyze the operative facts. To the contrary, the Court must examine

both the history and probable future of the market to assess whether anticompetitive effects are likely, even assuming relatively high post-merger concentration. *Gen. Dynamics,* 415 U.S. at 498.

The existing healthcare services market structure reflects a complex history of professional and governmental intervention in healthcare, not a competitive market equilibrium. The consequences have not produced clear benefits to consumers. (DX1406-005-06, ¶ 7 (Sage Report)). Hospitals in towns like Rockford are facing major changes in demand for their services, in the form and amount of payment available for those services, in the customers who will purchase their services, and in the very definition of what constitutes their services. (DX1406-005-06, ¶ 7 (Sage Report)). Understanding the competitive effects of the RHS-SAMC affiliation requires a forward-looking analysis based on evidence of future consumption patterns and supply innovations, not past practices or the biased views of market intermediaries (MCOs) defending existing business models. Complaint Counsel fail to take account of the degree to which regulation of healthcare has influenced market structures and performance in the past, and of the recent changes in regulations that will influence market structures and performance in the future. (DX1406-008, ¶ 12 (Sage Report)).

a. The Evidence Will Show that OSF Northern Region Will Not be Able to Increase Prices to Supracompetitive Levels Unilaterally

The evidence will show that the affiliation will not enable OSF Northern Region to raise prices above competitive levels. Complaint Counsel point to no evidence – because there is none – that either OSF or RHS even considered as a possibility obtaining higher rates from MCOs as a factor in the evaluation and decision to pursue the transaction. Similarly, no evidence suggests that the parties considered, let alone discussed, the affiliation's effect on MCO contract rates. Rather, OSF and RHS entered into the affiliation in response to the deteriorating economic

conditions confronting Rockford, each organization's declining financial condition and ability to make sufficient investments in infrastructure, technology and physician recruitment, and the need to eliminate costs and improve quality to meet the demands of the community and the imperatives of healthcare reform. (DX1210-085-97 ¶¶ 231-267 (Noether Report)). Complaint Counsel either ignore these market realities or, equally without merit and in disregard of *General Dynamics*, dismiss them as not descriptive of the competitive environment in which the hospitals exist. OSF and RHS are not complacent firms resisting change through consolidation, but innovators responding to a changing marketplace. They have credible, pro-competitive reasons and goals for merging, and are likely to accomplish their objectives. (DX1406-007, ¶ 11 (Sage Report)).

OSF Northern Region will not be able to increase prices to supracompetitive levels. Robust rivalry between SwedishAmerican and OSF Northern Region will maintain price competition and spur the rivals to achieve higher healthcare quality, in the same way that competition flourishes in two-hospital markets throughout the country. Specifically, the evidence shows that in Illinois cities such as Springfield, Champaign-Urbana and Bloomington, where there has been a reduction from three to two hospital systems, rates have not increased as Complaint Counsel speculates. (DX0705-032-36 (Ingrum Dep.) 121:15-139:3). Moreover, powerful BCBS-IL and the other MCOs are positioned to exert their bargaining strength to deter and defeat any attempt by OSF Northern Region to exercise market power. Indeed, MCOs can credibly threaten to exclude OSF Northern Region from network participation in favor of a narrow network with SwedishAmerican as the only in-network hospital provider.

(1) SAH Will Continue to Act as a Competitive Constraint on OSF Northern Region

SAH will effectively constrain any attempt by OSF Northern Region to raise rates above competitive levels. SAH is the largest and fastest growing hospital in the Rockford area. (DX1210-068-69, ¶¶ 178-79 (Noether Report)). It has invested over [redacted] million in facility renovations since 1997, opened a new [redacted] million Heart Hospital in 2006, and is aggressively expanding its services following an affiliation with UW-Madison. (DX1210-070-71, ¶¶ 185-86 (Noether Report); DX0717-011 (Walsh Dep.) at 38:6-18). SAH also has sufficient inpatient bed capacity to treat additional patients if MCOs increasingly choose to offer a health plan product in which SAH is the only in-network hospital provider. (DX1210-068-69, ¶ 185 (Noether Report)).

SAH is also the closest competitor to both RHS and SAMC. This is confirmed by the diversion analysis conducted by Complaint Counsel's economic expert, Dr. Capps. (PX2515-106, ¶ 199 (Capps Report)). Dr. Capps found that if RHS were no longer available, more patients would choose to be admitted at SAH than SAMC. (PX2515-106, ¶ 199 (Capps Report)). Likewise, were SAMC no longer available, more patients would elect SAH than RHS. (PX2515-106, ¶ 199 (Capps Report)). This undisputed evidence confirms that the affiliation will not allow OSF Northern Region to exercise unilateral market power.

(2) MCOs Have the Incentive and Proven Ability to Resist Price Increases

Complaint Counsel's charge that OSF Northern Region will impose anticompetitive price increases rests on counter-intuitive and counter-factual speculation that such conduct would work against large, sophisticated insurance companies such as BCBS-IL, United, and Coventry. Complaint Counsel's concern is predicated upon a misunderstanding of the dynamics in negotiations between MCOs and providers in the Rockford area.

The MCOs competing in Rockford have significant bargaining leverage. One of them, BCBS-IL, through health maintenance and preferred-provider products, holds approximately [redacted] of the commercial health-insurance market in the State of Illinois and is by far the largest MCO in Rockford. (DX1210-014, ¶ 27 (Noether Report)). Similarly, United is one of the largest U.S. commercial health insurers and second-largest in Illinois; it has approximately [redacted] insureds in Illinois and [redacted] in the Rockford area. (DX1210-014, ¶ 27 (Noether Report)). Coventry is the fifth- or sixth-largest U.S. health insurer with over [redacted] covered lives and annual revenues of [redacted] (DX1210-016, ¶ 31 (Noether Report)).

Moreover, MCOs have an informational advantage over the hospitals. When they negotiate contracts with the Rockford healthcare systems, MCOs are armed with a wealth of information, much of which the hospital providers do not have, including knowledge of the rates they pay to the negotiating provider's competitors and their insureds' historical utilization with the provider's competitors. (DX0715-011 (Seybold Dep.) at 37:11-16; DX0098-001-02 (Email from P. Dillon (RHS) re: Alliance)). Moreover, the Rockford hospitals, as do hospitals all across the United States, rely on the revenue they receive from MCOs to recover losses incurred by treating Medicare, Medicaid, self-pay and charity care patients; the hospitals need to contract with MCOs (to gain access to commercially-insured patients) more than MCOs need to include every hospital in their provider networks. (DX1210-087-88, ¶¶ 237-39 (Noether Report)). SAH agrees that MCOs have significant bargaining advantages. Its executive testified that [redacted] (DX0717-013 (Walsh Dep.) at 46:4-47:25).

