IN THE SUPREME COURT OF MISSISSIPPI

GREENWOOD LEFLORE HOSPITAL and GREENWOOD SPECIALTY HOSPITAL, L.L.C. and GREENWOOD SPECIALTY HOSPITAL II, L.L.C., d/b/a GREENWOOD SPECIALTY HOSPITAL	**APPELLANTS**
V.	**NO. 2007-SA-00877**
MISSISSIPPI STATE DEPARTMENT OF HEALTH and DELTA REGIONAL MEDICAL CENTER	**APPELLEES**

APPEAL FROM THE CHANCERY COURT OF THE FIRST JUDICIAL DISTRICT OF HINDS COUNTY, MISSISSIPPI

BRIEF OF THE APPELLEES DELTA REGIONAL MEDICAL CENTER AND THE MISSISSIPPI STATE DEPARTMENT OF HEALTH

ORAL ARGUMENT NOT REQUESTED

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CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons have an interest in the outcome of this case. These representations are made in order that the Justices of the Supreme Court and/or the Judges of the Court of Appeals may evaluate possible disqualification or recusal.

1. Greenwood Leflore Hospital and Greenwood Specialty Hospital, L.L.C. and Greenwood Specialty Hospital II, L.L.C., d/b/a Greenwood Specialty Hospital (Appellants).
2. Mississippi State Department of Health and Delta Regional Medical Center(Appellees).
3. Barry K. Cockrell, Esq. of Baker, Donelson, Bearman, Caldwell & Berkowitz, PC, counsel for Appellants.
4. Donald E. Eicher, III, Esq., counsel for the Mississippi State Department of Health.
5. Jeffrey S. Moore, Esq., of Phelps Dunbar LLP, counsel for Delta Regional Medical Center.
6. Darrell J. Solomon, Esq., of Phelps Dunbar LLP, counsel for Delta Regional Medical Center.
7. Ricky L. Boggan, Esq., Hearing Officer.
8. The Honorable Dewayne Thomas, Chancellor.

Respectfully Submitted,

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STATEMENT OF THE ISSUES

The following issues are presented in this appeal:

1. Whether the Mississippi State Department of Health's administrative decision to award a certificate of need to Delta Regional Medical Center for the establishment of a 40-bed long-term acute care hospital was correct because it was supported by substantial and credible evidence that Delta Regional Medical Center successfully demonstrated the proposed long-term acute care hospital would have the necessary minimum of 450 clinically appropriate restorative care admissions with an average length of stay of 25 days?

2. Whether this Court should disregard the Appellants' argument that the Mississippi State Department of Health's decision should be reversed and remanded due to new federal regulations because this argument implicates facts that are outside of the record of this proceeding and because the Appellants waived their right to raise this issue by failing to raise it on appeal to the Chancery Court?

I. INTRODUCTION

The matter before this Court is an appeal of the Chancery Court's decision to affirm the Mississippi State Department of Health's (hereinafter, the "Department" or "MSDH") grant of a Certificate of Need ("CON") to Delta Regional Medical Center ("DRMC") for the establishment of a long-term acute care hospital ("LTACH") in Greenville, Mississippi. The question of whether to grant the CON to DRMC has been weighed by no less than four distinct and independent entities: (1) the Department's Division of Health Planning and Resource Development (the "Staff"), (2) hearing officer Ricky Boggan (the "Hearing Officer"), (3) the State Health Officer and (4) the Chancery Court of Hinds County. The same conclusion was reached by all four of these bodies: DRMC proved with an overwhelming amount of substantial and credible evidence that its proposed LTACH would have at least 450 clinically appropriate restorative care admissions with an average length of stay ("LOS") of 25 days or greater by the end of its third year of operation. DRMC now asks this Court to affirm the independent decisions of the Department and the Chancellor granting the CON to establish an LTACH in Greenville, Mississippi.

Although the Appellants have requested oral arguments with respect to this proceeding, DRMC does not request to be heard orally. DRMC believes that the facts and legal arguments are adequately presented in the briefs and record and the decisional process would not be significantly aided by oral argument.

II. STATEMENT OF THE CASE

DRMC is a 405-bed, short term, general acute care, non-profit hospital located in Greenville, Washington County, Mississippi. [Tr. 84:26].[1] DRMC is a community hospital

[1] Referenced portions of the Hearing transcript are cited herein by page and line number as follows: "Tr. [page #]:[line #]." Exhibits introduced at the Hearing are referred to by exhibit number as follows: "Ex. [exhibit #]."

owned by Washington County, Mississippi, and is a political subdivision of the State of Mississippi. The main campus, located at 1400 East Union Street, is licensed for 228 acute care beds, while Delta Regional Medical Center, West Campus-King's Daughters Hospital (the "West Campus") is located at 300 South Washington Avenue and is currently licensed for 177 acute care beds. [Tr. 91:13-24].

On December 1, 2005, DRMC filed an application with the Department seeking a CON to establish a 40-bed LTACH at its West Campus. [Tr. 10:13-16]. DRMC proposed in its CON Application to establish and operate a "hospital within a hospital" (the "Project") by contracting with Allegiance Health Management ("Allegiance") to lease the 40 beds from DRMC and operate the LTACH. [Tr. 15:1-3]. DRMC supplemented its application by providing additional information to the Department (hereinafter, the application and its supplement shall be referred to as the "Application"). [Tr. 15:27-16:4]. DRMC's Application represented that the capital cost of the Project would be $1,076,000. [Tr. 14:29-15:1]. It further represented that the Project would be financially feasible with a net income of $1,891,876 by the end of the LTACH's third year of operation. [Tr. 13:1-4].

In February 2006, the Staff issued its Staff Analysis, in which it concluded that the Project was in substantial compliance with the *FY 2006 Mississippi State Health Plan* (the "SHP"), the *Mississippi Certificate of Need Review Manual, 2000 Revision* and all other relevant rules and procedures of the Department. [Ex. 3]. Based on its conclusion that the Project would meet the requirements set out by the Department, including the "Need Criterion," which requires the applicant to demonstrate that its proposed facility will have a minimum of 450 annual clinically-appropriate restorative care admissions with an average length of stay of 25 days, the Staff recommended approval of DRMC's Application. [Tr. 15:11; Ex. 3].

Subsequently, Greenwood Specialty Hospital ("GSH"), Select Specialty Hospital – Jackson ("Select") and Greenwood Leflore Hospital ("GLH") (hereinafter, all three parties collectively referred to as the "Original Opponents") filed requests for a hearing during the course of review under the provisions of Miss. Code Ann. § 41-7-197(2) (2005). The hearing took place at the Department in Jackson, Mississippi on July 24-26, 2006 and August 11, 2006 (the "Hearing") before the Hearing Officer. DRMC, GSH, GLH and Select, through legal representatives, fully and completely participated in all of the proceedings. Eleven witnesses presented testimony and 91 exhibits were introduced into evidence. A complete record of the hearing was made, consisting of a transcript of all testimony received and all documents introduced into evidence.

A. Delta Regional Medical Center Presented Substantial and Credible Evidence in Support of its Proposed Long Term Acute Care Hospital.

Importantly, the SHP **does not require any specific methodology** by which applicants are required to achieve 450 annual restorative care admissions with an average LOS of 25 days by the end of its third year of operation. Mr. Sam Dawkins of the Department testified that an applicant may use ***any* reasonable methodology** it deems appropriate to determine the need for an LTACH. [Tr. 35:24-36:1]. DRMC introduced substantial and credible evidence that Allegiance had used not one, but three industry-standard methodologies to show that the proposed LTACH would have the required 450 restorative care admissions with an average LOS of 25 days. [Tr. 270:29-284:14]. In addition, DRMC's expert witness testified to a fourth methodology at the Hearing and determined that there would be approximately 2,120 annual restorative care discharges from DRMC's main and West campuses alone. [Tr. 490:18-20].

DRMC, however, also put forth overwhelming evidence that it would not be relying only on discharges from its main and West campuses. DRMC anticipates that a significant number of admissions to its proposed LTACH will come from other hospitals in the surrounding area, many

of which wrote letters to DRMC in support of its proposed LTACH. [Exs. 16-19]. It also proved that there are yet more hospitals located in General Hospital Service Area Number 2 ("GHSA 2") that are not opposed to the Project and that have LTACH-appropriate patients. [Tr. 432:14-435:5; Ex. 62]. In 2005, GHSA 2, combined with Chicot County, Arkansas, had 16,889 LTACH-sensitive discharges. [Tr. 433:4-10; Ex. 62].

Following the submission of proposed findings by both parties, the Hearing Officer issued his Executive Summary (the "Executive Summary") in which he found that "DRMC provided substantial and credible evidence to show that its proposed LTACH would have the necessary minimum of 450 clinically appropriate restorative care admissions and those 450 clinically appropriate restorative care admissions would have an average length of stay of 25 days" and recommended that the State Health Officer follow the recommendation of the Staff and approve the Application. [R.E. 4:32].[2]

B. The State Health Officer and Hinds County Chancery Court Agreed with the Hearing Officer's Decision.

The State Health Officer agreed that there was substantial and credible evidence to support DRMC's Application, accepted the Hearing Officer's recommendation and on December 21, 2006, issued a Final Order (the "Final Order") approving the Application and granting the CON. [R.E. 3:3].

GLH, GSH and Greenwood Specialty Hospital II, L.L.C., d/b/a Greenwood Specialty Hospital, a successor-in-interest to GSH, (the three parties collectively referred to as the "Opponents")[3] appealed to the Chancery Court of Hinds County requesting that the State Health

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[2] Referenced portions of the Appellants' Record Excerpts are cited by tab and page number as follows: "R.E. [tab #]:[page #]."

