IN THE SUPREME COURT OF MISSISSIPPI

MISSISSIPPI STATE DEPARTMENT OF HEALTH and DESOTO IMAGING & DIAGNOSTICS, LLC — **APPELLANTS**

V. — **NO. 2007-SA-00035**

***BAPTIST MEMORIAL HOSPITAL-DESOTO, INC.*, d/b/a BAPTIST MEMORIAL HOSPITAL-DESOTO and DESOTO DIAGNOSTIC IMAGING, LLC, d/b/a CARVEL IMAGING** — **APPELLEES**

APPEAL FROM THE DECISION OF THE HINDS CHANCERY COURT, FIRST JUDICIAL DIVISION

REPLY BRIEF FOR APPELLANTS

ORAL ARGUMENT NOT REQUESTED

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REBUTTAL ARGUMENT

The Appellees are largely in agreement with the Brief for Appellants that the issues in this case are two: (1) was there *substantial evidence* for the Department's award of the CON? and (2) was the Department *arbitrary and capricious* in its interpretation of its rules and requirements? Carvel adds a third issue, (3) alleged noncompliance with the General Review Criteria ("GRC") of the CON Manual.

I. The Department Had Substantial Evidence to Support Granting the CON.

A. The Flawed Staff Analysis Was Correctly Disregarded.

Against our demonstration that the Staff Analysis erred in its disapproval of Desoto's application on the basis of an "optimum" number of procedures — one that was higher than the number in the Plan's need criterion — Carvel argues that "General Review Criterion [GRC] 5 *requires* the Department to evaluate every application in terms of the *existing utilization levels*." Carvel Br. at 9. This Court should not rely on Carvel as a sound guide to what the CON Manual actually says. Looking at GRC 5, this Court will find that the criterion is permissive, not a "requirement": "**Need for the Project**: One or more of the following items *may* be considered in determining whether a need for the project exists . . . ." (Emphasis added; Carvel actually quotes this in its brief, at 27). In other words, the Department is free to apply any one or more of the items set forth at GRC 5, or none at all. *See Hill Bros. Constr. & Eng'g Co. v. Miss. Transp. Comm'n*, 909 So. 2d 58, 66 (Miss. 2005) ("since the regulation uses the permissive language 'may' as opposed to the mandatory language 'shall,' whether to reject the bid is clearly within the discretion of the MTC").

Because the GRC need considerations are merely permissive, and because the "optimum" figure employed by the Staff Analysis was properly disregarded in favor of the actual need criterion

in the State Health Plan, the Department did not err in declining to agree with the Staff Analysis. We do agree with Carvel (in its Brief at 10 n.4) that the holding of the Staff Analysis is merely an intermediate step on the way to the final decision of the State Health Officer, and thus of no relevance to this appeal. Why, then, does Carvel argue the issue? We don't know.

B. Desoto Met the Applicable Need Criterion.

1. The Need Criterion Addresses the Number of Procedures, Not "Existing Route" or "Days of Service."

The arguments by Appellees as regards the "substantial evidence" issue should be compared by this Court with the actual text of the State Health Plan as regards the need criterion for a mobile MRI unit. Appellees insist, over and over again, that the issue comes down to whether or not Desoto would be joining an *existing route*. But as we showed in the Brief for Appellants, there is no such requirement in the State Health Plan, which does not even mention the word "route" in the need criterion.

> Need Criterion: **The entity desiring to offer MRI services must document that the equipment shall perform a minimum of 1,700 procedures per year**. The applicant shall use the procedures estimation methodology appearing in this section of the Plan to project the annual patient service volume for the applicant hospital. **This criterion includes both fixed and mobile** MRI equipment.
>
> Applicants for non-hospital based MRI facilities may submit affidavits from referring physicians in lieu of the estimation methodology required for hospitals [sic] based facilities. MRI procedures projected in affidavits shall be based on actual MRI procedures referred during the year.
>
> It is recognized that a particular MRI unit **may be utilized by more than one provider of MRI services; some of which may be located outside of Mississippi.** In such cases **all existing or proposed providers of MRI services must jointly meet the required service volume of 1,700 procedures annually**. If the MRI unit in question is presently utilized by other providers of MRI services, **the actual number of procedures performed by them during the most recent 12-month period may be used instead of the formula projections**.

(emphasis altered). In view of this criterion, it makes no sense for Baptist to argue that "the existing providers on the route expected, *and were entitled to*, certain designated days of MRI coverage."

Baptist Br. at 19 (emphasis added). The nature of this strange "entitlement" is not explained, but we refer the Court to the first paragraph at page 15 of the Brief for Appellants. There's evidently a tension between the hospital's wish for *days* of services, and the wish of the MRI owner (Alliance) for *numbers* of procedures performed. But there is no rule or requirement that Desoto, or the Department, look at "days of service"; the need criterion addresses the number of procedures performed, and thus takes the perspective of the MRI owner.[1] Baptist is confusing its institutional wishes with the actual requirements of the State Health Plan.

This Court should also note that, when Carvel writes (at 14) that "Smith [of Alliance] admitted . . . that Gilmore (an acute care hospital) has *never* accepted Saturdays as one of its main days of service from Alliance," Carvel is making an assertion that is not supported by its blanket citation to "R.E. 1 at 258-62." Studying those five pages, there is no such admission therein. What the record *does* show is that Alliance was already scanning at Gilmore as their volume demanded. T. at 250 (Appellants' R.E. 14); *see* Br. for Appellants at 14. Carvel's weasel word "*main* days of service" should not be mistaken for the false assertion that Gilmore wasn't already doing MRIs on Saturdays.

Why do Appellees strive to focus this Court's attention on an aspect of the case that has nothing to do with the need criterion? The answer is obvious: because, on the need criterion as set forth in the State Health Plan, Desoto's project *met* that criterion. Appellees must therefore work overtime to convince this Court that an imaginary "existing route" criterion exists, when it does not.

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[1]Procedures, after all, are what the billing for MRI services is based on, and thus what one would expect the State Health Plan to concern itself with. "The CON procedure was conceived as the basic component in an overall effort to control the unnecessary capital expenditures which contribute so greatly to the total national health bill." *Grant Ctr. Hosp. of Miss., Inc. v. Health Group of Jackson, Miss., Inc.*, 528 So. 2d 804, 806 (Miss. 1988) (citation & internal quotation marks omitted).

2. *Desoto Presented Substantial Evidence That the MRI Could Provide the Same Number of Procedures to Existing Providers, Plus More for Desoto.*

Baptist points to the portion of the need criterion that says "all existing or proposed providers of MRI services must jointly meet the required service volume of 1,700 procedures annually." Baptist Br. at 16. As Baptist says, this requires the applicant to "identify the specific MRI providers on a route as well as the number of MRI procedures performed on the route." Desoto did this. But then, rather than present an argument, Baptist merely says that the alleged "deficiencies" in Desoto's evidence "have been previously discussed" — presumably in the tendentious and argumentative "statement of facts" portion of Baptist's brief, though Baptist does not trouble to actually cite to any page therein.

