UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

NORFOLK COUNTY RETIREMENT SYSTEM, individually and on behalf of all others similarly situated, Plaintiff, v. COMMUNITY HEALTH SYSTEMS, INC., WAYNE T. SMITH and W. LARRY CASH, Defendants.	Consolidated Civil Action No.: 11-cv-0433 Class Action Judge Aleta Trauger Magistrate Judge Joe B. Brown JURY TRIAL DEMANDED
THIS DOCUMENT RELATES TO ALL ACTIONS	

DEFENDANTS' MEMORANDUM OF LAW IN SUPPORT OF
MOTION TO DISMISS THE AMENDED COMPLAINT

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TABLE OF CONTENTS

Page

TABLE OF CONTENTS – Cont'd

Page

TABLE OF AUTHORITIES

Page(s)

Cases

TABLE OF AUTHORITIES – Cont'd

Page(s)

TABLE OF AUTHORITIES – Cont'd

Page(s)

TABLE OF AUTHORITIES – Cont'd

Page(s)

TABLE OF AUTHORITIES – Cont'd

Page(s)

Statutes, Rules, and Regulatory Authorities

Page(s)

Other Authorities

INTRODUCTION

The First Amended Complaint ("FAC" or "Amended Complaint") alleges that Community Health Systems, Inc. ("CHSI"), a holding company with more than 200 affiliated hospitals in 29 states, its Chairman and CEO Wayne T. Smith, and its CFO W. Larry Cash (together, "Defendants"), adopted policies that led to the medically unnecessary admission of patients. According to the New York City Pension Funds ("Plaintiff"), CHSI-affiliated hospitals billed the Medicare and Medicaid programs for those inappropriate admissions.

None of this provides any basis for a federal securities case. It is not enough for Plaintiff to take issue with how thousands of doctors made treatment decisions for their patients at dozens of CHSI-affiliated hospitals. Instead, Plaintiff must allege that Defendants purposely *made material misrepresentations* to investors that *caused them economic losses*. The Amended Complaint's attempt to convert allegations of improper admissions practices into a securities fraud case falls well short of the high pleading standards applicable to such cases. Plaintiff attempts to allege two distinct securities frauds. Neither set of allegations states a valid claim.

I. Plaintiff asserts that, between July 27, 2006, and April 8, 2011, Defendants made a series of misrepresentations by attributing CHSI's financial performance to things like its "growth strategies" and "operating efficiencies." Those statements were misleading, according to Plaintiff, because they did not disclose that CHSI's strategies depended in part on use of "admissions criteria that were unsustainable and a substantial Medicare compliance risk." FAC ¶ 8. CHSI's true strategy, Plaintiff alleges, was revealed only when a competing hospital system sued CHSI in order to scuttle a takeover bid. That theory fails for three independent reasons.

First, nothing Defendants said with respect to their business, operations, or growth strategies misled the public. Companies have no duty to opine about the legality of their own actions, and, in any event Defendants *disclosed* the relevant regulatory risks. The Amended

Complaint is replete with Defendants' warnings to investors that, in a highly regulated environment, CHSI had considerable exposure to civil and criminal enforcement efforts targeting CHSI billing practices. Given those clear and repeated disclosures, no reasonable investor could have been misled that CHSI faced regulatory compliance risks.

Second, Plaintiff fails to allege facts supporting a "strong inference" that Defendants made misrepresentations with the specific intent to defraud the public. The Amended Complaint alleges that Defendants were motivated to increase the value of CHSI stock; but a desire to earn profits for shareholders does not establish an intent to defraud the shareholders.

Third, the Amended Complaint fails to plead that Defendants' alleged misstatements caused any economic loss. Plaintiff's loss causation theory is that the lawsuit filed by Tenet Healthcare Corporation on April 11, 2011, was a "corrective disclosure" that revealed Defendants' material misrepresentations about CHSI-affiliated hospital's admissions practices. But the Tenet Complaint did not reveal the *fact* of the existence of prior misrepresentations, as is required to constitute a corrective disclosure. Rather, it simply *alleged* fraud. And courts have held that mere allegations of fraud do not give rise to a corrective disclosure. Indeed, on that basis the Eleventh Circuit recently affirmed the dismissal of a complaint against another hospital system that made many of the same allegations that Plaintiff makes here. *Sapssov v. Health Management Assocs., Inc.*, 608 F. App'x 855, 863 (11th Cir. 2015) (per curiam). Beyond that, a corrective disclosure must reveal *new* information that was previously concealed. Here, however, Plaintiff specifically alleges that the allegations in the Tenet Complaint were based on information that already had been revealed to the public.

II. The Amended Complaint tacks on a new claim—and an expanded class of new plaintiffs, to boot—not previously asserted in this litigation. More than three years after

Plaintiff's July 2012 Initial Consolidated Class Action Complaint, Plaintiff now alleges for the first time that *after* the Tenet Complaint, Defendants fraudulently denied Tenet's allegations and made misstatements about the anticipated effect of changes to CHSI-affiliated hospitals' admissions criteria. According to Plaintiff, those misstatements were revealed in October 2011, when CHSI announced lower earnings and a reduction in hospital admissions. Plaintiff's new-found securities fails for four separate reasons.

First, Defendants' stated belief that the Tenet lawsuit was without merit, and that CHSI's change in admissions criteria would likely have little impact on the company's bottom line, are subjective, optimistic predictions that are immaterial to investors as a matter of law. Those statements also fall squarely within the statutory safe harbor for "forward-looking" statements.

Second, the Amended Complaint fails to plead facts establishing a "strong inference" of scienter, because it is devoid of factual allegations that Defendants' stated opinions were contrary to what they actually believed.

Third, Plaintiff fails adequately to plead loss causation. The face of the Amended Complaint establishes that CHSI's October 2011 earnings report did not reveal any new information to the market. Indeed, the public documents Plaintiff relies upon disclosed a reduction in CHSI's admissions (and earnings) *multiple times* before the October 2011 report.

Fourth, Plaintiff's new claim is barred by the two-year statute of limitations—and does not relate back to the allegations Plaintiff made in the Consolidated Complaint filed in July 2012. Indeed, in 2012 Plaintiff failed even to *mention* CHSI's October 2011 earnings statement that is now alleged to have revealed a distinct fraud. The Amended Complaint also improperly seeks to expand the initial putative class to include new plaintiffs who bought CHSI stock between April

9 and October 26, 2011. Even if Plaintiff could state its new claim on behalf of the original putative class, it may not assert that claim on behalf of new putative class members.

STATEMENT

A. Background

1. *Admission of Patients Through the Emergency Department*

Many hospital patients are admitted through the emergency department ("ED"). When a patient presents to a hospital's ED, a physician must decide whether to (1) admit the patient as an inpatient, (2) discharge the patient, or (3) place the patient under "observation" as an outpatient.[1] At many hospitals (including all CHSI affiliates), inpatients and patients in observation status are placed on nursing units together and receive virtually identical attention.

The Centers for Medicare and Medicaid Services ("CMS") has taken a shifting approach to observation services. On the one hand, CMS has repeatedly expressed concern that hospitals were *overusing* observation for patients who should have been admitted. *See*, *e.g.*, FY1998 OIG Work Plan, http://goo.gl/qkkgKp (noting many "observation stays should have been coded as inpatient admissions"); 78 Fed. Reg. 50,496, 50,908 (Aug. 19, 2013) (stating policy to "reduce the frequency of extended observation care"). On the other hand, CMS has also observed that some inpatient services "should have been provided in the outpatient setting." Recovery Auditing in the Medicare and Medicaid Programs for Fiscal Year 2011, https://goo.gl/iM5uI9.

Throughout this changing regulatory landscape, however, one factor has remained constant: "[T]he decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs [and] the types of facilities available to inpatients and to

[1] Observation services are a type of outpatient care used when a patient presenting to the ED "requires a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge." CMS, Medicare Benefit Policy Manual, Ch. 6, § 20.6 ("CMS Manual").

outpatients." CMS Manual, Ch. 1, § 10. Thus, while CMS offers some limited guidance to providers, it "rel[ies] on the physician to use his or her clinical judgment and evaluation of the patient's needs to make the determination." 78 Fed. Reg. 27,486, 27,645 (May 10, 2013).[2]

2. *Related Investigations and Proceedings*

The theory advanced by Plaintiff was first concocted four years ago when, on April 11, 2011, Tenet sued CHSI in an attempt to thwart a hostile takeover bid by CHSI.[3] The Tenet Complaint—which was dismissed for lack of standing—claimed that CHSI's stock price was inflated because CHSI-affiliated hospitals' admissions policies caused the hospitals to bill Medicare for inappropriate admissions. In May 2011, less than a month after Tenet filed its complaint, Plaintiff repackaged the same allegations in its initial complaint. The Amended Complaint likewise parrots Tenet's claims, citing the Tenet lawsuit no fewer than eighty times.

