IN THE SUPREME COURT OF MISSISSIPPI

THE MISSISSIPPI METHODIST HOSPITAL AND REHABILITATION CENTER, INC., d/b/a METHODIST SPECIALTY CARE CENTER — **APPELLANT**

V. — **NO. 2008-CA-01558**

MISSISSIPPI DIVISION OF MEDICAID and ROBERT L. ROBINSON, in his official capacity as Director of Mississippi Division of Medicaid — **APPELLEES**

APPEAL FROM THE HINDS CHANCERY COURT
FIRST JUDICIAL DISTRICT

BRIEF FOR APPELLANT

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CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons or entities 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 disqualifications or recusal.

1. The Mississippi Methodist Hospital & Rehabilitation Center, Inc., d/b/a Methodist Rehabilitation Center (Appellant).

2. Thomas L. Kirkland, Jr., Allison C. Simpson, Esq., Andy Lowry, Esq., and Tammy M. Voynik, Esq., counsel for Appellant.

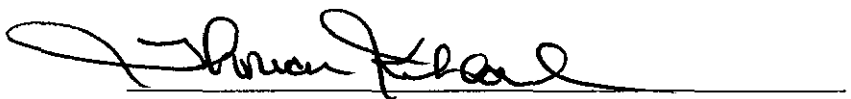
3. Mississippi Division of Medicaid and Robert L. Robinson (Appellees).

4. Charles P. Quartermain, Jr., Esq. and T. Richard Roberson, Jr., Esq., counsel for Appellees.

5. Suzanne S. Sharpe, Esq. (hearing officer).

6. The Honorable J. Dewayne Thomas, Chancellor.

Respectfully submitted,



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STATEMENT OF THE ISSUES

I. Whether Medicaid Failed to Reimburse Methodist as a Separate Category of Nursing Facility, in Violation of Miss. Code Ann. § 43-13-117(44).

II. Whether Medicaid Violated the Administrative Procedures Act.

STATEMENT OF THE CASE

I. Course of Proceedings Below

This appeal concerns a change to the Medicaid reimbursement of The Mississippi Methodist Hospital and Rehabilitation Center, Inc. ("Methodist"). Methodist learned of the change to its reimbursement from a January 30, 2007 letter sent to it by the Mississippi Division of Medicaid ("Medicaid") advising Methodist of its reduced reimbursement. R.31. This reduction in Methodist's reimbursement proved to be based upon Medicaid's amendment to its State Plan, SPA 2006-006, which became effective January 1, 2007. R.14-15. In pleadings later filed by Medicaid, Medicaid conceded that its own State Plan requires that a public notice of the proposed SPA 2006-006 should have been sent to "all Nursing Facilities," and that Medicaid did not do this. R.182.

Having finally been apprised of the amendment, Methodist appealed the diminished reimbursement based on the amendment, on February 27, 2007. R.4. No hearing was held, but the parties submitted briefs to a hearing officer, who on December 7, 2007, recommended to Medicaid that the amendment was proper. R.29. On December 11, 2007, the Executive Director of Medicaid wrote to Methodist, adopting the hearing officer's decision as Medicaid's final decision. R.5.

Methodist appealed to the Hinds Chancery Court (Thomas, J.) on January 2, 2008. R.1. On September 8, 2008, the chancery court rendered its opinion affirming Medicaid's decision. R.231. The chancery court issued its final judgment to that effect on September 11, 2008, and Methodist filed its notice of appeal the next day. R.238, 239.

Due to the severe hardship imposed by Medicaid's acts, Methodist filed a motion in this Court to expedite the present appeal, which motion was denied on October 15, 2008.

II. Relevant Facts

The facts in this case are not in dispute, as the case turns upon a pure question of law. Nevertheless, some background is helpful in understanding the case.

Methodist opened a nursing facility for the severely disabled ("NFSD" or "PNFSD") in February 2004. R.2. In contrast to an ordinary nursing home facility, Methodist provides specialized care for victims of traumatic brain or spine injuries, ventilator patients unable to breathe on their own, and other severely disabled patients who require care above and beyond that provided at an ordinary nursing facility. R.2; *see* Miss. Code Ann. § 43-13-117(44)(a) (defining scope of NFSD care). From its inception to this day, Methodist has been the only NFSD in Mississippi. R.22.