The reference appears, so far as we can tell, to be to page 9 of Baptist's brief, where Baptist is forced to admit the record evidence that Gilmore performed 1,440 MRI procedures in 2005, and Mission performed 560 in that year. Not only do those add up to well over the 1,700 required by the State Health Plan, but the use of those numbers also conforms to the need criterion's rule that "the actual number of procedures performed by them during the most recent 12-month period may be used instead of the formula projections." The word "them," note, refers to those who are presently utilizing the MRI unit's services — i.e., Gilmore and Mission. The requirement of the Plan, and the satisfaction of its requirement by Desoto, could not be clearer.

Baptist seeks to get around this by arguing that the number of days for the unit to be at Gilmore and Mission would change. Desoto addressed that at the hearing, and demonstrated as much in the Brief for Appellants: the same number of procedures could be done in fewer days with the 1.5T magnet to be used in place of the 1.0T magnet used in 2005. *What argument does Baptist present against that?* None: "the fact remained that, in view of the historical utilization of both

current sites — in Amory and in Vicksburg — the proposal to add two more days a week was neither reasonable nor feasible." Baptist Br. at 9.

"The fact remained," indeed. Baptist appears to imagine that its unsupported assertion becomes a "fact" just because it appears in the brief's "statement of facts." In *fact*, Desoto presented unrebutted record evidence at the hearing that the 1.5T magnet would indeed make the reduction of days at Gilmore and Mission "reasonable" and "feasible." Br. for Appellants at 13-14. Baptist presented *no evidence to the contrary* at the hearing, and now, it presents no argument to the contrary in its brief to this Court. It certainly doesn't help Appellees' case that Carvel cheerfully *agrees with Alliance* (and Appellants!) that "a single unit can perform anywhere from ten to fifteen procedures a day during normal working hours." Carvel Br. at 27;[2] compare Brief for Appellants at 14 ("can easily perform 15 procedures a day").

What's truly implausible is the argument that the Department lacked *substantial evidence* that the MRI application was feasible. The testimony of Alliance that it was performing the number of procedures required by the need criterion, and that its more powerful 1.5T magnet would allow it to maintain existing service to Gilmore and Mission, is no "mere scintilla" but rather meets the standard of "substantial evidence": reasonable people could draw the conclusion that the application was feasible, even if the chancery court — or even this Court — might have concluded otherwise. On that standard, which this Court is bound by law to apply, the Department did not err in finding substantial evidence to support Desoto's application.

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[2]That's where Carvel is arguing that *its* MRI can do *lots* of procedures, so that there's supposedly no need for Desoto's, of which more later. As for Carvel's argument regarding the present issue (at 12-16), it's redundant of Baptist's. Carvel tries to make hay out of Desoto's use of the phrase "existing route" in its application, but that is neither here nor there; this Court is concerned with what the Department ultimately found to be the case, not with the administrative equivalent of "allegations in the pleadings."

3. Nothing Required Desoto to Present "Assurances" from Existing Providers.

Once this Court looks at the substantial evidence in favor of Desoto's proposed route, rather than merely accepting Baptist's false assertion that there is no such evidence, the argument at issue B of Baptist's brief falls apart. The same is true of Baptist's issue C. Here, Baptist goes on and on about how Desoto didn't provide evidence that Gilmore and Mission would be happy with the new route — without, of course, ever pointing to where, in the State Health Plan or the CON Manual it says that any such evidence was necessary. Again, this Court should be attentive to what Baptist is doing: inventing a new criterion for the purpose of proving that Desoto didn't satisfy it. But that is not how the CON process works. An application is judged by the real criteria.

The Department is particularly concerned about this portion of the argument, because it appears that what Baptist is *really* doing is dictating policy to the Department. Apparently, although Baptist never explains what evidence would satisfy it on this issue, Baptist thinks that the applicant should present affidavits from the existing providers, attesting their intent to cooperate with the applicant in sharing MRI services: "All [Desoto] had to do was to submit evidence which showed that the route would work because the other participants would be willing to accept reduced days of coverage." Baptist Br. at 20.

The merits of that interesting requirement should be presented by Baptist to the State Board of Health at its next meeting, if Baptist thinks that is what the State Health Plan's need criterion for mobile MRI services should require. The fact remains, however, that no authority for any such requirement exists, let alone existed at the time of Desoto's application. Quite obviously, the need criterion was written with an eye to demonstrable procedures performed in the past, not promises of future conduct by entities that may have no relation to the applicant and no interest in its application. The policy reasons for setting an objective criterion of demonstrably performed

procedures are probably self-evident, but the point is that Baptist has no basis for asking this Court to write the Department's policies for it, or to rewrite the State Health Plan according to Baptist's preferences.[3]

Neither Gilmore nor Mission considered itself an "affected party" in this case. Neither Gilmore nor Mission showed up at the hearing during the course of review to argue against the proposed route. Instead, what the hearing officer was given was the best evidence available — the sworn testimony of the MRI unit's owner, Alliance, that it could and would reduce the number of days at Gilmore and Mission while providing them the opportunity for the same number of procedures, if not more. Please see the arguments at pages 14-16 of the Brief for Appellants, with which Baptist has completely, and it would seem deliberately, failed to grapple, preferring instead to argue to this Court that the need criterion should have been something other than what it actually is.

4. Desoto's Affidavits Were Admissible Evidence in Support of the Number of Procedures Projected.

Carvel attempts to make an issue of Desoto's affidavits that it provided pursuant to the need criterion, which expressly allows for such evidence:

> Applicants for non-hospital based MRI facilities may submit affidavits from referring physicians in lieu of the estimation methodology required for hospitals [sic] based facilities. MRI procedures projected in affidavits shall be based on actual MRI procedures referred during the year.

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[3]Because we cannot resist talking policy, we will point out that such affidavits would be worth approximately their weight in paper. Suppose that Gilmore had provided the assurances that Baptist thinks Desoto should've sought. Would those assurances have done anything to keep Gilmore from dropping Alliance as its MRI provider on the exact date that it did in this case? No. So, why should the Department require an MRI applicant to submit worthless assurances? Better to look at objective measures of past performance and extrapolate from there. It's not a guaranteed means of predicting the future, as the unusual facts of this case demonstrate; but then, what is?

"*No supporting evidence* for the attached affidavits" was provided, complains Carvel (at 17). Perhaps that is because, under the need criterion, affidavits *are* supporting evidence?

Nevertheless, Carvel attempts to invoke *Mississippi State Dep't of Health v. Natchez Community Hospital*, 743 So. 2d 973 (Miss. 1999), as authority for disregarding Desoto's affidavits. That ignores both the governing rules of this case and the actual facts of *Natchez*.

First, *Natchez* concerned an ambulatory surgery center ("ASC"), not an MRI route. 743 So. 2d at 975. The State Health Plan's need criterion for a non-hospital-based MRI route *expressly* allows for affidavits to be submitted in place of other documentation, but there is no such language regarding affidavits in the ASC need criterion. Thus, this Court is presented with a relevant distinction from *Natchez* that makes it improper to rule that affidavits are not substantial evidence, when the State Health Plan itself expressly allows for affidavits to substitute for other documentation.