Shortly after the Tenet Complaint was filed, the Department of Justice ("DOJ") announced an investigation into some ED admissions practices at CHSI affiliates. After three years, the parties resolved the investigation and announced a settlement payment of $98 million on August 4, 2014. Contrary to Plaintiff's suggestions, however, the settlement agreement made clear that the "claims resolved by [that] agreement are allegations only and there has been no determination of liability." DOJ Press Release, *Community Health Systems Inc. to Pay $98.15 Million to Resolve False Claims Act Allegations*, (Aug. 4, 2014), http://goo.gl/GQ5oO0.

3. *Procedural History*

Plaintiff filed suit on May 9, 2011 (Dkt. 1), and an Initial Consolidated Class Action Complaint on July 13, 2012 ("Initial Consolidated Complaint") (Dkt. 68). Defendants moved to

[2] In light of the uncertainty regarding inpatient admissions, CMS has issued a Final Rule (to be published on Nov. 13, 2015) that applies a time-based "presumption," where a patient's status is determined by the length of time he or she *actually* spends in the hospital, https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-27943.pdf.

[3] *Tenet Healthcare Corp. v. Community Health Systems, Inc.*, 3:11-cv-00732 (N.D. Tex.).

dismiss on September 11, 2012. Dkt. 74. On October 5, 2015, Plaintiff filed the Amended Complaint (their third overall), which is the subject of this Motion to Dismiss. Dkt. 167.

B. The Allegations In The Amended Complaint

Plaintiff asserts a claim against all Defendants for violations of Section 10(b) of the Securities Exchange Act and Rule 10b-5 (Count I), and a "controlling person" claim against Defendants Cash and Smith under Section 20(a) (Count II).

1. ***Plaintiff's Admissions-Criteria Allegations.*** Plaintiff alleges that Defendants tried to boost revenues by "aggressive admission" practices that encouraged hospitals to improperly admit Medicare patients as inpatients. FAC ¶ 4. Those allegations are just window dressing: This is not a False Claims Act case, but a securities fraud case. Plaintiff therefore must adequately allege that Defendants made material misstatements—not that Defendants applied admissions criteria that were "liberal and over-simplified" (*id.* ¶ 187), an allegation that is without merit in its own right. But because Plaintiff devotes the bulk of its Amended Complaint to such allegations, we review them briefly here.

Plaintiff first alleges that Defendants developed the "Blue Book" (titled "CHS Clinical Guidelines for Inpatient Care") rather than using an external tool such as InterQual to "trigger the medical staff to admit patients who otherwise could have been placed into observation." FAC ¶ 26; *id.* ¶¶ 24-35. But federal regulations require only that hospitals adopt some screening criteria to enable hospital staff to review the appropriateness of medical treatment. *See* 42 C.F.R. § 482.30. As Plaintiff alleges (at ¶ 27), fully 25% of all hospitals in the United States also chose not to use "third-party admissions criteria." Plaintiff's observation that CHSI-affiliated hospitals, like thousands of others, chose to comply with federal regulations by developing their own admissions guidelines rather than purchasing InterQual does not allege that any statement made by Defendants was false or misleading.

Plaintiff next alleges that Defendants pressured physicians to admit patients by requiring them to use Pro-MED—an ED software system developed and marketed by an external vendor—in their emergency departments. FAC ¶¶ 36-49. But the Pro-MED system was just the type of data-management tool that CMS encouraged hospitals to adopt to reduce errors and improve the flow of information. *See* CMS, Electronic Health Records (EHR) Incentive Programs, https://goo.gl/e07fyn. Indeed, Plaintiff does not allege that physicians using Pro-MED were prevented from making admissions decisions based on their own medical judgment. The most Plaintiff can muster is an allegation that some physicians were "aggravated" that they had to "justify their decision" to discharge a patient. FAC ¶ 47. But even if true, that is just an allegation that physicians had to document the rationale for their admission decisions (as required for any properly billed claim), *not* an allegation that they used Pro-MED to admit patients when they believed, in their medical judgment, that admission was unnecessary.

Finally, Plaintiff's allegation that Defendants "tracked" admission rates and applied admission "benchmarks," FAC ¶¶ 50-72, is a grievance that CHSI sought to increase its profits by increasing admissions at its affiliated hospitals. But there is nothing inappropriate about a public company setting revenue goals, monitoring admission rates, or incentivizing its affiliates' employees. Like all hospital operators, CHSI's affiliates monitored ED admissions to improve quality of services, manage risks, and address expense management concerns.

As these allegations make clear, the Amended Complaint amounts to a debate over whether these practices complied with best practice and Medicare guidance. For example, Plaintiff devotes vast swaths of the Amended Complaint to assertions that a "significant history of coronary artery disease" is not a justification to admit a patient who presents with chest pain, FAC ¶ 171; that "age is irrelevant" as a criterion for admission for syncope, *id.* ¶ 178; and that,

"on information and belief, many patients who have pneumonia—regardless of severity—show a cough and [fluid in the lungs] on exam," *id.* ¶ 181. But to state a claim of *securities fraud*, it is not enough to disagree with the admissions criteria used by CHSI's affiliated hospitals. Rather, Plaintiff must allege that Defendants intentionally made *materially misleading statements* about its admissions practices. After all, "[t]he securities laws were not designed to provide an umbrella cause of action for the review of management practices." *In re Citigroup, Inc. Sec. Litig.*, 330 F. Supp. 2d 367, 377 (S.D.N.Y. 2004).

2. *Plaintiff's Misrepresentation Allegations.* After 267 paragraphs about CHSI-affiliated hospitals' admissions practices, Plaintiff presents two categories of alleged misrepresentations.

(a) *Statements made before April 2011.* Plaintiff alleges that, before Tenet filed its lawsuit against CHSI on April 11, 2012, Defendants committed fraud by touting CHSI's "operation strategies," "operating efficiencies," and "growth strategies." According to Plaintiff's theory, those and similar statements were materially misleading because Defendants failed also to state that CHSI affiliates used "admissions criteria that were unsustainable and a substantial Medicare compliance risk." FAC ¶¶ 8, 268; *see id.* ¶¶ 268-419.

But the Amended Complaint shows that Defendants made no secret of the fact that CHSI's affiliates actively sought to increase admissions. For example, Defendants stated that "60% of its hospital admissions originate in the Emergency Room," FAC ¶ 132; that "we systematically take steps to increase patient flow in our ER," *id.* ¶ 205; and that the admissions rate at CHSI's affiliated hospitals is "higher than anybody else['s] in the country, *id.* ¶ 345.

Nor were Defendants silent regarding the "compliance risk[s]" (FAC ¶ 8) that CHSI and its affiliates faced as a result of its strategy to increase admissions. To the contrary, the public

documents cited by Plaintiff disclose those very risks. For example, CHSI expressly warned investors that, "[i]f we fail to comply with applicable laws and regulations, including fraud and abuse laws, we could suffer civil or criminal penalties," 2008 Form 10-K at 27, https://goo.gl/SSTBeF; that "qui tam or 'whistleblower' actions initiated under the civil False Claims Act may be pending" against CHSI, *id.* at 34; and that interpretations of Medicare rules "could cause our future financial results to decline" and "subject our current practices to allegations of impropriety or illegality or could require us to make changes in our facilities," *id.* at 54, 27.[4]

(b) ***Statements made after April 2011.*** The second, newly alleged fraud theory relies on a series of alleged misstatements that Defendants made *after* Tenet filed its complaint in April 2011. Plaintiff alleges that Defendants falsely stated that "Tenet's lawsuit has no merit," FAC ¶ 438(a), and that the use of InterQual rather than the Blue Book "would not have any impact on CHS's admissions," *id.* ¶ 455. Those statements, Plaintiff says, were proven false when the Company's October 26, 2011 earnings release showed a reduction in same-store admissions.

ARGUMENT

Allegations of securities fraud must "overcome the high pleading standards" of Fed. R. Civ. P. 9(b) and the Private Securities Litigation Reform Act ("PSLRA"). *In re Omnicare, Inc. Sec. Litig.* ("*Omnicare III*"), 769 F.3d 455, 482 (6th Cir. 2014). A plaintiff must allege with particularity facts showing that there was "(1) a material misrepresentation or omission by the defendant; (2) scienter; (3) a connection between the misrepresentation or omission and the purchase or sale of a security; (4) reliance upon the misrepresentation or omission; (5) economic loss; and (6) loss causation." *Indiana State Dist. Council of Laborers v. Omnicare, Inc.*

[4] On a motion to dismiss, a court may consider documents that "are referred to in the plaintiff's complaint and are central to her claim." *Weiner v. Klais and Co.*, 108 F.3d 86, 89 (6th Cir. 1997). In a securities case, courts may consider the "the full text of the SEC filings, prospectus, analysts' reports and statements 'integral to the complaint.'" *Bovee v. Coopers & Lybrand C.P.A.*, 272 F.3d 356, 360 (6th Cir. 2001).

