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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
MISSOULA DIVISION

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	CV 96-121-M-CCL
	)	
v.	)	
	)	PRE-DISCOVERY DISCLOSURE
GENERAL ELECTRIC COMPANY,	)	STATEMENT OF THE UNITED STATES
	)	
Defendant.	)	

The United States of America, by its attorneys, respectfully submits this Pre-Discovery Disclosure Statement pursuant to Local Rule 200-5(a), Federal Rule of Civil Procedure 26, and this Court's Order of April 29, 1997. Appendix A sets forth a factual basis for the claims advanced in the Complaint, as modified by this Court's Order of March 18, 1997. Appendix A also notifies the Court and General Electric Co. ("GE") of those areas of the country where the United States currently intends to demonstrate that GE's license agreements for Advanced Diagnostic software have had an actual detrimental effect on competition. Appendix B sets forth the legal theory upon which the claims in the Complaint, as modified, are based. Appendix C identifies those individuals believed to have discoverable information about

the claims. Finally, Appendix D describes the documents held by the Antitrust Division that are reasonably likely to bear on the claims.

The United States may modify or supplement this statement based on evidence gathered during the upcoming discovery period.

Dated: May 14, 1997

Respectfully submitted,

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APPENDIX A

FACTUAL BASIS FOR CLAIMS ADVANCED IN THE COMPLAINT

A. Background

GE is one of the world's largest manufacturers of medical imaging equipment, such as CT scanners, magnetic resonance imagers (MRI), mammography units and x-ray equipment. (Answer ¶ 4.) GE distributes and sells such equipment throughout the United States and is also in the business of servicing many brands of medical equipment in local markets throughout the United States. (Answer ¶¶ 2, 10-14.) Medical imaging equipment requires regular service in order to function properly. (Answer ¶ 15.)

To help service its equipment, GE has developed Advanced Diagnostic materials, including software and manuals, ("Advanced Diagnostics") for much of the medical imaging equipment it sells. (Dunham Dep. at 91-92.) The Advanced Diagnostics enable an engineer to calibrate, service, and maintain more quickly a particular model of imaging equipment. (GEMSX 020879.)[1] Using Advanced Diagnostics can increase the amount of time a hospital's GE imaging equipment is functional, which is important for maintaining high-quality patient care.[2]

[1]Documents identified with "GEMS," "GEMSI," and "GEMSX" refer to documents produced by GE. Those identified with "M" refer to documents produced by Martec, a GE consultant.

[2]GE also has developed "basic" diagnostic materials. Federal regulations require GE to provide those materials to every purchaser of its imaging equipment. See 21 C.F.R. § 1020.30(g) & (h) (1966).

This case challenges the agreements used by GE to license its Advanced Diagnostics to hospitals in the United States that own GE medical imaging equipment. As a condition to the issuance of the license agreements, GE has required the hospitals to agree not to compete with GE in the servicing of certain medical equipment at any other hospital or clinic. These agreements have reduced competition in the servicing of medical equipment. The United States will prove that these agreements are per se violations of the Sherman Act. The United States is also prepared to prove anticompetitive effects resulting from these agreements.

B. GE and Certain Hospitals Have Agreed Not to Compete in Servicing Third-Party Medical Equipment

Since at least 1988, GE has licensed Advanced Diagnostics to certain hospitals with in-house service capability. (GEMSI 000555.) Before a hospital can obtain and use the Advanced Diagnostics, GE requires it to sign a license in which the hospital agrees that it will not compete with GE to service various types of medical equipment. Through this arrangement, GE has required over 500 hospitals to agree not to compete with it.

The United States will prove that the clauses in the licenses that prevent hospitals from competing with GE are agreements between GE and the hospitals by demonstrating that: (1) the licenses on their face incorporate the non-compete clause as part of the agreement between GE and its licensees; (2) GE has

admitted, in various documents and statements to its licensees, that the clause in the written license is a material part of the license agreement between GE and the licensees; (3) GE sought to enforce the non-compete clause; and (4) GE's actions in negotiating the scope of the restriction with various licensees are inconsistent with GE's claim that the clause is merely an announcement of GE's unilateral policy.

From 1988 to April 1992, GE's standard Advanced Diagnostics license agreement read in part:

> Licensee [hospital] represents to Licensor [GE] at all times during the term of this License . . . that Licensee has no full or part time employee who services any type of medical diagnostic imaging equipment for any person or entity other than Licensee . . . . Licensor recognizes that . . . the foregoing representations of Licensee are material inducements to Licensor to grant this License. (GEMSI 000557.)

In 1992, GE modified its standard agreement to read:

> You [hospital] are not and you are not an affiliate of any person or entity who is a competitor of ours [GE].
>
> . . .
>
> You have no full or part time employee who services any type of medical equipment of any person or entity other than you.
>
> . . .
>
> You have requested us and we have agreed to grant this License to you based on your above representations . . . which are material inducements for our grant of this License. (GEMSI 000560.)

The 1988 and 1992 standard license agreements provide that the hospital breaches the agreement if it violates these clauses. Additionally, the standard agreements state that these

clauses survive the termination of the license agreement. (GEMSI 000558; GEMSI 000562.)