As part of the interactive process between Methodist, the Legislature, and Medicaid which led to the opening of Methodist's NFSD, the Legislature in 2001 enacted Miss. Code Ann. § 43-13-117(44), which addresses Medicaid reimbursement for nursing facilities for the severely disabled. It is undisputed by the parties that Methodist, d/b/a Methodist Specialty Care Center, is an intended object of this statute. Subsection 44 reads as follows:

> (44) Nursing facility services for the severely disabled.
>
> (a) Severe disabilities include, but are not limited to, spinal cord injuries, closed head injuries and ventilator dependent patients.
>
> (b) Those services must be provided in a long-term care nursing facility dedicated to the care and treatment of persons with severe disabilities, **and shall be reimbursed as a separate category of nursing facilities**.

(emphasis added).

Also before the facility opened, in February 2002, Medicaid addressed how Methodist would be reimbursed for treating Medicaid-eligible patients. In a letter to Methodist, Medicaid

indicated that it would not apply any ceiling to various costs, including "administrative and operating costs," so long as Methodist's facility continued to be the only NFSD in the state that participated in the Medicaid program. R.9.

In February 2004, when Methodist's NFSD opened, Medicaid amended its State Plan to provide for the method of reimbursement for that facility. R.7. This amendment, which was set forth as Attachment 4.19-D of the State Plan, essentially enacted the proposal of the February 2002 letter, reading in pertinent part as follows:

> In years when the rate is calculated for only one PNFSD [Private Nursing Facility for the Severely Disabled], **reimbursement will be based upon allowable reported costs** of the facility. Reimbursement for direct care, therapies, care related, **and administrative and operating costs** will be made **at cost** plus the applicable trend factors.

R.8 (emphasis added).

The present case arises out of Medicaid's change in 2006 to the just-quoted State Plan provision. This change, set forth in SPA 2006-006, sets the reimbursement for Methodist as follows:

> . . . Reimbursement for direct care, therapies, care related, and administrative and operating costs will be calculated at cost plus the applicable trend factors. **Reimbursement for administrative and operating costs will be subject to the ceiling for the facility as described in Section 3-4 E [of the Plan].**

R.15 (emphasis added). This emphasized language imposes a "ceiling," or upper limit, on Methodist's reimbursement. The cross-reference to Section 3-4 E of the State Plan for Medicaid indicates how that ceiling is determined. Section 3-4 E reads in pertinent part as follows:

> For PNFSD's with 60 Medicaid certified beds or less, the ceiling calculated for **the small nursing facility class** will be used.

R.17 (emphasis added). "PNFSD" is the abbreviation for "Private Nursing Facility for the Severely Disabled," i.e., Methodist. It is undisputed that "the small nursing facility class" is made up of nursing facilities other than nursing facilities for the severely disabled.

SUMMARY OF THE ARGUMENT

Methodist operates a unique nursing facility for the severely disabled ("NFSD"), and the Legislature has directed that its services "shall be reimbursed as a separate category of nursing facilities" rather than on a basis computed for other, non-comparable nursing facilities which treat very different patients. Disregarding the Legislature's command, Medicaid has begun limiting Methodist's reimbursement for certain costs to a ceiling calculated for an existing "category of nursing facility" that is not an NFSD. Medicaid has no legal basis for disregarding the law, and the chancery court erred in holding otherwise. As our discussion of the issue will show, Medicaid's defiance of the Legislature is rooted, not in any defensible legal interpretation, but in a deep-seated refusal to reimburse Methodist for its reasonable costs in operating a facility which cares for some of Mississippi's most needy patients.

Not only did Medicaid disregard the Legislative mandate on reimbursements to Methodist, it also enacted the regulation in question without complying with its own rules for notice to the affected entity, Methodist. Medicaid thus violated the Administrative Procedures Act, since an agency's acting in disregard of its own rules is tantamount to its acting on secret rules not promulgated according to law, and the regulation enacted in such a manner must be ruled invalid. The chancery court erred in effectively holding that compliance with the law is purely optional for Medicaid.

This Court should therefore reverse the decisions below of the chancery court and the Division of Medicaid.

reimbursement scheme treated Methodist as a separate category of nursing facility, as the statute required.