("*Omnicare I*"), 583 F.3d 935, 942 (6th Cir. 2009). The complaint also must plead "more than a sheer possibility that a defendant has acted unlawfully" or facts "merely consistent with a defendant's liability." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). Allegations that are "no more than conclusions" are "not entitled to the assumption of truth." *Id.* at 679. The Amended Complaint fails to meet these requirements as to any of Plaintiff's claims.[5]

I. PLAINTIFF FAILS TO STATE A CLAIM BASED ON DEFENDANTS' PUBLIC STATEMENTS BEFORE THE APRIL 2011 TENET COMPLAINT

Plaintiff's principal claim is that Defendants' pre-April 2011 statements touting CHSI's business strategies, regulatory compliance, and commitment to patient care (FAC ¶¶ 269-419) were materially misleading for not disclosing that the Company's "strategies depended in large part on utilizing aggressive non-industry admissions criteria that were unsustainable and a substantial Medicare compliance risk." *Id.* ¶ 8. Those allegations fail to state a securities fraud claim for three independent reasons.

A. The Complaint Fails Adequately To Allege That Defendants Made Any Actionable Misrepresentations Before April 2011

Mistaking "quantity for quality," *Metzler Inv. GMBH v. Corinthian Colleges, Inc.*, 540 F.3d 1049, 1070 (9th Cir. 2008), the Amended Complaint sets forth *151 paragraphs* of statements Defendants made between July 2006 and March 2011. FAC ¶¶ 269-419. The alleged misrepresentations fall into three categories: (1) statements about CHSI's business strategies, *see id.* ¶ 8; (2) statements about CHSI's compliance risks, *id.* ¶¶ 10-11; and (3) statements about CHSI's mission to provide quality patient care, *id.* ¶ 9. Plaintiff fails adequately to allege that any of these statements would have misled a reasonable investor. *Omnicare III*, 769 F.3d at 472.

[5] To state a claim under Section 20(a), Plaintiff must first state a claim under Section 10(b)—and then show that, in addition, the individual Defendants are "controlling persons" within the meaning of the Exchange Act. For the reasons stated below, Plaintiff fails to state a primary claim of securities fraud under Section 10(b)—and therefore also fails to state a claim under Section 20(a).

1. *Statements Regarding CHSI's Business Strategies*

Plaintiff alleges that Defendants made a series of misrepresentations by attributing CHSI's performance to its "business strategy," "operating strategies," "growth strategies," "acquisition strategy," "revenue strategies," "ER strategy," and the like.[6] Plaintiff does not allege, however, that CHSI did *not*, in fact, employ a "business strategy," "operation strategy," or "ER strategy." More particularly, Plaintiff does not allege that CHSI did *not* seek to "[i]ncrease revenue at our facilities," FAC ¶ 288; that CHSI did *not* seek to acquire other hospitals, *id.* ¶ 270; or that CHSI did *not* see a "16.9% increase in total inpatient admissions," *id.* ¶ 280. Rather, the nub of Plaintiff's claim is that all of these statements were misleading because they *failed to disclose* that CHSI's business strategies depended, in part, on "admissions criteria that were unsustainable and a substantial Medicare compliance risk." *Id.* at 8; *see id.* ¶ 268.

Defendants' statements attributing CHSI's performance to its business strategy are not actionable, as a matter of law, for three independent reasons. First, CHSI had no duty to opine on whether that strategy presented legal risks. Second, Defendants' touting of CHSI's "synergies," "efficiencies," and other business-school jargon is immaterial to a reasonable investor, and therefore created no duty to disclose. Finally, Defendants *did* disclose information regarding ED admissions initiatives and risks that Plaintiff faults them for failing to disclose.

(a) ***CHSI was under no duty to speak about its compliance risks or specific admissions practices.*** Plaintiff's principal contention is that CHSI affiliates' admissions practices condoned and encouraged *illegal* inpatient admissions contrary to Medicare's medical-necessity regulations. It is black-letter law, however, that "[s]ilence, absent a duty to disclose, is not misleading under Rule 10b–5." *Basic Inc. v. Levinson*, 485 U.S. 224, 239 n.17 (1988). And the

[6] *See, e.g.*, FAC ¶¶ 8, 268, 272, 273, 281, 287, 300, 302, 305, 310, 314, 322, 323, 327, 334, 345, 358, 362, 364, 369, 377, 385, 405, 419.

Sixth Circuit has made clear that "companies have no duty to opine about the legality of their own actions," because "[s]uch information is considered 'soft,' and, therefore, disclosure is not required." *Omnicare I*, 583 F.3d at 945.

Plaintiff tries to wordsmith around that dispositive obstacle by repeatedly calling CHSI affiliates' admissions practices "unsustainable" instead of labeling them "illegal,"[7] but the Complaint speaks for itself: The only reason given for why the admissions practices were "unsustainable" is that they were "improper," FAC ¶ 4, "ignored Medicare rules," *id.* ¶ 187, or otherwise constituted "potential Medicare violations," *id.* ¶ 10. CHSI had no duty to disclose a legal opinion on whether its admissions practices were "illegal" and therefore "unsustainable."

Nor did the fact that CHSI *chose* to speak about its business practices *generally* create a duty to disclose the *specific aspects* of those practices—down to the level of admissions criteria and medical-records software used by each of the more than 100 affiliated hospitals. "Requiring that disclosures be complete and accurate does not mean that by revealing one fact about a product, one must reveal all others that, too, would be interesting, market-wise." *FindWhat Investor Grp. v. FindWhat.com*, 658 F.3d 1282, 1305 (11th Cir. 2011). Accordingly, courts routinely reject arguments that statements about business practices and revenue are misleading merely because they fail to disclose every facet of those practices or attendant risks.

In *In re Sofamor Danek Group., Inc.*, for example, plaintiffs similarly alleged that defendants misleadingly attributed a medical-device company's revenues and success "to such things as increased sales volume without properly explaining how the sales were being achieved." 123 F.3d 394, 400 (6th Cir. 1997). The Sixth Circuit squarely rejected that

[7] FAC ¶¶ 3, 8, 12, 268-70, 275-76, 285, 292, 300, 302, 305, 309-10, 313, 318, 322-23, 327, 334, 345, 350, 354, 358, 362, 364, 369, 374, 377, 383, 385, 391, 399, 411, 503.

argument, noting that the plaintiffs—like Plaintiff here—never challenged the accuracy of the sales figures. The court went on to hold that defendants were under no obligation to disclose exactly *how* they arrived at those sales figures—namely, by "engaging in illegal promotion of its products." *Id.* at 401. Soft information such as an opinion on the legality of a business strategy, the court explained, "must be disclosed only if virtually as certain as hard facts." *Id.* at 402.

Similarly, in *In re Almost Family, Inc. Sec. Litig.*, No. 10-520, 2012 WL 443461 (W.D. Ky. Feb. 10, 2012), the court rejected the argument that statements about a company's "strategy, success, and management" were materially misleading because the company's "growth was substantially due to its scheme to manipulate Medicare's reimbursement system, rather than the explanations" offered by the company. *Id.* at *6. The court held that the company was not obligated to disclose its specific Medicare billing practices simply because it chose to discuss *some* aspects of its business strategy. The company's success "could be attributed to several factors," the court explained, and the company's choice to discuss some of those factors but not others was not misleading because plaintiffs did not show that the factors cited by the company were entirely "farcical." *Id.* at *7. *See also Miller v. Champion Enterprises, Inc.*, 346 F.3d 660, 682 (6th Cir. 2003) ("Just because defendants issued a press release and held a conference call to discuss their second quarter earnings does not mean that they chose to speak on any situation that could possibly affect their financial condition.").

Plaintiff here relies on the same misrepresentation theory rejected in *Sofamor Danek* and *Almost Family*. It alleges that virtually every statement Defendants made during the class period referring to CHSI's "strategy," "operation," "revenue," or "growth" was misleading solely because those statements failed *also to disclose* that the admissions practices at CHSI-affiliated hospitals were allegedly "unsustainable." The Sixth Circuit has rejected that exact theory, and

rightly so: "Such a rule would require almost unlimited disclosure on any conceivable topic related" to the topics that the corporation chose to talk about. *Miller*, 346 F.3d at 682.

To be sure, "a party who discloses material facts in connection with securities transactions assume[s] a duty to speak fully and truthfully on those subjects." *Helwig v. Vencor, Inc.*, 251 F.3d 540, 561 (6th Cir. 2001) (en banc). But as shown above, that does not mean that, once a company speaks about a topic, it must disclose every fact related to that topic. Instead, "[d]isclosure is required . . . only when necessary to make statements made, in the light of the circumstances under which they were made, not misleading." *Matrixx Initiatives, Inc. v. Siracusano*, 131 S. Ct. 1309, 1321 (2011); *Starkman v. Marathon Oil Co.*, 772 F.2d 231, 238 (6th Cir. 1985). Courts have therefore explained that "[a] corporation has a duty to neutralize only the natural and normal implication of its statements." *FindWhat*, 658 F.3d at 1305.

CHSI's statements touting its "centralized and standardized operating strategy," FAC ¶ 270, and "successful acquisition and integration track record," *id.* ¶ 397, did not give rise to the "natural and normal implication" that CHSI—a large company in a heavily regulated industry—faced no compliance risk. Nor did CHSI's discussions of admissions growth "affirmatively create an impression," *Indiana Elec. Workers' Pension Trust Fund IBEW v. Shaw Grp., Inc.*, 537 F.3d 527, 541 (5th Cir. 2008), that CHSI and its affiliates had no compliance risks as to the medical necessity of admissions or the particular admissions criteria used. Defendants' references to CHSI's business strategies were not misleading for failure adequately to disclose its focus on admissions and compliance risk.