Second, Carvel has made *nothing like* the showing that defeated the physician statements in *Natchez*. This Court must look at how egregious the discrepancies between statement and fact in *Natchez* really were, before it can properly understand why this Court took the unusual step of finding that the Department had no substantial evidence before it. To do so, we must look closely at the actual language of the *Natchez* decision:

> Dr. Feldman, in his application for the CON, estimated his projected usage for the ASC to be 1,600 cases. He testified at the hearing that **he arrived at that number because the State required a minimum usage of 800 cases per year per room**. He had **no factual basis** for his estimated usage.
>
> Dr. Feldman then testified that he would be the major admitting physician to this ASC. The record shows that Dr. Feldman **performed only 235 surgeries at his single-service surgery center** the year before the application for the CON was filed. The record further shows that Dr. Feldman performed only 87 additional out-patient procedures at NCH and NRMC. This totals only 322 procedures actually performed. While it is feasible that Dr. Feldman's practice will continue to grow, **it is not**

> **realistic to believe that Dr. Feldman himself will be able to perform 800 to 1,000 cases at the ASC as he speculates.**

Id. at 977 (emphasis added). Thus, in the case of the "major admitting physician," Dr. Feldman, the opponents to the ASC application were able to refute his estimate by presenting *facts on the record* that made a hash of Dr. Feldman's numbers. Dr. Feldman himself conceded that he had "no factual basis for his estimated usage." In the present case, by contrast, each affidavit swears that the projections are based on actual records and referral patterns. And despite its opportunities in the pre-hearing discovery process to subpoena documents and testimony, Carvel did not actually present *any* contrary evidence to suggest that any of the physicians in question were lying or mistaken in their (relatively modest) estimates.

(Strangely, Carvel seeks to impugn the proffered testimony of Carol Ann Wright Smith, M.D., despite the fact that she was not even one of the physicians who submitted an affidavit. How many of the attesting physicians did Carvel call as witnesses in this case, to subject them to the same kind of cross-examination as in the *Natchez* case? None.)

A further look at the rest of the physicians' statements in *Natchez* will further distinguish it from the present case:

> Dr. James Todd, Jr., testified that he planned to use the ASC to perform **approximately 200 surgeries per year**. However, Dr. Todd later testified that he had performed **only 90 surgeries in 1996 and 57 surgeries in 1997.** He also testified that he would send approximately one-half of his surgery patients to the proposed ASC.
>
> Taking Dr. Todd's information as true, he would have to perform 400 surgeries per year in order to transfer one-half to the ASC to reach the estimated rate of 200 surgeries. **Dr. Todd would, in effect, have to more than triple his current rate of surgery to meet his estimate**.
>
> Additionally, NRMC proffered testimony that Dr. Todd, in previous litigation, **swore under oath that he was permanently and totally disabled and that he had severe difficulties in performing even the simplest tasks**. This further casts doubt on the ability of Dr. Todd to triple his current rate of surgery.

Id. at 978 (emphasis added). Again, the Court did not find Dr. Todd's testimony lacking merely because it was "unsupported," but rather because the alleged support was proved to be incredible. In the present case, the support for the affidavits' numbers—the records and referral patterns of the swearing physicians—has not been similarly attacked. The same pattern is obvious in the Court's discussion of the remaining physicians' avowals:

> Dr. Richard Meyers, Jr., testified that he would transfer **350-500 cases** to the ASC from either his office or from Field Memorial Hospital. Dr. Meyers testified that he performed 99% of his surgeries at Field, estimating that number to be "[p]robably in excess of 400." The actual records show that Dr. Meyers performed only **165** procedures in 1995, **119** procedures in 1996, and **130** procedures in the first ten months of 1997. **Dr. Meyers then changed his testimony to state that he would probably only transfer 100 cases to the ASC.**
>
> During and after the hearing, Dr. Feldman introduced letters and affidavits from other doctors who pledged to use the facility. Dr. Bernadette Sherman, through letter and affidavit, projected her usage to be **in excess of 100 cases per year.** However, **affidavits from NCH and NRMC show that in 1997, Dr. Sherman performed only 21 procedures at the two hospitals.** No evidence was offered in support of Dr. Sherman's projections.
>
> Dr. Frank Guerdon submitted a letter in support of the ASC stating that he would perform **between 50 and 100 procedures**. Dr. Alphonse Reed, also through a letter, estimated his usage of the ASC at **100 or more**. The affidavits submitted by NCH and NRMC show that Dr. Guerdon performed **only 51** procedures in 1997, while Dr. Reed performed **only 11.** As was the case with Dr. Sherman, no evidence was offered to support this projected increase.

Id. (emphasis added). Thus, counter-affidavits were introduced into evidence, from the hospitals where these physicians practiced, to show the flaws of their alleged projections. *Only after this review* was the Court able to declare that "[t]he estimate of projected procedures supplied to the Hearing Officer has *no factual basis*." *Id.* (emphasis added).

The *Natchez* case does not, and in light of the MRI need criterion, *cannot*, stand for the proposition that affidavit evidence of projected referrals to a non-hospital-based MRI — where those affidavits expressly state that they are based on records and referrals, and where no contrary evidence

is opposed to those projections — cannot form substantial evidence of MRI procedures. In short, the opponents to the ASC in *Natchez* did the necessary legwork to successfully oppose the ASC's projections. Carvel, in the present case, did not.

The only basis, therefore, on which to disregard the affidavits of the eight physicians, is merely the fact that they are affidavits. That is not what this Court did in *Natchez*; it is not consistent with the express intent of the State Health Plan; and it is not what the Department did in this case. This Court has no basis on which to rule the affidavits were not substantial evidence.

Finally, we should recall that the affidavits, at most, plug a hole in the application caused by the potential diminution of the procedures performed by Gilmore and Mission, which is all they are required to do. Those providers were already doing over 2,000 procedures a year, 300 over the number required by the joint-MRI need criterion. The Department could, and did, credibly find that, given the existing providers' surplus; the more than 300 procedures evidenced by the affidavits; and the reasonable projection that, there being more than just those eight physicians in Desoto County, the actual first-year procedures by Desoto would be in the 500s; *all considered together* (rather than piece by piece, as Carvel and Baptist would have it), this constituted substantial evidence that the joint route would meet the 1,700 minimum. The chancery court erred in holding otherwise.

C. Appellees' Real Issue Is with the State Health Plan Itself.

Reflecting upon the briefs of Appellees, it becomes apparent that what they really intend is an oblique attack against the State Health Plan itself. Baptist complains that Desoto and the Department "are suggesting that if [Desoto] can come up with a route having more than 1,700 procedures, Desoto does not have to show any other need for the new service at all." Baptist Br. at 24. That is not quite how Appellants put it in their brief (at 11-12), but it's a fair summary of what the need criterion says.

Baptist attempts to cite the 1998 *St. Dominic* case for the proposition that Appellants are somehow dodging the requirement to show need. In that case, as this Court will remember, St. Dominic opposed an effort to build a new facility in northeast Jackson with "phantom beds" (licensed but not actually in use) from a south Jackson hospital. This clever proposal aimed at dodging the State Health Plan's need criterion for a "new hospital" in favor of the much less rigorous need criterion for a "relocation." This Court has shot down that argument twice, once when St. Dominic opposed such a "relocation," and again when St. Dominic tried the same kind of "relocation" itself a few years later. *St. Dominic-Jackson Mem'l Hosp. v. Miss. State Dep't of Health*, 728 So. 2d 81 (Miss. 1998); *St. Dominic-Madison County Med. Ctr. v. Madison County Med. Ctr.*, 928 So. 2d 822 (Miss. 2006).