Just before the United States filed this suit in 1996, GE again modified its standard license agreement to forbid hospitals from servicing GE imaging equipment of the same type or modality as that for which the Advanced Diagnostics was licensed. (Letter from Gary Foster to Licensees of GE Medical, dated April 30, 1996.) (The clauses from GE's 1988, 1992 and 1996 standard license agreements which prohibit service competition are collectively referred to as the "Restrictive Clause.")

GE told its licensees that their agreement to comply with the Restrictive Clause was consideration for the Advanced Diagnostics. (GEMSI 000557, 000560; see also GEMSX 7787.) GE also advised the hospitals that their violation of that clause would constitute a breach of the license agreement. (E.g., GEMSX 038882; GEMSX 041023; GEMSX 041930; Scaduto Dep. at 192-93.) If a licensed hospital violated the clause by competing with GE, GE's service representatives would remove the Advanced Diagnostics "per the terms of the license agreement," or threaten to find the hospital in breach of contract unless the hospital agreed to stop providing third-party service. (GEMSX 020880, GEMSX 7785, Plasse Dep. at 37-39, 49, 52-55; see also GEMSX 7806.)

GE's conduct also demonstrates that the clause is part of an agreement and not GE's unilateral policy. The evidence shows that GE told several licensees that they had breached their

agreement not to compete because one of their employees was providing third-party imaging service during his off hours. In those cases, GE required the licensees to comply with the restriction in the license. Once, GE proposed a "settlement" in which the licensee would stop the employee from servicing medical equipment in competition with GE. (GEMSX 41930.)

GE has negotiated the scope of the non-compete agreement with many of its licensees. GE has allowed some hospitals to continue their existing service operations, provided they agreed not to service new hospitals or clinics. GE has agreed with other hospitals that their in-house employees could service certain types of third-party equipment in competition with GE. GE has agreed with still other hospitals that the hospital could service any equipment outside of the hospital so long as it did not use the Advanced Diagnostics to perform such service. Examples of some such negotiated modifications to GE's standard license agreements are reflected in the following GE documents or testimony:

- In June 1993, with Shadyside Hospital in Pittsburgh, Pennsylvania (Flieder Dep. at 54-56 & Ex. 2);
- In 1993, with North Iowa Mercy Health Center (GEMSX 36616-36619);
- In November 1994, with Crouse Irving Memorial Hospital in Syracuse, New York (GEMSX 016271-81);
- In 1994, with Valley Medical Center in Renton, Washington (GEMSX 41714-24);
- In 1994, with Forbes Regional Health Systems in Pennsylvania (GEMSX 29968-70); and

- In 1994, with Children's Hospital of Alabama. (GEMSX 033075-100.)

C. GE and Its Licensees Are Actual or Potential Competitors in the Servicing of Third-Party Medical Equipment

A number of hospitals successfully compete with GE in the service of medical equipment. Other hospitals have been or would be competitors of GE but for their agreements with GE not to compete. (McKelvey Dep. at 59; Young Dep. at 42-49.) GE recognizes that hospitals with in-house service departments are competitors. GE's documents show that GE and its consultants viewed hospitals with in-house service abilities to be a competitive threat and that teaching hospitals were GE's "greatest threat" in markets for servicing medical equipment. (GEMS 49875.)

GE closely monitored the competitive threat of hospitals. It recognized that many hospitals with in-house service departments already offered or planned to offer service to others and that their efforts were increasing. (GEMSX 50208-11; GEMSX 2640.) Studies GE's consultants prepared found that hospitals with in-house service departments had taken service business away from manufacturers of medical equipment ("Original Equipment Manufacturers" or "OEMs") such as GE. (M 1953.) They concluded that hospitals with in-house service organizations had service strength equal to or better than the OEMs, and that such hospitals had shown the greatest growth potential in the service field. (GEMS 75419.)

Hospitals with in-house departments that currently do not service third-party equipment are recognized as potential competitors. Many do not currently offer service only because their agreements with GE prohibit competition. Some hospitals previously had serviced equipment at other hospitals or clinics before entering into an Advanced Diagnostics license agreement with GE. (E.g., Columbus Hospital in Great Falls, Montana.) Other hospitals have stated that they would like to, but have been prevented from doing so by their agreement with GE. (E.g., Deaconess Medical Center in Billings, Montana.) Still other hospitals have employees that have and would compete with GE during their free time but are prevented from doing so because of their employers' agreement with GE. (E.g., University of Alabama, Birmingham.)

D. The Restrictive Clause Is Not Necessary to Protect Any Legitimate Interest GE Has in Licensing Its Intellectual Property

The United States has not been able to identify any legitimate justification for GE's and its licensees' agreement not to compete. GE bears the burden of identifying and establishing any such justification. In various white papers and in discussions with the United States, GE has suggested that these agreements are necessary to prevent its licensees from

misappropriating its intellectual property.[3] However, the evidence does not support this position.