(b) ***Defendants' immaterial puffery and forward-looking statements are nonactionable.*** Plaintiff's claim fails for the additional reason that "no duty to disclose arises from disseminating immaterial . . . information." *In re Yum! Brands, Inc. Sec. Litig.*, 73 F. Supp.

3d 846, 865 (W.D. Ky. 2014). Immaterial information includes "vague, soft, puffing statements or obvious hyperbole," *Omnicare III*, 769 F.3d at 472, "forward-looking statements," and "generalized statements of optimism that are not capable of objective verification," *Grossman v. Novell, Inc.*, 120 F.3d 1112, 1119 (10th Cir. 1997). In *Pension Fund Group v. Tempur-Pedic Int'l, Inc.*, for example, the Sixth Circuit rejected a claim that a company misled the market by stating that the company "delivered strong financial performance, strengthened [its] competitiveness and implemented a range of strategic growth initiatives," all without disclosing that a new competitor was breaking into the company's primary niche market. 614 F. App'x 237, 245 (6th Cir. 2015). Those statements were the "sort[s] of rosy affirmation commonly heard from corporate managers that [are] immaterial as a matter of law." *Id.*

Because the "business strategy" statements Plaintiffs point to are just the sort of "puffery or hyperbole that a reasonable investor would not view as significantly changing the general gist of available information," they are not actionable "even if they were misleading." *In re Ford Motor Co. Sec. Litig.*, 381 F.3d 563, 570 (6th Cir. 2004). Plaintiff nevertheless asserts that Defendants committed fraud by touting CHSI's "consistent growth in revenues," FAC ¶ 376; its strong "fundamentals," *id.* ¶ 362*;* the "continued success of [its] centralized operating strategy," *id.* ¶ 368; its goal of "improv[ing] quality," *id.* ¶ 288; and its implementation of "standards for operational best practices," *id.* ¶ 291. But such statements are not actionable because "[a]ll public companies praise their products and their objectives," *In re Ford*, 381 F.3d at 570, and no reasonable investor would be misled by Defendants' praise of their own business strategy.

(c) ***Defendants disclosed the existence of Medicare compliance risks.*** Defendants' statements were not misleading for the additional reason that they *did* disclose the risks that Plaintiff claims they concealed.

As the Supreme Court recently reiterated, an "analysis of whether [a statement] is misleading must address the statement's context." *Omnicare, Inc. v. Laborers Dist. Council Constr. Indus. Pension Fund* ("*Omnicare IV*"), 135 S. Ct. 1318, 1333 (2015). "That means the court must take account of whatever facts [a defendant] *did* provide . . . as well as any other hedges, disclaimers, or qualifications it included." *Id.* Here, CHSI expressly—and repeatedly—warned investors of the Company's exposure to "heightened coordinated civil and criminal enforcement efforts" relating to "the health care industry," including investigations related to "billing practices." 2008 Form 10-K at 27, https://goo.gl/SSTBeF. CHSI also warned investors about potential lawsuits under the federal False Claims Act, *id.* at 34, and that "[s]ettlements of suits involving Medicare and Medicaid issues routinely require both monetary payments as well as corporate integrity agreements," *id.* at 34. "If we fail to comply with extensive laws and government regulations, including fraud and abuse laws," Defendants explained, "we could suffer penalties or be required to make significant changes to our operations." 2008 Form 10-K at 27. In light of these disclosures, Plaintiff cannot plausibly assert that reasonable investors were misled into believing that there was no risk associated with CHSI's affiliates' Medicare billings.

What is more, Defendants also repeatedly disclosed that a core part of the business strategy of CHSI and its affiliates was their "Emergency Room Initiatives" to "systematically take steps to increase patient flow in our ER as a means of optimizing utilization rates for our hospitals." FAC ¶¶ 205, 289. Indeed, one of the "steps" specifically disclosed was "the implementation of specialized computer software"—*i.e.*, Pro-MED—"designed to assist physicians in making diagnoses and determining treatments." *Id.*; *see also id.* ¶ 321 (alleging that Defendant Cash expressly credited Pro-MED for admission-rate increases). Defendants also

told investors that CHSI-affiliated hospital's admission growth was "higher than anybody else['s] in the country," *id.* ¶ 345; that their "ER Strategy has contributed to same store admission growth," *id.* ¶ 403; that "CHS reported a 16.9% increase in total inpatient admissions," *id.* at ¶ 280; and that, over a dozen years, "the admission rate out of ER" had increased from 11% to 15%," *id.* at 224.[8]

In other words, Defendants *told* investors that CHSI was pursuing a business strategy of increasing admissions through the ED in an environment in which intense regulatory scrutiny of "billing practices" made Medicare claims for inpatient admissions vulnerable to regulatory scrutiny. In light of those risk disclosures, no reasonable investor could have been misled by Defendants' *other* statements into thinking those risks did not exist.

2. *Statements Regarding CHSI's Risk Disclosures*

Perhaps recognizing that CHSI's risk disclosures belie Plaintiff's claim that CHSI failed to disclose its "compliance risk," FAC ¶ 8, Plaintiff alleges that those very risk disclosures were themselves misleading. According to Plaintiff, Defendants' repeated statement that any failure to comply with "extensive laws and government regulations, including fraud and abuse laws," could require "significant changes to our operations" was misleading without the further disclosure of "*known* risks and unsustainable practices" that might have caused that risk to materialize. *Id.* ¶ 275 (emphasis added).[9]

The Sixth Circuit rejected the same theory in *Bondali v. Yum! Brands*, No. 15-5064, 2015 WL 4940374 (Aug. 20, 2015). There, plaintiffs contended that a restaurant's risk disclosures

[8] *See also* FAC ¶ 224 ("When we came to the company . . . the admission rate out of ER was 10, 11%. Now it's 15%. Actually, the Triad hospitals had an admit rate which was lower than the CHS [sic], and we've improved that admit rate so far."); *see id.* ¶¶ 321 332, 335, 339, 363, 382 (reporting to the market CHS's increases in admissions volumes or rates).

[9] *See also* FAC ¶¶ 276, 278, 282-83, 296, 297, 301, 303, 306, 311-12, 317, 319, 328-29, 337- 38, 340-41, 348, 355-56, 359-60, 365-66, 373, 375, 380-81, 385, 387-88, 393, 395, 410, 412.

that "food-borne illness or other food safety issues" *could* negatively affect results were misleading because "food safety issues had already come to pass and were presently harming investment." *Id.* at *3. Affirming the dismissal of that claim, the Court of Appeals held that "cautionary statements are not actionable to the extent plaintiffs contend defendants should have disclosed risk factors 'are' affecting financial results rather than 'may' affect financial results." *Id.* at *7. As the Sixth Circuit explained, "[r]isk disclosures . . . are inherently *prospective* in nature" and intended to "warn an investor of what harms *may* come to their investment." *Id.* They are not misleading for failing also to disclose risks that *are* affecting an investment.

The same is true here. Defendants disclosed that they could be subject to False Claims Act actions and changes in operations relating to Medicare compliance. Plaintiff contends that those disclosures were misleading because they failed to disclose "*known* risks"; rather, they disclosed only possible risks, or future risks. FAC ¶ 275 (emphasis added). As in *Bondali*, however, "a reasonable investor would be unlikely to infer anything regarding the current state of a corporation's compliance, safety, or other operations from a statement intended to educate the investor on future harms." 2015 WL 4940374, at *7.[10]

Plaintiff also alleges that Defendants' disclosure that "[w]e believe that our hospitals are in substantial compliance with current federal, state, and local regulations and standards," FAC ¶ 294, was materially misleading "in failing to disclose long-standing potential Medicare violations at numerous hospitals," *id.* ¶ 10. But as the Sixth Circuit explained in *Omnicare I*, a company's assertion that it was in "legal compliance" with federal and state laws and regulations did not give rise to a "duty to disclose its 'illegal' operations." 583 F.3d at 946. That is

[10] The fact that Defendants disclosed regulatory risks *in general*, moreover, did not create a duty to disclose *specific* alleged risks. To the contrary, "where there is disclosure that is broad enough to cover a specific risk, the disclosure is not misleading simply because it fails to discuss the specific risk." *In re Bank of Am. AIG Disclosure Sec. Litig.*, 980 F. Supp. 2d 564, 579 (S.D.N.Y. 2013).

particularly true where, as here, "the materiality of the alleged omission derived solely from predictions regarding the actions of third parties, particularly whether fines or other sanctions would be brought based on findings of regulatory violations." *Id.* at 947. Indeed, the Sixth Circuit recently explained that "boilerplate" statements of legal compliance are typically immaterial because "one might be skeptical of whether a reasonable investor would put much stock in [them]." *Omnicare III*, 769 F.3d at 478;[11] *see also City of Pontiac Policemen's and Firemen's Ret. Sys. v. UBS AG*, 752 F.3d 173, 183 (2d Cir. 2014) ("general statements about reputation, integrity, and compliance with ethical norms are inactionable 'puffery.'").