In the present case, by contrast, there is no dispute as to what the controlling need criterion is, and there's no effort by Desoto or the Department to apply any "lesser showing of need" than what the State Health Plan requires. What Baptist really takes issue with, then, is not Appellants' application of the correct need criterion, but the fact that the State Health Plan's need criterion says what it does.

Unfortunately, Baptist did not come out and admit that it wants this Court to rewrite the Plan. Appellants are unaware of any case where this Court has struck down a provision of the State Health Plan, and if that's what Appellees wanted this Court to do, then we respectfully suggest they should have argued expressly for it. This Court should decline the backhanded invitation to second-guess the State Health Plan and substitute its own healthcare expertise for that of the State Board of Health and of the Department.[4]

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[4]Again, although the policy issues are not within this Court's scope of review, we address them. The flaw in Baptist's argument is that it ignores the particular facts of mobile MRI usage: Where the MRI

II. The Department's Procedures Were Not Improper.

A. No Other "Affected Parties" Were Prejudiced.

One of Baptist's procedural objections is that "affected parties" did not have the opportunity to demand a hearing on the change in route. Baptist Br. at 13-14. This Court should note, right off the bat, that Baptist's attempted implication that there are "affected parties" out there beside the present Appellees, can be safely disregarded; it is difficult to conceive who could be an affected party who was not already an affected party before Gilmore's terminating its contract with Alliance. Certainly the Appellees do not mention any names. Nor does anything in the CON Manual require an affected party to be given notice of any new factual developments that require changes in the application (say, the death of the president of the applying company); the notice is of the fact of the application itself, not of every detail therein. The "affected party" issue is a red herring.

B. The Appellees Had Notice and a Meaningful Opportunity to Be Heard . . . and Waived Anything Further.

We have already seen, at part II.B of the Brief for Appellants, that an agency can be flexible in how it affords due process, particularly in unusual factual situations like the one in the present case, where the Department applied its expertise regarding the MRI business and interpreted its rules regarding CON hearings and changes in MRI routes to reach what it considered the best substantive result. "[T]he administrative processes of this state, including the appellate variety thereof, should operate to facilitate desirable substantive results, not to thwart them." *Grant Ctr.*, 528 So. 2d at 811.

The fact is that Baptist and Carvel, the Appellees, had notice of the change in route from the pleadings on July 26, 2006, when they learned of it from the pleading served by Desoto, and they

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equipment already exists, and where that equipment is already performing the set number of procedures, the "need" for the equipment is already amply demonstrated, and it doesn't matter whether an additional provider is adding 50 procedures to the equipment's use, or 500.

accounting division. R.E. 2 at 22. Although the Staff Analysis professed to find that the application provided insufficient evidence of viability, the staff wrongly added a "without encroaching on the ability of existing providers to provide MRI services" element that is nowhere to be found in General Review Criterion 4. Thus, the Department was under no obligation to accept the Staff Analysis's recommendation on this point, based as it was upon a mistaken principle. In any event, the Department independently found no such encroachment.

Carvel focuses upon the Department's rejection of Appellants' efforts to nickel-and-dime the application by questioning whether $20,000.00 was a sufficient allotment for salaries, raising questions about a receptionist's hourly rate, and similar issues. R.E. 2 at 22. For example, testimony at the hearing showed that a "medical director" need not be a separate salaried employee, but merely an existing physician adding "an additional responsibility . . . to a title." T. 231.

The Department found only one discrepancy of any note — a lease cost of $360,000, which was $178,000 higher than the $182,000 in the application — and found substantial evidence that this would be balanced out by Desoto's performing only *eight* more procedures in the project's second year than previously projected. R.E. 2 at 22-23. Given the nature of projections, the expert, Mr. Falls, testified that a discrepancy based on eight scans per year, more or less, "is not statistically significant, and it is certainly not materially significant." T. 590. The hearing officer correctly found that "Desoto Imaging is not at liberty to simply bump that number up or down during the hearing,"[5] R.E. 4 at 23, but he also correctly found that, given "the reality of the situation," the relatively trivial costs disputed by Baptist and Carvel were not in fact likely to jeopardize the financial success of the project, given the hugely increasing population of Desoto County.

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[5]Language that Carvel liked so much, it plagiarized it for its brief (at 25).

Carvel's petty efforts to show that the application did not include every conceivable cost ("image storage"?) are not accompanied by any demonstration that those alleged costs would be substantial enough to affect the financial viability of the project — or even, in the case of "image storage," by any citation to the record. As for its allegations that the project would be losing money by its third year, they are based on the assumption that *only* the referral estimates in the eight affidavits presented by Desoto may be relied upon to project Desoto's income. (Contrary to Carvel's allegation that the hearing officer "recognized . . . [this] issue[ ] in his Findings," Carvel Br. at 26, there is no discussion of this topic in the hearing officer's opinion.) Why it would be reasonable to expect that only these eight physicians, out of the many doctors in Desoto County, would refer anyone to Desoto, is merely assumed by Carvel.

Carvel also glides carefully over the fact that its expert, Mr. Witek, made his "conservative" projections (T.at 562, Carvel Br. at 26 n.17) on the assumption of a *flat* utilization rate for Desoto County, despite his admission under cross-examination that this rate had in fact "been increasing every year over the last five years." T. at 562, 565. As Mr. Witek admitted, he makes "conservative" calculations as well as others which are "less conservative" and then lets his clients pick which one they'll use. T. at 563. Obviously, Carvel chose to use the conservative estimate for purposes of this appeal. The hearing officer was at liberty to find it implausible that the skyrocketing population growth of Desoto County would continue as projected, while the MRI utilization rate that had risen every year for five years suddenly and inexplicably went flat. Pinned down as to whether the flat rate was really a reasonable projection, Mr. Witek resorted to pleading ignorance: "well, I don't think anybody can predict the future." T. at 564. Some predictions, however, are more plausible than others.

Thus, especially given the evidence regarding population growth and expected growth in the rate of MRI utilization in Desoto County, and the failure of Carvel to demonstrate that any of the allegedly missing costs was actually significant, the Department had *at least* substantial evidence upon which to conclude that the project was economically viable. This Court should so hold.

B. The Department Had Substantial Evidence of Need.

We have already seen that the Department is not actually required to consider any of the items at GRC 5, due to the permissive "may be considered" language. Regardless, Carvel plunges on with its assertions that Desoto's MRI is not needed, because the area is sufficiently served by none other than the Appellees, Baptist and Carvel. Absent any showing that the Department was *required* to consider the factors alleged by Carvel at pages 27-29 of its brief, Carvel cannot show that the Department acted arbitrarily or capriciously in not attaching to them the weight that Carvel placed upon them.

