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**
VS.	**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

REPLY BRIEF OF APPELLANTS GREENWOOD LEFLORE HOSPITAL and GREENWOOD SPECIALTY HOSPITAL, L.L.C. and GREENWOOD SPECIALTY HOSPITAL II, L.L.C., d/b/a GREENWOOD SPECIALTY HOSPITAL

ORAL ARGUMENT REQUESTED

Barry K. Cockrell (MSB [redacted]
BAKER, DONELSON, BEARMAN, CALDWELL & BERKOWITZ, PC
P. O. Box 14167
Jackson, MS 39236
(601) 351-2426

Counsel for Appellants

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I. INTRODUCTION

This Reply Brief is submitted by the Appellants, Greenwood Leflore Hospital ("GLH") and Greenwood Specialty Hospital, L.L.C. and Greenwood Specialty Hospital II, L.L.C., d/b/a Greenwood Specialty Hospital ("GSH"), in response to the Brief of the Appellees, Delta Regional Medical Center ("DRMC") and the Mississippi State Department of Health (the "MSDH").

A careful review of the DRMC/MSDH Brief confirms what GLH and GSH have been arguing all along: there is no credible evidence to show that DRMC's proposed LTACH would achieve **both** 450 clinically-appropriate restorative care admissions **and** an average length of stay of 25 days. The evidence cited by DRMC and the MSDH either supports a number of restorative care admissions **or** a number regarding average length of stay **but there is no evidence which ties the two together, as required by the *State Health Plan's* Need Criterion.**[1]

We respectfully submit that there is a reason that DRMC never presented this evidence. DRMC simply does not have the LTACH patient volume necessary to sustain an LTACH. There is no evidence or argument cited in the Appellees' Brief which credibly responds to our argument on this point. Moreover, the only substantial evidence which directly and properly addressed the Need Criterion showed that DRMC's LTACH would **not** achieve 450 restorative care admissions **with** an average length of stay of 25 days. Consequently, the project should not have been approved under well-established Mississippi law.

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[1] As discussed below, DRMC also presented certain "methodologies" which were not reasonable or acceptable methods for projecting LTACH patients. Even though DRMC contends that these methodologies tied together both requirements, expert testimony showed that the methodologies themselves were flawed and, therefore, cannot be considered substantial and credible evidence.

II. ARGUMENT

A. Delta Regional Medical Center Did Not Demonstrate That Its LTACH Would Have the Necessary Minimum of 450 Clinically Appropriate Restorative Care Admissions AND an Average Length of Stay of 25 Days.

The first argument advanced by DRMC and the MSDH (pages 13-17 of their Brief), discusses various methodologies used by DRMC in an effort to show that the LTACH would have 450 restorative care admissions. More particularly, DRMC and the MSDH allege that DRMC used "three separate and distinct methodologies" to determine that there was a need for an LTCH in Greenville. *Brief of Appellees* at p.13. However, as discussed extensively in our initial Brief, there are several major problems with this argument.

The first and most significant problem is that a methodology which projects restorative care admissions is only one-half of the equation. The only methodology which is legally correct is a methodology which takes into account both restorative care admissions and average length of stay. The methodologies discussed by DRMC and the MSDH in this section of their Brief do not meet this legal requirement. The mere fact that there may be a potential pool of LTACH candidates does not mean that they are appropriate for an LTACH admission. The truth of the matter is that relatively few patients qualify for admission to an LTACH. It is very difficult to have a patient population with both a restorative care admission and an average length of stay of 25 days or greater. It is not sufficient for DRMC to show merely *potential* LTACH admissions. Instead, DRMC is required to demonstrate 450 restorative care admissions with an average length of stay of 25 days. The best source of this information is patient data from DRMC itself; however, DRMC never provided the data at the hearing. Rather than furnishing the hard numbers which showed compliance with the standard, DRMC offered these "methodologies" which did not meet the legal standard.