If OSF Northern Region tried to raise rates for general acute care inpatient services to supra-competitive levels, MCOs could offer a narrower provider network, for all or some of their health insurance products, at lower cost to their insureds. The evidence demonstrates that narrow provider networks are an increasingly common, employer-accepted response to spiraling healthcare costs. For example, prior to 2010, ECOH's River Valley product, which included only RHS, covered about [redacted] of ECOH's commercially-insured lives. (DX0712-014 (Pocklington Dep.) at 49:3-50:16). BCBS-IL also offers an HMO product with SAH as the sole in-network hospital. (DX0197-028 (Breeden IHT) at 105:7-107:14; DX1210-014, ¶ 27 (Noether Report)). And United recently introduced its "Core" product in the Rockford area, which has SAH as its only in-network hospital. (DX0707-008 (Lobe Dep.) at 27:20-28:21). This marketing by MCOs of products with narrow provider networks is not unique to Rockford; it is a nationwide trend. (DX1210-029-34, ¶ 64-72 (Noether Report)).

The combination of these factors will empower and enable MCOs to defeat any threatened OSF Northern Region price increase by refusing to contract with OSF Northern Region and marketing a health insurance product with SAH as the only in-network hospital provider. Narrow provider networks are viable, marketable options that represent an alternative to two- or three-hospital networks. (DX1210-020-23, ¶ 47-52 (Noether Report)). Forcing hospital markets to remain artificially and inefficiently fragmented in the name of MCO leverage would reduce hospitals' incentives and ability to achieve scale economies, accurately measure their clinical performance, and accept forms of payment that reward productive efficiency, including safety and quality improvements that reduce demand for inpatient services. (DX1406-006-07, ¶ 10 (Sage Report)). The prohibition will harm Rockford consumers by depriving them

of the innovation and efficiency benefits that would be realized by allowing RHS and SAMC to combine. (DX1406-049, ¶ 71 (Sage Report)).

Moreover, in response to continually escalating healthcare costs, many Rockford-area employers are trying to reduce costs by offering health plans with fewer provider choices to their employees, or contracting directly with the hospitals in Rockford for healthcare services. For example, Rockford Acromatic now contracts directly and only with SAMC to provide healthcare services to its employees to reduce its healthcare costs. (DX0711-017 (Olson Dep.) at 62:11-64:11).

Claims by the MCOs and Complaint Counsel that narrow networks are not marketable nor viable are unsubstantiated, and wrong. No MCO declarant or deponent in this case conducted [redacted] (*See, e.g.*, DX0712-024, 30 ([redacted] Dep.) at 89:6-10, 115:21-116:5 [redacted] DX0703-014-15, 28 ([redacted] Dep.) at 50:13-16, 50:19-51:13, 53:9-22, 145:2-6 [redacted]; DX0707-039 ([redacted] Dep.) at 151:19-152:18). To the contrary, ECOH's Director of Provider Services testified that a [redacted] to a number of employers in Rockford. (DX0712-042 ([redacted] Dep.) at 163:10-19).

Moreover, Complaint Counsel ignore the changing nature of MCO negotiations and rate structures. The Medicare program has initiated a movement toward rewarding providers for quality improvements. MCOs have been moving in the same direction [redacted] (DX0699-016-017

([redacted] Dep.) at 59:2-62:15). These newer arrangements bring providers and MCOs more into alignment over the total cost of care and decrease the importance of rate negotiations. (DX0197-018 (Breeden IHT) at 67:14-68:17).

(3) OSF Northern Region Will Not Have the Ability to Exclude SAH

Complaint Counsel have claimed that OSF Northern Region will have the power to require MCOs to exclude SAH from their networks. (Pre-Hearing Brief, at 48). This allegation is inconsistent with how things actually work in two-hospital markets in Illinois similar in size to Rockford, where most MCOs contract with both hospitals at substantially discounted rates. (DX0705-019-20, 29-30, 41-42 (Ingrum Dep.) at 71:20-74:15, 112:11-113:8, 160:24-161:20). Nonetheless, OSF and RHS have agreed to stipulate that: (1) they will not demand the exclusion of SwedishAmerican as a condition to contracting with OSF Northern Region; and (2) neither OSF nor OSF Northern Region will require an MCO to contract with OSF system-wide or any other OSF hospital as a condition for a contract with OSF Northern Region. (DX0938-001 (OSF & RHS Stipulation)). These commitments will enable and encourage MCOs to negotiate alternative rates from OSF Northern Region and SAH – one rate as the network's only Rockford provider and another if both systems are in-network.

Employers, therefore, will have three options at potentially different price points: a single-hospital network consisting of OSF Northern Region, a network consisting of only SAH, or a network with both Rockford systems. SAH's CEO testified that with such a stipulation, the transaction will foster, not deter, competition between the Rockford hospitals, because SAH [redacted] (DX1162-047 ([redacted] Dep.) at 183:1-11). In other words, the transaction will have procompetitive, not anticompetitive, effects.

(4) Complaint Counsel's Economic Expert Fails to Demonstrate an Actual Price Effect of the Proposed Affiliation

After measuring a merger's impact on market concentration, the Court must examine the history and probable future of the market in order to assess whether anticompetitive effects are likely, even assuming relatively high post-merger concentration. *Gen. Dynamics,* 415 U.S. at 498. "Analysis of the likely competitive effects of a merger *requires* [a determination] of . . . the transaction's probable effect on competition in the relevant product and geographic markets." *Arch Coal*, 329 F. Supp. 2d at 117 (emphasis added). Complaint Counsel cannot "simply [make] conclusory allegations that . . . the merger will significantly limit competition without any evidence." *Advocacy Org. v. Mercy Health Servs.*, 987 F. Supp. 967, 974 (E.D. Mich. 1997). Rather, they must show "anticompetitive effects...that will result from the merger." *Id.* "[A]ntitrust theory and speculation cannot trump facts." *Arch Coal*, 329 F. Supp. 2d at 116-17.