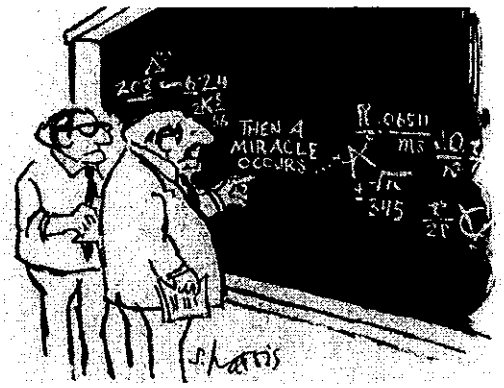
As for Carvel's assertion that the hearing officer erred in supposing that the GRC need considerations don't apply where there is a service-specific need criterion, we can only say that if the hearing officer erred, he was in good company. The Department's own CON application form, posted on its website for all to see, reads as follows with regard to GRC 5:

> Need for the Project (Criterion 5): Answer questions 5a through 5c **only if there are no service-specific criteria and/or policy statements in the most current State Health Plan applicable to your proposed project**.

(emphasis added) (see App. A to Reply Br., at 12). There does not seem to be any question as to what the Department's actual practices are regarding the use of GRC 5 where, as in the present case, the State Health Plan provides a service-specific need criterion.

Regardless, Carvel's "argument" at this section of its brief is sadly wanting. We are told that Carvel used to offer only one day's service a week, but will now have a fixed unit available five days

a week . . . and that *therefore*, "it is evident . . . there is no shortage of MRI capacity in Southaven or Desoto County." Carvel Br. at 28. The logical leap resembles that in the well-known cartoon:



"I think you should be more explicit here in step two."

from *What's so Funny about Science?* by Sidney Harris (1977)

Step two, we suppose, would be a demonstration not only that the estimated need would be satisfied by Carvel and Baptist, but also that this manner of evaluating need is required to be applied by the CON Manual or the State Health Plan. We can gather that Carvel thinks *it* is the solution to Desoto County's MRI needs now and for time to come, but Carvel's brief presents no basis for holding that the Department erred by disagreeing with Carvel's high opinion of itself.

Too, we find no record evidence that Carvel *is* operating a fixed unit; instead, we're told that Carvel's owner "testified at the hearing that she planned to begin providing MRI service in Southaven seven days a week within a few months."[6] Carvel Br. at 27. If Carvel's alleged fixed MRI unit were evidence that this Court could consider, then Desoto could discuss how many days a week it's now operating, and compare the number of procedures it's actually performing with the

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[6]Saturdays and Sundays, too — we thought we had heard that weekend scanning was a ridiculous thing to expect in the MRI business. Oh, but that was *Desoto*'s unit, not Carvel's.

As before with Carvel, however, this Court should not confuse its assertions in the brief with what the record actually shows. Actually, all that Dr. Carvel testified to regarding seven-day-a-week service was that the "potential" for such service now existed. T. at 132.

modest numbers projected in its application. But Desoto, like Carvel, must confine itself to the record before the Court. On that record, Carvel fails to raise a valid issue as to need.

C. The Department Had No Specific Evidence of Any Adverse Impact.

Finally, there's Carvel's tossed-off allegation that "the only conclusion reasonably to be drawn" is that Desoto's project would inflict "unquestionably significant adverse impact" on existing MRI providers. Carvel Br. at 29. Presumably, it's because this is "unquestionable" that Carvel need present no evidence in support. Rather, we get the (unquestionable?) assertion that the burden was on Desoto to prove it would have no adverse impact on existing providers.

The hearing officer found "little, if any, impact on the existing providers," R.E. 4 at 26, and noted that "no specific evidence" of "any sort of adverse impact" was presented by Baptist or Carvel. The Department is required, at most, to "consider the impact on existing providers," *Delta Reg'l Med. Ctr. v. Miss. State Dep't of Health*, 759 So. 2d 1174, 1181 (Miss. 1999), and the hearing officer did just that. Despite Carvel's attempt to shift the burden onto Desoto, the fact remains that Carvel presented no substantial evidence of any adverse impact on it or Baptist, and the Department did not therefore err in finding no such evidence.

Therefore, Carvel's additional issues fail to demonstrate that the Department acted without substantial evidence for its decision. The chancery court's decision was an abuse of discretion and should be reversed.

FOR ALL THE REASONS STATED ABOVE and in the Brief for Appellants, the decision of the Hinds Chancery Court should be reversed, and the Department's award of the CON to Desoto should be affirmed.

Respectfully submitted, this the ***24th*** day of October, 2007.

DESOTO IMAGING & DIAGNOSTICS, LLC

By: _____
Andy Lowry

MISSISSIPPI STATE DEPARTMENT OF HEALTH

By: _____
Donald E. Eicher, III

OF COUNSEL:

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CERTIFICATE OF SERVICE

The undersigned counsel hereby attests that he has caused the foregoing document to be served via United States mail (postage prepaid) on the persons listed below:

The Honorable Patricia D. Wise
HINDS CHANCERY COURT, First Judicial Division
Post Office Box 686
Jackson, Mississippi 39205-0686

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Counsel for Desoto Diagnostic Imaging, LLC, d/b/a Carvel Imaging

So certified, this the ***24th*** day of October, 2007.

Andy Lowry

MISSISSIPPI DEPARTMENT OF HEALTH
APPLICATION FOR A CERTIFICATE OF NEED

INSTRUCTIONS FOR COMPLETION OF APPLICATION

1. Applicants are required to use this application format for submission of CON applications by the March 1, 2006 review cycle unless prior approval has been received by the Department. The CON Application is currently available on the Department's website at **http://www.msdh.state.ms.us/** under Certificate of Need, Forms, (see "CON Application – Substantive Review" and "CON Application – Financial Analysis."

2. The original application including attachments should be mailed or delivered to the following address:

   Mississippi Department of Health
   Health Planning and Resource Development Division
   570 East Woodrow Wilson
   Jackson, MS 39215-1700

   The application (excluding attachments) may be submitted by e-mail (to Sam.Dawkins@msdh.state.ms.us and Rachel.Pittman@msdh.state.ms.us) or by facsimile (601-576-7530). If the application is submitted electronically by e-mail, only one (1) original should be mailed or delivered to the above address. If the application is not submitted electronically by e-mail, then one (1) original and three (3) copies must be mailed or delivered to the above address.

   If the application is to be submitted via e-mail, please use the following guidelines to ensure proper receipt of the application by the department.

   a. Only the following document formats will be acceptable:
      a. Microsoft Word,
      b. Microsoft Excel,
      c. Adobe Acrobat PDF,
      d. WordPerfect, and
      e. Rich text format.

   b. Be sure to include the following words in the subject line of the e-mail.

      CON application submission

3. Instructions for electronically selecting check box: 1) place cursor over appropriate check box; 2) left click on mouse. [To make this functional, you may have to Exit Design Mode by going to the following menus: VIEW – TOOLBARS – WEB TOOLS and clicking the "Exit Design Mode" button].

4. The majority of the financial analysis section is now a separate document (CON Application Financial_Analysis.xls). Please make sure to complete the Excel spreadsheets and submit along with this part of the application.