A good illustration of the problems with DRMC's methodologies is shown by an argument made in the Brief itself. On page 8, footnote 6, the Appellees state that "[a]t the hearing, DRMC bolstered the information set forth in its Application and offered evidence that the pool of potential LTCH candidates from DRMC alone is not 2,299, but rather is 5,302." *Brief of Appellees* at p.13, fn.7. Obviously, there is a huge gap between 2,299 patients and 5,302 patients. This is a very significant leap, and just goes to show that these projections by DRMC are an unreliable "moving target," which cannot be accepted as credible or substantial.

Another major problem with the methodologies offered by DRMC is that for the most part, they were not valid methodologies accepted by the health care industry. As discussed in our initial Brief, Dan Sullivan, an expert in health planning, pointed out the problems with Mr. Bordelon's methodologies which used a "10 to 1 ratio rule" and a "3 to 5% admissions rule." According to Mr. Sullivan, these are not reasonable or acceptable methodologies. They are unsupported theories which were offered by Mr. Bordelon, who is not a health planner. Significantly, Mr. Noel Falls, who testified as an expert in health planning for DRMC, did not validate these methodologies. That fact alone shows that the methodologies do not have support among health planning experts, and cannot be considered substantial or credible evidence.

As further justification for its project, DRMC argues that these methodologies "take into account the pool of potential admissions coming out of DRMC's Main and West Campuses and do not even factor in those from surrounding hospitals." *Brief of Appellees* at p.17. The problem with this argument is that DRMC never quantified the number of LTACH patients that would come from these hospitals. In fact, Mr. Sullivan pointed out that most of these hospitals were small, rural facilities which would generate very few LTACH admissions. (T.524). This is another example of DRMC offering speculative theory in lieu of hard, substantive numbers.

The essence of DRMC's argument on this point is set forth in the following statement from the Brief of Appellees:

> Allegiance and DRMC used not one, but three different methodologies to ascertain need for the proposed LTCH and all three methods arrived at the same result: there are a significant number of potential LTCH candidates in Washington County, Mississippi and the surrounding area to more than justify locating a 40-bed LTCH in Greenville, Mississippi.

Brief of Appellees at p.22. This statement shows the fundamental problem with this entire line of argument by DRMC. In this argument, DRMC says that "potential LTCH candidates" automatically translates into a need for an LTACH. This is simply not true. As previously discussed, identifying potential LTACH admissions is only the first step of a two-step process. This alleged pool of potential LTACH patients is grossly overstated unless and until you take into account the fact that they must have an average length of stay of 25 days or greater. Thus, this argument advanced by the Appellees it legally insufficient because it is based on methodologies which are incomplete, based on the express requirements of *State Health Plan* Need Criterion.

Other problems with the methodologies presented by DRMC are discussed in our initial Brief, and will not be repeated here. Again, the key point is that, in addition to being flawed in various respects, the methodologies are legally incorrect because they do not directly and properly address the Need Criterion in the *State Health Plan* by taking into account both restorative care admissions and average length of stay.

B. Delta Regional Medical Center Did Not Demonstrate That Its LTACH Would Have 450 Clinically Appropriate Restorative Care Admissions With an Average Length of Stay of 25 Days.

As previously discussed, the crux of the issue in this appeal is: can DRMC demonstrate, through substantial evidence, that its LTACH will have 450 clinically appropriate restorative

care admissions **with an average length of stay of 25 days**. Therefore, it is important to further review the Joint Brief of DRMC and the MSDH in order to examine the testimony and evidence cited by the them which purportedly demonstrates compliance with this requirement.

First, the DRMC and the MSDH cite testimony from Mr. Sam Dawkins, who testified as the MSDH representative at the hearing. However, in this testimony, Mr. Dawkins simply repeats what is contained in the CON application filed by DRMC with regard to projected average length of stay. (T.16-17). His testimony does not show where these numbers came from, or whether they are reliable and credible. Rather, Mr. Dawkins simply quoted what was contained in the CON application, in response to questioning by DRMC's counsel. He offered no testimony to explain or validate these numbers.