Medicaid's purported 2006 amendment (the "Amendment") to the Plan violated the statute's plain and direct language, because it placed Methodist in the same category as another type of nursing home. The Amendment stated in part that "[A]dministrative and operating costs will be calculated at cost plus the applicable trend factors. Reimbursement for administrative and operating costs will be subject to the ceiling for the facility *as described in Section 3-4E [of the Plan].*" R.15 (emphasis added). As we saw in the Relevant Facts above, Section 3-4E sets forth a reimbursement ceiling that is the same as either "the small nursing facility class" or "the large nursing facility class" (in practice, the small class, given Methodist's number of beds).

In short, the amended Plan reimburses Methodist in the same category as a small nursing facility, despite the fact that regular nursing facilities do not provide the intensive acute care that Methodist provides (which costs more than regular nursing-home care), and despite the fact that the Legislature has forbidden Medicaid to reimburse Methodist on the same basis as any other category of nursing home. Returning to the language of the statute, we find:

> (44) Nursing facility services for the severely disabled.
>
> (a) Severe disabilities include, but are not limited to, spinal cord injuries, closed head injuries and ventilator dependent patients.
>
> (b) Those services must be provided in a long-term care nursing facility dedicated to the care and treatment of persons with severe disabilities, **and shall be reimbursed as a separate category of nursing facilities.**

Miss. Code Ann. § 43-13-117(44) (emphasis added). The violation is obvious.

Unfortunately, it wasn't so obvious to the chancery court, which attempted to square the circle by opining that only *part* of Methodist's reimbursement is being calculated on the same

basis as that of a small nursing facility, so that overall, Methodist is still being reimbursed "as a separate category." R. 235-36.

That holding so completely misses the point of subsection (44) that it's clear the chancery court never paused to wonder why the Legislature enacted that law in the first place. If Medicaid were to reimburse part of Methodist's costs as if Methodist were a small nursing facility, part as if it were a medium nursing facility, and part as if it were a large nursing facility, this would evidently satisfy the chancery court that Methodist was in "a separate category."

But the basis for reimbursing Methodist "as a separate category" is not a matter of mere labels, or so that Methodist may bask in the feeling of being special and unique. Rather, the underlying purpose behind reimbursement "as a separate category" is that reimbursement for *other* categories is based on the actual expenditures of *those* types of facilities. Because the ceiling for small nursing facilities is an *average* of their actual costs, which are incurred in the administration and operation of facilities whose patients are not nearly so ill or so challenging as those at Methodist's facility for the severely disabled, such a ceiling can only reduce Methodist's reimbursement, and is derived from the costs of a different category of nursing home that is not subject to Methodist's particular needs. If the Legislature had intended for any of Methodist's costs to be reimbursed at the same ceiling as those of other facilities, it would not have enacted a statute expressly prohibiting Medicaid from doing so, without any exceptions, qualifications, or alternatives.

The chancery court's opinion amounts to a determination to affirm the decision of the agency, right or wrong. That is not the standard of review which an appellate court properly applies. Under the correct standard of review, the agency is required to comply with the law, and Medicaid has failed to do so. The lower court's decision should be reversed, as should

and may not make rules that conflict with or are contrary to the provisions of the statute. Generally an administrative agency's decision is afforded deference by the courts, but in this case, there is direct, contradicting language in the statute regarding the treatment of NFSD for reimbursement purposes; therefore, the Amendment is clearly "beyond the power of the administrative agency to make" and should not be applied to determine Methodist's reimbursement.

D. "Reasonableness" Is Not an Issue in This Case.

Because SPA 2006-006 so clearly violates the letter of the law, Medicaid naturally preferred to change the subject in briefing the case for the chancery court: SPA 2006-006 applies only to administrative and operating costs, we were told, and Methodist supposedly has unusually high (and therefore "unreasonable") administrative and operating costs, which somehow justifies Medicaid's (mis)reading of the statute.

While this claim is without merit, it does point to the background of the present case: Medicaid's motive in enacting the Amendment was, we submit, an effort to undo the result of its own audit, which had found that Methodist's expenses *were* reasonable. Whether or not Medicaid renews this argument on appeal from the chancery court, we believe that this Court will benefit from seeing that "reasonableness" is not an issue in this case, and from understanding Medicaid's motives.

1. The Statute Does Not Have Any "Administrative and Operating Costs" Exception to the Requirement of a Separate Category.