[3] Select Specialty Hospital – Jackson, an Original Opponent in this matter, did not participate in the appeal to the Chancery Court of Hinds County and likewise is not a party to this appeal.

Officer's decision be overturned (the "Initial Appeal"). In support of their appeal, the Opponents raised only two issues:

> (1) Whether the MSDH's administrative decision to award a CON to DRMC for the establishment of a 40-bed LTACH was supported by substantial evidence?
>
> (2) Whether the MSDH's administrative decision was contrary to the manifest weight of the evidence?

The Chancellor, after considering the briefs and hearing oral arguments from both sides, found that the Department's decision was "not based upon a single statistic or assertion; the decision was a thoughtful and reasoned response to a voluminous amount of evidence. The decision was supported by substantial evidence and was not arbitrary or capricious." [R.E. 3:11]. The Chancellor, therefore, affirmed the decision of the Department. [R.E. 3:12.]

The Opponents now appeal to this Court raising the same two issues they raised in their Initial Appeal, along with a third issue concerning new federal regulations that were not in existence at the time of the Hearing or the Initial Appeal. As the Hearing Officer, State Health Officer and the Chancellor concluded, these first two issues have no merit. The decisions of the Department and the Chancellor were supported by substantial credible evidence and were not contrary to the manifest weight of the evidence. The third issue should be dismissed out of hand, as it speaks only to the financial feasibility of the Project and the Opponents failed to raise financial feasibility as an issue on appeal to Chancery Court. Additionally, this third issue requires an examination of facts that are not a part of the record before this Court. Accordingly, the decisions of the Staff, the Hearing Officer, the State Health Officer and the Chancellor, each of whom independently considered evidence of DRMC's need for an LTACH, should be affirmed.

III. SUMMARY OF THE ARGUMENT

The Department's decision to approve the Application and thereby grant a CON to DRMC was based on three separate levels of review at the Department, including the Staff, the Hearing Officer and the State Health Officer. In addition, upon review of the record transcript, reading the briefs of the parties and hearing oral arguments from both sides, the Chancellor found that the Department's decision was based on substantial credible evidence and was not arbitrary or capricious and affirmed the Department's decision granting a CON to DRMC to establish a 40-bed LTACH in Greenville, Mississippi. [R.E. 3:12]. In order for the Opponents to win this appeal, they must show that the Department's decision, in spite of being based on three levels of Department analysis, and in spite of being affirmed in the Chancery Court of Hinds County, was not supported by more than a scintilla of evidence or a mere suspicion.

DRMC provided much more than a mere scintilla of evidence, however, as it produced overwhelming evidence in support of its need for an LTACH. The SHP requires that applicants for a CON to establish an LTACH prove a minimum of 450 clinically appropriate restorative care admissions with an average LOS of 25 days by the end of their third year of operation. **It does not, however set out any particular methodology by which to do so.** [Tr. 35:24-36:1]. DRMC documented 1,571 restorative care admissions and an additional pool of 728 other LTACH appropriate admissions, for a total of 2,299, in the Application submitted to the Department. [Tr. 33:14, Ex. 9]. DRMC determined that the average LOS for its patients would be 27 days. [Tr. 16:29-17:4].

At the Hearing, DRMC offered even stronger numbers in support of the need for an LTACH by proving that in fact the pool of potential LTACH admissions was approximately 5,302 from DRMC alone. [Tr. 180:26-181:2].[4]

The Brief of Appellants also completely ignores the fact that DRMC's proposed LTACH is supported by hospitals located in DRMC's service area that, when considered together, will serve as a significant source of patient referrals to the LTACH. Bolivar Medical Center, South Sunflower County Hospital, Humphreys County Memorial Hospital, Sharkey Issaquena Community Hospital and Chicot Memorial Hospital support DRMC's proposed LTACH. [Tr. 101:19, Exs. 16-19].

The fact is that at the Hearing, DRMC used not one methodology to prove need for the LTACH, but three, and each one produced more than the necessary 450 restorative care admissions with an average LOS of at least 25 days. In spite of the SHP's silence as to a particular preferred methodology, the Opponents argue that DRMC's methodologies do not suffice. They make this argument despite the fact that GSH used the exact same methodologies when applying for its CON for an LTACH to be located in Greenwood, Mississippi, which application was approved by the Department. DRMC also introduced abundant evidence that its methods for documenting 450 restorative care admissions with an average LOS of at least 25 days were sound practice within the industry.

The Opponents also ask this Court to consider reversing and remanding this proceeding with a mandate to reopen the record before the Department due to new federal regulations that

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[4] In an effort to obscure DRMC's overwhelming evidence that the Project would have the necessary 450 restorative care admissions with an average LOS of 25 days, the Opponents claim that DRMC "presented a hodge-podge of theories and methodologies." [Opponents' Brief at 4]. With respect to the different numbers presented by DRMC, it should be noted that when DRMC originally analyzed the need for an LTACH in Greenville, Mississippi, it found a potential pool of 2,299 LTACH-appropriate patients and submitted that number it is Application. During its preparation for the Hearing, however, DRMC did further market research and determined that the potential pool of LTACH-appropriate patients was, in fact, much higher.

have been issued since the Initial Appeal. These new regulations would effectively limit to 50% of the LTACH's total Medicare admissions, the number of admissions that may originate from DRMC. DRMC's proposed LTACH could, in reality, continue to take an unlimited percentage of Medicare admissions from DRMC, but for those DRMC patients admitted above the 50% threshold, the LTACH would receive a reduced amount of federal reimbursement. [*See* Part II, Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Annual Payment Rate Updates, and Policy Changes; and Hospital Direct and Indirect Graduate Medical Education Policy Changes; Final Rule, 72 Fed. Reg. 26918, 26920 (May 11, 2007)]. Practically speaking, therefore, DRMC would have a financial incentive to admit no more than 50% of its patients from DRMC.

This proceeding should not be remanded based on the adoption of these new federal regulations. The existence of these new federal regulations represents a fact outside of the Hearing and Chancery Court record. This Court has consistently held that it will not look to facts outside of the record when weighing an issue on appeal. In addition, the new federal regulations have no effect whatsoever on any issue that is the subject of this appeal. In their Initial Appeal, the **only** issue raised by the Opponents was whether DRMC could prove a minimum of 450 clinically appropriate restorative care admissions with an average LOS of 25 days. The new federal regulations have no effect on DRMC's ability to prove 450 clinically appropriate restorative care admissions with an average LOS of 25 days. Instead, the new regulations may arguably have an impact on the *financial feasibility* of the Project. But the Opponents cannot raise the issue of financial feasibility in this appeal; they waived their right to do so by not raising the issue of financial feasibility in their Initial Appeal. The Chancellor confirms in his Opinion that financial feasibility of the Project is not an issue on appeal, stating

that "**[t]he issue of financial feasibility was not raised on appeal and appears to be undisputed.**" [R.E. 3:4].

Notwithstanding the above, DRMC's Project will be financially feasible by its third year of operation even with the new federal regulations in effect due to the overwhelming support pledged by hospitals in the Delta area. Bolivar Medical Center in Cleveland, South Sunflower County Hospital in Indianola, Humphreys County Memorial Hospital in Belzoni, Sharkey-Issaquena Community Hospital in Rolling Fork, and Chicot Memorial Hospital across the Mississippi River in Lake Village, Arkansas have all pledged their support for the Project and will serve as referral sources for the proposed LTACH. [Tr. 101:19, Exs. 16-19]. In addition, DRMC offered substantial evidence at the Hearing that there are a number of other hospitals located in GHSA 2 that are not opposed to the Project and that have patients that are LTACH-appropriate. [Tr. 432:14-435:5; Ex. 62]. DRMC also offered testimony at the Hearing that Allegiance planned to hire a dedicated community educator whose *sole job* would be to promote DRMC's LTACH in Northeastern Louisiana and Southeastern Arkansas. [Tr. 298:14-21]. Finally, due to the fact that GSH is similarly limited to the 50% threshold with respect to the number of Medicare admissions that it can take from GLH and receive full LTACH Medicare reimbursement, DRMC's proposed LTACH anticipates admitting a significant number of GLH's patients as well.

The Department's decision must be afforded great deference upon review. The Opponent's burden, therefore, is a high one and they have not shown that the granting of the CON to DRMC was based on a mere scintilla or suspicion of evidence. DRMC respectfully requests this Court to affirm the Department's decision granting DRMC a CON for the establishment of a 40-bed LTACH in Greenville, Mississippi.

IV. ARGUMENT

A. Standard of Review.

Miss. Code Ann. § 41-7-201(2)(f) controls the review of appeals of finals orders of the Department, providing that:

> [t]he order shall not be vacated or set aside, either in whole or in part, except for errors of law, unless the court finds that the order of the State Department of Health is not supported by substantial evidence, is contrary to the manifest weight of the evidence, is in excess of the statutory authority or jurisdiction of the State Department of Health, or violates any vested constitutional rights of any party involved in the appeal.

The Supreme Court of Mississippi does not perform administrative functions. In *Miss. State Bd. of Nursing v. Wilson*, 624 So. 2d 485, 489 (Miss. 1993), this Court opined that "[o]ur Constitution does not permit the judiciary of this state to retry de novo matters on appeal from administrative agencies. Our courts are not permitted to make administrative decisions and perform the functions of an administrative agency. Administrative agencies must perform the functions required of them by law."