1. Advanced Diagnostics Designed for and Installed on One GE Machine Will Not Work on Any Other Machine

GE's Advanced Diagnostic software will not function on any other OEM's equipment because such equipment's internal computer systems will not recognize GE's software. (McKelvey Dep. at 45; Plasse Dep. at 59.) Further, GE's Advanced Diagnostic software will not run on older generations of GE imaging equipment. (McKelvey Dep. at 54-56.) Finally, the Advanced Diagnostics for one model of GE imaging equipment is not compatible with another model of the same type of imaging equipment. (McKelvey Dep. at 46-47.)

2. GE Employs Security Devices That Eliminate Any Need for the Restrictive Clause

GE employs a "product specific" or "site specific" technology on the Advanced Diagnostic software it licenses. (GEMSX 002328; GEMSX 016677.) This technology, also known as "fingerprinting," ensures that the Advanced Diagnostic software designated for and installed on one particular machine will work only on that machine and no other. (McKelvey Dep. at 42-43.)

In addition to the fingerprinting feature, GE also has introduced a key card security device for some of its imaging equipment. (Mills Dep. at 311-13; Schmidt Dep. at 248.) The key

[3]GE's standard form agreement also restricts a hospital's use of the Advanced Diagnostics to the particular piece of equipment for which it was licensed. The United States does not challenge that restriction.

card is encoded with the serial number of a particular GE machine. The key card is needed to unlock the Advanced Diagnostics inside a machine, but will do so only if inserted in the one GE machine whose serial number matches the number encoded on the key card. (Mills Dep. at 310-13; Schmidt Dep. at 248.) The key card also has a "timeout," "time bomb," or "detonation date" feature, which causes the key card to stop working after approximately a year. (Schmidt Dep. at 248; Moore Dep. at 239, 283-84.) Because these features prevent a licensee from using GE's software to repair third-party equipment, GE does not need the agreements not to compete in order to protect its property rights in its software.

E. The Relevant Markets Affected by GE's Conduct

GE's agreements have lessened competition in two different types of markets: markets for the sale of service for medical equipment and markets for the sale of medical imaging equipment.

1. Markets to Service Medical Equipment

The sale of service for each type or model of medical equipment is a separate product market. Hospitals, clinics, and other users of medical equipment need to purchase both repair service and preventive maintenance for their medical equipment. (Answer ¶ 15.) If the price of service for any particular type of medical equipment increases significantly, the owners of that equipment do not have any substitutes to which to turn.

Moreover, the owner of a given piece of medical equipment will only purchase service from a provider able to service that particular piece of equipment; it will not substitute service on another piece of equipment. For example, if the price of service for a MRI machine increased by a small but significant amount, the owner of the MRI machine would not forego service on the MRI machine and instead purchase service for a CT scanner. Thus, the service of each type or model of medical equipment constitutes a separate product market.

The geographic markets for the sale of service are local, although the precise contours of those markets differ for different types of equipment. Generally, customers prefer to purchase service from nearby service providers where such providers are qualified and able to service their equipment. Where no qualified local providers are available, customers must pay the increased transportation and labor costs associated with flying someone in. (Declaration of Michael Wright.) However, the farther away is the service provider, the longer the customer's machine will be down and unable to generate revenue, and, more importantly, unavailable to help diagnose and treat patients. Id. Where there are qualified service providers in the same town as the facility where the equipment is located, the geographic market for that facility is likely to be that town and its immediate surroundings. Where there are no locally-based service providers near a facility, the geographic market for that

facility will be larger; its contours will depend on the nature of the equipment and the location of the nearest providers.

2. Markets for the Sale of Medical Imaging Equipment

Each "modality" of medical equipment (e.g., CT scanner, MRI, etc.) constitutes a separate product market. Each modality of medical equipment performs a different function and has a different medical purpose. (Answer ¶ 18.) Thus, medical facilities typically do not purchase one modality of medical equipment, such as a CT scanner, as a substitute for another, such as an MRI, in response to a small, but significant increase in the price of the MRI.

When a health care facility purchases new medical equipment, it considers not only the cost, quality, and features of the equipment itself, but also the cost of servicing that equipment over time. As previously discussed, transportation, labor and downtime costs are greater if local service is not available for a particular machine. A health care provider will purchase equipment from manufacturers based across the nation but, because service is of critical importance, will generally only do so if local service is available for that equipment. Consequently, the geographic markets for the sale of medical imaging equipment are local as determined by the availability of local service for particular equipment.

F. GE's License Agreements Have Harmed Competition

1. In the Markets for the Sale of Medical Equipment Service

GE's non-compete agreements have harmed competition in the sale of medical equipment service by preventing numerous hospitals across the United States, including those in Montana, from providing high-quality, low-cost service. These hospitals are often GE's most significant actual or potential competitors in service markets.

There often are only a limited number of effective providers in a service market. To compete effectively, a service provider must offer high-quality, timely, reliable, and reasonably priced service. Customers in a local service market often only have a few qualified service providers who can meet their service needs.

An OEM may not have enough equipment to support a local service engineer in an area, and thus will be forced to provide service from a distant region, which results in higher service costs. Few independent service organizations ("ISOs") offer a competitive alternative since they may not have the reputation for quality and reliability or have the skills necessary to effectively service complex medical equipment. As a result, in many markets across the United States, few realistic service options exist.