Complaint Counsel cannot establish that the proposed affiliation will cause the rates that MCOs pay the Rockford hospitals to increase substantially to supracompetitive levels. Beyond showing that the number of independent rivals will decline from three to two, Complaint Counsel and its economic expert have nothing but theory-based speculation in support of their contention that the proposed affiliation will result in anticompetitive effects. Complaint Counsel's economist, Dr. Capps, does not calculate an actual price effect from the proposed affiliation; he only speculates about what general effect the affiliation may have on prices. (DX1210-055-57, ¶ 129-140 (Noether Report)).

Dr. Capps did not perform a merger simulation to estimate econometrically the affiliation's price effect. (PX2515-123, ¶ 231 n.337 (Capps Report) [redacted] In addition, not only does Dr. Capps' willingness-to-pay model also lack a price component, the evidence presented at trial will

demonstrate that his model is unreliable. It purports to show that [redacted] has the highest willingness-to-pay, which implies that [redacted] should obtain the highest average case-mix-adjusted prices from MCOs (reflecting its status as the system to which payors are most willing to pay for services). To the contrary, however, Respondents will show through the testimony of Dr. Noether that [redacted] has *lower* average prices (as adjusted) than RMH. This analysis shows that Dr. Capps' willingness-to-pay theory is fatally flawed and ill-suited to form the basis for a conclusion that prices will rise to anticompetitive levels following the affiliation.

(5) The MCOs Testified Only to Speculation on Future Rates

The remaining evidence on which Complaint Counsel rely (unsubstantiated, self-serving testimony from MCOs) is insufficient to show a "substantial lessening of competition [that] will be sufficiently probable and imminent to warrant relief." *Arch Coal*, 329 F. Supp. 2d at 115 (citations omitted). No MCO representative has offered, or will offer, anything other than pure speculation that rates charged by OSF Northern Region will increase as a result of the acquisition. No MCO has conducted a study or analysis which establishes there will be a rate increase as a result of the acquisition. And, MCO representatives will offer nothing but speculation that hospital mergers cause rate increases. {*See* DX0699-035 ([redacted] Dep.) at 133:14-134:10 [redacted] DX1151-043 ([redacted] Dep.) at 168:12-22 [redacted] DX0718-042 ([redacted] Dep.) at 161:21-25 [redacted] DX1157-047 ([redacted] Dep.) at 182:2-8 [redacted]

[redacted] DX0704-037 ([redacted] Dep.) at 144:4-20 [redacted] DX0705-035-036 [redacted] Dep.) at 136:16-138:5 [redacted] DX0703-039 ([redacted] Dep.) at 151:11-14 [redacted] DX1201-11 (Lobe (United) PI Tr.) at 42:17-25 (testifying she would not be comfortable projecting an amount of change in terms of what the rates of a merged OSF and RHS would be). Accordingly, any testimony by any MCO representative insinuating that the affiliation would lead to increased rates must be ignored as it is based on pure speculation and conjecture. Indeed, the MCO testimony in this case is contrary to that relied upon by Complaint Counsel in *ProMedica*, where MCOs had attempted to conduct analyses to support their predictions. *In re ProMedica Health Sys., Inc.*, No. 9346, 2011 LEXIS 294, *165 (F.T.C. Dec. 12, 2011). No MCO has done so here.

b. The Evidence Will Demonstrate that the Affiliation Will Result in Substantial, Merger-Specific Efficiencies

"A primary benefit of mergers to the economy is their potential to generate significant efficiencies and thus enhance the merged firm's ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products." U.S. Dep't of Justice and Fed. Trade Comm'n, *Horizontal Merger Guidelines*, § 10 (2010). In no line of commerce is this factor more important than in the delivery of healthcare, where hemorrhaging, out of control costs threaten the entire economy. Here, the evidence will demonstrate that the affiliation will provide the Rockford community with substantial benefits that cannot be achieved

without the merger. As a result, the likely competitive effects of this affiliation are hugely positive and require dismissal of this case.

Evidence of efficiencies may be introduced to rebut a plaintiff's *prima facie* case. *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 720 (D.C. Cir. 2001); *Baker Hughes*, 908 F.2d at 982-83. The Eleventh Circuit has held that "a defendant may rebut the government's *prima facie* case with evidence showing that the intended merger would create significant efficiencies in the relevant market." *Univ. Health*, 938 F.2d at 1222-23 (holding that a defendant could overcome a presumption that the proposed acquisition would lessen competition by demonstrating that the acquisition would result in significant efficiencies to benefit consumers). Courts, therefore, should consider "evidence of enhanced efficiency in the context of the competitive effects of the merger." *Tenet*, 186 F.3d at 1054. Further, in the hospital merger context, evidence may show that "a hospital that is larger and more efficient . . . will provide better medical care than either of those hospitals could separately." *Id.* Efficiencies are particularly compelling in the healthcare industry, where hospitals face significant challenges to meet the demands of new healthcare legislation, and regulatory reforms are changing the competitive landscape such that "a merger, deemed anticompetitive today, could be considered procompetitive tomorrow." *Id.* at 1054-55 (citing *United States v. Mercy Health Servs.*, 107 F.3d 632, 637 (8th Cir. 1997)). For example, in *Tenet*, the Eighth Circuit criticized the district court for not "properly evaluat[ing] evolving market forces in the rapidly-changing healthcare market." *Id.* at 1055. The urgency presented by, and reflected in, the Accountable Care Act and other healthcare reform legislation makes this consideration an imperative. (DX1406-006-07, ¶¶ 8-10 (Sage Report)).

Despite explicit, uncontested testimony that the hospitals sought and relied upon the Business Efficiencies Report prepared by FTI in making their decision to enter into the

Affiliation Agreement, Complaint Counsel continue to misleadingly claim that the Business Efficiencies Report was not generated to assist OSF and RHS in deciding whether to enter the affiliation, and instead was created "expressly" for litigation. (Pre-Hearing Brief, at 57). To the contrary, the evidence demonstrates that the FTI Business Efficiency Report was performed for a *dual* purpose. (DX0191-049 (Sister McGrew IHT) at 191:6-20; DX1202-084 (Schertz PI Tr.) at 649:5-650:16; DX1202-070 (Schertz PI Tr.) at 594:10-22). The study was performed after the parties signed a Letter of Intent and as part of the due diligence in which they were engaged. *Id.* The primary reason for commissioning the study was to enable each party to make a business decision as to whether to go forward with the affiliation. (DX1202-084 (Schertz PI Tr.) at 649:5-650:16). Thus, the study had to be accurate and reliable, and it was. Secondarily, the parties understood that they could only proceed if the transaction was acceptable under the antitrust laws and that the FTC might challenge the merger. So the report also was properly and accurately prepared to address the issues that would be important to the FTC's analysis, if the FTC were to challenge the affiliation. (DX0191-034 (Sister McGrew IHT) at 131:17-23; DX1202-084 (Schertz PI Tr.) at 649:5-650:16).