There is a rebuttable presumption in favor of an agency's decision in such matters and the burden of proving the contrary is on the challenging party. *Sprouse v. Miss. Employment Sec. Comm'n*, 639 So. 2d 901, 902 (Miss. 1994). This Court has recognized that Miss. Code Ann. § 41-7-201(2)(f) imposes a heavy burden on appellants in CON appeals, opining that "the decision of the hearing officer and the State Health Officer is afforded great deference upon judicial review. . . ." *St. Dominic-Jackson Mem'l Hosp. v. Miss. State Dep't of Health*, 728 So. 2d 81, 83 (Miss. 1998) (*quoting Miss. State Dep't of Health v. Southwest Miss. Reg'l Med. Ctr.*, 580 So. 2d 1238, 1240 (Miss. 1991)). This Court has further held that the same deference due the Department's finding must also be given to the Chancellor who, on appeal, affirms and adopts

the Department's finding. *Ricks v. Miss. State Dep't of Health*, 719 So. 2d 173, 177 (Miss. 1998).

It is important to note this Court's interpretation of the term "substantial evidence" as used in § 41-7-201(2)(f). In *Miss. State Dep't of Health v. Natchez Cmty. Hosp.* 743 So. 2d 973, 977 (Miss. 1999), the Court opined that:

> **Substantial evidence means more than a scintilla or a suspicion**. If an administrative agency's decision is not based on substantial evidence, it necessarily follows that the decision is arbitrary and capricious. An administrative agency's decision is arbitrary when it is not done according to reason and judgment, but depending on the will alone. **An action is capricious if done without reason, in a whimsical manner, implying either a lack of understanding of or disregard for the surrounding facts** and settled controlling principles.

(emphases added) (interior citations omitted).

In other words, in order for the Opponents to prevail in this appeal, they must prove that DRMC presented the Department with no more than a mere "scintilla" of evidence or a "suspicion" that DRMC's LTACH would have 450 restorative care admissions with at least a 25-day average length of stay by the end of its third year of operation. The Opponents must prove that the Department's decision to grant the LTACH CON to DRMC was reached "in a whimsical manner" with a "lack of understanding of or disregard for the surrounding facts." *Id.*

The Appellants cannot satisfy this high burden of proof on appeal. DRMC, through its 8 witnesses and 79 exhibits, offered substantial and credible evidence at the Hearing that proved beyond a doubt that its LTACH would have 450 restorative care admissions with an average length of stay of 25 days or greater by the end of its third year of operation. The Department's action granting a CON to DRMC to establish a 40-bed LTACH in Greenville was correct and was appropriately affirmed by the Chancellor.

B. Delta Regional Medical Center Successfully Demonstrated That Its LTACH Would Have the Necessary Minimum of 450 Clinically Appropriate Restorative Care Admissions with an Average Length of Stay of 25 Days.

Under the requirements of the SHP, an applicant seeking to establish an LTACH must document a minimum of 450 clinically appropriate restorative care admissions[5] with an average LOS of 25 days by the end of its third year of operation. Importantly, the SHP provides no specific methodology with which to calculate the 450 admissions with and average LOS of 25 days.

1. Three Separate and Independent Methodologies Prove the 450 Clinically Appropriate Restorative Care Admissions with an Average Length of Stay of 25 Days.

In its Application, DRMC provided the Department with a list of potential LTACH admissions broken down by the four restorative care groups and a fifth category titled "All Other Qualified Admissions." [Tr. 33:14, Ex. 9]. The list of admissions included in the Application revealed that DRMC had a potential pool of 1,571 restorative care admissions and an additional pool of 728 other admissions reflecting DRGs[6] appropriate for admission to an LTACH, for a total of 2,299[7]. [Ex. 9 at p.5].

Mr. Rock Bordelon,[8] chief executive officer of Allegiance, testified as to how Allegiance determined the need for an LTACH in Greenville. [Tr. 270:29-284:14]. According to his testimony, Allegiance used three separate and distinct methodologies to determine that there was

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[5] Rather than requiring applicants to prove 450 admissions from specific Diagnosis-Related Groups ("DRGs"), the SHP mandates that the admissions must fall within one of four categories of restorative care admissions: neurological disorders, central nervous system disorders, cardio-pulmonary disorders and pulmonary cases. (*FY 2006 Mississippi State Health Plan* at XI-67).

[6] DRGs are part of a system to classify hospital cases into one of approximately 540 groups , or DRGs, expected to utilize similar hospital resources, developed as the basis of payment under Medicare's inpatient hospital prospective payment system.

[7] As detailed below, the 1,571 and 2,299 totals come from only 26 DRGs. If DRMC had used all the restorative care DRGs, it undoubtedly would have arrived at even higher totals. At the hearing, DRMC bolstered the information set forth in its Application and offered evidence that the pool of potential LTACH candidates from DRMC alone is not 2,299, but rather is 5,302. [Tr. 180:26-181:2].

[8] Mr. Bordelon was accepted by the Hearing Officer as an expert witness with respect to the operation of LTACHs. [Tr. 261:4].

a need for an LTACH in Greenville. [Tr. 279:14-16]. The first methodology required Allegiance to take DRMC's total discharges over a 12-month period, and pull out those discharges attributable to 26 specific DRGs that lend themselves to LTACH admissions.[9] [Tr. 270:29-272:16]. This step produced the 1,571 restorative care admissions and 2,299 total admissions previously referenced. [Tr. 274:12-275:15] The industry standard is to take 25-35% of this LTACH admission pool to arrive at potential LTACH admissions. [Tr. 276:16-25] A conservative use of 25% produced 575 potential LTACH admissions. [Tr. 276:19]. Importantly, this methodology did not consider potential LTACH referrals from other hospitals located in GHSA 2 and surrounding areas that have expressed support for DRMC's LTACH. Consideration of these additional LTACH referrals from other short term acute care hospitals located in GHSA 2 and surrounding areas would put DRMC even further beyond the 450 restorative care admissions threshold. The numbers produced using Mr. Bordelon's methodology were provided to the Department in the Application.

A second methodology applied by Allegiance, also an industry standard according to Mr. Bordelon's expert testimony, was to look at the number of licensed beds in the market and use a ten-to-one ratio to determine LTACH bed need. [Tr. 277:6-278:2]. In this case, DRMC has 405 licensed beds, so it alone would support a 40-bed LTACH. [277:17-19]. The secondary service area, including DRMC along with Bolivar Medical Center, South Sunflower County Hospital, North Sunflower Medical Center and Chicot Memorial Hospital, has approximately 700 beds, meaning there is a need for 70 LTACH beds in the area in addition to the 40 LTACH beds

[9] The 26 DRGs come from the State of New Jersey's Certificate of Need process. New Jersey CON regulations outline a specific methodology required to establish need, the first step of which is to identify discharges for these 26 DRGs. [Ex. 34]. While the Opponents attempt to make an issue out of the fact that Mr. Bordelon did not "follow the methodology all the way through," [Appellants' Brief at 12], Mr. Bordelon testified that Allegiance **did not attempt to use the New Jersey methodology**. Mr. Bordelon merely used New Jersey's list of 26 DRGs as a starting point because that list is a conservative one with respect to patients who frequently require LTACH services. [Tr. 273:26].

already licensed at GSH. [Tr. 277:20-22]. As there are 1,300 beds licensed in GHSA 2, it follows, according to this methodology, that there is a need for 130 total LTACH beds in GHSA 2. [Tr. 277:23-26]. There are currently only 40 LTACH beds in GHSA 2 resulting in a deficit of 90 LTACH beds.

Allegiance's third methodology was to examine the total acute care hospital admissions or discharges in a given 12-month period and take 3-5% of that figure to arrive at the number of LTACH candidates who would have a diagnosis appropriate for admission to an LTACH and whose LOS would average 25 days. [Tr. 279:14-22]. Mr. Bordelon testified that this methodology, too, is standard in the industry and his claim was corroborated by testimony in the Regency Hospital of Meridian's CON hearing, the transcript of which was admitted into evidence [Tr. 277:6-12; Ex. 44]. In that hearing, Regency's president, Mr. Ron Laughlin, testified that:

> generally, four to five percent of the hospital's admissions or discharges will be LTAC eligible patients, **and we've just got this from something dozens and dozens of hospitals and getting their data and looking, comparing it back to their admissions.**[10]

[Tr. 379:9, Ex. 44 at p.84 (emphasis added)].

Applying this methodology to DRMC alone, a methodology that was ultimately validated by this Court in *Miss. State Dep't of Health v. Rush Care, Inc.*, 882 So. 2d 205, 210 (Miss. 2004), *infra*, Allegiance identified over 400 LTACH eligible patients. [Tr. 279:23-27]. When admissions from Bolivar Medical Center, South Sunflower County Hospital, North Sunflower

[10] It is noteworthy that Regency's expert witness in its CON hearing was Mr. Ed Witek who, at that time, was under the employ of Mr. Dan Sullivan's company, the Sullivan Consulting Group. [Tr. 575:25]. At the Regency CON hearing, Mr. Witek corroborated Mr. Laughlin's testimony by supporting the need for a 40-bed LTACH in the city of Meridian, even though a 49-bed LTACH was already operating in Meridian less than half a mile away. [Ex. 44 at p.159]. Mr. Witek, representing the Sullivan Consulting Group, had no objections to Mr. Laughlin's methodology that examined 4-5% of hospital admissions in order to determine LTACH bed need.

Medical Center and Chicot Memorial Hospital are added, the number of potential LTACH patients rises to 630 using the 3% figure and 1,050 using the 5% figure. [Tr. 280:2-9].