3. *Statements Regarding CHSI's Commitment to Quality Patient Care*

Plaintiff's final misrepresentation theory is that Defendants misled investors by "tout[ing]" their desire to "provid[e] quality patient-centered healthcare." FAC ¶ 9. Those statements were misleading, Plaintiff contends, because CHSI's commitment to patient care was "compromised by its goal of boosting revenues by unsustainable admissions practices." *Id.* ¶ 350.[12] That claim fails, for several reasons.

To begin with, Defendants' desire to increase revenues generally, and through ED admissions in particular, was no secret. The Amended Complaint alleges that the Company's SEC filings stated that, "because 55% to 60% of our hospital admissions originated in the ER, we systematically take steps to increase patient flow in our ER as a means of optimizing

[11] In *Omnicare III*, the complaint alleged that the company made its "legal compliance" statements after it had recently settled another case with the government. The court therefore went on to hold that the compliance statement at issue was potentially material to investors, but only because it came *after* the government settlement. 769 F.3d at 478. Plaintiff here makes no such particularized allegations of a "recent history of legal problems surrounding non-compliance." *Id.* Indeed, Plaintiff does not allege *any* settlement with the government (or a private plaintiff) regarding issues relating to its admissions criteria until more than three years *after* the last alleged misstatement. FAC ¶ 472.

[12] *See* FAC ¶¶ 70, 85, 292, 295, 305, 318, 350, 354, 374, 411.

utilization rates for our hospitals."[13] FAC ¶ 205; *see id.* at 289.

Nor should it have been a secret: Plaintiff's theory boils down to the assertion that for-profit hospitals *cannot* be committed to patient safety because they also seek to return a profit to shareholders (including Plaintiff). Much of the Amended Complaint is therefore devoted to allegations that Defendants stated that "ED admissions increased revenues." FAC ¶ 24; *see id.* ¶¶ 37-40; 52, 66. Indeed, Plaintiff devotes an entire section to the blasphemy that "CHS Developed a Corporate Culture Centered Around Boosting Admissions." *Id.* at 37. But that is true of *every* for-profit hospital company; it is what their shareholders (rightly) demand. *See United States ex rel. Williams v. Renal Care Grp.*, 696 F.3d 518, 528 (6th Cir. 2012) ("Why a business ought to be punished solely for seeking to maximize profits escapes us.").

B. Plaintiff Fails To Plead Facts Giving Rise To A Strong Inference Of Scienter

To plead scienter, a plaintiff must allege facts showing that "defendants knowingly misrepresented or omitted facts" with the specific intent "to deceive, manipulate, or defraud the public." *Omnicare III*, 769 F.3d at 472. And to meet the PSLRA's "[e]xacting pleading requirements," *Tellabs, Inc. v. Makor Issues & Rights, Ltd.*, 551 U.S. 308, 313 (2007), a plaintiff must "state with particularity facts giving rise to a strong inference that the defendant acted with the required state of mind," 15 U.S.C. § 78u-4(b)(2)(A). A "strong" inference is one that is "at least as compelling as any opposing inference of nonfraudulent intent." *Tellabs*, 551 U.S. at 314. "[M]erely plausible or reasonable" inferences will not do. *Id.*[14]

[13] *See* FAC ¶ 132 ("Throughout the Class Period, CHS highlighted in its public filings . . . that the key components of its business strategy were: increasing revenues and earnings at its hospital facilities"); *id.* ¶ 289 ("Defendants made 'Emergency Room Initiatives' the central feature of its revenue strategies"); *see also id.* ¶¶ 288, 325, 376, 384.

[14] The PSLRA did not apply in the derivative case, so Judge Nixon's ruling on the defendants' motion to dismiss cannot support scienter here (*see* FAC ¶ 215). "[C]onstru[ing] the complaint liberally in the Plaintiffs' favor," Judge Nixon ruled that one could "reasonably infer" from Smith's and Cash's sophistication that they knew that "significant increases in admissions rates . . . could not have been done without using improper means." *Plumbers & Pipefitters Local Union No. 630 Pension Annuity Trust Fund et al v. Smith et al.*, No. 10-489, Dkt. 87 at 10, 18.

The scienter analysis for the individual defendants, Smith and Cash, turns on the "straightforward" question whether they had the required state of mind as to the statements they made. *Omnicare III*, 769 F.3d at 473. While the analysis for corporate scienter can be more "complicated," *id.* at 473, in this case the individual and corporate analyses merge. That is because Smith and Cash "made virtually all of the alleged misstatements," FAC ¶ 204, and Plaintiff proceeds on the theory that only their scienter matters for the corporation.[15]

Plaintiff fails to plead facts that give rise to a strong inference that Smith or Cash (and by extension, CHSI) "knowingly" misrepresented material facts with the specific intent "to deceive, manipulate, or defraud the public." *Omnicare III*, 769 F.3d at 472. Plaintiff alleges that Smith and Cash sold stock after changes in the Blue Book were made but before they "were implemented or publicly disclosed." FAC ¶ 240; *see id.* ¶¶ 240-50. But because many corporate executives are compensated via stock and stock options, a court will find a stock sale to be "probative of motive" only if a plaintiff pleads with particularity that the sale was "at unusual or suspicious levels." *In re Comshare Inc. Sec. Litig*., 183 F.3d 542, 553 (6th Cir. 1999). "Insider trading, however, is suspicious only when it is dramatically out of line with prior trading practices at times calculated to maximize the personal benefit from undisclosed inside information." *Konkol v. Diebold*, 590 F.3d 390, 399 (6th Cir. 2009). Thus, for stock sales to raise an inference of scienter, "plaintiffs must provide a meaningful trading history for purposes of comparison to the stock sales within the class period." *Id*. Plaintiff has failed to do so here.

All that remains of Plaintiff's threadbare allegations of intent to defraud are allegations that "Smith and Cash personally focused on admissions as the driver of the Company's stock

[15] Although the Amended Complaint alleges that other management personnel were aware of allegedly improper practices at CHSI-affiliated hospitals, it does not allege that they "ratified, recklessly disregarded, or tolerated" any of the alleged misrepresentations, *Omnicare III*, 769 F.3d at 476.

value." *See* FAC ¶¶ 207-10. But nefarious as Plaintiff tries to make it sound, that demonstrates absolutely nothing improper. *Of course* Smith and Cash, as executives of a for-profit hospital operator, focused on admissions (among other things) to drive CHSI's stock value. "Earning profits for the shareholders is the essence of the duty of loyalty, and therefore it would be an unusual case where accomplishment of this objective constitutes the requisite motive to defraud the shareholders" *ECA, Local 134 IBEW Joint Pension Trust of Chicago v. JP Morgan Chase Co.*, 553 F.3d 187, 200 (2d Cir. 2009). This is certainly not that unusual case.

C. Plaintiff Fails To Plead That The Decline In CHS's Stock Price On April 11, 2011, Was Caused By Any Alleged Fraud

To state a claim under Rule 10b-5, a plaintiff must adequately plead loss causation. *Dura Pharm., Inc. v. Broudo*, 544 U.S. 336, 342 (2005). That requires Plaintiff to do "more than note that a stock price dropped after a [negative] announcement." *D.E. & J. Ltd. P'ship v. Conaway*, 133 F. App'x 994, 1000 (6th Cir. 2005). "Rather, a complaint must specify the relevant economic loss the plaintiff sustained and describe how the loss occurred." *Fla. Carpenters Reg'l Council Pension Plan v. Eaton Corp.*, 964 F. Supp. 2d 875, 891 (N.D. Ohio 2013).[16]

When a plaintiff relies (as Plaintiff does here) on the so-called "fraud on the market presumption" to establish reliance, it typically seeks to meet this pleading burden by identifying a "corrective disclosure"—a disclosure of information "that reveals to the market the pertinent truth that was previously concealed or obscured by the company's fraud." *FindWhat*, 658 F.3d at 1311. The plaintiff also must allege that the stock price dropped because of the corrective disclosure's revelation of the previously concealed truth, and not as a result of other causes. *Id.*

Here, Plaintiff relies on a single asserted corrective disclosure as to the alleged pre-April

[16] Several courts have held that Rule 9(b) applies to loss causation. *See Oregon Pub. Emps. Ret. Fund v. Apollo Grp., Inc.*, 774 F.3d 598, 604-605 (9th Cir. 2014). Here, Plaintiff fails adequately to allege loss causation under any pleading standard.

2011 fraud: the Tenet Complaint filed in April 2011, which, according to Plaintiff, revealed the "truth" that had been concealed by CHSI and its officers. That theory of loss causation fails as a matter of law because (1) the Tenet Complaint comprises mere *allegations* of fraud, rather than the revelation of the *truth* as to prior misstatements; and (2) the factual allegations in the Tenet "complaint disclose[] nothing new, but merely attribute[] an improper purpose to the previously disclosed facts," *Teachers' Ret. Sys. of LA v. Hunter*, 477 F.3d 162, 187 (4th Cir. 2007).