Next, DRMC and the MSDH argue that Noel Falls, the expert witness for DRMC, presented testimony and exhibits to back up these projections. However, it is very important to look at exactly what Mr. Falls did in this particular exercise. He came up with 598 potential LTACH patients by counting "those patients with an LOS higher than the geometric mean LOS, aged 45 and older, and with a higher case mix index than GLH's case mix index." *Brief of Appellees* at p.19-20. The problem with this approach is that it does not result in identifying patients with true "clinically appropriate restorative care admissions," as dictated by the *State Health Plan*. Rather, this exercise merely involved the application of three criteria developed by Mr. Falls himself. In our initial Brief, we addressed this testimony and exhibit by Mr. Falls as follows:

> Mr. Falls introduced Exhibit 66 in an effort to deal with the issue of LTACH lengths of stay. According to Mr. Falls, the 598 potential LTACH patients that are identified in the exhibit are patients who meet three criteria developed by Mr. Falls. (T.563). However, as noted by Mr. Sullivan, none of those criteria

> necessarily indicates a need for LTACH services. For example, being 45 years or older. Or having a case mix index greater than Greenwood Leflore Hospital. Or having a length of stay greater than the geometric mean length of stay. None of these criteria, in and of themselves, establish that a patient needs LTACH services. Once again, 'We are not shooting at the target. We are dancing around the issue.' (Sullivan, T.563). Exhibit 66 simply does not tell us anything about restorative care discharges at DRMC. (T.564).

Brief of Appellants at pp.19-20. Thus, in this particular situation, DRMC tried to show an average length of stay of 25 days or greater, but did not properly handle the first part of the equation, *i.e.* identifying patients with true "clinically appropriate restorative care admissions," as mandated by the *State Health Plan*. Mr. Falls cannot substitute his personal need standard for the very specific Need Criterion contained in the *State Health Plan*.

DRMC and the MSDH then go on to argue that "Mr. Falls also made a salient point when he stated that if GLH [Greenwood Leflore Hospital] can host an LTCH that operates with a 25-day average LOS, then DRMC could certainly support an LTCH whose patients remain for an average of at least 25 days," since "DRMC is a much larger hospital than GLH, with a greater patient population and a higher case mix index." *Brief of Appellees* at p.20. This is yet another example of the speculative type of arguments and evidence advanced by DRMC throughout the administrative hearing. Instead of providing the hard data, DRMC makes arguments such as "if Greenwood Leflore Hospital can do it, Delta Regional Medical Center can do it too." There is no evidence to support this theory. It is simply that: a theory. GLH and DRMC are completely different hospitals. The mere fact that one can support an LTACH does not, in and of itself, mean that the other one can too. Once again, where are the hard numbers from DRMC to show that it will meet the legally mandated standard?

We now turn to the remaining evidence cited by DRMC which purported to show that it will meet both requirements of 450 restorative care admissions and an average length of stay of 25 days. The next evidence was a quote from the testimony of Rod Bordelon, an owner of the company which would operate the LTACH in Greenville. In that testimony, Mr. Bordelon simply offered his personal views of why he felt the LTACH would meet the 25-day average length of stay requirement. *See Brief of Appellees* at p.21. This is nothing more than Mr. Bordelon's personal opinion, which is not backed by any statistical data. Moreover, Mr. Bordelon is not an independent health planner and, in fact, has a vested economic interest in the proposed project. This testimony certainly does not rise to the level of substantial evidence required under Mississippi law.

The final evidence offered by the Appellees in support of their argument that DRMC met the Need Criterion is the testimony of Mr. Richard Williams, an employee of DRMC. Mr. Williams testified that "patients referred to an LTCH from DRMC's rehabilitation unit would have no trouble meeting the 25-day LOS requirement." *Brief of Appellees* at p.21. Once again, this testimony avoids the hard questions: How many rehabilitation patients are we talking about? Where are the numbers to support this theory? The answer is that there are no hard numbers. There is merely a general statement being offered by an employee of the applicant.

In connection with this argument, DRMC points out that the average length of stay requirement is exactly that: an average. Some patients will stay for 20 days, some for as few as 4 days. Others may stay for 70 or 80 days. *Brief of Appellees* at p.22. We certainly agree with this point. However, the fact remains that the applicant is required to present patient data which demonstrates that the proposed LTACH will have both a minimum number of restorative care admissions and an average length of stay of 25 days or greater. GLH and GSH have never

suggested that each patient must have a length of stay greater than 25 days. The key argument of GLH and GSH is that it is incumbent upon the applicant to provide a methodology which directly addresses the Need Criterion by analyzing data which considers both the nature of the restorative care admission and the average length of stay.