Importantly, the three methodologies presented by DRMC factor in **both** restorative care admissions **and** average LOS. The fundamental—and incessantly repeated—basis of the Opponents' argument is that DRMC failed to present any methodology that considered both restorative care admissions and average LOS. **Average LOS, however, is embedded into each of the three methodologies used by Allegiance and DRMC**. With respect to the first methodology introduced by DRMC, taking 25-35% of discharges attributable to 26 specific LTACH-appropriate DRGs, average LOS is factored in by the very fact that the DRGs examined are LTACH-appropriate. Among the reasons these DRGs are LTACH-appropriate is that their average LOS makes them so. DRMC's second methodology, a ten-to-one ratio of short term acute care beds to LTACH bed need, is simply an industry-standard method of determining the need for LTACH beds in an area—by its very nature, this methodology factors in average LOS. Average LOS is also embedded into DRMC's third methodology, taking 3-5% of total acute care hospital discharges or admissions. This methodology, which is used throughout the LTACH industry and is employed by Regency according to Regency's president, inherently factors in average LOS because it produces a projection of LTACH-appropriate patients. Logic provides that the reason the industry settled on 3-5% of discharges as opposed to a higher percentage, is that such a low multiplier eliminates all but the patients that are truly LTACH-appropriate. And to be LTACH-appropriate, a patient pool must have an average LOS of 25 days.

The Chancellor recognized that the above methodologies factor in average LOS, opining:

> [i]t is imperative to note that each of the three methodologies presented by DRMC factor in **both** restorative care admissions **and** average LOS. Indeed, contrary to the assertions of the Appellants, average LOS is intrinsically embedded into each of these three methodologies.

[R.E. 3:9 (emphasis in original)].

2. Corroborating Evidence of Need.

Mr. Noel Falls[11], an expert in health planning who consulted with DRMC in completing the Application, prepared a fourth methodology which also proves need for the 40-bed LTACH and corroborates the need identified by Mr. Bordelon's methodologies. In preparing for the Hearing, Mr. Richard Williams, DRMC's Director of Inpatient-Outpatient Rehabilitation, at the behest of Mr. Falls, prepared a report listing DRMC's discharges for Fiscal Year 2005 that were attributed to 182 certain LTACH-appropriate DRGs. [Tr. 179:13-21, Ex. 28]. Mr. Falls had selected these 182 LTACH-appropriate DRGs because the Centers for Medicare and Medicaid Services' ("CMS") Medicare Payment Advisory Commission considers these 182 DRGs to be common to both LTACHs and acute care hospitals. [Tr. 489:3-25]. Mr. Williams' report reveals that, based upon these 182 DRGs, DRMC discharged 5,302 LTACH-appropriate patients in FY 2005. [Tr. 490:9]. Mr. Falls testified that approximately 40% of these discharges were restorative care patients, which would translate to roughly 2,120 restorative care discharges at DRMC for FY 2005. [Tr. 490:18-20].

Importantly, these totals, well over the 450 threshold, only take into account the pool of potential admissions coming out of DRMC's main and West Campuses and do not factor in those admissions from surrounding hospitals. In fact, letters of support from surrounding hospitals were introduced at the hearing, each pledging support for DRMC's Application to locate an LTACH in Greenville. Bolivar Medical Center, South Sunflower County Hospital,

[11] DRMC offered, and the Hearing Officer accepted, Mr. Noel Falls as an expert in the fields of (i) health planning, (ii) health market research, (iii) health systems analysis and (iv) the CON process. His resume is found at Exhibit 45. Mr. Falls has been involved in the health care industry for more than 30 years, the last twenty-five years of which have been focused on health planning consulting work. His work is conducted throughout the southeastern United States. He has performed services in connection with over 500 CONs and has testified as an expert in both administrative and judicial forums in several states. He was accepted at the Hearing as an expert in the fields specified above without objection by the Original Opponents.

Humphreys County Memorial Hospital and Sharkey-Issaquena Community Hospital each stated in letters addressed to Mr. Ray Humphreys, chief executive officer of DRMC, that they have LTACH candidates among their patient populations and that they see great value in their patients' having an LTACH in Greenville as an option for long term care. [Exs. 16-19]. In addition, Chicot Memorial Hospital provided Mr. Humphreys with verbal assurances of its support for an LTACH to be located on DRMC's campus. [Tr. 101:19].

Further, Mr. Falls offered substantial evidence at the Hearing that there are yet more hospitals located in GHSA 2 that are not opposed to the Project and that have LTACH-appropriate patients. [Tr. 432:14-435:5; Ex. 62]. In 2005, GHSA 2, combined with Chicot County, Arkansas, had 16,889 LTACH-sensitive discharges. [Tr. 433:4-10; Ex. 62]. Mr. Bordelon also offered testimony at the Hearing that Allegiance planned to hire a dedicated community educator whose *sole job* would be to promote DRMC's LTACH in Northeastern Louisiana and Southeastern Arkansas. [Tr. 298:14-21]

Not surprisingly, the Opponents make no mention in their Brief of these other area hospitals and their written and verbal assurances of support for DRMC's proposed LTACH, implying that the only pool of potential patients from which the LTACH may draw is from DRMC's own campus. While there are certainly enough LTACH-appropriate restorative care patients originating from DRMC's own campus to support its LTACH, DRMC anticipates admitting a large number of its LTACH-appropriate restorative care patients from these, and potentially other, surrounding area hospitals.

Another significant point to note is that CMS considers many DRGs aside from those classified by the Department as restorative care admissions to be appropriate DRGs that lend themselves to LTACH admission. In fact, Mr. Sam Dawkins acknowledged that the Department views CMS' inclusive approach to DRGs as "an important determination" when ascertaining

need for an LTACH. [Tr. 36:10]. Mr. Falls introduced an exhibit revealing that from March 2005 through May 2006, a full 69.9% of admissions to GSH were for diagnoses **other than restorative care categories** as defined in the SHP. [Tr. 452:9, Ex. 69]. In *Rush Care*, this Court acknowledged that "Medicare has listed 527 DRGs which are suitable for LTACH."[12] [Ex. 7 at p.6].

DRMC also offered substantial evidence on a national phenomenon that will certainly increase the need for LTACH services in Washington County, the state of Mississippi and the country as a whole – the aging of the baby boomer generation. According to the testimony of Mr. Falls, baby boomers began hitting age 65 around 2007. [Tr. 722:20-21]. Mr. Falls' Exhibit 83 details a projected 21% increase in the population of persons aged 65 and older from 2005 to 2010 in DRMC's service area, or an increase in 2,896 Medicare beneficiaries. [Tr. 722:6-29, Ex. 83]. This includes a 25% increase in Bolivar County, a 23% increase in Sunflower County and a 19% increase in Washington County. These trends, in combination with the known health problems of Delta residents[13], point toward a growing market for LTACH admissions in GHSA 2, and particularly in DRMC's service area. As Mr. Falls pointed out, a full 91% of GSH's admissions were Medicare patients. [Tr. 451:3-12, Ex. 68]. DRMC expects that 86% of its LTACH admissions will be Medicare patients. [Tr. 307:26-308:2].

3. Corroborating Evidence of the 25-Day Average Length of Stay.

In its Application, DRMC predicted an average LOS of 27 days by the end of its third year of operation. [Tr. 16:29-17:4]. Mr. Falls' exhibits backed up this projection. Mr. Falls culled from DRMC's FY 2005 LTACH-appropriate discharges those patients with characteristics even more likely to lend themselves to admission to an LTACH. Specifically, he counted those

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[12] *Rush Care, Inc.*, 882 So. 2d at 210 n.6. CMS has since expanded their list to include 559 LTACH-appropriate DRGs. [Ex. 29].

[13] *See Self-Reported Health of Residents of the Mississippi Delta*, 15 JOURNAL OF HEALTH CARE FOR THE POOR AND UNDERSERVED 645 (2004). [Tr. 407:26; Ex. 53].

patients with a LOS higher than the geometric mean LOS[14], aged 45 and older, and with a higher case mix index[15] than GLH's case mix index. [Tr. 426:16]. This resulted in 598 patients. [Ex. 60]. Mr. Falls then examined these 598 patients, multiplying Medicare's geometric mean LOS for each corresponding DRG by the number of cases for each DRG, to arrive at 16,775 total patient days. He then divided total patient days by 598 patients, to arrive at an average LOS of 28.1 days for DRMC's LTACH-appropriate discharges[16]. [Tr. 445:19, Ex. 66]. The 28.1-day average LOS corroborates DRMC's predicted 27-day average LOS.

In their brief, the Opponents attempt to cast doubt on the use of geometric mean LOS, patient age and case mix index as a means of projecting a patient's expected LOS in an LTACH. [Appellants' Brief at 17-19]. According to Mr. Falls, however, there is a strong correlation between patient age, a patient's acuity level, geometric mean length of stay and long term acute care need. Mr. Falls testified that, in determining whether a hospital patient may become an LTACH patient, "CMS and Med-Pac, which is the Medicare Payment Advisory Commission, use[] a methodology that looks at the severity of the patient's illness, whether or not the patient stays beyond the geometric mean length of stay, and patient age." [Tr. 417:23].

Mr. Falls also made a salient point when he stated that if GLH can host an LTACH that operates with a 25-day average LOS, then DRMC could certainly support an LTACH whose patients remain for an average of at least 25 days. [Tr. 446:8]. Indeed, DRMC is a much larger hospital than GLH, with a greater patient population and a higher case mix index (indicating a more medically complex mix of patients). DRMC is certified by the Department as a Level II

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[14] Geometric mean LOS refers to the average LOS that CMS ascribes to a particular DRG. For example, the average length of stay for a patient with DRG 78, pulmonary embolism, is 22.6 days. Therefore, the geometric mean LOS for DRG 78 is 22.6. [Ex. 29].

[15] The term "case mix index" refers to the average DRG weight for all of a hospital's Medicare volume. Mr. Falls provided expert testimony that case mix index is a good proxy for the acuity level or complexity level of a patient.