Although Medicaid argued below that Methodist wants the courts to "re-write the plain language in the law," R.179, the truth is exactly the opposite. Medicaid was effectively asking the chancery court to read an "administrative and operating costs" exception into § 43-13-

117(44), so that the "revised" statute would go something like this: "shall be reimbursed as a separate category of nursing facilities, *except for administrative and operating costs, which may be reimbursed as if the PNFSD fell into some other category of nursing facility.*" The Legislature could have enacted the statute with that language, and Medicaid is free to lobby for them to do so. However, Medicaid chose instead to lobby the chancery court — successfully, as it turned out.

But neither Medicaid nor the chancery court is free to amend the statute. They cannot pick and choose which costs may be reimbursed as a "separate category" and which costs may be lumped in together with those of typical nursing homes. Unfortunately, that is exactly what the chancery court did in its opinion, which is why that opinion should be reversed.

2. The Remedy for Any "Unreasonable" Costs Is to Adjust the Cost Report — NOT to Rewrite the Statute.

The other problem with Medicaid's reliance on the alleged "unreasonableness" of Methodist's costs is that the recourse for Medicaid, if any of Methodist's submitted costs appear to it as "unreasonable," would be for Medicaid to conduct a desk review or an audit of Methodist's cost reports, in conformity with Medicaid's rules for long term care ("LTC") reimbursement.

There has never been any question that Methodist, like every other provider, is entitled to reimbursement only for its reasonable costs, including its administrative and operating costs. If Medicaid were to find any unreasonable costs, it could adjust Methodist's allowable costs after a desk review or audit, and Methodist would then have certain federally-guaranteed appeal rights. R.200-02. That is how the system is supposed to work, with Medicaid actually required to make

its case on whether particular costs are reasonable, and with the facility on notice as to the particular costs being challenged so that it can present evidence on that issue.

How the system is *not* supposed to work, is for Medicaid to preemptively change the rate of reimbursement in violation of statute, and to support that *ultra vires* act by waving around dubious statistics that purportedly show that Methodist's administrative and operating costs are "unreasonable" in general. Below, we will dissect some examples of those statistics, and provide the real story behind Medicaid's effort to evade the clear intent of the Legislature.

3. Medicaid Has Already Tried to Challenge the "Reasonableness" of Methodist's Costs Before — and Its Own Audit Found Otherwise.

We've seen that the statute simply does not allow Medicaid to do what it seeks to do, and that the issue of "reasonableness" is no defense to Medicaid's *ultra vires* action. This Court may nonetheless wonder whether Methodist's costs are in fact reasonable, or just why Medicaid sought before the chancery court to redirect attention from the statutory issue to "reasonableness." The answer to these questions is that Medicaid has previously sought to challenge Methodist's rates in an earlier proceeding — and that Medicaid's own audit concluded that Methodist should in fact be reimbursed at a higher rate than Medicaid had sought to impose.

Medicaid's own rule is that a facility's rates are to be "reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers . . ." (quoting 42 C.F.R. § 447.253). While there was no administrative hearing in the present case, there *was* such a hearing previously, with exhibits and testimony, on November 21, 2005, in the matter of Medicaid's *first* effort to challenge the rate of reimbursement to Methodist.

At that hearing, it was shown that Methodist opened its PNFSD facility in February 2004 (not to be confused with the Methodist Rehabilitation Center proper, which is a hospital and

whose reimbursement is not an issue in either that case or today's case). R.203-08 (transcript of Nov. 2005 hearing). Thus, for Medicaid to dwell today on the facility's 2005 cost report is, as we said above, to focus on a start-up facility's naturally lower occupancy rate. Nursing homes, particularly those for the severely disabled as opposed to the ordinary type of resident, do not open their doors with all their beds filled on the first day.

Therefore, where Medicaid represented to the chancery court that Methodist supposedly "testified that there were inefficiencies during the initial cost report period primarily on account of the low occupancy rate," that was a one-sided version of the real testimony, on par with Medicaid's complaint (R.172) that Methodist's cost report submitted in January 2005 claimed $454.42 for administrative and operating costs, out of a per diem rate of $1,106.68 per patient per day. However, as Medicaid itself conceded, the reason for this relatively high percentage was because its occupancy rate for the relevant period was 26.3%. R.172. A nursing facility has to occupy a building, pay its salary and utility bills, and provide for its other expenses, whether its beds are 1/4 full or 3/4 full. But in the former case, those fixed costs will form a higher percentage of the per diem costs than they will when there are more patients.