In summary, a close examination of the evidence cited by DRMC and the MSDH in their Joint Brief reveals that DRMC failed to provide substantial and credible evidence to show that DRMC will meet the twin requirements of 450 restorative care admissions and an average length of stay of 25 days. Accordingly, DRMC did not meet the legal requirement in order to receive a CON for an LTACH.

C. The Department of Health's Decision is Not Supported by Substantial Evidence and, in Fact, is Contrary to the Only Substantial Evidence Which Properly Addressed the Need Criterion.

In their next argument, DRMC and the MSDH contend that the MSDH's decision was supported by substantial and credible evidence because DRMC offered "more than a scintilla" of evidence to show compliance with the legal requirements. However, the fact of the matter is that DRMC presented **no evidence** to show compliance with the legal requirement for an LTACH, as set forth in the Need Criterion in the *State Health Plan* As previously discussed, DRMC never presented evidence which took into account both requirements of (1) a clinically appropriate restorative care admission and (2) an average length of stay of 25 days. Mr. Sullivan put it well when he stated that DRMC "never hit the target." The fact that DRMC offered various theories and evidence does not mean that DRMC offered evidence which directly and correctly addressed the Need Criterion.

1. The Methodology Must be Reasonable AND Must Directly and Properly Address the Need Criterion.

DRMC and the MSDH argue that the *State Health Plan* does not require any specific methodology in order to arrive at the magic number of 450 restorative care admissions with an average length of stay of 25 days. According to the Appellees, an applicant may use any reasonable methodology it deems appropriate to determine the need for an LTACH. *Brief of Appellees* at p.24-25.

We certainly agree that the *State Health Plan* does not contain a specific formula to be used in determining compliance with the Need Criterion. Nevertheless, it is abundantly clear that whatever need methodology is used must meet two conditions. First, as DRMC and the MSDH correctly note, it must be a *reasonable* methodology. But the methodology must be more than merely reasonable. **In order to be legally sufficient, the methodology must directly and correctly address the Need Criterion itself.** In other words, a methodology may be reasonable, but incomplete. That is precisely what happened here. Even if we were to assume that some of the methodologies offered by DRMC are reasonable in projecting a *potential pool* of LTACH patients, the methodologies are still incomplete in terms of projecting LTACH *admissions* until they also take into account the average length of stay of that patient population. DRMC never presented a methodology which did both. Its methodologies did one or the other.

In fact, the only methodology presented during the hearing which met the legal requirement was presented by Mr. Sullivan, the expert witness for GLH and GSH. In our initial Brief, we discussed in considerable detail Mr. Sullivan's methodology, and how it showed that, when the numbers are properly applied, DRMC did not meet the requirement of 450 restorative care admissions with an average length of stay of 25 days. We will not repeat those arguments

here, but simply point out that once again, the only substantial and credible evidence introduced on this issue showed that DRMC would not meet the *State Health Plan* requirement.[2]

DRMC and the MSDH challenge Mr. Sullivan's methodology by citing the finding of the Hearing Officer, in which he states the following:

> 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 LTCH 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.

Brief of Appellees at p.26. The fundamental problem with this argument is that it mixes apples and oranges. A common flaw throughout DRMC's presentation of its case was to compare Delta Regional Medical Center to Greenwood Leflore Hospital. Clearly, these hospitals are completely different and have different patient populations. DRMC cannot meet the requirements of the *State Health Plan* by relying on patients at Greenwood Leflore Hospital. Instead, DRMC is required to focus on its own patient population, and had the burden of proof to show compliance with the *State Health Plan* by using its own numbers in projecting admissions.