MISSISSIPPI DEPARTMENT OF HEALTH
APPLICATION FOR A CERTIFICATE OF NEED

SUBSTANTIVE REVIEW

TITLE OF PROPOSED PROJECT:	
Capital Expenditure:	**$**

I. APPLICANT/FACILITY INFORMATION

APPLICANT					
Applicant Legal Name:					
d/b/a (if applicable):					
Address:					
City:		State:		Zip Code:	
County:		Telephone:			
Parent Organization (if applicable):					
PRIMARY CONTACT PERSON					
Name:		Title or Position:			
Firm:					
Address:					
Telephone:		Fax:			
E-mail Address:					
LEGAL COUNSEL (if applicable)					
Name:					
Firm:					
Address:					
City:		State:		Zip Code:	
CONSULTANT (if applicable)					
Name:					
Firm:					
Address:					
City:		State:		Zip Code:	
Telephone:		Fax:			
E-mail Address:					

1. **Is the name of the existing or proposed facility different than the Applicant's legal name?**

   ☐ Yes ☐ No

   If YES → Enter the facility information below.
   If NO → Continue to question 2.

FACILITY					
Facility Name:					
Facility Address:					
City:		State:		Zip Code:	
County:		Phone:			

2. **Will the existing or proposed facility be operating by a different Management Entity other than the Applicant?**

   ☐ Yes ☐ No

   If YES → Enter the entity information below.
   If NO → Continue to question 3.

MANAGEMENT / OPERATING ENTITY					
Organization Name:					
Address:					
City:		**State:**		**Zip Code:**	
Telephone:		**Fax:**			

3. Select the type of ownership of present or proposed facility.

TAX EXEMPT	☐ Not-for-Profit Corporation		
	☐ Public (Hospital or Government)		
TAX PAYING	☐ General Partnership	☐ Business Corporation	☐ Sole Proprietor
	☐ Limited Liability Partnership or Limited Partnership	☐ Limited Liability Company	
State of Incorporation / Organization:			

4. Please provide documentation of the organizational and legal structure as indicated in the table below.

ORGANIZATIONAL STRUCTURE	
Not-for-Profit Corporation	▪ Name of Each Officer and Director ▪ Letter of Good Standing from Secretary of State
Public	▪ All Governing Authority Approvals for this Project
Sole Proprietor	▪ County Business Authorization Documents, if available
General Partnership	▪ Name, Partnership Interest, and Percentage Ownership of Each Partner ▪ Partnership Agreement
Limited Liability Partnership or Limited Partnership	▪ Name, Partnership Interest, and Percentage Ownership of Each Partner ▪ Letter of Good Standing from Secretary of State
Business Corporation	▪ Name of Each Officer and Director ▪ Letter of Good Standing from Secretary of State
Limited Liability Company	▪ Name of Each Member and Managing Member, Officers, and/or Directors ▪ Letter of Good Standing from Secretary of State

II. PROJECT DESCRIPTION

Project Type (select as many as applicable)

☐ Construction, development or other establishment of a new health care facility

☐ Renovation and/or expansion of an existing health care facility

☐ Offering of health services

☐ Relocation of health services

☐ Acquisition of major medical equipment

☐ Relocation of health care facility or major medical equipment

☐ Change in bed complement

☐ Change of ownership

1. **Describe, in as much detail as possible, all of the characteristics of the proposed project.**

2. **Describe the final objectives of the proposed project.**

3. **Describe and/or provide the following components of the proposed project:**

   a. **Facility**
      i. **Number of licensed beds by category.**

	Current Beds			
	Licensed	**Setup & Staffed**	**Beds Proposed**	**Total Beds at Completion**
Short-Term Acute Care Beds				
Swing Beds				
Long-Term Acute Care Beds				
Rehabilitation Beds				
Adult Psychiatric Beds				
Adolescent Psychiatric Beds				
Adult Chemical Dependency Beds				
Adolescent Chemical Dependency Beds				
Psychiatric Residential Treatment Beds				
Long-Term Care Beds				
TOTAL:				

ii. Facility Type (select one).

☐ Hospital-Based ☐ Freestanding ☐ Not Applicable

b. Equipment

i. Will any single item of equipment cost in excess of $150,000?

☐ Yes ☐ No

If YES ⟶ Enter the equipment information below & attach copies of any equipment leases or rental agreements, if applicable.
If NO ⟶ Continue to question 4.

Fixed or Non-Fixed	Description	Manufacturer	Proposed Installation Date

4. The proposed project involves:

☐ New Construction ☐ Renovation ☐ Neither

If New Construction or Renovation ⟶ Answer questions 4a through 4g.
If Neither ⟶ Continue to Section III.

a. Describe the new construction and/or renovation (including but not limited to site work, grounds work, drainage, parking, fencing, mechanical and electrical systems).

b. Enclose plot plan of site. If proposed project includes construction, modernization, or alteration of the physical plant, enclose schematic drawings (8½" x 11" format).

c. **Describe any capital expenditure projects completed within the past two years in excess of $200,000.**

d. **Describe any outstanding Certificates of Need.**

e. **Provide evidence that the Division of Licensure and Certification has approved the site of construction or new service. No project will be approved unless the site has been approved.**

f. **Provide evidence that the Division of Radiological Health has approved the plans for provision of radiation therapy services, if applicable.**

g. **If the project involves the renovation of an existing facility and the facility has licensure code or accreditation standard deficiencies, enclose a copy of the most recent report or survey from the licensing authority or accreditation program citing deficiencies.**

III. SERVICE-SPECIFIC CRITERIA *(STATE HEALTH PLAN)*

1. The following table documents the service-specific criteria currently used by the Department of Health as provided by the current State Health Plan. Carefully review this table and place an "X" in the box provided for any and all service-specific review criteria that apply to your proposed project.

SERVICE-SPECIFIC CRITERIA			
	Service	**State Health Plan Chapter**	**Mark if Applicable**
Long-Term Care	Nursing Home Care Services	Chapter VIII	
	Nursing Home Care Services for Mentally Retarded and Other Developmentally Disabled Individuals	Chapter VIII	
	Pediatric Skilled Nursing Facility	Chapter VIII	
Mental Health	Acute Psychiatric, Chemical Dependency, and/or Psychiatric Residential Treatment Facility Beds/Services	Chapter IX	
Perinatal Care	Obstetrical Services	Chapter X	
	Neonatal Special Care Services	Chapter X	
Habilitation & Rehabilitation	Comprehensive Medical Rehabilitation Beds/Services	Chapter XII	
Other	Ambulatory Surgery Services	Chapter XIII	
	Home Health Agency and/or Home Health Services	Chapter XIII	
	End Stage Renal Disease (ESRD) Facilities	Chapter XIII	
Acute Care	General Acute Care Hospitals & Beds	Chapter XI	
	Swing-Bed Services	Chapter XI	
	Therapeutic Radiation Equipment and/or Services (other than Gamma Knife)	Chapter XI	
	Gamma Knife Therapeutic Radiation Equipment and/or Gamma Knife Radiosurgery	Chapter XI	
	Magnetic Resonance Imaging (MRI) Equipment and/or Services	Chapter XI	
	Digital Subtraction Angiography (DSA)	Chapter XI	
	Positron Emission Tomography (PET) Scanner & Related Equipment	Chapter XI	
	Extracorporeal Shock Wave Lithotripsy (ESWL) Equipment and/or Services	Chapter XI	
	Long-Term Care Hospitals and Long-Term Care Beds	Chapter XI	
	Cardiac Catheterization Equipment and/or Services	Chapter XI	
	Open-Heart Surgery Equipment and/or Services	Chapter XI	