1. *The Tenet Complaint Merely Alleges—Rather Than Discloses—Fraud*

The Tenet Complaint amounted to nothing more than an *allegation* of fraud, not a revelation of the *truth* of any fraud. And mere allegations of fraud in a civil complaint are not "corrective disclosures." That is just what the Eleventh Circuit held in *Sapssov v. Health Management Associates, Inc.*, 608 F. App'x 855 (11th Cir. 2015).[17] In that case, some of the same plaintiffs as are involved here brought nearly identical allegations against another hospital system, contending that it had "devised a corporate policy mandating unnecessary admission of Medicare patients to [its] hospitals to boost its financial position and stock price." *Id.* at 857. As they do in this case, the *Sapssov* plaintiffs alleged that the truth was revealed by a whistleblower lawsuit claiming that the company had engaged in fraudulent billing practices. The district court squarely rejected that argument and dismissed the complaint because "[t]he filing of a civil complaint certainly does not establish that the defendant committed or is liable for the conduct alleged." 22 F. Supp. 3d 1210, 1231 (M.D. Fla. 2014). The Eleventh Circuit affirmed, holding that the civil suit did not constitute a corrective disclosure "because *a civil suit is not proof of liability*." 608 F. App'x at 863 (emphasis added).

The Court of Appeals' reasoning in *Sappsov* follows from a line of cases holding that

[17] Plaintiffs in *Sappsov* filed a petition for rehearing en banc. *Sapssov v. Health Management Association, Inc.*, No 14-12838 (June 1, 2015). The Court of Appeals has not yet ruled on that petition.

"disclosure of [a government] investigation, absent an actual revelation of fraud, is not a corrective disclosure." *In re Almost Family*, 2012 WL 443461, at *13.[18] The reason for that rule is self-evident: A corrective disclosure "must reveal a previously concealed *truth*." *FindWhat*, 658 F.3d at 1311 n.28 (emphasis added); *see Dura*, 544 U.S. at 347 (the complaint must allege that the share price fell "after the truth became known"). But the "announcement of an investigation reveals just that—an investigation—and nothing more." *Meyer*, 710 F.3d at 1201. Thus, because a government investigation may end inconclusively or even exonerate its target, the announcement of such an investigation "does *not* 'reveal' fraudulent practices to the market." *Loos*, 762 F.3d at 890 (emphasis added).

This case is exactly the same as *Sappsov*: The mere filing of a "civil suit"—in this case, the Tenet Complaint—"is not proof of liability." 608 F. App'x at 863. To be sure, the market may respond negatively to a lawsuit, just as it may respond negatively to the commencement of a government investigation. But "any decline in a corporation's share price following the announcement of an investigation"—or lawsuit—"can only be attributed to market speculation about whether fraud has occurred" or regarding the impact of any potential future remedial action. *Loos*, 762 F.3d at 890. Mere market speculation that fraud *might* have occurred is not sufficient to establish loss causation under *Dura*. "If the disclosure of a mere *risk* of fraud was enough to trigger loss causation," as Plaintiff here argues, "a private cause of action for securities fraud would accrue every time an allegation or rumor of wrongdoing circulated." *In re Almost Family*, 2012 WL 443461, at *12. That is not the law.

[18] *See also, e.g.*, *Meyer v. Greene*, 710 F.3d 1189, 1201 (11th Cir. 2013)*; Mauss v. Nuvavsive, Inc.*, No. 13-2005, 2014 WL 6980441, at *6 (S.D. Cal. Dec. 9, 2014) (applying *Loos v. Immersion Corp.*, 762 F.3d 880 (9th Cir. 2014)).

2. *The Tenet Complaint Merely Repackages Already-Public Information*

Even if a civil complaint could ever serve as a corrective disclosure, the Tenet Complaint fails to qualify as a corrective disclosure for another reason: It did not reveal any "pertinent truth" that was "previously concealed or obscured by the company's fraud," *FindWhat*, 658 F.3d at 1311, because the "sources used in [drafting it] were already public," *In re KBC Asset Mgmt.* 572 F. App'x 356, 362 (6th Cir. 2014).

As numerous courts have held, prior market knowledge of the facts contained in any alleged corrective disclosure is "fatal to the [plaintiff's] claim of loss causation." *In re KBC*, 572 F. App'x at 362. That rule applies *even if* the alleged corrective disclosure—whether it takes the form of a security analyst report, a presentation by a market expert, or a civil complaint—adds some form of analysis not previously available to the market. *Meyer*, 710 F.3d 1189 (expert analysis by hedge fund); *Sapssov*, 608 Fed. App'x 855 (analyst report discussing previously filed qui tam complaint); *Hunter*, 477 F.3d 162 (securities complaint filed by company's former CEO).[19] In such instances, the only new information being added to the market is the *opinion* of the drafter, which, "standing alone, cannot reveal to the market the falsity of a company's prior factual representations." *Meyer*, 710 F.3d 1199.

As Plaintiff alleges, the supposed corrective disclosure here—the Tenet Complaint—relied exclusively on readily "available data from CMS." FAC ¶ 189. Indeed, the Tenet Complaint itself makes clear that "[t]he information set forth in [the Tenet] Complaint is based on *public information* relating to Medicare patients alone." Complaint for Violations of Federal

[19] *Accord In re Herbalife, Ltd. Sec. Litig.*, No. 14-2850, 2015 WL 1245191 (C.D. Cal. Mar. 16, 2015); *Central States, Southeast & Southwest Areas Pension Fund v. Federal Home Loan Mortgage Corporation*, 543 F. App'x 72 (2d Cir. 2013); *In re Omnicom Grp. Inc. Sec. Litig.*, 597 F.3d 501 (2d Cir. 2010) (citing *Hunter* and *In re Merck & Co. Sec. Litig.*, 432 F.3d 261 (3d Cir. 2005)). *Cf. Pub. Emps.' Ret. Sys. of Miss. v. Amedisys, Inc.*, 769 F.3d 313 (5th Cir. 2014) (article revealing the "hidden meaning" of data through complex expert analysis may constitute a partial corrective disclosure).

Securities Laws ¶ 4 n.2, 19 & n.5, 27, *Tenet Healthcare Corp. v. Cmty. Health Sys., Inc.*, No. 11-cv-00732, 2011 WL 1346942 (N.D. Tex. Apr. 11, 2011) (emphasis added).

Nor was Tenet the first party to analyze that "available data." To the contrary, as Plaintiff acknowledges, "the *same allegations* of improper admissions practices were raised in [a] *Qui Tam* Action filed on January 7, 2009 against CHS" and "unsealed on December 27, 2010"—more than three months *before* Tenet filed its suit on April 11, 2011. Dkt. 68 ¶ 31 (Initial Consolidated Complaint) (emphasis added). Indeed, as early as September 2010 the Service Employees International Union sent a letter to CHSI citing several *other* publicly available whistleblower lawsuits making the same allegations as those asserted by Tenet and now by Plaintiff here. *See* Orseck Decl. Ex. 1. The CtW Investment Group also sent CHSI a letter in September 2001 alleging that "publicly available Medicare data" revealed "CHS' corporate strategy to increase [ED] admissions"—again, the very same allegations made by Tenet. *See* http://goo.gl/MbJJtQ. Because the factual information in the Tenet Complaint was widely available to the market, the Complaint itself was not a corrective disclosure. *Hunter*, 477 F.3d at 187.

II. PLAINTIFF FAILS TO STATE A CLAIM BASED ON PUBLIC STATEMENTS AFTER THE APRIL 2011 TENET COMPLAINT

When Plaintiff filed its Initial Consolidated Complaint in July 2012, it alleged a securities fraud claim on behalf of people who bought CHSI shares from July 27, 2006, through April 8, 2011—the business day before the Tenet Complaint was filed. *See* Dkt. 68 ¶ 2 (Initial Consolidated Complaint). Now, more than three years later, Plaintiff alleges a new and different claim for the first time: That *after* the Tenet Complaint, Defendants "publicly denied" its allegations and "misrepresented the true impact discontinuing the Blue Book would have on CHS financial performance." FAC ¶ 489. That new fraud, as Plaintiff tells it, was revealed to

the market when CHSI announced its third-quarter earnings on October 26, 2011, which showed a 7% decline in same-store admissions. *Id.* ¶ 463. Plaintiff brings that independent claim on behalf of new putative class members who bought CHSI shares between April 9 and October 26, 2011—not just the members of the putative class pleaded back in 2012. *See id.* ¶ 2.

The Amended Complaint fails to state a claim based on the statements made after April 11, 2011, for four independent reasons: (1) it fails to plead any actionable misstatement; (2) it fails to plead a strong inference of scienter; (3) it fails to plead that the October 28 decline in CHSI's stock price was caused by any alleged misstatement; and (4) the new claims and expanded putative class are time barred.

A. The Complaint Fails Adequately To Allege That Any Defendant Made Any Actionable Misrepresentation After Tenet Filed Suit In April 2011

Plaintiff rattles off a variety of statements that one or more of the Defendants made after the Tenet Complaint was filed, but fails to identify a single actionable misstatement among them.