[16] 16,775 patient days ÷ 598 patients = 28.1 average LOS for each patient.

trauma center while GLH is only a Level IV trauma center, meaning that DRMC is certified by the Department to treat patients with a higher level of trauma than GLH. [Tr. 153:23-154:29]. Surely, if GSH operates with a 25-day average LOS, then DRMC's proposed LTACH should have no trouble doing the same. It is absurd to think that DRMC, a hospital that is much larger than GLH, offers more services than GLH, and treats patients that are sicker than the patients at GLH cannot meet the 25 day average LOS requirement when this requirement is being met by GSH in Greenwood, Mississippi.

Mr. Bordelon also testified that, from Allegiance's perspective, an LTACH in Greenville would have no problem meeting the 25-day average LOS requirement. When asked why he believed the Project would have no difficulty complying with the 25-day average length of stay requirement, Mr. Bordelon answered:

> as a facility, we look at and appropriately manage that which is specific to Medicare patients. And moreover, when you're looking at the discharges that are coming from the acute care setting and are either going to SNFs or comprehensive rehab or Palmer [sic], whatever destination they're going to now, if they come to an LTACH that has services that are geared towards catering to getting these people better and – and actually giving them optimal care, as opposed to going into an enigmatical setting that may not be geared up to take care of these acutely-ill patients, there – there will be no issue with having a 25-day average length of stay for those patients.

[Tr. 302:10-23].

Mr. Richard Williams also testified that patients referred to an LTACH from DRMC's rehabilitation unit would have no trouble meeting the 25-day LOS requirement. [Tr. 183:2-10]. While the average LOS for all diagnoses accepted in DRMC's rehabilitation unit is 15 days, Mr. Williams stated that many of those would have a longer LOS in an LTACH. [Tr. 183:2-14]. Too, 40% of DRMC's rehabilitation patients are stroke patients whose average LOS is between 25 and 28 days. [Tr. 184:4].

An important point to note when considering the average LOS requirement is that it means just that: an average. The Hearing Officer rightly noted in his decision:

> As Mr. Bordelon testified, there is no requirement that every LTACH admission must stay for 25 days. Some will stay for 20, some for 15, some for 4 days. But others, such as ventilator patients, may need to stay for 70 or 80 days. It does not take very many 70- or 80-day patients to bump up a facility's [average LOS].

[R.E. 4:20 (citations omitted)].

In his cross-examination of Mr. Williams, the Opponents' counsel elicited an admission from Mr. Williams that many of DRMC's discharges in FY 2005, as itemized in Exhibit 28, were patients whose LOS was "substantially less than 25." [Tr. 191: 26] Mr. Williams went on to acknowledge that many of the patients had stays of just a day or two. [Tr. 192:5-9]. Exhibit 28, however is simply a list of discharges from DRMC, a short term acute care hospital. Of course there are going to be many patients whose stay was, in a word, short. This line of questioning misses the point of the concept of *average* length of stay. Exhibit 28 also lists patients whose stay was 30, 40, even 50 days. Additionally, as Mr. Bordelon attested, when these LTACH-appropriate patients are admitted to an LTACH, where the services are specialized and catered to complex diagnoses, this group of patients, as a whole, will meet the 25-day *average* LOS requirement. [Tr. 302:6-23].

Allegiance and DRMC used not one, but three different methodologies to ascertain need for the proposed LTACH and all three methods arrived at the same result: there are a significant number of potential LTACH candidates in Washington County, Mississippi and the surrounding area to more than justify locating a 40-bed LTACH in Greenville, Mississippi. Additionally, Noel Falls corroborated Allegiance's and DRMC's findings with a fourth methodology that proves the need for the Project. DRMC's three independent methodologies demonstrating compliance with the 450 restorative care admissions and 25-day average LOS threshold

constitute much more than a "scintilla" or "suspicion" of evidence and clearly qualifies as substantial and credible evidence of need for the LTACH. As DRMC exhibited much more than a mere scintilla of evidence documenting compliance with this SHP criteria and standard, the Hearing Officer's recommendation and the Department's decision, affirmed by the Chancellor, should likewise be affirmed by this Court.

C. More Than A Scintilla: The Department's Decision to Grant a CON to Delta Regional Medical Center was Supported by Substantial and Credible Evidence and was Not Contrary to the Manifest Weight of the Evidence.

Contrary to arguments made by the Opponents, the Department's decision to grant a CON to DRMC was supported by vast amounts of substantial and credible evidence and was certainly not contrary to the weight of the evidence introduced. The decision was not a mere "rubber stamp," but was based on a favorable Staff Analysis as well as on the decision of the Hearing Officer who, after listening to four days of testimony offered by 11 witnesses, carefully examining the 91 exhibits, and considering the proposed findings of facts presented by DRMC and the Original Opponents, determined that there was a need for an LTACH in Greenville, Mississippi.

The Opponents attempt to make an issue out of the fact that the Department "simply accepted the numbers provided by DRMC and its consultants" without further analysis of its own. [Appellants' Brief at 7]. It is not ordinarily the job of the Staff to "go behind the numbers" and investigate applicants' methodologies—that typically is the job of the Hearing Officer. In this case, however, the Opponents are wrong: the Staff *did* conduct further analysis on its own. During the course of its review of the Application, the Staff contacted Mr. Falls, and asked him for additional information concerning DRMC's projected restorative care admissions. Mr. Falls replied to the Staff's request by faxed transmission dated February 13, 2006. [Ex. 9]. In his correspondence, Mr. Falls provided the Staff with a breakdown by DRG of the 2,299-patient

pool in order to reflect the number of patients that fall into each restorative care category. Mr. Falls' correspondence is, in fact, a part of the record, at Exhibit 9. [Tr. 32:8]. Therefore, it is not accurate to state that the Staff "simply accepted the numbers provided by DRMC" when in reality the Staff took active steps to obtain clarification and confirmation of DRMC's numbers.

The Opponents point to Mr. Dawkins' testimony that the Staff did not conduct any independent assessment of DRMC's numbers. [Tr. 58:28-59:4]. However, when testifying to the origin of Exhibit 9, Mr. Dawkins stated that "[t]his is a fax transmission from Falls Marketing Group, the consultant, I believe, who worked up the application, **and it contains certain supplementary information that was requested by the staff analyst in this case**." [Tr. 31:15-19 (emphasis added)]. The very existence of Exhibit 9 is proof of the Staff's diligence in reviewing DRMC's LTACH admission numbers.

In order for the Department's decision to be overturned, it must be shown that it was based on no more than a "scintilla" or "suspension" of evidence in support of DRMC's LTACH. As demonstrated throughout this brief, not only did DRMC present more than a scintilla of evidence in support of the need for an LTACH in Greenville, Mississippi, it provided *overwhelming* proof that there is a significant need for additional long term acute care beds in the Tri-State Delta area.

1. Any Reasonable Methodology.

Need for an LTACH in Greenville, Mississippi, of course, is the crux of the matter in this appeal. Under the requirements of the SHP, applicants seeking approval for an LTACH must document a minimum of 450 clinically appropriate restorative care admissions with an average LOS of 25 days by the end of their third year of operation. It is important to note that the SHP **does not require any specific methodology** by which applicants are required to arrive at the

magic number of 450 restorative care admissions with an average LOS of 25 days.[17] Mr. Dawkins testified that an applicant may use ***any* reasonable methodology** it deems appropriate to determine the need for an LTACH. [Tr. 35:24-36:1].

In the Appellants' Brief, the Opponents reiterate their mantra repeatedly, stating that DRMC "danced around the issue" and never presented an "acceptable methodology" that documented both restorative care admissions and an average LOS. This statement is patently false. At the Hearing, DRMC presented multiple methodologies with which it proved well in excess of 450 restorative care admissions with an average LOS of 25 days or greater.

The Opponents appear to be less concerned with the projected restorative care admissions and average LOS that DRMC presented to the Department than they are with the particular methodologies DRMC used to determine these numbers. Of course, the Opponents must attack DRMC's methodologies because these methodologies produce numbers that more than fulfill the requirements of the SHP—that is to say, they demonstrate a need for an LTACH to be located in Greenville, Mississippi. The Opponents seem to lose sight of the fact that, as Mr. Dawkins testified, as long as applicants utilize the restorative care admission categories as set forth in the SHP criteria and standards, applicants may use **any reasonable methodology** to calculate need.

In their brief, the Opponents slyly attempt to cast aspersions upon DRMC's methods of proving need by using quotation marks around the word "methodologies" when referring to the those utilized by DRMC. [Appellants' Brief at 12.] The Opponents also employ another neat trick in order to derogate DRMC's methodologies, describing the particular method of determining need conjured up by their expert witness, Mr. Dan Sullivan,[18] and then lamenting

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[17] The SHP requires only that the restorative care categories set forth in the LTACH criteria and standards be utilized when analyzing compliance with the 450 restorative care admissions threshold.

[18] Mr. Sullivan was tendered as an expert witness at the Hearing in the areas of health planning and health care finance. [Tr. 504:1]. The credibility of his calculations and projections, however, was called into question when it was revealed that some of his testimony was based on obsolete data. [Tr.

the fact that "[i]nstead of presenting this methodology, DRMC offered alternative methodologies...." [Appellants' Brief at 10]. The implication of this statement is that the Opponents' is the one true and correct methodology and that DRMC failed to use "this methodology." The term "alternative methodologies" has the same misleading implication: surely in a system with no required or even favored methodology, there can be no such thing as an "alternative" methodology. Alternative to what?

The Opponents' answer to this question would undoubtedly be, alternative to *their* favored methodology. At the Hearing, Mr. Sullivan testified that a more appropriate method would have been to pare down DRMC's projected pool of 2,299 potential LTACH patients by determining which of these patients had a LOS of greater than 15 days. Not surprisingly, this more restrictive method produced a projection of only 248 LTACH candidates originating from DRMC's main and West Campuses. [Tr. 516:12, Ex. 74 at p.11]. The Opponents have apparently found one methodology that is so conservative and limiting that even DRMC's considerable number of potential LTACH patients is pared down below the necessary 450 admissions.