In their Pre-Hearing Brief, Complaint Counsel criticize the parties for not pursuing additional integration efforts before the affiliation is consummated. (Pre-Hearing Brief, at 58). But this complaint ignores the antitrust constraints prohibiting the parties from exchanging competitively sensitive information before they have the right to do so. (DX0706-052 (Kaatz Dep.) at 201:15-202:12; DX0714-034 (Schertz Dep.) at 131:15-132:3; *see also* Smithfield Foods and Premium Standard Farms Charged with Illegal Premerger Coordination, DOJ Press Release, Jan 21, 2010). Complaint Counsel seek to have it both ways. They claim that the efficiencies cannot be credited because the parties have not exchanged the competitively sensitive

information necessary to make definitive integration decisions. But if the parties had shared such information, then Complaint Counsel would be citing that activity as "evidence" of coordinated interaction.[6]

The evidence demonstrates that OSF Northern Region will be a more sustainable and higher quality healthcare delivery system than either RHS or SAMC could be independently. Rockford area residents will realize a significant number of benefits from the affiliation of RHS and OSF that could not be achieved by either hospital alone. For example, the affiliation will promote greater patient access to integrated primary, secondary and tertiary healthcare services. (DX1209-016-11, ¶¶ 7-12 (Manning Report)). It will also allow the consolidation of several services (such as trauma, women's and children's, and cardiovascular surgery), which will enable OSF Northern Region to create centers of excellence. (DX0698-041 (Kaatz IHT) at 160:16-161:8).

In addition, for many services, neither RHS nor SAMC independently meets the generally-accepted minimum patient volume thresholds associated with improved outcomes. (DX0698-028 (Kaatz IHT) at 108:16-112:2; DX1209-016-11, ¶¶ 7-12 (Manning Report)). By combining patient volumes, the proposed affiliation will enable OSF Northern Region to meet or exceed these thresholds. (DX1209-016-11, ¶¶ 7-12 (Manning Report)). This, in turn, will allow OSF Northern Region to become a regional referral center and enhance OSF Northern Region's ability to recruit talented specialist and sub-specialty physicians to Rockford, thereby resulting in fewer patients leaving the community to receive treatment. (DX1203-020-21 (Kaatz PI Tr.) at

[6] In their Pre-Hearing Brief, Complaint Counsel claim, incorrectly, that Respondents' outside counsel altered FTI's work. This is untrue. The documents to which Complaint Counsel refer show that counsel did not want FTI to speculate about the possible outcome of an FTC investigation. None of the documents show that counsel influenced any of the business recommendations contained in that report. As Phillip Dawes of FTI explained during his deposition, the comments made on the FTI report by counsel "did not change any of the substance of the report." (Dawes Dep., 4/6/12, at 70:20-71:6, attached as Exhibit A).

731:2-732:15). The affiliation also will allow the merging hospital systems to combine best practices to improve their quality. (DX0192-019 (Benink IHT) at 72:15-25). For example, the affiliation will afford physicians the ability to share techniques, procedures, and tools to become more efficient and deliver higher-quality outcomes. (DX0700-063-64 (Brown Dep.) at 248:10-249:8).

The affiliation will enable OSF Northern Region to achieve efficiencies and substantial cost-savings in the delivery of healthcare that neither hospital system could achieve on its own. Respondents' expert, Dr. Susan Manning, has identified significant efficiencies and cost savings that can be attained only through the affiliation of SAMC and RHS and has detailed how each of the efficiencies are merger-specific and cognizable under Section 10 of the Horizontal Merger Guidelines. ((DX1209-006-07, ¶ 7-8 (Manning Report)). These savings include at least $114 million in one-time capital cost avoidance and over $37 million in annual recurring operating cost reductions, leading to cost savings in 5 years of over $187 million. (DX1209-007-08, ¶ 7-8 (Manning Report); DX1426-025 (Manning Dep.) at 94:10-96:24). Dr. Manning has found these efficiencies to be merger-specific and cognizable under the Merger Guidelines. (DX1209-031, ¶ 49 (Manning Report); DX1426-025 (Manning Dep.) at 95:8-24). By combining underutilized or complementary assets, the affiliation will allow the parties to more productively deploy capital resources in the community. (DX1209-141, ¶ 309 (Manning Report)).

In Table 1 below, Dr. Manning identifies specific cost savings that will permit Respondents to more efficiently provide quality care to the Rockford community and restrain the upward spiral of healthcare costs, while providing valuable resources, support programs, and services that neither system presently can afford on its own. (DX1209-010, ¶ 12 (Manning Report); DX0708-007, (Manning Dep.) at 21:6-25). For example, Rockford is located in the

only Illinois trauma region outside of the Chicago area which maintains two Level 1 trauma units. (DX1209-032, ¶ 51 (Manning Report). They are redundant. After a thorough analysis of available labor, supplies and capacity, Dr. Manning concluded that consolidation of Level 1 trauma services at one campus is merger specific, cognizable and likely will result in recurring annual savings of approximately $3.72 - $4.30 million. (DX1209-030, ¶ 48 (Manning Report).

TABLE 1

ESTIMATED COST SAVINGS BY OPERATING AREA AND COST CATEGORY (in $000)

	Labor Costs Savings	Purchased Services Savings	Total Estimated Savings
Clinical Operations:			
Level I Trauma Services	$1,472-$3,081	$ 1,226-$2,251	$ 3,723-$4,308
Oncology	$ -	$ 2,608	$ 2,608
Women's & Children's	$ 1,557	$ -	$ 1,557
Clinical Effectiveness	(1)	(1)	$ 7,800
Clinical Operations Subtotal	**$3,029-$4,638**	**$ 3,834-$4,859**	**$15,688-$16,273**
Other Clinical and Ancillary Services:			
Physician Practices/Ambulatory Services	$ 330	$ 228	$ 558
Laboratory Services	$ 994-1,504		$ 994-1,504
Other Clinical Support	$ 200	$ -	$ 200
Other Clinical and Ancillary Subtotal	**$1,524-$2,034**	**$ 228**	**$ 1,752-$2,262**
Revenue Cycle	**$ 432**	**$ -**	**$ 432**
Operational Support:			
Supply Chain Management	$ 516	$ -	$ 516
Facilities Management	$ 797	$ 2,874	$ 3,671
Food & Nutritional Services	$ -	$ 104	$ 104
Operational Support Subtotal	**$ 1,313**	**$ 2,978**	**$ 4,291**
General & Administrative:			
Finance	$ 1,238	$ 877	$ 2,114
Information Technology	$ 7,718	$ 1,766	$ 9,484
Human Resources	$ 1,367	$ 156	$ 1,523
Legal	$ 177	$ 200	$ 377
Marketing & Strategy	$ 267	$ 645	$ 912
Executive Management	$ 1,082	$ -	$ 1,082
General & Administrative Subtotal	**$ 11,848**	**$ 3,644**	**$ 15,492**
TOTAL	**$18,146-$20,265**	**$10,684-$11,709**	**$37,655-$38,750**

(1) Labor and supplies costs savings are captured in the clinical and operational effectiveness.