2. The *Rush Care* Decision Supports the Legal Argument of GLH and GSH.

DRMC and the MSDH cite the decision of this Court in *Mississippi State Department of Health v. Rush Care, Inc.*, 882 So.2d 205 (Miss. 2004) as support for their position. However, they are not correct in asserting that this Court held that "mere assumptions" can be sufficient to support a claim that LTACH admissions would have a 25-day average length of stay. In that decision, the Supreme Court actually confirmed that an applicant for a CON for an LTACH must

[2] DRMC and the MSDH criticize Mr. Sullivan's methodology as being overly conservative. The fact of the matter is that Mr. Sullivan's methodology was actually liberal, and gave DRMC the benefit of the doubt by using an average length of stay of 15 days, as opposed to 25 days. (T.514-515).

show both LTACH-appropriate admissions **and** average length of stay. This Court has never allowed a "mere assumption" to constitute substantial evidence. In fact, the Court has expressly held that unsupported assertions or estimates are not substantial evidence to justify the issuance of a CON. *See Miss. State Dept. of Health v. Natchez Community Hosp.*, 743 So.2d 973, 978 (Miss. 1999) ("unsupported statements do not constitute substantial evidence").

In their discussion of the *Rush Care* case, DRMC and the MSDH also state that if there is a need for two LTACHs in Meridian, Mississippi, there must be a need for an LTACH in Greenville, Mississippi, which is located 55 miles away from Greenwood Leflore Hospital. *Brief of Appellees* at p.29. This is yet another good example of the speculative arguments advanced by DRMC and the MSDH in this proceeding. The mere fact that there is a need for two LTACHs in Meridian has nothing to do with whether there is a need for an LTACH in Greenville. The two areas are completely different, with different demographics, different population bases, different patients, different medical staffs, and many other distinguishing factors. This argument has no basis in fact or in law.

3. "Goose and Gander" is Not a Legal Standard.

DRMC and the MSDH contend that Mr. Bordelon, who was initially involved in the operation of the Greenwood LTACH facility, assisted Greenwood Leflore Hospital in applying for its CON and used the same need methodology that he used in the Delta Regional Application. Since the CON for the Greenwood LTACH was approved, DRMC and the MSDH assert that "what's good for the goose is good for the gander."

Even assuming for the sake of argument that Mr. Bordelon played a role in the GLH application, the fact remains that, once again, DRMC is shooting at the wrong target. Greenwood Leflore Hospital is a different institution than Delta Regional Medical Center. They

serve different patients with different needs, and have different medical staffs. Moreover, at the time that the Greenwood Leflore Hospital application was filed, there was no other LTACH in the Mississippi Delta. Thus, Greenwood Specialty Hospital, which is located within Greenwood Leflore Hospital, was the first LTACH to operate in the Delta. It is not at all inconsistent for GLH and GSH to argue that there was a need in the Mississippi Delta for an LTACH when they applied, and that there is no longer a need, in part, because they are already serving the needs of the Delta residents with regard to LTACH services.

On a more fundamental level, the problem with this argument by DRMC and the MSDH is that it again avoids the key question: does *Delta Regional Medical Center* have the patient population necessary to sustain an LTACH? Greenwood Leflore Hospital is not the applicant here. The hearing was about Delta Regional Medical Center, not Greenwood Leflore Hospital. It was incumbent upon DRMC to provide its own numbers and evidence, and not rely on Greenwood, Meridian or any other area to support its project.

4. DRMC's Solicitation of Bids Speaks Volumes Regarding the True Number of LTACH Admissions.

In our initial Brief, we pointed out the importance of the fact that, in the process of pre-hearing discovery, DRMC produced e-mails from Select Medical Corporation and Regency Hospital Company, both of which conducted an evaluation of potential LTACH admissions prior to determining whether to submit a proposal to DRMC. Both of these companies prepared projections which showed that the LTACH patient census at DRMC would be below the *State Health Plan* requirement. In our Brief, we argued that this was important evidence because it took into account both restorative care admissions and average length of stay at Delta Regional Medical Center, based on patient data furnished to third parties by DRMC itself.

In response to this argument, DRMC and the MSDH allege, without any proof whatsoever, that Select Medical Corporation had "an ulterior motive" in obtaining this information and, in fact, never intended to submit a bid. *Brief of Appellees* at p.32. Under this theory, Select engaged in some type of conspiracy to obtain the data from Delta Regional Medical Center, with the intention of opposing a CON application down the road.