Hospitals with in-house service departments are ideally positioned to compete in the markets for medical equipment service. Many hospitals with in-house service departments would

charge much less than OEMs to provide service. For example, hospitals (or their off-duty employees) that do compete with GE (and forego the Advanced Diagnostics) charge far less (sometimes less than half as much) than GE, which charges as much as $150 an hour. (E.g., Geisinger Hospital in Pennsylvania, Sacred Heart Hospital in Washington; GEMS 68871-73.) Hospitals that do desire Advanced Diagnostics are restrained by their GE license agreements from offering such service. In a market where one of very few service providers is restrained, prices typically increase and service quality declines.

Montana contains a number of markets for the service of various types of medical equipment. GE, which has in Montana the largest installed base of medical imaging equipment of any manufacturer, has service personnel based in Billings, Missoula, Butte, Great Falls, and several other communities. Of the other major OEMs, only Picker, and possibly Accuson and Siemens, have any service employees based in Montana. Moreover, their employees service only that OEM's brand of equipment. Other OEMs must fly in service engineers from distant locations such as Denver, Salt Lake City, and Seattle. There are only a very few qualified ISOs in Montana, and like ISOs in many areas of the United States, many lack the training, skills, response capabilities, and reputation to compete effectively with GE in servicing more complex types of medical equipment. As a result, customers in Montana have very few service options.

At least two Montana hospitals with in-house service departments, Deaconess Medical Center in Billings and St. Patrick Hospital in Missoula, have the ability and desire to provide service to third parties. (Young Dep. at 52; McKelvey Dep. at 61-63.) These hospitals could offer quality service at a price that is attractive to consumers of medical equipment service in of Montana and its bordering areas. At one time, Columbus Hospital in Great Falls offered service to smaller hospitals and clinics at prices far below GE's prices. (Young Dep. at 23, 49.) However, as a result of their agreements with GE, each of these hospitals is prevented from competing with GE to service other facilities' equipment. (McKelvey Dep. at 61; Young Dep. at 38-39, 50.)

Absent the Restrictive Clause, these Montana hospitals would have offered quality medical equipment service to third-party area health care facilities at a much lower price than GE's. (McKelvey Dep at 61,63; Young Dep. at 37.) By eliminating these competitors, GE has caused consumers in Montana and its surrounding areas to pay more for service than they otherwise would have. Their elimination especially has harmed smaller hospitals and medical facilities. (McKelvey Dep. at 61.)

2. In the Markets for the Sale of Medical Imaging Equipment

GE's non-compete agreements also have harmed competition in markets for the sale of medical imaging equipment. When deciding what type of medical imaging equipment to purchase, hospitals and other health care facilities consider not only the

cost, quality, and features of the equipment, but also the availability of service for it. As previously explained, in numerous areas of the country, including Montana, many imaging equipment OEMs lack a sufficient installed base to support service personnel. These OEMs must either fly someone into the area from a distant location or rely on other service providers to service their equipment. If the only available service providers are far away, the OEM would be at a significant competitive disadvantage to GE in the sale of imaging equipment because the service costs to the customer would be much higher.

Absent the Restrictive Clause, an OEM could enlist a hospital with an in-house service department to service its machines. Such an arrangement would improve its ability to compete with GE in the sale of imaging equipment. The Restrictive Clause, however, prevents the hospital with an in-house department from providing this service for an OEM. This limits competition from other OEMs and effectively denies customers the option of purchasing equipment from some OEMs that may be more desirable and less expensive. (Declaration of Barker.)

3. Evidence of Actual Detrimental Effects on Competition

The evidence will demonstrate that GE's agreements with its licensees have had the actual effects of raising service prices, reducing the amount of service purchased, and reducing consumer choice. For example, the 1992 Restrictive Clause barred licensee hospitals from servicing all types of third-party

medical equipment in competition with GE. GE's conduct likely harmed competition in the sale and service of medical equipment in numerous markets throughout the United States. To streamline trial presentation, rather than produce evidence of actual effects on competition in every market, the United States currently intends to demonstrate actual detrimental effects in and around the following states: Montana, Alabama, Illinois, Indiana, South Carolina, Texas (Panhandle area), and Washington.

APPENDIX B

LEGAL THEORY FOR THE CLAIMS IN THE COMPLAINT

The Court's Order of March 18, 1997 and the United States' briefs in opposition to GE's motion to dismiss already have set forth the legal theories underlying the United States' claims. For the convenience of the Court and the Defendant, however, those legal theories are summarized below.

Section 1 of the Sherman Act, as interpreted by the courts, makes unlawful contracts or agreements that unreasonably restrain trade. Arizona v. Maricopa County Medical Society, 457 U.S. 332, 342-43 (1982). The Supreme Court has held that "agreements whose nature and necessary effect are so plainly anticompetitive that no elaborate study of the industry is needed to establish their illegality" are "illegal per se." Northern Pacific Ry. Co. v. United States, 356 U.S. 1, 5 (1958).