But as the Hearing Officer noted in his well-reasoned Executive Summary, Mr. Sullivan's reasoning on this issue "runs into several problems":

> If Mr. Sullivan's methodology—that is, reducing the potential patient pool by only counting those patients with a greater-than-15-day LOS—is applied to the 1,054 potential LTACH patients that GLH had documented in its CON application, a mere 66 patients would have met the criteria. Yet in its first year, GSH admitted over 280 patients and out of that number, 232 came from GLH.

[R.E. 4:16].

716:26-717:12] For example, his population projections for 2010 were calculated using projections for 2005 that were formulated in 2002, rather than using actual 2005 population figures. [Ex. 74, p.21].

In other words, the methodology held out by the Opponents as the gold standard for determining LTACH need is so limiting that, when applied to GSH's own pool of potential patients presented in GLH's CON application, GSH would have projected only 66 restorative care admissions with an average LOS of 25 days—a meager 14.6% of the 450 year-three admissions it needed to prove. [Tr. 703:15-704:6]. Yet, as the Hearing Officer noted, **GSH actually admitted over 280 patients in its first year of operation as an LTACH.** [Tr. 660:21-27].

Mr. Falls also testified as to the fallacy of the Opponents' favored methodology. He confirmed that using a greater-than-15-day LOS methodology is too conservative as there are plenty of LTACH-appropriate patients in short term acute care hospitals that are not going to stay a full 15 days in such a facility. [Tr. 424:15]. This is because short term acute care hospitals have a strong incentive, due to Medicare's prospective payment system, to discharge patients as soon as possible, preferably within the time allotted by Medicare for that particular DRG. If a hospital does not discharge a Medicare patient within this allotted time, Medicare does not reimburse the short term acute care hospital for the hospital's costs related to the days exceeding the DRG's geometric mean LOS limits.

This Medicare-based incentive reveals itself clearly in an exhibit DRMC introduced through Mr. Falls examining patients discharged from DRMC and subsequently admitted to GSH. Of the 14 patients listed, 4 of them had a LOS of less than 15 days and yet were admitted to GSH. In a striking example, one patient whose LOS was only 9 days at DRMC was subsequently transferred to GSH where he remained for 32 days. In fact, almost 29% of the patients GSH accepted from DRMC would not have been counted using the Opponents' preferred methodology. [Ex. 59]. **At the national level, according to Mr. Falls, a full 54% of LTACH admissions are acute care hospital *non*-LOS outliers, meaning more than half of**

the patients in LTACHs across the county are patients who do not exceed the geometric mean LOS in a short term acute care hospital setting. [Tr. 729:4, Ex. 85].

2. Mississippi Supreme Court Precedent.

While each CON Application must be judged on its own merits, the precedent set by this Court in its only reported LTACH CON decision cannot be ignored. In a decision regarding Regency Hospital of Meridian's CON, this Court acknowledged that the SHP provides no methodology with which to calculate average LOS.[19] There, the Court observed that:

> Regency asserts that each [LTACH]-appropriate patient on its list would have an ALOS of 29 days. It bases this conclusion on the fact that Riley LTACH-appropriate patients had an ALOS of 18.2 days and Jeff Anderson [LTACH]-appropriate patients had an ALOS of 17 days. Regency then **assumed that these patients would have stayed in the hospital longer had the respective hospital not discharged the patients due to Medicare's cut-off of benefits after a short period of time**....We find that Regency's calculation of average length of stay was supported by substantial evidence and that **the chancellor erred when she substituted her judgment for that of [the MSDH]**.

[*Rush Care, Inc.*, 882 So. 2d at 210; Ex. 7 at p.6 (emphasis added)]. Thus, in *Rush Care*, this Court overruled the chancellor's decision reversing the MSDH's approval of Regency's CON and held that Regency's *mere assumptions* were sufficient to support its claim that its LTACH admissions would have a 25-day LOS.

The *Rush Care* Court also considered the need for a second LTACH to be located within the Meridian, Mississippi city limits and the potential adverse financial impact that Regency's proposed LTACH might have on Select Specialty Hospital of Meridian, located at Rush Hospital. The LTACHs would be located less than a mile apart. In holding that the chancellor should have affirmed the MSDH's finding that there was a need for Regency's LTACH and that the new LTACH would not adversely affect other facilities, the Court opined:

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[19] *Rush Care, Inc.*, 882 So. 2d at 209.

> Specialty's own occupancy percentages and history of growth show that the market for [an LTACH] in the Meridian area is growing. Beginning with only 20 beds, Specialty now has 49, and its occupancy percentage has pretty much stayed constant with the increase of beds.

[*Id.*; Ex. 7 at p.6].

A review of the post-Regency LTACH market in Meridian reveals that this Court's decision was a wise one. Whereas in 2001, there were 49 LTACH beds in Meridian operating at 70% capacity, after Regency added 37 beds to that total and eventually became a mature LTACH in 2004, the combined 86 LTACH beds were operating at an average occupancy rate of 82%. [Tr. 708:25-709:8]. Indeed, the two facilities located in the same rural city of Meridian have complimented, rather than harmed, one another. As awareness of LTACHs in the area grew, so grew the facilities' occupancy rates.

If there is a need for two LTACHs within a mile of one another in Meridian, Mississippi, and there is strong evidence that the two LTACHs can coexist without adversely affecting each other, as was the situation in *Rush Care*, there is an even stronger argument in the case *sub judice* that there is a need for an LTACH in Greenville, Mississippi, located 55 miles away from GSH.[20]

3. What's Good for the Goose is Good for the Gander.

Adding an interesting twist to this case is the fact that Mr. Bordelon prepared the need and financial analysis for GLH's LTACH CON application. Allegiance was the original operator and manager of the Greenwood LTACH facility and Mr. Bordelon assisted GLH in applying for its CON, providing the need analysis and the financial projections for the CON

[20] The Hearing Officer determined that the cities of Greenville and Meridian are comparable for the purposes of LTACH need, pointing out that "[t]he two cities each have approximately 38,000 residents. Greenville is on the Arkansas border and close to the Louisiana border, while Meridian is on the Alabama border. Both cities are easily accessible by highways. DRMC argues that Greenville, however, has a much sicker population than Meridian, and therefore a population that is at a greater risk for the types of diagnoses that lend themselves to treatment in an LTAC." [Executive Summary at 28 n.16. (citations omitted)].

application—an application that was ultimately approved by the Department. [Tr. 254:2]. In preparing the need analysis for the Greenwood LTACH to be operated by GSH, Mr. Bordelon applied the very same methodologies as he did for DRMC, including an examination of the same 26 DRGs that DRMC looked at to determine a pool of potential LTACH patients. Using those 26 DRGs, Mr. Bordelon found 1,054 potential LTACH candidates at GLH (as opposed to the much higher number of 2,299 for DRMC). [Tr. 289:18, Ex. 36]. Thus, not only were Mr. Bordelon's methodologies good enough for GLH to use when it applied for and received its CON from the Department, but GLH's use of the same methodologies produced a pool of potential LTACH patients that was 1,245 patients *fewer* than the pool of patients DRMC calculated. Yet the Department approved GLH's LTACH CON. Significantly, in its first year of operation, in what by all accounts should have been a ramp-up year, GSH turned a profit of $1,263,843[21]. [Tr. 665:3].

Yet, all of the sudden GSH now views these methodologies—the same exact ones that it used to obtain its CON—as insufficient for documenting compliance with the SHP's Need Criterion. In this case, what's good for the goose is good for the gander.

The Opponents attempt to diminish Mr. Bordelon's credibility in their brief by claiming that he is not a health planner and that he "has never held a full-time position in the day-to-day operation of an LTACH." [Appellants' Brief at 12]. The Opponents are kind enough to at least acknowledge that Mr. Bordelon has had "various corporate and development positions." [*Id.*] The fact is, Mr. Bordelon has worked his way up the ranks in LTACHs from an employee to a supervisor, then to management, and ultimately to an ownership position. [Tr. 245:23-248:2].

[21] This $1,263,843 figure represents net income before non-operating expenses. GSH booked a non-operating expense of $1.5 million for CY 2005. This non-operating expense, as the name implies, had nothing whatsoever to do with the operation of its LTACH. [Tr. 312:9-313:8] Instead, it represents a settlement amount owed by GSH to Allegiance stemming from a legal dispute that arose when Allegiance and GSH went their separate ways in 2004. [Tr. 662:20-663:3].

While he may not have held a full-time permanent position in the day-to-day operations of an LTACH, he has ample experience managing people involved in the day-to-day operation of LTACHs. [Tr. 259:7-10]. At the Hearing, Mr. Bordelon declared that, with respect to his past affiliations with LTACHs, "I have held many full-time positions in a corporate capacity of which facility-level people that are below me report up to me." [Tr. 259:7]. It is, then, somewhat disingenuous to paint Mr. Bordelon as being inexperienced in the operations of LTACHs. He has years of experience of managing the operations of LTACHs and is currently the chief executive officer of a $60 million health care management company that is currently involved in developing five LTACHs in four different states. [Tr. 250:13-251:9; 369:21].

4. DRMC's Solicitation of Bids for Its Proposed LTACH.

At the beginning of this project, DRMC solicited bids from health care companies to own and operate the LTACH to be located on DRMC's West Campus. Allegiance Health Management, Regency Hospital Company and Select Medical Corporation responded to the bid request. [Tr. 107:14-110:2] In making their case for a lack of need for DRMC's proposed LTACH, the Opponents point to two responses to DRMC's solicitation of bids, noting that:

> Select Medical Corporation and Regency Hospital Company...conducted an evaluation of potential LTACH admissions prior to determining whether to submit a proposal to DRMC. Regency projected that DRMC would have a total of only 126 LTACH admissions, and 2,547 patient days. Select Medical projected that DRMC would have a total of only 3,148 LTACH patient days, and a projected average daily census of 8.62. This projection of patient days is substantially less than DRMC's projection of 11,557 patient days by Year 3.