2. **Obtain a copy of each set of service-specific criteria and policy statements that apply to this Certificate of Need application from the most recent State Health Plan. These criteria and policy statements are available on the Department's website at http://www.msdh.state.ms.us/msdhsite/_static/29,0,184,116.html.**

3. **Document the proposed project's compliance with each of the applicable standards. The application must have narrative sections corresponding to each item of the service-specific criteria and policy statements and any supporting documents.**

4. **Submit letters of comment from: 1) physicians; 2) health care facilities; 3) consumers and; 4) health related community agencies in your health planning area. Also include letters of comment from city, county, or area government officials.**

5. **Is the proposed project to provide a new institutional service which is based on physician referrals?**

   ☐ Yes ☐ No

   If YES → Answer question 5a.
   If NO → Continue to question 6.

   a. **Provide affidavits of commitment from the referring physicians that include the actual number of referrals from the prior year, the projected number of referrals and/or the number of procedures or treatments to be rendered.**

6. **Does the proposed project involve a replacement facility?**

   ☐ Yes ☐ No

   If YES → Answer questions 6a through 6b.
   If NO → Continue to question 7.

   a. **What is the proposed disposition for the existing facility?**

   b. **What financial impact will the disposition have on this proposed project?**

7. **Does the proposed project involve a relocation of services?**

   ☐ Yes ☐ No

   If YES → Answer question 7a.
   If NO → Continue to question 8.

   a. **Explain how the existing space will be utilized after the relocation.**

8. Is the proposed project for the development or expansion of an end-stage renal disease (ESRD) facility?

☐ Yes ☐ No

If YES ⟶ Answer questions 8a through 8g.
If NO ⟶ Continue to Section IV.

b. Complete the following table.

Type of Station	Current Number	Proposed Number
Home Training		
Self-Care Hemodialysis		
Self-Care Peritoneal Dialysis		
Staff Assisted Hemodialysis		
Staff Assisted Peritoneal Dialysis		
Other (specify)		
Other (specify)		

c. If the proposed project involves the expansion of an existing ESRD facility, describe the types of ancillary services provided.

d. If the proposed project involves the expansion of an existing ESRD facility, complete the following table.

Number of Transplants in the Past Three Years:	
Name of Transplant Facility:	
Location of Transplant Facility:	
Projected number of patients who will be candidates for transplantation during the first three years of operation:	

e. Provide the name and address of all nephrologists and other physicians who will serve the patients of the facility.

f. List all existing ESRD facilities in your service area and approximate distance from your proposed facility.

g. Submit letters of comment from any other ESRD facilities, hospitals, physicians, community agencies or political entities in your ESRD service area.

IV. GENERAL REVIEW CRITERIA (CON MANUAL – CHAPTER 8)

1. State Health Plan (Criterion 1): *Refer to Service-Specific Criteria, Section III of the application.*

2. Long Range Plan (Criterion 2): **Describe how the proposed project is consistent with the applicant's long-range plans. Include a discussion of the planning process which preceded submission of this application.**

3. Availability of Alternatives (Criterion 3):
   a. **Identify alternative approaches to the project which were considered. Describe the advantages and disadvantages of each alternative as well as the reason(s) they were not chosen.**

   b. **Demonstrate in specific terms how the option selected most effectively benefits the health care system.**

   c. **If an effective and less costly alternative for the proposed project is currently available in the area, demonstrate:**
      i. **Why the proposed project is not an unnecessary duplication of services.**

      ii. **Why the proposed project is a more efficient solution to the identified need.**

   d. **State how your proposed project fosters improvements or innovations in the financing or delivery of health services, or promotes health care quality assurance or cost effectiveness.**

   e. **Explain the relevancy of the proposed project in relation to changing trends in service delivery and community health care needs of the foreseeable future.**

4. Economic Viability (Criterion 4):

   a. **Fully explain and justify any financial forecasts which deviate significantly from the financial statements of the three-year historical period.**

   b. **Describe how the applicant will cover expenses incurred by the proposed project in the event that the project fails to meet projected revenues.**

c. **Discuss the impact of the proposed project on the cost of health care. This discussion should include the proposed project's impact on gross revenues and expenses per patient day or per procedure as well as the impact on Medicaid, if applicable.**

d. **Discuss both the proposed charges for the service and the profitability of the proposed service compared to other similar services in the state.**

e. **If the capital expenditure of the proposed project is $2,000,000 or more, submit a financial feasibility study prepared by an accountant, CPA, or the facility's financial officer. The study must include the financial analyst's opinion of the ability of the facility to undertake the obligation and the probable effect of the expenditure on present and future operating costs. In addition, the report must be signed by the preparer.**

Supplemental Financial Information required for all applications:

- **CON Application Financial Analysis** (Excel spreadsheet) consists of seven (7) tables that must be completed and submitted along with application.

- **Copies of financial statements are required with each application.** Please provide audited financial statements when possible. Audited financial statements to be submitted must include, at a minimum, balance sheet, operating statement, and cash flow statement. Be sure financial information for the last three years is included.

If applicable:

- Copy of all existing and/or proposed management contracts.

5. **Need for the Project (Criterion 5): Answer questions 5a through 5c only if there are no service-specific criteria and/or policy statements in the most current State Health Plan applicable to your proposed project.**

   a. **Discuss the need that the population served or to be served has for the services proposed to be offered or expanded.**

   b. **In the case of the relocation of a facility or service, the need that the population presently served has for the service and the extent to which that need will be met adequately by the proposed relocation or by alternative arrangements.**

   c. **Document the community reaction to the facility. Submit endorsements from community officials and individuals expressing their reaction to the proposal, if applicable.**

6. **Access to the Facility or Service (Criterion 6):**

a. **Do all residents of the health planning service area, hospital service area or patient service area, including Medicaid recipients, charity/medically indigent patients, racial and ethnic minorities, women, handicapped persons and the elderly have access to the services of the existing facility?**

☐ Yes ☐ No ☐ Not Applicable

b. **Will these residents have access to the proposed services and/or facility as described in this application?**

☐ Yes ☐ No

c. **Provide the percentage of gross patient revenue and actual dollar amount of health care provided to medically indigent patients for the last two years as well as the projected amount for the two years following completion of the proposed project. This should include only those patients for whom there is no expectation of payment upon admission and should not include bad debt. Discuss any significant changes between historical and projected utilization. Be sure to identify what years are the historical years.**

	Gross Patient Revenue (percent of)	Gross Patient Revenue (dollar amount)
Historical Year 20____		
Historical Year 20____		
Projected Year 1		
Projected Year 2		

d. **Address the following access issues:**
   i. **Transportation and travel time to the facility.**

   ii. **Restrictive admissions policies. Provide a copy of the current or proposed admissions policy.**

   iii. **Access to care by medically indigent patients.**

   iv. **Provide the hours per week the proposed service and/or facility will be manned and operating:**
      1. **Regular operation.**

      2. **Emergency only operation.**

e. **Does your facility have existing obligations under any federal regulation requiring provision of uncompensated care, community service, or access by minority/handicapped persons?**

☐ Yes ☐ No

If YES ⟶ Answer question 6e (i).
If NO ⟶ Continue to question 7.

i. **Describe the remaining obligation.**

7. **Information Requirement (Criterion 7):** See affirmative statement checklist.