Non-ancillary agreements between actual or potential competitors to allocate territories or customers are illegal per se because they are "naked restraints of trade with no purpose except stifling of competition." Palmer v. BRG of Georgia, 498 U.S. 46, 49-50 (1990). Such agreements "are anticompetitive regardless of whether the parties split a market within which both do business or whether they merely reserve one market for one and another for the other." Id. An agreement not to compete in terms of price or output, without some pro-competitive justification, is simply "inconsistent with the Sherman Act's

command that price and supply be responsive to consumer preference." National Collegiate Athletic Association v. Board of Regents of the University of Oklahoma, 468 U.S. 85, 109-10 (1984). Moreover, "the existence of a vertical aspect to the relationship between [GE and its hospital licensees] does not foreclose per se treatment of agreements to eliminate competition between them." United States v. General Electric Co. (Order of March 18, 1997), 1997-1 CCH Trade Cases, ¶ 71,765, pp. 79,408-409 (citing Palmer); see also United States Surreply to Defendant's Motion to Dismiss, pp. 3-5).

Because the non-compete agreements between GE and the hospitals are between horizontal competitors, they are per se illegal unless shown to be ancillary to some other legitimate agreement. An agreement is ancillary only if it is "subordinate and collateral [to a legitimate transaction] and necessary to make that transaction effective." Los Angeles Memorial Coliseum Comm'n. v. National Football League, 726 F.2d 1381, 1395 (9th Cir.), cert. denied, 469 U.S. 990 (1984); see also General Leaseways, Inc. v. National Truck Leasing Ass'n., 744 F.2d. 588, 595 (7th Cir. 1984); United States v. Addyston Pipe & Steel Co., 85 F. 271 (6th Cir. 1898), affirmed, 175 U.S. 211 (1899).

Even if the Court determines that these non-compete agreements should be analyzed under the rule of reason, rather than treated as per se illegal, the agreements unreasonably restrict competition and are therefore still illegal. The essence of a rule of reason analysis is a determination "whether

the challenged agreement is one that promotes competition or one that suppresses competition." National Society of Professional Engineers v. United States, 435 U.S. 679, 691 (1978). The United States is prepared to demonstrate the anticompetitive effects of GE's agreements in two ways. First, the United States will show actual adverse effects on price, output, and choice. "[P]roof of actual detrimental effect . . . can obviate the need for an inquiry into [market definition and] market power." FTC v. Indiana Federation of Dentists, 476 U.S. 447, 460-61 (1986); Oltz v. St. Peters Community Hosp., 861 F.2d 1440, 1448 (9th Cir. 1988). Second, the United States will prove that GE's agreements eliminated a significant competitor in many markets where there are few competitors, thereby reducing competition in those markets. See, e.g., Columbia Metal Culvert Company v. Kaiser Aluminum & Chemical Corp., 579 F.2d 20, 32 (3rd Cir.), cert. denied, 439 U.S. 876 (1978).

APPENDIX C

LIST OF INDIVIDUALS WHO MAY HAVE RELEVANT INFORMATION

Attached is a list of individuals whom the United States reasonably believes have discoverable information about the United States' claims. The list is divided into the following categories, indicating the types of discoverable information that each person is believed to have:

(1) Individuals associated with hospitals, clinics and doctors' offices across the country that likely possess information pertaining to: (a) the office's equipment and service needs, options, and preferences; (b) the prices charged for medical equipment, service, and parts; (c) the costs of performing service on medical equipment; (d) the functions of different types of medical equipment; (e) the effects of limiting competition for the service of medical equipment; (f) GE's licensing of Advanced Diagnostics; (g) competitive analyses and marketing strategies; and/or (h) the qualifications needed to service medical equipment. (See Appendix C - 4 to C - 52.)

(2) Individuals associated with equipment and parts vendors that likely possess information pertaining to: (a) the costs to manufacture medical equipment and parts and to perform service on medical equipment; (b) the prices charged for medical equipment, service, and parts; (c)

the functions of different types of medical equipment; (d) the equipment and service needs, options, and preferences of their customers; (e) the effects of limiting competition for the service of medical equipment; (f) competitive analyses and marketing strategies; (g) the licensing of proprietary materials, including diagnostic materials; and/or (h) the qualifications needed to service medical equipment.

(See Appendix C - 53 to C - 54.)

(3) Individuals associated with non-vendor service providers that likely possess information pertaining to: (a) the costs of performing service on medical equipment; (b) the prices charged for such service and parts; (c) the functions of different types of medical equipment; (d) the service needs, options and preferences of their customers; (e) the effects of limiting competition for the service of medical equipment; (f) competitive analyses and marketing strategies; and/or (g) the qualifications needed to service medical equipment.

(See Appendix C - 55 to C - 57.)

(4) Individuals associated with industry associations and government agencies that likely possess information pertaining to: (a) the prices of medical equipment, service and parts; (b) the functions of different types of medical equipment; (c) regulations for imaging

equipment; and/or (d) market data, including trends in the medical equipment or service industries. (See Appendix C - 58 to C - 60.)

(5) GE's current and former employees, managers, officers or directors that likely possess information pertaining to this litigation.[4] (See Appendix C - 61.)