Dr. Manning also determined that the affiliation would result in one time merger specific cognizable capital avoidance of $114.8 million. *See* Table 2 below. The largest savings result from avoiding the need to build a bed tower for the purpose of creating much needed private

rooms at SAMC. Not only are private rooms highly desired by patients, they are important for infection control. SAMC's percentage of private rooms is substantially lower than those at RMH and SAH. (DX1209-135, ¶ 293 (Manning Report). But, as a result of the affiliation and the consolidation of services, OSF Northern Region will be able to convert many semi-private rooms to private rooms and, therefore, negate the need to build a bed tower. (DX1209-135, ¶ 293 (Manning Report). In 2008, the OSF Board approved [redacted] in capital budget expenses for the initial planning and design for a [redacted] bed tower. (DX1209-132 ¶ 283 (Manning Report)). Some rehabilitation considered in conjunction with the initial bed tower plans would still be needed after the affiliation, and, therefore, a net savings of $100.72 million will be realized. (DX1209-132 ¶ 283 (Manning Report)).

TABLE 2

ESTIMATED CAPITAL AVOIDANCE SAVINGS

ONE-TIME SAVINGS		**$(000)**
OSF-SAMC Bed Tower	$	100,720
Duplicative Equipment / Resources:		
Intensity Modulated Radiation Therapy (IMRT)	$	2,400
DaVinci Robot	$	4,000
Trauma Helicopter Replacement Cost at RHS	$	7,000
Duplicative Primary Care Facilities - Cherry Valley	$	1,050
Less Offsetting One-time Capital Costs:		
OSF-Aviation Helicopter NICU Equipment	$	(125)
Trauma Helicopter Staff Training	$	(35)
Addition of RHS to OSF Payroll System (API)	$	(124)
Total Estimated Net One-Time Capital Avoidance Savings	$	**114,886**

Note: The Parties may be able to avoid additional capital spending, as I describe in this Report. These areas include MRI, PET/CT, and ambulatory and physician practice facilities. These potential capital avoidance savings require additional study through the detailed implementation planning process before they can be validated. For this reason, I do not include these potential savings in my calculation of cognizable avoided capital expenditures.

These efficiencies rebut – indeed, reverse – any presumption of illegality arising from any post-affiliation HHIs and increases in market concentration. *See Butterworth Health Corp.*, 946 F. Supp. at 1302 (concluding that defendants rebutted the government's *prima facie* case with evidence of, among other things, substantial efficiencies). Indeed, these efficiencies must be given primacy, and substantial weight, in the Court's analysis of whether consumers will be best served by permitting this affiliation. *Long Island Jewish Med. Ctr*, 983 F. Supp. at 137 (*citing Univ. Health*, 938 F.2d at 1222). As Dr. Sage explains, the Affordable Care Act signals a necessary and imminent, major reshaping of hospital services. Achieving these efficiencies will allow the innovation that will be required to succeed under healthcare reform. (DX1406-037, 70, ¶¶ 61, 70 (Sage Report)).

c. The Affiliation Will Not Result in Unlawful Coordinated Effects

The FTC has no evidence to support its claim that OSF Northern Region and SAH will impermissibly coordinate their competitive activities in the future. As an initial matter, the FTC's simultaneous assertion that OSF Northern Region will impermissibly *exclude* and *collude* with SAH exposes the absence of facts supporting either theory, for the presence of facts supporting one would make the other implausible.

Moreover, the examples on which Complaint Counsel rely to support their theory of coordinated effects – other than their "three is more than two" mantra – are not only mostly stale, but do not reveal any likelihood of collusion, even if admissible (which they should not be). Complaint Counsel's reliance on the "evidence" supplied by the 1989 Rockford case underscores

the absence of anything meaningful or relevant.[7] (Pre-Hearing Brief, at 45-47). Indeed, the 2006 FTC-DOJ Commentary on the Horizontal Merger Guidelines cautions that the Agencies must "focus on how the mergers affect the likelihood of successful coordination *in the future.*" (emphasis added). As a result, "[e]vidence of past coordination is less probative if the conduct preceded significant changes in the competitive environment that made coordination more difficult or otherwise less likely," because "these [changes] may have altered the incumbents' incentives or ability to coordinate successfully." (PX0206-027 (2006 DOJ and FTC Commentary on the Horizontal Merger Guidelines)).

Here, the evidence is undeniable that the competitive and contracting circumstances in the healthcare services market have changed dramatically since 1989. Contracting between hospital systems and MCOs has become much more complex, managed care has evolved from its infancy, and negotiations now address a myriad of inpatient and outpatient services that are included in the typical contract. (DX1210-011-14, 76-77 ¶¶ 22-23, 206 (Noether Report)). In addition, contracts involve a variety of payment methods, special provisions such as payment for out-of-network services, and non-price terms – a much different process from the indemnity arrangements that were prevalent in 1989. (DX1210-076-77, ¶¶ 205-209 (Noether Report)).

As a result of the crisis in out-of-control healthcare costs and the enactment of healthcare reform legislation, major changes are underway in the demand for services, the form and amount of payment available for those services, the customers who will purchase the services, and even in the very definition of what constitutes services. (DX1406-005, ¶ 7 (Sage Report)). Thus, the

[7] In his decision on the FTC's motion for preliminary injunction, Judge Kapala opined that any collusion found among the Rockford hospitals in the 1989 case is stale and cannot be relied upon today. *FTC v. OSF Healthcare System and Rockford Health System*, No. 11-50344, at *30 n.15 (N.D. Ill. Apr. 5, 2012).