Also, the "estimates to Medicaid" provided by Methodist were based on the pro forma projections for the first 12 months of operation, which envisioned a 97% occupancy rate by year's end. However, the interim cost report required by Medicaid was for only the first *four* months of operation. R.207, 208. Of course, the initial four months' rates for a start-up facility were not the same as what was projected for twelve months of gradually increasing bed occupancy. Moreover, one obstacle to admitting new patients was Medicaid's own perplexity about the admission criteria for Medicaid eligibility at the facility. R.208.

Thus, any "inefficiency" due to there simply not being very many patients in a given period, had nothing to do with whether Methodist was "efficiently and economically operated." So 42 C.F.R. § 447.253 has nothing to do with the reasons why Methodist had a relatively high proportion of administrative and operating costs soon after it opened.

What actually happened in the prior dispute between Methodist and Medicaid, is that Medicaid balked at reimbursing Methodist the amounts claimed in its cost report. The ultimate result was that the Hinds Chancery Court (Wise, J.) ordered Medicaid to complete an audit and to pay Methodist accordingly — *which Medicaid did.* As this Court can see (R.209-10), although Medicaid had sought to reimburse Methodist at a rate of only $650.00 per diem, its *own audit* yielded a rate of $989.52. So much for any "unreasonable" rates. If Methodist had been charging any "unreasonable" rates, it would have been the duty of Medicaid's auditors to find and disallow them.

Having once audited Methodist and failed to find that its costs were actually unreasonable, Medicaid in the present case has tried to go back and rewrite the statute in order to obtain the result it could *not* obtain by following the proper appeal procedures. That is what Medicaid really meant when it told the chancery court "[a]fter the administrative hearing, Medicaid reviewed its State Plan," etc. R.173. That really means that, after the hearing in the *previous* Medicaid appeal, and the failure of Medicaid to document that Methodist's costs really were unreasonable, Medicaid went back to the old drawing board and tried to find another way to evade its legal duty to reimburse Methodist for the reasonable, and unique, costs it incurs as the *only* Private Nursing Facility for the Severely Disabled ("PNFSD") in the state of Mississippi. This second bite at the apple is what's presently before this Court.

4. Medicaid Simply Balks at Acknowledging the Legislature's Directive That Methodist Is Entitled to Special Reimbursement.

Now that this Court has the background on Medicaid's stubborn struggle against Methodist, it can more easily discern the flawed arguments that Medicaid presented to the chancery court. For instance, Medicaid complained that Methodist's administrative and operating costs "are nearly **double** the average total per diem rate for skilled nursing facility care." R.174 (emphasis in original). It even turns out that "Methodist's total rate as calculated by Medicaid is *clearly distinguishable from the rates of other nursing facilities*." R.175 (our italics).

Well, of course it is, because as Medicaid concedes (R.171), Methodist "is a type of long term care facility which provides specialized nursing facility care to severely disabled patients." It is the *only* such facility in the State of Mississippi. It is undisputed that Methodist's typical patients are such severely disabled people as quadriplegics (due to trauma, cerebral palsy, multiple sclerosis, or brain injury); ventilator-dependent patients who are unable to wean, have reached maximum pulmonary rehabilitation potential, and are respiratorily stable; and permanent tracheostomy patients who need maximum assistance with activities of daily living. These are not run-of-the-mill nursing-home residents, and caring for such patients runs up *all* the costs of the facility, including administrative and operating costs.

Before the chancery court, Medicaid repeatedly compared Methodist to ordinary nursing homes, as if that proves anything. It does not. The entire point of Methodist's facility, and the entire basis for the statute at issue in this case, is that *Methodist is in a class by itself, and must be reimbursed on that basis*. Once this principle is kept in mind, it becomes evident that Medicaid's "reasonableness" argument was premised on the notion that apples are really oranges,

and that administering and operating a state-of-the-art facility for the most severely disabled nursing-home residents is somehow comparable to doing the same thing for a typical nursing home. That notion will not bear the slightest scrutiny: apples are apples, oranges are oranges, and Medicaid compares them at its peril.

Methodist is under no burden here to prove that its costs as a PNFSD are qualitatively different from those of an ordinary nursing home. The Legislature has spoken, and ordered that those costs be reimbursed as a separate category from ordinary facilities.