[4]GE, of course, likely has better information than the United States as to which of its employees have discoverable information. Nevertheless, the United States has identified, either by job assignment or name, those employees it reasonably believes to have discoverable information.

APPENDIX D

A DESCRIPTION OF THOSE DOCUMENTS REASONABLY LIKELY TO BEAR ON THE CLAIMS

I. Signed Declarations

1. Declaration of Sam Allen (Community Hospital of Anaconda; Anaconda, MT).
2. Declaration of Sean Arthur (Crouse Irving Memorial Hospital; Syracuse, NY).
3. Declaration of Thomas Asay (Powell Hospital; Powell, WY).
4. Declaration of John Bandringa (Sacred Heart Hospital; Spokane, WA).
5. Declaration of Edward Barker (Instrumentarium Imaging, Inc.; Milwaukee, WI).
6. Declaration of John Bartos (Marcus Daly Memorial Hospital; Hamilton, MT).
7. Declaration of Karen Beemer (West Park Hospital; Cody, WY).
8. Declaration of Richard Bourne (Spectrum Medical; Great Falls, MT).
9. Declaration of J. A. Brinkers (Veterans Affairs Medical Center; Sheridan, WY).
10. Declaration of Christopher Buck (Kelowna General Hospital, British Columbia, Canada).
11. Declaration of Carolyn Carver (Philips County Hospital; Malta, MT).

12. Declaration of John Chioutsis (Rosebud Health Care Center; Forsyth, MT).
13. Declaration of Tom Christensen (Glendive Medical Center; Glendive, MT).
14. Declaration of Sharon Cramer (Clark Fork Valley Hospital; Plains, MT).
15. Declaration of Grant Crawford (St. John's Lutheran Hospital; Libby, MT).
16. Declaration of Sharlett Dale (Wheatland Memorial Hospital; Harlowton, MT).
17. Declaration of Jim Davis (Carbon County Hospital; Red Lodge, MT).
18. Declaration of Robert Dion (U.S. Public Health Indian Hospital; Harlem, MT).
19. Declaration of Robert Epstein (Queen's Health Technologies, Inc.; Honolulu, HI).
20. Declaration of Stephen Etienne (Crouse Irving Memorial Hospital; Syracuse, NY).
21. Declaration of Jim Everson (Sidney Health Center; Sidney, MT).
22. Declaration of Robert Fladeland (Community Hospital; Poplar, MT).
23. Declaration of Roger Fleishour (Group Health of Spokane; Spokane, WA).
24. Declaration of Barry Foster (Mt. Carmel Health System; Columbus, OH).

25. Declaration of Scott Friedrick (Memorial Hospital; Sheridan, WY).
26. Declaration of Stewart Garson (Appleton Medical Center; Appleton, WI).
27. Declaration of Eloise Gutzke (Sheridan Memorial Hospital; Plentywood, MT).
28. Declaration of Carol Hansen (Big Horn County Memorial Hospital; Hardin, MT).
29. Declaration of Joseph Happ (Mt. Carmel Health Systems, Columbus, OH).
30. Declaration of Anna Hazen (Missouri River Hospital Medical Center; Fort Benton, MT).
31. Declaration of Sally Henkel (Wenatchee Valley Clinic; Wenatchee, WA).
32. Declaration of Robert Hertert (Veterans Administration Hospital; Portland, OR).
33. Declaration of Glen Hilton (Liberty County Hospital; Chester, MT).
34. Declaration of Melynda Holtsberry (Mt. Carmel Health Systems, Columbus, OH).
35. Declaration of Allen Hrejsa (Lutheran General Hospital; Park Ridge, IL).
36. Declaration of William Hunter (Livingston Memorial Hospital; Livingston, MT).
37. Declaration of George Ingram (B.M.C. DeKalb Medical Center; Fort Payne, AL).

38. Declaration of Kenneth Kellum (Roundup Memorial Hospital; Roundup, MT).
39. Declaration of Barry Kenfield (Community Medical Center; Missoula, MT).
40. Declaration of Bob Knight (Sacred Heart Hospital; Spokane, WA).
41. Declaration of Sherry Langstaff (Stillwater Community Hospital; Columbus, MT).
42. Declaration of Davee Letford (Granite County Medical Assistance Facility; Philipsburg, MT).
43. Declaration of Merle Loseke (Trinity Regional Hospital; Fort Dodge, IA).
44. Declaration of Don Majerus (Bozeman Deaconess Hospital; Bozeman, MT).
45. Declaration of Miles Matthews (Toole County Hospital; Shelby, MT).
46. Declaration of Norman McLarin (Sacred Heart Hospital; Spokane, WA).
47. Declaration of Douglas McMillan (Frances Mahon Deaconess Hospital; Glasgow, MT).
48. Declaration of Michael Moakley (Philips Medical Systems; Sheldon, CT).
49. Declaration of Ramona Nations (Sidney Health Center; Sidney, MT).
50. Declaration of Mario Noveloso (Queens Medical Center; Honolulu, HI).