First, most of the alleged misstatements are "loosely optimistic statements that are so vague, so lacking in specificity, or so clearly constituting the opinions of the speaker" that "[c]ourts have consistently found immaterial" because "no reasonable investor could find them important." *Omnicare I*, 583 F.3d at 944. Most prominently, these include statements describing CHSI's views that the Tenet lawsuit was "wrong," "inaccurate," "irresponsible," and without "merit." FAC ¶¶ 422; 425; 428; 438(a)-(e). Defendants' "optimistic prediction that [CHSI] would win the lawsuit," is just "the sort of forward-looking puffery that could not be a false or misleading statement of fact." *Cardiac Pacemakers, Inc. v. St. Jude Medical Inc.*, No. 96-1718, 2001 WL 483977, at *2 (S.D. Ind. May 2, 2001). *See also* pages 14-15, *supra*. "Investors can evaluate this sort of posturing for what it is worth." *Anderson v. Abbott Labs*, 140

F. Supp. 2d 894, 907 (N.D. Ill. 2001).[20]

Second, those and other statements are also "inherently subjective and uncertain assessments" and statements of opinion. *Omnicare IV*, 135 S. Ct. at 1327. These include CHSI's statement that "[w]e believe that Tenet is wrong," FAC ¶ 438(b); Cash's view that the Blue Book was "fairly close" to InterQual, *id.* ¶ 454; Cash's belief that CHSI could convert to InterQual "by the end of 2011 without any material negative impact," *id.* ¶ 423; and Simon's "belie[f]" that CHSI-affiliated hospitals had not made "bonus payments to physicians related to ER admissions," *id.* ¶ 436. Such subjective assessments—of the strength of a lawsuit, the relationship between different admissions criteria, and the prospective financial effect of switching from one set of criteria to the other—are mere opinions that are not actionable unless it is pleaded with particularity that the speaker *actually disbelieved his own assessment* when he stated it. Plaintiff makes no such allegations—with particularity or otherwise.

Third, Defendants' predictions of the outcome and effect of the Tenet lawsuit (*e.g.*, FAC ¶ 422) and the future impact of the switch to InterQual on CHSI's bottom line (*id.* ¶ 455) are classic forward-looking statements that fall squarely within the PSLRA's safe harbor. *See* 15 U.S.C. § 78u-5(c)(1). Defendants are not liable with respect to forward-looking statements—*even if material and knowingly false*—unless the plaintiff pleads particularized facts "that the statement was not identified as 'forward-looking' or lacked meaningful cautionary language." *In re Empyrean Bioscience, Inc. Sec. Litig.*, 255 F. Supp.2d 751, 765 (N.D. Ohio 2003). That is not

[20] Similarly immaterial are CHSI's statement that "[p]roviding high-quality patient care is the Company's most important priority" FAC ¶ 422; Smith's statement that he was "confident that our business practices are appropriate"; *id.* ¶ 425; and Dr. Simon's April 28 statement that "CHS maintains strong controls regarding physician contracts," *id.*¶ 436. No reasonable investor would have been misled by such vague and optimistic puffery. *E.g. Boca Raton Firefighters & Police Pension Fund v. Bahash*, 506 F. App'x 32, 37 (2d Cir. 2012) (statement about internal business practices); *In re BP p.l.c. Sec. Litig.*, 851 F. Supp. 2d 767, 852 (S.D. Tex. 2012) (statement about priorities); *In re Austl. & N.Z. Banking Grp. Ltd. Sec. Litig.*, No. 08-11278, 2009 WL 4823923, at *11 (S.D.N.Y. Dec. 14, 2009) (statement about internal controls).

this case. Indeed, the source of the bulk of the alleged post-Tenet misstatements—CHSI's April 28, 2011, Response Presentation to the Tenet Complaint—opened with the very cautionary language required by the PSLRA. *See* CHS Response Presentation, at Slide 1, http://goo.gl/v222bG. Plaintiff's conclusory allegation that CHSI's "'Safe Harbor' warnings . . . were ineffective" because they were "generalized boilerplate that was not meaningful," FAC ¶ 492, is insufficient to deprive Defendants' forward-looking statements of the protections afforded by the safe harbor. *See In re Cutera Sec. Litig.*, 610 F.3d 1103, 1112 (9th Cir. 2010).[21]

Finally, Plaintiff alleges that Defendants' "literally true" statements, made in connection with CHSI's July 28, 2011, earnings release—that economic and industry forces were increasing outpatient volume at the expense of inpatient volume—were materially false. FAC ¶ 461. Even if Plaintiff's concession of truth did not defeat the allegation of falsity (it does), Cash disclosed that 160 basis points of the inpatient-admissions decline had resulted from "[a] reduction in one-day stays" and a "reaction to the publicity" of the Tenet Complaint during the very same call during which Defendants made their allegedly misleading (yet "literally true") statement about the forces driving volume trends. Orseck Decl. Ex. 2 at 4 (7/29/2011 Tr.).[22]

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[21] Plaintiff also alleges that certain statistical representations made in the CHS Response Presentation were false because an unidentified expert thinks CHSI relied on "a faulty analysis." FAC ¶ 451. That allegation simply ignores the fact that CHSI fully disclosed the sources of the data and the formulas used to analyze it. CHS Response Presentation, at Slides 7, 35. Anyone who did not find the methodology useful was free to disregard it, but he or she could not plausibly claim to have been misled by the information.

[22] Plaintiff does not allege with particularity any facts supporting an inference that Cash's descriptions of Pro-MED as a "tracking system" FAC ¶ 438(c), 435, 454, were untrue or misleading. Indeed, Plaintiff alleges that, *in fact*, Pro-MED was "used to track, in real time, patient, ED and individual physician statistics." *Id.* ¶ 36; *see also id.* ¶¶ 36, 50 (alleging that Pro-MED "tracked" admission benchmarks), *id.* ¶ 44 (alleging that Pro-MED "track[ed]" physicians who overrode quality-review alerts when discharging patients). And it is only through sleight-of-hand—and not facts pleaded with particularly—that Plaintiff purports to allege the falsity of Cash's statement that Pro-MED "does not order tests." *Id.* ¶¶ 262, 435. The Complaint alleges the existence of a contrary document stating that "tests ordered for each medical condition were determined, or 'locked down,' at the corporate level." *Id.* ¶ 42. But Plaintiff does not actually allege—nor could it—that *Pro-MED* ordered such tests. Rather, Plaintiff misleadingly refers to "test mapping" practices through which Pro-MED was programmed *to suggest to physicians* that certain tests be ordered when a patient presented with a given set of symptoms.

In sum, the Amended Complaint alleges only that Defendants made a series of vague, optimistic statements about the merits of the Tenet lawsuit, and about the potential impact of the transition to InterQual at CHSI-affiliated hospitals. Because none of those statements was materially misleading, Plaintiff fails to state a claim of securities fraud.

B. Plaintiff Fails To Plead Facts Giving Rise To A Strong Inference Of Scienter

The Amended Complaint lacks the requisite allegations of scienter that are specific to the statements that Defendants made after April 2011. Rather, Plaintiff cites to the allegations it made regarding Defendant's knowledge in the *prior*, pre-April 2011 period, to support that Defendants also must have known that their statements made after April 2011 were misleading.

Thus, for example, Plaintiff alleges that "CHS knew" that its statements about the merits of the Tenet Complaint were false for the reasons "described herein" (FAC ¶ 429)—presumably a reference to scienter allegations that Plaintiff made somewhere in the prior 428 paragraphs of the Amended Complaint. *Id.* ¶ 429. But Plaintiff must plead the required state of mind "with respect to *each* act or omission," 15 U.S.C. § 78u-4(b)(2)(A) (emphasis added)—including the alleged misstatements made after April 2011. Plaintiff's reliance on unspecified allegations of scienter made *elsewhere* in the Amended Complaint (and with respect to other alleged misstatements) flunks that requirement. *See N.Y. State Teachers Ret. Sys. v. Fremont Gen. Corp.*, No. 07-5756, 2009 WL 3112574, at *6 (C.D. Cal. Sept. 25, 2009) (noting that this type of "'puzzle pleading' makes it extremely difficult for the Court to identify . . . which allegations are intended to establish the falsity and scienter requirements in relationship to each challenged statement").

Moreover, Plaintiff's generalized allegations regarding Defendants' knowledge before April 2011 are insufficient to give rise to a strong inference that Defendants made the statements after April 2011 in order "to deceive, manipulate, or defraud the public." *Omnicare III*, 769 F.3d

at 472. As discussed above (at 20), the mere desire to make a profit does not establish such an intent to defraud. As a matter of law, then, Plaintiff fails adequately to plead scienter.

C. Plaintiff Fails To Plead Loss Causation

Plaintiff also fails to plead that the October 2011 decline in CHSI's stock price was caused by the alleged fraud.