This "theory" was based solely on speculation offered by Mr. Ray Humphreys, the CEO of Delta Regional Medical Center. (T.110). There is no evidence to remotely suggest any such scheme on the part of Select Medical Corporation. We find it interesting that DRMC accuses Select of having an "ulterior motive," but never refutes Select's analysis, which showed that DRMC did not have enough patients to meet the CON requirement. This is characteristic of the evidence offered through the hearing. DRMC offers speculation and conjecture, while GLH and GSH offer specific statistical proof.

5. The Testimony of Amy Dowdy is Close to Conclusive Regarding the True Number of LTACH Admissions.

In our initial Brief, we pointed out that significant testimony came from DRMC's own Director of Case Management, Amy Dowdy. Ms. Dowdy testified that DRMC refers only 5 to 7 patients a month to LTACHs. (T.220). On an annual basis, this amounts to only 84 LTACH admissions, which is substantially below the required minimum of 450.

In response, DRMC and the MSDH try to explain away these numbers. Specifically, they allege that as a result of two factors, driving distance from Greenville to Greenwood, and Greenwood Specialty Hospital's purported failure to accept charity and Medicaid patients, "many of DRMC's LTCH-appropriate patients are not currently transferred to an LTCH." *Brief of Appellees* at p.35. This argument is flawed in several respects.

First, even if we assume for the sake of argument that Greenwood Specialty Hospital would not accept charity and Medicaid patients from DRMC (which we deny), it is undisputed that the vast majority of LTACH patients are *Medicare* beneficiaries or private-pay patients. (T.616). The evidence at the hearing was clear that relatively few patients are Medicaid or charity care. Consequently, Greenwood Specialty Hospital's position on accepting Medicaid or charity care patients from DRMC would have little impact on the overall number of LTACH admissions.

Additionally, even though driving distance to an LTACH obviously could pose a problem for some patients and families, DRMC presented no statistical evidence to show how many actual patients could not be referred to an LTACH because of travel problems. DRMC offered only the testimony of two witnesses concerning their personal problems with travel distance.

For these reasons, the testimony of Amy Dowdy certainly cannot be discounted, and remains some of the most conclusive evidence in the entire case about the true number of LTACH patients at Delta Regional Medical Center. All parties agree that acute care hospitals, such as Delta Regional Medical Center, have a strong economic incentive to transfer long-term patients out of the hospital and into an LTACH. Due to Medicare reimbursement limitations, acute care hospitals will suffer significant financial loss if they allow a Medicare patient to stay in a hospital too long, because Medicare pays only a fixed fee for their hospital stay. (T.197-98; 217). Ms. Dowdy testified that one of her responsibilities as case manger was to monitor the status of patients and determine whether they qualify for transfer to an LTACH. (T.217). Her testimony concerning the number of LTACH transfers actually made by DRMC is both credible and compelling.

D. We Respectfully Request This Court to Address and Consider the Relevance and Impact of New Federal Regulations in this Appeal.

In our initial Brief, we pointed out that new federal regulations, which became effective after the Chancery Court ruling, could have a significant impact on the project which is the subject of this appeal. Although the regulations were proposed prior to the issuance of the Chancery Court Opinion, they did not become final until after the Final Judgment was entered in the lower court. Now that these regulations are final, it is appropriate to consider their relevance to, and impact on, the issues in this appeal.[3]

In response, DRMC and the MSDH oppose the Court's consideration of these new regulations in this appeal, and argue that the Court should not consider "facts outside the record that occurred subsequent to the initial appeal." *Brief of Appellees* at p.36. Additionally, DRMC and the MSDH argue that this matter goes to the question of financial feasibility, which was not raised by GLH and GSH on appeal. Finally, DRMC and the MSDH contend that DRMC successfully demonstrated that it will admit a sufficient number of patients from other area hospitals, so that the new federal regulations would not impact the proposed project in any event. We will briefly address each of these contentions.