51. Declaration of Daniel Owens (St. Peters's Community Hospital; Helena, MT).
52. Declaration of Thomas O'Hara (Rosebud Health Care Center; Forsyth, MT).
53. Declaration of William O'Leary (Kalispell Regional Hospital; Kalispell, MT).
54. Declaration of Catherine Palmer (Missoula Community Medical Center; Missoula, MT).
55. Declaration of Linda Parsons (Ruby Valley Hospital; Sheridan, MT).
56. Declaration of Don Pearson (North Valley Hospital; Whitefish, MT).
57. Declaration of David Pepper (University of Alabama; Birmingham, AL).
58. Declaration of Douglass Perston (Sequoia Hospital; Redwood City, CA).
59. Declaration of Larry Peterson (Oregon Health Sciences University; Portland, OR).
60. Declaration of Herb Phipps (Veterans Administration Hospital; Fort Harrison, MT).
61. Declaration of Dennis Popp (Community Memorial Hospital; Enumclaw, WA).
62. Declaration of Bobbie Raynor (Powell County Memorial Hospital; Deer Lodge, MT).
63. Declaration of Richard Seibel (Samaritan Hospital; Moses Lake, WA).

64. Declaration of Donnita Snyder (St. Luke Community Hospital; Ronan, MT).

65. Declaration of Arnie Solberg (Northeast Montana Medical Services; Wolf Point, MT).

66. Declaration of Jody Sprout (Madison Valley Hospital; Ennis, MT).

67. Declaration of Dale Surratt (St. Francis, Inc.; Peoria, IL).

68. Declaration of Terry Van Luchene (Pondera Medical Center; Conrad, MT).

69. Declaration of Chris Watson (Mineral Community Hospital; Superior, MT).

70. Declaration of Arden Will (U.S. Public Health Indian Hospital; Crow Agency, MT).

71. Declaration of Michael Wright (Holy Rosary Health Center; Miles City, MT).

72. Declaration of Kim Zinda (Prairie Community Medical Assistance Facility; Terry, Montana).

II. Depositions

1. Deposition of Richard I. Adduci (Jan. 10, 1991).

2. Deposition of John N. Batchelor (Jan. 14, 1991).

3. Deposition of Carol A. Brickler (Sep. 19, 1995).

4. Deposition of Richard S. Chormanski (Mar. 13, 1996).

5. Deposition of Virginia M. Della (May 15, 1996).

6. Deposition of Thomas E. Dunham (Oct. 10, 1995).

7. Deposition of Stephen Flieder (Oct. 11, 1995).

8. Deposition of Gary F. Foster (May 17, 1996).

9. Deposition of Gary F. Foster (June 10, 1996).

10. Deposition of Gary F. Foster (June 12, 1996).

11. Deposition of Thomas P. Hilmer (Jan. 15, 1991).

12. Deposition of Gary R. Holforty (Jan. 12, 1995).

13. Deposition of John Keith Mills (Feb. 7, 1995).

14. Deposition of Stephen T. Kellett (Oct. 11, 1995).

15. Deposition of Kenneth J. Kopidlansky (Sep. 19, 1995).

16. Deposition of Kenneth J. Kopidlansky (Jan. 11, 1991).

17. Deposition of Jeffrey A. McCaulley (Feb. 9, 1995).

18. Deposition of Bryan D. McDowell (Jan. 10, 1995).

19. Deposition of Douglas McKelvey (Aug. 22, 1995).

20. Deposition of Henry Montenegro (Aug. 17, 1995).

21. Deposition of Michael D. Moore (Jan. 9, 1991).

22. Deposition of Adolph Munoz (Jan. 16, 1991).

23. Deposition of David N. Olson (Jan. 14, 1991).

24. Deposition of Ronald J. Plasse (Sep. 27, 1995).

25. Deposition of Daniel Rabin (Sep. 20, 1995).

26. Deposition of Anthony F. Ronchik (Jan. 11, 1995).

27. Deposition of Bernard Sandler (Jan. 16, 1991).

28. Deposition of Anthony Scaduto (Feb. 8, 1995).

29. Deposition of John Jeffrey Schaper (Jan. 18, 1991).

30. Deposition of Neil L. Schmidt (May 16, 1996).

31. Deposition of Neil L. Schmidt (June 12, 1996).

32. Deposition of David W. Snider (Jan. 15, 1991).

33. Deposition of Robert W. Sullivan (Apr. 25, 1996).

34. Deposition of Frank Tusing (July 28, 1995).

35. Deposition of Frank Vensel (Aug. 17, 1995).

36. Deposition of George Vunovic (Aug. 15, 1995).

37. Deposition of Mark T. Wagner (June 11, 1995).

38. Deposition of Randolph Whittell (Jan. 17, 1991).

39. Deposition of Rex H.L. Young (Aug. 23, 1995).

III. Documents and Interogatory Responses Provided by the Following Entities

1. Advanced Computer Services (Essexville, Michigan).

2. Advanced Technology Laboratories, Inc.(Bothell, Washington).

3. Alamance County Hospital (Burlington, North Carolina).

4. American Biomedical Group, Inc. (Oklahoma City, Oklahoma).

5. AMI Piedmont Medical Center (Rock Hill, South Carolina).

6. Bay Medical Center (Panama City, Florida).

7. Benefis Health Care, West Campus (Great Falls, Montana).

8. Butterworth Hospital (Grand Rapids, Michigan).