First, Plaintiff fails to allege that the October 2011 earnings announcement revealed any new factual information about the merits of the Tenet Complaint or the financial effect of discontinuing use of the Blue Book. *See In re KBC*, 572 F. App'x at 362.[23] As early as April 28, 2011, Cash acknowledged that CHSI was "seeing some effect" from reaction to the Tenet Complaint's allegations. Orseck Decl. Ex. 3 at 14 (4/28/2011 Tr.). Moreover, on July 28, 2011, CHSI announced a 5.6% decline in same-store admissions attributed in part to "[a] reduction in one-day stays for emergency room with a corresponding increase in outpatient visits"—including the "removal of inpatient criteria to direct chest pain in admissions" and "a natural reaction to the publicity" of the Tenet lawsuit. Orseck Decl. Ex. 2 at 4 (7/29/2011 Tr.). When analysts asked during July 2011 whether CHSI had experienced any effect from the modification of its admissions criteria, Cash further stated that CHSI's one-day stays were "probably down 15% to 20% year-over-year." *Id.* at 15.

Given those disclosures, it is not (and was not) surprising that CHSI announced *further* decreased same-store admissions in October 2011. Indeed, Smith noted that analysts already had predicted as much based on what they had been told to "expect" during the immediately preceding quarters. Orseck Decl. Ex. 4 at 16 (10/27/2011 Tr.). The October 2011 earnings

[23] Plaintiff does not even attempt to allege that this disclosure revealed any "pertinent truth" about how CHSI-affiliated hospitals used Pro-MED or whether they had adequate controls over physician contracts. FAC ¶¶ 435, 436, 438, 455.

announcement therefore fails as a matter of law to constitute a corrective disclosure.

Second, Plaintiff fails to plead with particularity that its loss was caused by revelation of the impact of the change from the Blue Book to InterQual, rather than by one of the other "tangle of factors affecting price," such as "changed economic circumstances, changed investor expectations, new industry-specific or firm-specific facts, conditions, or other events." *Dura*, 544 U.S. at 343. For example, on the October 27 earnings call, CHSI announced a decline in third-quarter *Medicaid* reimbursement of 130 basis points, which was forecast to "continue to affect the second half of the year." Orseck Decl. Ex. 4, at 7 (10/27/2011 Tr.); *see id.* at 12 (discussing possible impact of a budget sequestration). CHSI announced a decrease in the EBITDA margin "primarily due to low margins of recently acquired facilities" as well as legal expenses. *Id.* at 5; *see also id.* at 10. And CHSI announced significant expenditures on IT infrastructure and associated losses in productivity that surprised some analysts. *Id.* at 17-18.

Plaintiff, however, does not mention *any* of those public disclosures, let alone plead facts supporting a plausible inference that it was the alleged October 2011 "corrective disclosure—as opposed to other possible depressive factors—that caused at least a 'substantial' amount of the price drop." *FindWhat*¸ 658 F.3d at 1312. What is more, the October 2011 disclosure has *nothing* to do with whether or not the Tenet allegations had "merit." Because the October 2011 earnings statement does not speak to that issue, it cannot possibly constitute a corrective disclosure that reveals the "truth" regarding Defendant's statements about the Tenet Complaint.

D. Plaintiff's New Claim Is Time Barred

1. *The Statute Of Limitations Has Expired On Plaintiff's New Claim*

Federal securities fraud claims must be filed within "2 years after the discovery of the facts constituting the violation." 28 U.S.C. § 1658(b)(1). That limitations period "begins to run once the plaintiff did discover or a reasonably diligent plaintiff would have discovered the facts

constituting the violation—whichever comes first." *Merck & Co. v. Reynolds*, 559 U.S. 633, 653 (2010). At the very least, Plaintiff was on notice of the alleged new claim concerning an asserted October 2011 corrective disclosure when Plaintiff filed its Initial Consolidated Class Action Complaint on July 13, 2012. Plaintiff does not allege otherwise.

2. *Plaintiff's New Claim Does Not Relate Back To The Initial Consolidated Complaint*

Because the limitations period has run on Plaintiff's newly added claims, Rule 15 permits amendment at this late date only if the amendment "asserts a claim or defense that arose out of the conduct, transaction, or occurrence set out—or attempted to be set out—in the original pleading." Fed. R. Civ. P. 15(c)(1)(B); *see Moross Ltd. Partnership v. Fleckenstein Capital, Inc.*, 466 F.3d 508, 518 (6th Cir. 2006). In determining whether an amendment "relates back" to an earlier pleading, courts look to "whether the party asserting the statute of limitations defense had been placed on notice that he could be called to answer for the allegations in the amended pleading." *Zundel v. Holder*, 687 F.3d 271, 283 (6th Cir. 2012). Thus, amendment will not be permitted where, as here, the time-barred claims plaintiff seeks to add would fundamentally alter the "nature and scope" of the plaintiff's previously asserted claims. *United States ex rel. Bledsoe v. Cmty. Health Sys., Inc.*, 501 F.3d 493, 516 (6th Cir. 2007).

Plaintiff's allegations of post-April 11 conduct constitute an entirely new securities fraud claim. Indeed, Plaintiff's 2012 Initial Consolidated Complaint did not even *mention* (though it clearly could have) the critical October 26, 2011, earnings statement—much less allege that the earnings statement revealed to the market an entirely new fraud effectuated by a series of vague and immaterial statements previously cited only as evidence of scienter.

Permitting such an untimely amendment would violate the fair-notice principles embodied in Rule 15. By alleging a second fraud and corrective disclosure, expanding the size

of the putative class, and extending the class period, Plaintiff's amendment aims to add hundreds of millions of dollars of potential damages. Nothing in the Initial Consolidated Complaint gave Defendants "the essential information necessary to determine both the subject matter and size of the prospective litigation." *Cliff v. Payco Gen. Am. Credits, Inc.*, 363 F.3d 1113, 1132-33 (11th Cir. 2004) (refusing to allow amendment to vastly increase the size of the class). To the contrary, far from giving defendant "enough notice of the nature and scope of the plaintiff's claim," Plaintiff's decision to reference but not charge as fraudulent the post-April 11 statements led the Defendants to believe that Plaintiff did *not* intend to pursue them. *Bledsoe*, 501 F.3d at 516 (allowing relation back only if defendant "shouldn't have been surprised by the amplification of the allegations of the original complaint in the amended one").

In deciding whether to permit amendment, a court also should consider "undue delay in filing, lack of notice to the opposing party, bad faith by the moving party, repeated failure to cure deficiencies by previous amendments, undue prejudice to the opposing party, and futility of amendment." *Moross*, 466 F.3d at 518-19. Those factors also disfavor treating the Amended Complaint as relating back to the prior Complaint. As discussed above, the new allegations in the Amended Complaint are futile because they fail to state a claim of securities fraud. In addition, Plaintiff's course of conduct is the very picture of "undue delay." Plaintiff's motive for this tardy addition is no secret: Plaintiff sought leave to amend their complaint *two days* after Defendants brought to the Court's attention just how baseless their prior (April 11, 2011) theory of loss causation was. *See* Dkt. 138 at 10-14 (Aug. 18, 2015); Dkt. 139 ¶ 2 (Aug. 20, 2015). Plaintiff slept on its proposed new claims for *three years*—until well after the lapse of the statute of limitations. It should not be permitted to add new claims at this late date.[24]

[24] When Plaintiff proposed amending the Initial Consolidated Complaint, this Court ordered that Defendants could

3. *In Any Event, This Court Should Not Permit Plaintiff To Expand The Putative Class*

It is well established that "an amendment which adds a new party creates a new cause of action and there is no relation back to the original filing." *Asher v. Unarco Material Handling, Inc.*, 596 F.3d 313, 318 (6th Cir. 2010). Thus, even if this Court permits the Plaintiff to state additional claims on behalf of those who already fell within the putative class, it should exclude from any putative class any plaintiff who did not "purchase or otherwise acquire the publicly traded securities of CHS from July 27, 2006 through on April 8, 2011"—*i.e.*, the class alleged in the Initial Consolidated Complaint (Dkt. 68 ¶ 2).

Altering the definition of the class in a securities action fundamentally changes the nature of the alleged conduct and the parties involved. *In re Syntex Corp. Sec. Litig.*, 95 F.3d 922, 935 (9th Cir. 1996). The newly proposed class members "are different because the[y] bought stock at different values and after different disclosures and statements were made by Defendants and analysts." *Id.*[25] Rule 15 therefore does not permit relation back to add them as class members. *Id.*

CONCLUSION

For the reasons stated above, this Court should dismiss the Amended Complaint with prejudice.

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object to the permissibility of amendment under Rule 15 in this Motion to Dismiss. *See* Dkt. 162, at 37 (Aug. 19, 2015, hearing). This Court should deny Plaintiff leave to amend for the same reason that it should dismiss Plaintiff's new claims outright—because amendment would be futile and because Plaintiff slept on its rights for three years.

[25] In some circumstances a plaintiff may "add additional plaintiffs where the action, as originally brought, was a class action," *Hill v. Shelander*, 924 F.2d 1370, 1376 (7th Cir. 1991), but only in order to add the names of those that are "similarly situated," *Culver* v. *Bell & Loffland, Inc.*, 146 F.2d 29, 30 (9th Cir. 1944). The new putative class members are not similarly situated to the putative members of the initial class because "the newly proposed class members bought stock at different values and after different disclosures and statements were made by Defendants and analysts." *Syntex Corp.*, 95 F.3d at 935.

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Respectfully submitted,

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