"evidence" cited by Complaint Counsel as probative of coordination is not only stale, but entirely without meaning.

In addition, executives from all three hospitals have categorically and uniformly testified, and will testify again, that they have not coordinated, and do not intend in the future to coordinate their competitive activities. (DX0717-041 (Walsh Dep.) at 159:11-23; DX1203-024 (Kaatz PI Tr.) at 744:1-745:3; DX1202-072-73 (Schertz PI Tr.) at 602:18-604:5). SAH is not aware of hospital executives in Rockford exchanging any competitively sensitive information with each other regarding negotiations with health plans. (DX0717-041 (Walsh Dep.) at 159:11-23). SAH unequivocally disavowed any intent to directly or indirectly communicate confidential information about its strategic plans or its negotiations with commercial health plans to OSF Northern Region. (DX0717-040-41 (Walsh Dep.) at 156:16-157:8). And, SAH affirmatively stated that it would not agree with OSF Northern Region to defer competitive initiatives. (DX0717-040-41 (Walsh Dep.) at 156:16-160:6). SAMC's CEO has testified, that in the sixteen years he has led SAMC, he has never been involved in discussions with other hospitals in Rockford about dividing services lines, coordinating or discussing prices, rates charged to MCOs, or potential boycotts of MCOs. (DX1202-072-073 (Schertz PI Tr.) at 602:18-604:8). Likewise, RHS CEO Kaatz testified that he was not aware of any coordination among the hospitals in Rockford, and, as the future CEO of OSF Northern Region, he would not permit any such coordination. (DX1203-023-24 (Kaatz PI Tr.) at 743:21-745:3).

The "evidence" of coordinated effects that Complaint Counsel rely on, and references in its Pre-Trial Brief, is incompetent and misleading. (Pre-Hearing Br., at 46-47). Complaint Counsel have omitted relevant parts of the record that explain, and directly and indisputedly rebut, the implications for which they are being offered. None of the exhibits show a history of

coordinated activity or exchange of competitively sensitive information in the Rockford healthcare market. They cannot, individually or collectively, form the basis for an assertion that the proposed affiliation will increase the ability to coordinate among the hospital systems in the Rockford area. The unreliability of the "evidence" of coordinated effects that Complaint Counsel rely upon, and the misleading manner in which the evidence is cited are highlighted below:

1) PX0630 is RHS Finance & Audit Advisory Committee Minutes from October 26, 2005, which Complaint Counsel offer to suggest that RHS and SAH exchanged information regarding whether negotiations were ongoing with BCBS-IL. 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 twelve years), Complaint Counsel never did. *See* DX0698 (Kaatz IHT); DX0706 (Kaatz Dep.); DX1203-015 (Kaatz PI Tr.). Mr. Kaatz and Richard Walsh, COO of SAH, both testified unequivocally that RHS and SAH have never exchanged competitively-sensitive information. (DX1203-023-24 (Kaatz PI Tr.) at 743:21-745:3; DX1202-072-073 (Schertz PI Tr.) at 602:18-604:8; DX0717-041 (Walsh Dep.) at 159:11-23; DX1158-054 (Dillon Dep.) at 209:3-6). The statements in these exhibits that Complaint Counsel misleadingly rely upon are hearsay and misleading.

2) PX3151 is a November 3, 2005 email between Carol Stever and Mary Breeden of OSF. Complaint Counsel offer this document 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 email that Mr. Vayr was "told ... that RHS [is]

terminating ALL BCBS Agreements – including 'Commercial,'" contains at least three layers of hearsay. Second, despite two opportunities to question Mr. Vayr about this alleged 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* DX1185-039 (Vayr Dep.) at 150:3-6.) Complaint Counsel's use of this exhibit to suggest coordinated effects is misleading.

3) PX0349 and PX0350 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) and Dr. William Gorski, President and CEO of SwedishAmerican Health System (PX0350). As David Schertz, President and CEO of 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 healthcare facilities and systems in the broader service area "to confirm that this is the general direction everybody sees the world moving in." (DX1202-083 (Schertz PI Tr.) at 644:4-14). None of the information in these exhibits contains proprietary information – as a simple review of the documents reveals. (DX1202-083 (Schertz PI Tr.) at 644:20-23). [redacted] (DX706-055-56 ([redacted] Dep.) at 216:2-219:18). 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 and PX0350 are hearsay are unreliable and

Complaint Counsel's intended use of them is misleading and does not provide evidence of coordinated effects among the Rockford hospitals.[8]

4) PX1265 is a letter from Epstein Becker & Green, P.C., counsel for SAH, to Paul Brand, Executive Director of ECOH, dated September 26, 2008, and PX4000-019 and 024 are portions of the deposition transcript of Richard Walsh, COO of SAH, relating to PX1265. Complaint Counsel misleadingly offer the letter 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 if it had been, it would still constitute at least two layers of hearsay. Mr. Walsh's testimony, upon which Complaint Counsel also rely, 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 (Kaatz IHT); DX0706 (Kaatz Dep.); (DX1203-015 (Kaatz PI Tr.) at 707-776; DX0189 (Schertz IHT); DX0394 (Schertz IHT); DX0713 (Schertz Dep.); (DX1202 (Schertz PI Tr.) at 565-651). Moreover, Complaint Counsel misleadingly failed to mention in their Pre-Trial Brief that their theory collapsed when [redacted] To the contrary, [redacted]

[8] Judge Kapala described these HCF documents as "benign" and not evidence of collusion. *FTC v. OSF Healthcare System and Rockford Health System*, No. 11-50344, at *29 (N.D. Ill. Apr. 5, 2012).

[redacted]

(DX1151-042-43 ([redacted] Dep.) at 164:15-165:13). Kelly Davit, ECOH's Members Services Director at the time, confirmed this. (DX1157-003, 13-14 (Davit Dep.) at 8:20-24, 48:3-51:15). Both PX1265 and Mr. Walsh's testimony regarding this topic (PX4000-019 and 024) are unreliable and misleading, and do not support Complaint Counsel's coordinated effects theory.

5) PX0704 is an email chain between RHS CFO Henry Seybold and RHS Director of Managed Care Paula Dillon from July 17, 2008. Complaint Counsel suggest 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 cannot offer any evidence of what this means. More importantly, when they did question the supposed participants to this meeting during their depositions, all three individuals [redacted] (DX0937-044 (Seybold Dep.) at 171:24-172:17; DX1182-013 (Seybold Dep.) at 47:1-48:22; DX1158-049-50 (Dillon Dep.) at 192:24-194:16; DX0937-044 (Breeden Dep.) at 171:24-172:17). Complaint Counsel's use of this exhibit to suggest coordinated activity between Respondents is misleading. It does not support their coordinated effects theory.