8. **Relationship to Existing Health Care System (Criterion 8):**

a. **Identify any existing, comparable services within your service area and describe any significant differences in population served or service delivery. If there are no existing, comparable services in the area, describe how the target population currently accesses the proposed service(s).**

b. **State how the proposed project will affect existing health services available in the region or statewide, if applicable. Describe how each proposed new or expanded service will:**
   i. **Complement existing services.**
   ii. **Provide an alternative or unique service.**
   iii. **Provide a service for a specific target population.**
   iv. **Provide services for which there is an unmet need.**

c. **Describe any adverse impact to the existing health care system that may result from failure to implement the proposed project.**

d. **Provide a list of transfer/referral/affiliation agreements between the current or proposed facility and other providers of health care within your health planning service area that are directly related to the proposed project.**

9. **Availability of Resources (Criterion 9):**

a. **Document the availability of new personnel required to staff the proposed service and/or facility. If applicable, demonstrate that sufficient physicians are available to ensure proper implementation of the proposed project.**

b. **Describe your plan for recruiting any new personnel required.**

c. **If applicant owns existing facilities or services, demonstrate a satisfactory staffing history.**

10. **Relationship to Ancillary or Support Services (Criterion 10): Ancillary services are defined by Medicare as services for which there is a charge in addition to the routine room and board service charge. Ancillary services can include but not be limited to laboratory services, drugs, dressings, radiology, operating room services, respiratory services, physical therapy services, anesthesiology, etc.**

    a. **Demonstrate that all necessary support and ancillary services for the proposed project are available.**

    b. **Describe any change in costs or charges as a result of this proposed project.**

    c. **Describe how you plan to accommodate any change in costs or charges.**

11. **Discuss the effect of the proposed service and/or facility on the clinical needs of health professional training programs in the service area (Criterion 11).**

12. **Access by Health Professional Schools (Criterion 12):** State how your proposed project will meet the clinical needs of health professional training programs.

13. **If the applicant proposes to provide service(s) to individuals not residing in the service area, document any special needs or circumstances that should be considered (Criterion 13).**

14. **Construction Projects (Criterion 14).** *Included in Economic Viability.*

15. **Competing Applications (Criterion 15): If there are any competing applications, refer to *Guidelines for Competing Applications.***

16. **Quality of Care (Criterion 16):**

    a. **If the project involves existing services or facilities, describe how the applicant has demonstrated past quality of care.**

b. Describe how the proposed project will improve the quality of care being delivered to the target population.

c. List any accreditation and/or certifications held.

V. STATE AND LOCAL COMPLIANCE

1. **Does the proposed project involve construction or renovation?**

   ☐ Yes ☐ No

   If YES ⟶ Submit documentation that applicant will or has complied with state and local building codes, zoning ordinances, and/or appropriate regulatory authority.
   If NO ⟶ Continue to question 2.

2. **Complete and sign the Certification on page 20** (submit the original).

VI. UTILIZATION

Use the table on the following page to list utilization statistics for the past two years, current year, and the first three years following project completion. Be sure to identify the corresponding calendar year for each column. Only include data that is relevant to the proposed project. The data provided for the past two years should be consistent with the data submitted on the Annual Survey of Hospitals for the respective years. See Project Description, question 3a for a list of bed types. Service types include but may not be limited to: 1) magnetic resonance imaging; 2) positron emission tomography; 3) digital subtraction angiography; 4) extracorporeal shock wave lithotripsy; 5) adult open-heart surgery; 6) pediatric open-heart surgery; 7) adult cardiac catheterization; and 8) pediatric cardiac catheterization.

1. **Clearly identify the methodology and any assumptions used to project utilization.**

2. **Discuss the specific reasons for increases and/or decreases in the various categories.**

3. **How does projected levels of utilization compare to those experienced by similar facilities in the service area?**

4. **Explain how projected levels of utilization are consistent with the need level of the service area.**

	Prior two years		Current year	Three years after project completion		
	Year 20	Year 20	Year 20	Year 1	Year 2	Year 3
Bed Type:						
# Licensed Beds						
# Setup Beds						
Admissions						
Inpatient Days						
Outpatient Days						
Discharges						
Discharge Days						
Average Length of Stay						
Average Daily Census						
Occupancy Rate						
Bed Type:						
# Licensed Beds						
# Setup Beds						
Admissions						
Inpatient Days						
Outpatient Days						
Discharges						
Discharge Days						
Average Length of Stay						
Average Daily Census						
Occupancy Rate						
Service Type:						
# Procedures						
Service Type:						
# Procedures						

VII. AFFIRMATIVE CHECKLIST

The applicant affirms that they will comply with checked statements below (check all that apply).

☐ Applicant will record and maintain data regarding charity care, care to the medically indigent, and care to the Medicaid population and that this data will be made available to MDH within 15 days of request.

☐ Applicant will comply with all applicable State statues and regulations for the protection of the environment, including: 1) approved water supplies; 2) sewage and water disposal; 3) hazardous waste disposal; 4) water pollution control; 5) air pollution control; and 6) radiation control.

☐ Within the scope of its available services, the facility shall not have policies or procedures which would exclude patients because of race, age, sex, eithnicity, or ability to pay

☐ Applicant will provide a "reasonable amount" of indigent/charity care as described in Chapter 1 of the State Health Plan

☐ Applicant has internal policies and procedures that are used to monitor quality of care

MDH USE ONLY
CON Review #:
Proposal Type:
Review Cycle:

MISSISSIPPI DEPARTMENT OF HEALTH
CERTIFICATION

APPLICANT: _____

TITLE OF PROPOSED PROJECT: _____

TOTAL CAPITAL EXPENDITURE: _____

I (we) swear or affirm on behalf of _____, After diligent research, inquiry and study, that the information and material contained in the attached application for a Certificate of Need is true, accurate, and correct, to the best of my (our) knowledge and belief. It is understood that the Mississippi Department of Health will rely on this information and material in making its decision as to the issuance of a Certificate of Need, and if it finds that the application contains distorted facts or misrepresentation or does not reveal truth or accuracy, the Department may refrain from further review of the application and consider it rejected. It is further understood that if a Certificate of Need is issued based upon evidence contained in this application, such Certificate may be revoked, canceled or rescinded if the Department of Health determines its findings were based on evidence, not true, factual, accurate, and correct.

I (we) certify that no revision or alteration of the proposal submitted will be made without obtaining prior written consent of the Department of Health. Furthermore, I (we) will furnish to the Department of Health a progress report on the proposal every six (6) months until the project is completed.

_____ Signature

_____ Signature

_____ Title

_____ Title

STATE OF _____

COUNTY OF _____

Sworn to and subscribed before me, this the _____ day of _____, 20____.

_____ Notary Public

_____ My Commission Expires