9. Carolinas Medical Center (Charlotte, North Carolina).

10. CIC Corp. (College Station, Texas).

11. Community Medical Center (Missoula, Montana).

12. Community Memorial Hospital (Enumclaw, Washington).

13. Crouse Irving Memorial Hospital (Syracuse, New York).

14. Danbury Hospital (Danbury, Connecticut).

15. Deaconess Medical Center (Billings, Montana).

16. Delta Medical Systems (Helena, Montana).

17. Department of Environmental Quality (Helena, Montana).

18. Diagnostic Imaging Systems (Rapid City, South Dakota).

19. Diagnostic Medical Systems (Fargo, North Dakota).

20. ECS Nuclear (Sunland, California).

21. Elscint, Inc. (Hackensack, New Jersey).

22. Forbes Health System (Pittsburgh, Pennsylvania).

23. Geisinger Medical Center (Danville, Pennsylvania).

24. General Electric Co. (Fairfield, Connecticut).

25. Glendive Medical Center (Glendive, Montana).

26. Great Plains Regional (North Platte, Nebraska).

27. Huntsville Hospital System (Huntsville, Alabama).

28. Imaging Equipment Services (Pittsburgh, Pennsylvania).

29. Instrumentarium Imaging, Inc.(Milwaukee, Wisconsin).

30. Intermountain Biomedical (Kalispell, Montana).

31. Iowa Health System (Des Moines, Iowa).

32. Kadlec Medical Center (Richland, Washington).

33. Kaiser Permanente (Oakland, California).

34. Kelowna General Hospital (Kelowna, British Columbia, Canada).

35. Les Wilkins & Associates, Inc. (Seattle, Washington).

36. Lutheran General (Park Ridge, Illinois).

37. Martec Group Inc. (Chicago, Illinois).

38. Medical Electronics Services (Billings, Montana).

39. Mercy Healthcare (Phoenix, Arizona).

40. Montana Deaconess Medical Center (Great Falls, Montana).

41. Mt. Carmel Health System (Columbus, Ohio).

42. National Electrical Manufacturer Association (Rosslyn, Virginia).

43. North Carolina Baptist Hospital (Winston-Salem, North Carolina).

44. North Iowa Mercy Health Center (Mason City, Iowa).

45. Northern X-Ray (Minneapolis, Minnesota).

46. Nuclear Regulatory Commission (Armington, Texas).

47. Oregon Health Sciences University (Portland, Oregon).

48. Pacific X-Ray (Portland, Oregon).

49. Philips Medical Systems North America Co. (Shelton, Connecticut).

50. Picker International, Inc. (Highland Heights, Ohio).

51. Progressive Medical Corp. (Seattle, Washington).

52. QRS, Inc. (Great Falls, Montana).

53. Queen's Medical Center (Honolulu, Hawaii).

54. Radiographic Supply (Kalispell, Montana).

55. Royal Columbian Hospital (Westminster, British Columbia, Canada).

56. Sacred Heart Medical Center (Spokane, Washington).

57. Samaritan Health Systems (Phoenix, Arizona).

58. San Juan Regional (Farmington, New Mexico).

59. Schumpert Medical Center (Shreveport, Louisiana).

60. ServiceMaster Co. (Downers Grove, Illinois).

61. Serviscope Corp. (Wallingford, Connecticut).

62. Shadyside Hospital (Pittsburgh, Pennsylvania).

63. Siemens Corp. (New York, New York).

64. Sisters of Charity Health Care Systems, Inc. (Cincinnati, Ohio).

65. St. Elizabeth Hospital (Appleton, Wisconsin).

66. St. Vincent Hospital & Health Center (Billings, Montana).

67. St. Patrick Hospital (Missoula, Montana).

68. Standard Medical Imaging, Inc. (Columbia, Maryland).

69. Standard Medical Imaging (Spokane, Washington).

70. Sun Health Corp. (Charlotte, North Carolina).

71. Superior X-Ray (Great Falls, Montana).

72. Surrey Memorial Hospital (Surrey, British Columbia, Canada).

73. Tenet Healthcare (Santa Barbara, California).

74. Texas Children's Hospital (Houston, Texas).

75. Thomas Jefferson (Philadelphia, Pennsylvania).

76. Toshiba America, Inc. (New York, New York).

77. University of Alabama Medical Center (Birmingham, Alabama).

78. Veterans Affairs (Hines, Illinois).

79. Veterans Affairs Hospital (Fort Harrison, Montana).

80. Veterans Affairs Hospital (Portland, Oregon).

81. Washington County Hospital (Hagerstown, Maryland).

82. Waterbury Hospital (Waterbury, Connecticut).

83. West Tennessee Health Care, Inc. (Jackson, Tennessee).

84. Western X-Ray, Inc. (Reno, Nevada).

CERTIFICATE OF SERVICE

This certifies that the foregoing Pre-Discovery Disclosure Statement of the United States was duly served by hand or by Federal Express, as indicated, upon the following counsel of record at their address this 14th day of May, 1997.

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