[Appellants' Brief at 10].

a) Select Medical Corporation's "Bid" Was not Legitimate.

Instead of responding to DRMC's request with an actual bid, Select Medical Corporation replied with an email detailing a "data analysis" that it allegedly conducted to determine the need

for an LTACH in Greenville, Mississippi. In fact, based on its response to the bid request, it appears that Select never intended to submit a legitimate bid for the LTACH project. Mr. Humphreys of DRMC, testified that he:

> feel[s] as though possibly they were positioning themselves for the process of opposing the Certificate, and there seemed to be somewhat of an ulterior motive in their lengthy response.

[Tr. 110:20-23]. Standard practice indicates that if Select Medical Corporation were simply not interested in bidding on the project, it would have just said "thanks, but no thanks." Or, it could have not responded to the bid request at all. But to go to the trouble of providing a scaled-down needs analysis smacks of, as Mr. Humphreys asserted, an ulterior motive. Select was, after all, one of the Original Opponents. Weighing these facts, the Hearing Officer "agree[d] [with Mr. Humphreys] and accordingly put little stock in Select's response." [R.E. 4:21].

b) Regency Hospital Company Determined There Was a Need for an LTACH in Greenville and Bid on the Project.

As to Regency Hospital Company's bid and needs analysis, Regency saw a tremendous need for long term acute care beds in Greenville, Mississippi, and obviously saw that an LTACH located in Greenville, Mississippi would have no problem meeting the 450 restorative care admission threshold and 25-day average LOS requirement as evidenced by its competitive bid for the LTACH project. [Tr. 107:14-109:8; Ex. 20]. Regency was intimately familiar with the 450 admission threshold and 25-day average LOS requirement before submitting its bid due to the fact that it has been through the Mississippi LTACH CON process before with respect to the three LTACHs it already operates in the State of Mississippi. In addition, Regency was successful in proving with substantial and credible evidence that its LTACH in Meridian, Mississippi could meet the 450 restorative care admission threshold and 25-day average LOS requirement. [*Rush Care, Inc.*, 882 So. 2d at 210; Ex. 7 at p.6].

Regency's first year projections for the DRMC LTACH were very conservative. First, Regency's projections take into account only those admissions originating from DRMC's main campus. They do not factor in admissions from DRMC's West Campus and, more importantly, do not contemplate admissions from any other hospitals in the surrounding area. As noted above, Bolivar Medical Center, South Sunflower County Hospital, Humphreys County Memorial Hospital and Sharkey-Issaquena Community Hospital each notified Mr. Humphreys that they have LTACH candidates among their patient populations and Chicot Memorial Hospital provided Mr. Humphreys with verbal notice that it provides healthcare to LTACH candidates at its facility and supports the construction of an LTACH on DRMC's campus. [Tr. 101:19, Exs. 16-19]. DRMC, in fact, anticipates admitting LTACH patients from these surrounding area hospitals.

Secondly, Regency's projections were based on actual patient data from DRMC's main campus for 2004 and determined only the number of patients that could be admitted to DRMC's LTACH in its first year of operation. The SHP criteria and standards for LTACHs do not require an LTACH to meet the 450 admission criteria until the end of its third year of operation. Regency's projections, therefore, fail to reflect the aging of the baby boomer generation. As reflected above, Mr. Falls introduced evidence of an estimated 21% increase in the population of persons aged 65 and older from 2005 to 2010 in DRMC's service area—an increase of 2,896 people. [Tr. 722:6-29, Ex. 83].

Finally, as referenced above, Mr. Falls testified to the fallacy of using a greater-than-15 day LOS methodology, as it is too conservative to be valid. [Tr. 424:15]. The Hearing Officer, too, noted that such a method would have resulted in a projection of only 66 patients to GSH in its first year, while in actuality, GSH admitted 280 patients in its first year of operation. [R.E. 4:16].

The fact that Regency saw such a need for an LTACH in Greenville is quite evident: it was intimately familiar through the *Rush Care* case with the 450 restorative care admission criteria and the 25-day average LOS requirement and submitted a competitive bid on the project. [Tr. 107:16].

5. Testimony of Amy Dowdy.

The Opponents point to testimony of Amy Dowdy, Director of Case Management at DRMC, who declared that DRMC refers "5 to 7 patients" per month to LTACHs. [Appellants' Brief at 7-8]. Ms. Dowdy's statement, however, actually highlights two of the primary reasons why there is an immediate need for long term acute care hospital beds in Greenville, Mississippi: DRMC currently refers a relatively small number of patients to LTACHs because the closest LTACH—GSH—is 55 miles away and refuses to accept even one Medicaid patient or charity care patient from DRMC.

As to the 55-mile distance, the record is replete with testimony from both DRMC staff and patients that the one-hour drive between Greenville and Greenwood presents a significant hardship on patients who would otherwise be perfect LTACH candidates, as well as on those patients' family members.[22] This is especially true for the Mississippi Delta's largely indigent population. [Exs. 21, 47-53].

DRMC questioned two witnesses via telephone regarding this driving distance barrier. Mr. John Roberson and Ms. Elizabeth Bright Hayes are residents of Greenville who were forced to put a family member in GSH in Greenwood. They both testified as to the difficulties of maintaining a regular visitation schedule under such circumstances. In addition to the financial hardships, Ms. Hayes stated that her husband "felt very isolated, and he said it bothered him

[22] Dr. Rodney Frothingham, DRMC's Chief Medical Officer, was accepted at the Hearing as an expert in fields of neurosurgery and rehabilitation medicine. Dr. Frothingham testified that he knew of specific situations in which DRMC LTACH-appropriate patients refused to go to LTACH facilities in Greenwood and Jackson due to their distance from Greenville. [Tr. 163:16-21].

knowing...that in ten minutes I could be there if he were in Greenville. But if they had to call me, it was going to be an hour before I could get to Greenwood." [Tr. 234:29]. That feeling of isolation was among the reasons Ms. Hayes eventually pulled her husband out of GSH and brought him back to DRMC, even with the knowledge that DRMC did not offer long term acute hospital care.

With respect to GSH's Medicaid and charity policies, according to Ms. Dowdy, GSH explicitly informed her that its policy is such that it refuses to take *any* Medicaid patients or charity patients from DRMC. [Tr. 210:14-211:10]. In fact, GSH's marketing representative told Ms. Dowdy that GSH "[does] not have a charity care policy." [Tr. 211:9].[23] The importance of charity care to the Department is evidenced by the fact that the very first paragraph of the SHP asserts that, as part of the Department's mission, the SHP "establishes policies to encourage the provision of appropriate care **to all people [] regardless of...ability to pay**." (*2006 Mississippi State Health Plan* at I-1) (emphasis added). SHP Criterion 4 states that the "application shall affirm that the applicant will provide a 'reasonable amount' of indigent/charity care as described in Chapter I of this *Plan.*" (*2006 Mississippi State Health Plan* at XI-68).

The result of these two factors, driving distance and GSH's failure to accept charity and Medicaid patients from DRMC, is that many of DRMC's LTACH-appropriate patients are not currently transferred to an LTACH. Mr. Falls testified to the unfortunate result of this situation:

> [The patients] either stay in the hospital and become a length-of-stay outlier, which is an added cost to the...health delivery system, or they are discharged to a nursing home, if you can find a nursing home that is willing to take a patient with complex medical conditions. And that is a very real problem.

[23] By the admission of its own Chief Executive Officer, GSH has yet to take even one charity care patient from *any* referral source, in spite of the fact that GLH's CON application to the Department included assurances that 2% of its admissions would be comprised of charity care patients. [Tr. 653:11-29]. DRMC's LTACH will meet this indigent and charity care need for LTACH services not currently being met by GSH.

> Very few nursing homes, because of the amount of staffing required to take care of those patients, particularly if the patient also has an infectious disease, is going to be willing to take those patients, or they're going to be discharged to home with home health care.
>
> The problem with either being discharged to a nursing home or discharged to home with—with home health, as we've heard, and studies also support this, and information from Med-Pac also supports it, there's a higher rate of recidivism, or readmission for those patients back into the acute care setting. And they usually come back sicker than they were when they were there the first time.

[Tr. 402:8-29]. It is more than a bit hypocritical for the Opponents to make an issue out of the fact that DRMC only refers 5 to 7 patients per month to LTACHs when the closest LTACH to DRMC, GSH (1) is an hour's drive away and (2) refuses to accept even one member of DRMC's sizable Medicaid and charity patient population.[24] One may look as these two factors as primary reasons that there is, in fact, a need an LTACH in Greenville, Mississippi.

D. The Court Should Not Reverse and Remand Due to New Federal Regulations

The Opponents ask this Court to reverse the holding of the Chancellor and remand the proceeding "to the lower court and the Department of Health" with a mandate to reopen the record due to new federal regulations that have been issued since the Initial Appeal. [Opponents' Brief at 29]. For the reasons outlined below, the Court should deny this request and affirm the decision of the Chancellor.

1. This Court Should Not Overturn the Chancellor's Holding and Remand Based on Facts Outside the Record That Occurred Subsequent to the Initial Appeal.