6) Complaint Counsel reference PX4626 in their Pre-Trial Brief, a December 2, 2010 email exchange between [redacted] Complaint Counsel argued in the federal court proceeding that this email, [redacted] constitutes "coordinated" activity. Despite two opportunities, Complaint Counsel never questioned [redacted] about this document. (*See* DX0183 ([redacted] IHT); DX1185 ([redacted] Dep.)). Complaint Counsel waited to confront [redacted] with PX4626 until her deposition on February 16, 2012. (DX1158-050-54 ([redacted] Dep.) at 194:20-212:25). When Complaint Counsel asked [redacted]

about PX4626, [redacted] No matter how hard they tried to manipulate PX4626, [redacted] (DX1158-050-54 ([redacted] Dep.) at 194:20-212:25). This exchange between [redacted] and [redacted] does not constitute any sort of coordinated activity, and Complaint Counsel's attempt to suggest it does is misleading.

Moreover, none of the purportedly shared information shows that the Rockford area hospitals are likely to coordinate or impermissibly monitor their competitive activities in the future. (DX1210-080-81, ¶ 219 (Noether Report)). Indeed, hospital systems' monitoring of one another's service line offerings, recruitment, and capital expenditures is consistent with competition, not coordination. (DX0717-020-21 (Walsh Dep.) at 74:22-77:2). Each hospital system makes its own decisions regarding investments, services and amenities independently to fulfill its mission to provide quality healthcare to the community, based on its perception of the best interests of the Rockford community. (DX0717-020-21, 22 (Walsh Dep.) at 74:22-77:2, 81:1-10). Further, competition between healthcare systems involves not only price, but also quality and service dimensions. (DX1210-078-79, ¶¶ 210-15 (Noether Report)). It would be exceedingly difficult for OSF Northern Region and SAH to monitor or enforce any attempt to coordinate their competitive behavior in connection with MCO contracts (the terms of which are not public) or the quality or services they offer. (DX1210-078-79, ¶¶ 210-15 (Noether Report)).

This case is not 1989 re-visited. The suggestion in the 1989 record that the hospital systems may have colluded with one another has no analog and no support in the record pertinent

to the present transaction. *See United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1286 (7th Cir. 1990); *Rockford Mem'l Corp.*, 717 F. Supp. at 1286. The proposed merger of OSF and SAH in 1997, which the Antitrust Division of the U.S. Department of Justice investigated and approved, is far more analogous. That merger, like this one, involved the two smaller hospitals, whose objectives mirrored those of OSF and RHS today – to generate cost savings, efficiencies and quality improvements in a declining economic environment that they could not achieve on their own, for the benefit of the community. Faced with the new imperatives of healthcare reform, it is only through consolidation that OSF and RHS can maximize the value of the healthcare services provided to Rockford citizens.

3. Complaint Counsel Cannot Meet Their Burden of Proving that the Affiliation Violates Section 7 in the Primary Care Physician Market

Complaint Counsel also cannot meet their burden with respect to the second relevant market they allege – primary care physician services sold to commercial health plans. As noted above, Complaint Counsel are now relying on calculations of market shares and concentration in a market defined differently than the market has been previously defined. While Respondents do not concede that Complaint Counsel's definition of the PCP market is correct (those physicians practicing in family, general and internal medicine), Dr. Capps calculated market shares based on a different market definition than alleged by Complaint Counsel. (PX2515-155, ¶ 316 (Capps Report)). In particular, Dr. Capps adds hospitalists and physicians at urgent care centers, neither of which engage in primary care, to increase improperly the market shares held by SAMC and RMH. He then removes PCPs who practice at Crusader Clinic and downweights the physicians who practice at UIC to increase, improperly, the market shares of SAMC and RMH. Using the correct, non-manipulated data, Respondents' expert, Dr. Noether, has calculated a combined share that just reaches 30%. (DX1210-101, ¶ 279 (Noether Report)).

The evidence will demonstrate that, post-affiliation, anticompetitive effects in the primary care physician services market are unlikely. First, MCOs have substantial bargaining leverage over physician service contracts. (DX0197-006 (Breeden IHT) at 20:2-21; DX0716-011 (Seybold Dep.) 37:11-16). For example, [redacted] dictates prices for physician services in Rockford, allowing no negotiations. (DX0197-006 (Breeden IHT) at 20:2-21; DX0716-011 (Seybold Dep.) at 37:11-16). Second, entry into the primary care physician services market is easy. (DX1210-102, ¶ 282 (Noether Report)). Primary care physicians are recruited nationally, not locally. (DX0717-022 (Walsh Dep.) at 84:11-13; DX0184-046 (Seybold IHT) at 177:3-22) (SAH, SAMC, and RMH all recruit their primary care physicians from all over the country). Moreover, SAH also has Rockford's only family residency program. (DX0717-022-23 (Walsh Dep.) at 84:8-85:13). Entry is facilitated through the family residency program, as well as through independent primary care physicians, physicians who practice at the Crusader Clinic, and national recruitment of primary care physicians. (DX0717-022-23 (Walsh Dep.) at 84:8-87:5; DX1210-100, ¶ 277 (Noether Report)). In addition, most physicians admit to only one hospital, and for those who admit to two hospitals, the two are usually not both RMH and SAMC. (DX1210-075, ¶ 202 (Noether Report)). Thus, the transaction will not change physician referral patterns.

In sum, the consolidation of the SAMC and RHS physician practices will not change the competitive landscape for the physician services offered by the hospitals. Complaint Counsel cannot meet their burden with respect to this alleged market, and this claim should be dismissed.

II. THE AFFILIATION WILL PROVIDE SIGNIFICANT COMMUNITY BENEFITS

The affiliation will result in substantial efficiencies and benefits for the Rockford community, including improving access to medical services, consolidating programs and services, allowing for care of patients at a single site, and improving quality. (DX1209-016-11,

¶¶ 7-12 (Manning Report)). The affiliation will also benefit the Rockford community by creating the opportunity to reduce costs and clinically integrate and enhance services to be provided locally. (DX1209-016-11, ¶¶ 7-12 (Manning Report)). These benefits outweigh any potential anticompetitive effects and rebut any presumption resulting from an alleged decrease in competition.