In conclusion, there is no issue before this Court about whether Methodist's costs are "reasonable." That question has already been answered by Medicaid's own audit — and the answer was "yes." Rather, in its understandable but misguided zeal to cut its own budget, Medicaid is trying to deny Methodist even the allowable reimbursement that is not only proper for a PNFSD, but mandated by the Legislature. Cost containment is an important goal for Medicaid, but it cannot come at the expense of the law. The chancery court erred in holding otherwise, and its decision should be reversed.

II. Medicaid Violated the Administrative Procedures Act.

Medicaid, as a state agency, is subject to the provisions of Mississippi's Administrative Procedures Act ("APA"). Miss. Code Ann. § 25-43-1.101 et seq. The APA requires an agency to provide public notice, comment and a hearing on any proposed revision to a rule which would affect the rights or duties of the public, such as Methodist. Miss. Code Ann. § 25-43-3.103. If an agency fails to comply with the APA's provisions, the rule is invalid. Miss. Code Ann. § 25-43-3.111(1).

Medicaid specifically disregarded its own procedures for amending the Plan. Section 1-8 of the Plan provides that "[a]ll Nursing Facilities . . . will receive a copy of the public notice"

whenever Medicaid offers "any significant proposed change in its methods and standards for setting payment rates for services." Plan at pp. 42-43. Medicaid conceded its failure to comply. R.182.[1]

Methodist, the sole affected party because it is the sole facility to which the amendment was applicable, never received notice or an opportunity to be heard before the amendment was implemented. The monetary change in Methodist's reimbursement from $319.24 to $74.22 per day for Methodist's administrative and operating costs is unquestionably "significant" for the year at issue. However, Methodist received no notice, and only learned of the purported amendment when Medicaid advised it that it would be reimbursed at the lower rate determined by the imposed ceiling.

It is "axiomatic that an [administrative] agency is bound by the language of its own regulation and cannot construe it in such a manner that the plain language on the face of the regulation is rendered meaningless." *Steck v. Jorling*, 631 N.Y.S.2d 737, 739 (N.Y.A.D. 1995). We believe that the holding of the *Steck* court should be good law in Mississippi, since such a construal that "rendered meaningless" the agency's own rules would itself be arbitrary and

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[1]Medicaid's concession points up the indefensible ruling of the hearing officer, which was adopted by Medicaid. The hearing officer ruled against Methodist on the theory that Medicaid had submitted notice of the proposed rule to the Secretary of State's office. Even if this complied with the APA, however, it did not comply with the agency's own rules, which expressly provided for notice to all nursing facilities. The hearing officer attempted to evade this by finding that Medicaid "satisfied the more stringent process pertaining to notice as required by state law." R.29. However, the notion that quietly depositing a single notice with the Secretary of State's office is "more stringent" than providing copies of the notice to all nursing facilities (let alone to the sole affected facility, which might be expected to raise a fuss) was purely a figment of the hearing officer's imagination, and had no basis in law or fact — as Medicaid appears to belatedly have conceded.

capricious. The chancery court's opinion, which spoke sternly to Medicaid while relieving the agency of any duty to obey its own rules, simply ratified Medicaid's lawless behavior.

Since Medicaid failed to comply with the APA and its own procedures for providing notice and an opportunity to be heard prior to the enactment of the proposed amendment to the Plan, the amendment is invalid. Therefore, Medicaid should calculate Methodist's reimbursement for its administrative and operating per diem based upon reasonable costs without the imposition of a ceiling, unless and until such time as Medicaid implements a contrary rule in accordance with its own procedures — and, one would hope, in accordance with § 43-13-117(44).

CONCLUSION

The Legislature has commanded Medicaid to reimburse Methodist as "a separate category of nursing facility." Medicaid has done expressly the opposite, and picked out some costs that it seeks to reimburse as the same category as an ordinary nursing home. That action is contrary to law and must be reversed.

For all the foregoing reasons, Methodist asks that this Court reverse the decision of the chancery court, reverse the Division of Medicaid's SPA 2006-006, and enjoin Medicaid from reimbursing any of Methodist's costs in the same category as any other type of facility.

Respectfully submitted, this the 16th day of December, 2008.

THE MISSISSIPPI METHODIST HOSPITAL & REHABILITATION CENTER

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CERTIFICATE OF SERVICE

The undersigned attorney for Appellant hereby attests that a true and complete copy of the foregoing document has today been served upon the following via U.S. mail, postage prepaid:

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So certified, this the ***16th*** day of December, 2008.

Andy Lowry