In *Open MRI v. Miss. Dep't of Health*, 939 So. 2d 813, 815 (Miss. Ct. App. 2006), the Mississippi Court of Appeals considered the appellants' appeal of the chancery court's decision

[24] Culturally rich, but economically impoverished, the Mississippi Delta has a tragically unhealthy and indigent population that requires significant health care services. The poor health of this area has been called "a public health crisis." *Self-Reported Health of Residents of the Mississippi Delta*, 15 JOURNAL OF HEALTH CARE FOR THE POOR AND UNDERSERVED 645 (2004). [Tr. 407:26; Ex. 53].

to affirm the Department's grant of a CON to Coastal County Imaging Services, LLC ("Coastal") to provide MRI services. In their appeal to the Court of Appeals, the appellants asked that court to consider evidence to the effect that, after prevailing in chancery court, Coastal submitted a letter to the Department stating that it intended to use a different make of MRI scanner than the one it referenced in its CON application. *Id.* at 822. The appellants attempted to argue that Coastal was pulling a "bait and switch" and that the change in scanners required the submission of a new application to the Department. *Id.* **The Court of Appeals, however, refused to "overturn a factual finding based on facts outside the record that occurred subsequent to appeal," noting that "[w]e cannot set this order aside unless there was an error of law, a factual finding that was not supported by substantial credible evidence, the Department exceeded its jurisdiction, or the Department violated any constitutional rights."** *Id.* at 822-23. The Supreme Court, too, has consistently held that it will not go outside of the record to find facts when considering appeals from lower courts. *See In re City of Jackson*, 912 So. 2d 961, 971 (Miss. 2005); *Commercial Credit Equip. Corp. v. Kilgore*, 221 So. 2d 363, 367 (Miss. 1969).

By arguing the existence of new federal regulations, the Opponents likewise attempt to introduce "facts outside the record that occurred subsequent to appeal." Although strictly speaking, these federal regulations constitute "law," in the context of this appeal, their existence represents a *fact*. The "law" that is germane to this proceeding has been set out by the Department in the SHP and the *Mississippi Certificate of Need Review Manual, 2000 Revision* as well as by the Mississippi Legislature in the Mississippi Code at § 41-7-201(2)(f), described in Section III.A., *supra*. Indeed, appeals of CON matters in this state are not guided by federal regulations that set forth various levels of Medicare reimbursement. The introduction of the

existence and details of such regulations, therefore, constitutes a **fact** with respect to this proceeding—a fact outside of the record.

This Court should follow its long-standing precedent and refuse to examine facts outside of the record; rather, it should base its decision on the substantial, credible evidence of the need for an LTACH in Greenville, Mississippi as set forth by DRMC and included in the record.

2. The Opponents Have Waived Their Right to Argue the Issue of Financial Feasibility on Appeal.

As the Chancellor noted in his Opinion below, "**[t]he issue of financial feasibility was not raised on appeal and appears to be undisputed.**" [R.E. 3:4]. Yet, by raising the issue of new federal regulations promulgated by CMS, the Opponents now attempt to argue and appeal the issue of financial feasibility.[25]

In their brief, the Opponents state that CMS' new payment regulations place "a hard limitation on the percentage of patient referrals that an LTACH may receive from any one hospital." [Opponents' Brief at 26-27]. This statement is not correct. The new regulations do not limit the *number of patients* an LTACH may receive from any one hospital. They limit to 50% of the LTACH's total Medicare admissions the number of *Medicare patients* an LTACH may receive from any one hospital *and still receive the full amount of federal reimbursement.* [*See* Part II, Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Annual Payment Rate Updates, and Policy Changes; and Hospital Direct and Indirect Graduate Medical Education Policy Changes; Final Rule, 72 Fed. Reg. 26918, 26920 (May 11,

[25] It is noteworthy that the CMS issued its proposed rule notifying the public about its planned payment changes to LTACH payment rules on **February 1, 2007**. [*See*, Part II, Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2008: Proposed Annual Payment Rate Updates, and Policy Changes; and Proposed Hospital Direct and Indirect Graduate Medical Education Policy Changes; Proposed Rule, 72 Fed. Reg. 4775, 4809 (Feb. 1, 2007)]. The Opponents, therefore, were on notice that these payment changes were in the works when they submitted their Brief of the Appellants to the Chancery Court on **March 2, 2007**. In spite of such notice, the Opponents failed to raise as an issue to the Chancery Court, financial feasibility, generally, or, specifically, Medicare's proposed changes to LTACH payment rules.

2007)]. DRMC's proposed LTACH could continue to take an unlimited percentage of admissions from DRMC, but for those DRMC Medicare patients admitted above the 50% threshold, the LTACH would receive a reduced amount of federal reimbursement. Although the proposed LTACH would, therefore, have a strong financial incentive to admit no more than 50% of its Medicare patients from DRMC, the LTACH would not be prohibited by state or federal law from admitting these patients to its LTACH and having these patients count toward the 450 restorative care admission threshold.

In any event, while it may be argued that these new federal regulations speak to the financial feasibility of the Project, they do not have even the slightest impact on the issues that are the subject of this appeal. That is to say, the new regulations do not affect the proof set forth by DRMC that its LTACH would have the necessary minimum of 450 clinically appropriate restorative care admissions with an average LOS of 25 days. As the Chancellor noted in his Opinion, the Opponents did not raise the issue of financial feasibility in their Initial Appeal. The Court, therefore, should not allow the Opponents to argue the issue of financial feasibility in this appeal.

3. Delta Regional Medical Center Successfully Demonstrated That It Will Admit A Sufficient Number of Patients from Other Area Hospitals Such That It Will Not Be Adversely Impacted by the New Federal Regulations.

Even with the new federal regulations in effect, the Project will be financially feasible by its third year of operation due to the overwhelming support pledged by hospitals in the tri-state Delta area, the fact that it will receive LTACH admissions from hospitals located in and outside of GHSA 2 and due to admissions from GLH itself. At the Hearing, letters of support from surrounding hospitals were introduced, each pledging support for DRMC's Application to locate an LTACH in Greenville. Bolivar Medical Center in Cleveland, South Sunflower County Hospital in Indianola, Humphreys County Memorial Hospital in Belzoni and Sharkey-Issaquena

Community Hospital in Rolling Fork each stated in letters addressed to Mr. Humphreys that they have LTACH candidates among their patient populations and that they see great value in their patients' having an LTACH in Greenville as an option for long term care. [Exs. 16-19]. In addition, Chicot Memorial Hospital in Lake Village, Arkansas provided Mr. Humphreys with verbal assurances of its support for the proposed LTACH. [Tr. 101:19]. Finally, substantial and credible evidence was presented by Noel Falls that other patients located in GHSA 2 will need LTACH services and would be eligible for admission to the proposed LTACH in Greenville. Specifically, Mr. Falls noted that hospitals located in GHSA 2 have substantial numbers of LTACH-appropriate patients. [Tr. 432:14-435:5; Ex. 62]. In 2005, GHSA 2, combined with Chicot County, Arkansas, had 16,889 LTACH-sensitive discharges. [Tr. 433:4-10; Ex. 62].

Importantly, due to the fact that GSH is similarly limited to the 50% threshold with respect to the number of Medicare admissions that it can take from GLH and receive full Medicare reimbursement, DRMC anticipates admitting many GLH patients as well. GLH, in fact, was limited to the 50% threshold even before the new federal regulations were released, do to the fact that GSH is a hospital-within-a-hospital that is located on GLH's "main campus."[26] There was testimony at the Hearing, therefore, as to the likelihood of DRMC's proposed LTACH admitting GLH patients. When Mr. Falls was asked where GLH's patients would go once GSH had reached the 50% threshold with respect to Medicare admissions from GLH, he replied:

> [w]hen they hit the 50 percent mark, they're either going to have to take a big financial hit, which is certainly their—their prerogative, or—or [GLH] is going to have to find another place to send those patients. Certainly the patient can go anywhere they want to go. But the closest one, assuming that DRMC's project is approved, the closest one to them would be in Greenville.

[Tr. 434:27-435:5].

[26] By comparison, DRMC's proposed LTACH would be located off of DRMC's "main campus"—on DRMC's West Campus.

In other words, where the Project may be negatively impacted by the new federal regulations with respect to admitting Medicare patients from DRMC, it will be positively impacted by similar limitations placed on GSH with respect to its admitting Medicare patients from GLH. As Mr. Falls pointed out, should DRMC's LTACH be approved, it would be the closest LTACH to GSH.

Accordingly, DRMC does not anticipate a negative impact on the Project's financial feasibility as a result of the new federal regulations. It fervently believes and proved at the Hearing that it will admit enough referrals from hospitals in the surrounding area, including from GLH, so that the Project will be financially feasible by its third year of operation.

V. CONCLUSION

DRMC proved to the Department with substantial and credible evidence that the LTACH to be located in Greenville, Mississippi, would have at least 450 annual clinically appropriate restorative care admissions with an average LOS of 25 days or greater by the end of its third year of operation. The Department's decision to grant DRMC a CON for its proposed LTACH was no "rubber stamp." The facts were carefully weighed by the Staff, the Hearing Officer and the State Health Officer, and the CON was appropriately granted. The Chancellor affirmed the Department's decision based on the overwhelming amount of substantial and credible evidence put forth by DRMC.

In light of the well-reasoned decision of the Chancellor in the appeal below, and based on the determinations of the Staff, the Hearing Officer and the State Health Officer, DRMC respectfully requests this Court to affirm the decision made by the Department granting a CON to DRMC for the establishment of a 40-bed LTACH in Greenville, Mississippi.

Dated this the 18th day of October, 2007.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

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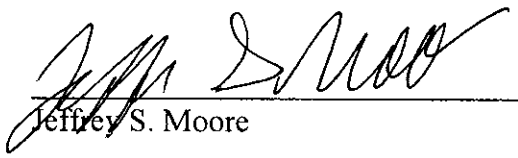
This the 19th day of October, 2007.



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