First, we are not requesting the Court to consider facts outside the record which occurred subsequent to the appeal. We completely agree that it would be inappropriate to attempt to reopen the administrative record based on the development of subsequent *facts*. This development, however, is a significant change in *law* which is directly relevant to the central issue in this appeal: the number of LTACH admissions at DRMC's proposed facility.

[3] It is very common for federal agencies to make changes in regulations between the time of initial publication and the date on which they become final. Consequently, until the regulations became final, it was premature to argue their impact on this appeal.

Consequently, the cases cited by DRMC and the MSDH have no applicability here. In fact, we were unable to locate any prior precedent of this Court on this specific issue, and are requesting the Court to address this as a matter of first impression.

Second, we strongly disagree that the new federal regulations go to the question of financial feasibility. Rather, the new federal regulations relate specifically to the matter of projected LTACH admissions. Obviously, if the new federal regulations place a cap of 50% on the number of LTACH patients that the proposed DRMC facility may receive from any single hospital, it impacts the central issue of LTACH admissions. It has nothing to do with financial feasibility. It has everything to do with whether, based on this new regulation, DRMC can meet the regulatory requirement of 450 clinically-appropriate LTACH admissions with an average length of stay of 25 days or greater.

Finally, DRMC and the MSDH contend that the new federal regulations do not matter because DRMC demonstrated at the hearing that it will have a sufficient number of patients from other hospitals anyway. Of course, this is the same issue that we have been debating throughout this appeal. On the one hand, DRMC argues that it will have enough LTACH patients, and meets the regulatory criterion. On the other hand, GLH and GSH contend that DRMC failed to demonstrate a sufficient number of LTACH admissions, even before the adoption of the new federal regulations.

Aside from this continuing debate, the key point is that in both its CON application and at the hearing itself, DRMC consistently maintained that the vast majority of its LTACH patients would come from DRMC itself. As previously discussed, DRMC did contend that it would receive LTACH admissions from other hospitals, but DRMC failed to quantify those projected admissions. Further, the other hospitals were small, rural facilities, which would not generate

many LTACH admissions at all. Now that DRMC will be able to refer only 50% of the admissions to the LTACH (pursuant to the new federal regulations), that will have a material impact on this project. Under these circumstances, we believe that it is appropriate to bring this matter to the Court's attention for review and decision.

III. CONCLUSION

On the basis of the foregoing arguments and authorities, GLH and GSH respectfully request this Court to reverse and vacate the Final Judgment of the Chancery Court, and to direct the Chancery Court to reverse and vacate the Final Order of the MSDH. Alternatively, GLH and GSH respectfully request this Court to reverse the Final Judgment of the Chancery Court, and to direct the Chancery Court to remand this proceeding to the MSDH, and to conduct further administrative proceedings in order to take into account the impact of the new federal regulations on the project proposed by DRMC.

Respectfully submitted,

GREENWOOD LEFLORE HOSPITAL, GREENWOOD SPECIALTY HOSPITAL, L.L.C. and GREENWOOD SPECIALTY HOSPITAL II, L.L.C, d/b/a GREENWOOD SPECIALTY HOSPITAL

By Their Attorneys
BAKER DONELSON BEARMAN, CALDWELL & BERKOWITZ, PC

By: _____
Barry K. Cockrell

Barry K. Cockrell (MSB No. [redacted]
BAKER, DONELSON, BEARMAN, CALDWELL & BERKOWITZ, PC
4268 I-55 North
Meadowbrook Office Park
P. O. Box 14167
Jackson, MS 39236
(601) 351-2426

CERTIFICATE OF SERVICE

I hereby certify that I have this day caused to be mailed by United States Mail, postage prepaid, a true and correct copy of the foregoing Reply Brief of Appellants to Donald E. Eicher III, Esq., counsel for the Mississippi State Department of Health, and Jeffrey S. Moore, Esq., counsel for Delta Regional Medical Center, at their usual business mailing addresses. I further certify that I have this day mailed by United States mail, postage prepaid, a true and correct copy of the foregoing Reply Brief to Honorable Dewayne Thomas, Chancellor of Hinds County, Mississippi, at his usual business mailing address.

DATED: December 5, 2007.

Barry K. Cockrell