The affiliation will help to remedy the over supply of hospital-based services in Rockford and increase the effective use of healthcare dollars. In this rapidly changing healthcare world, three hospital systems in Rockford is one too many, and unsustainable. Hospitals have been artificially subsidized by the government for decades in both their capital investment and their ongoing operations. (DX1405-006-07, 16-17, 27-28, ¶¶ 8-10, 28-29, 43 (Sage Report)). In small communities such as Rockford, relatively large hospitals have proliferated because of the availability of funds under federal government policies. Those policies have now been revamped and are sending the healthcare system in a new direction, in which efficient and effective delivery of healthcare is paramount. Without the incentives to build hospitals supplied by Hill-Burton funds, tax-exempt bond financing, and Medicare cost-plus and capital cost reimbursement, small and medium-sized communities like Rockford would have had fewer and smaller hospitals. (DX1212-027-28, ¶ 43 (Sage Report)). Those incentives are now being reversed. Three hospital systems in Rockford is not sustainable, because the external subsidies that have supported them are disappearing. (DX1212-029, ¶ 47 (Sage Report)). No Rockford hospital staffs even close to all of its licensed beds, and occupancy rates of staffed beds range from roughly [redacted] (DX1210-073, ¶ 192, Exhibit 15 (Noether Report)). In addition, there is extensive duplication and triplication of expensive services in Rockford, including, for example: three open-heart surgery programs, two Level I trauma centers, three obstetrics

programs, multiple MRI/CT scanners, three pediatric units, and three helicopter services. (DX0698-028, 31 (Kaatz IHT) at 107:6-108:1, 118:17-119:22; DX0196-024 (Schoeplein IHT) at 91:2-92:3). Expensive equipment is underutilized, wasting precious healthcare dollars that can only be saved through consolidation. (DX1209-118-129, ¶¶ 256-72 (Manning Report)).

Given the primacy of cost savings, efficient and improved delivery of services is particularly important in the unique world of healthcare, where less must provide more. Complaint Counsel claim that they seek to preserve innovation through competition, but the most important innovations in the health care delivery will focus on better ways to deploy new technology, not just the technology itself, and will require both acute care consolidation and integration among hospitals and physicians. (DX1212-037, ¶ 61 (Sage Report)). The evidence presented will show that the affiliation is the best way to address the challenges of healthcare reform, reduce costs going forward, combat out-migration, attract and recruit sub-specialists, support graduate medical education in Rockford, and maximize the ability to deliver effective, efficient health care services to the Rockford community.

CONCLUSION

Complaint Counsel cannot satisfy their burden of proving each element of their Clayton Act Section 7 case. The evidence will show that Complaint Counsel have nothing but speculation to add to their market share and concentration data. Market share and concentration data simply are not a reliable predictor of OSF Northern Region's ability to obtain supracompetitive prices. OSF and RHS will demonstrate, with real evidence, that the affiliation will result in substantial efficiencies and cost savings that will benefit the Rockford community, and that the affiliation will best answer the call for effective delivery of healthcare services under healthcare reform. The evidence will establish that the affiliation will not result in a substantial

lessening of competition in either market Complaint Counsel alleges and, therefore, does not violate Clayton Act Section 7.

Dated: April 12, 2012

Respectfully submitted,

/s/ Alan I. Greene

Alan I. Greene
Matthew J. O'Hara
Kristin M. Kurczewski
Hinshaw & Culbertson LLP
222 N. LaSalle Street, Suite 300
Chicago, IL 60601
Telephone: (312) 704-3000
Facsimile: (312) 704-3001
agreene@hinshawlaw.com
mohara@hinshawlaw.com
kkurczewski@hinshawlaw.com

Michael Iasparro
Hinshaw & Culbertson LLP
100 Park Avenue
Rockford, IL 61101
Telephone: (815) 490-4945
Facsimile: (815) 490-4901
miasparro@hinshawlaw.com

Attorneys for Respondent OSF Healthcare System

David Marx, Jr.
William P. Schuman
Amy J. Carletti
McDermott Will & Emery LLP
227 West Monroe Street
Chicago, IL 60606
Telephone: (312) 372-2000
Facsimile: (312) 984-7700
dmarx@mwe.com
wschuman@mwe.com
acarletti@mwe.com

Jeffrey W. Brennan
Carla A. R. Hine
Nicole L. Castle
Rachael V. Lewis
Daniel G. Powers
James B. Camden
Shauna A. Barnes
McDermott Will & Emery LLP
600 13th Street, N.W.
Washington, D.C. 20005-3096
Telephone: (202) 756-8000
Facsimile: (202) 756-8087
jbrennan@mwe.com
chine@mwe.com
ncastle@mwe.com
rlewis@mwe.com
dgpowers@mwe.com
jcamden@mwe.com
sabarnes@mwe.com

Attorneys for Respondent Rockford Health System

CERTIFICATE OF SERVICE

I, Kristin M. Kurczewski, hereby certify that I served a true and correct copy of the foregoing Respondents OSF Healthcare System's and Rockford Health System's Pre-Trial Brief upon the following individuals by hand on April 12, 2012:

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

The Honorable D. Michael Chappell
Administrative Law Judge
Federal Trade Commission
600 Pennsylvania Avenue, N.W.
Washington, D.C. 20580

I, Kristin M. Kurczewski, hereby certify that I served a true and correct copy of the foregoing Respondents OSF Healthcare System's and Rockford Health System's Pre-Trial Brief upon the following individuals by electronic mail on April 12, 2012:

Matthew J. Reilly
Jeffrey H. Perry
Kenneth W. Field
Richard Cunningham, Esq.
Jeremy P. Morrison
Katherine A. Ambrogi
Andrea Zach
Jeanne Liu
Stephanie Reynolds
Theresa Lau
Federal Trade Commission
600 Pennsylvania Ave., N.W.
Washington, D.C. 20580
mreilly@ftc.gov
jperry@ftc.gov
kfield@ftc.gov
rcunningham@ftc.gov
jmorrison@ftc.gov
kambrogi@ftc.gov
azach@ftc.gov
jliu@ftc.gov
sreynolds@ftc.gov
tlau@ftc.gov

Complaint Counsel

EXHIBIT A

REDACTED IN ENTIRETY – FILED IN CAMERA

Dated: April 12, 2012

/s/ Kristin M. Kurczewski
Kristin M. Kurczewski
Counsel for Respondent
OSF Healthcare System