

IN THE MISSOURI SUPREME COURT

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No. SC92015

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MERCY HOSPITALS EAST COMMUNITIES  
(f/k/a St. John's Mercy Health System),

Plaintiff/Appellant,

v.

MISSOURI HEALTH FACILITIES REVIEW COMMITTEE,

Defendant/Respondent,

JAMES K. TELLATIN,

Defendant/Respondent,

PATIENTS FIRST COMMUNITY HOSPITAL,

Intervenor/Respondent.

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Appeal from the Circuit Court of St. Louis County  
Honorable Richard C. Bresnahan, Circuit Judge

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**SUBSTITUTE REPLY BRIEF OF APPELLANT  
MERCY HOSPITALS EAST COMMUNITIES**

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## ARGUMENT

### I. Point on Appeal I – This Case Is Ripe and Justiciable

In its brief, Mercy showed that the trial court erred in dismissing this case on ripeness grounds. The plain language of § 536.050.1, § 536.053, and Rule 87.02(c) precludes any argument that an agency must apply a rule before the validity of that rule can be challenged. Mercy Br. 11-13. Patients First contends that Mercy was not really challenging a rule, but was challenging a decision by MHFRC, even though that decision had not been made when Mercy filed this action. Patients First (PF) Br. 7. MHFRC makes a similar argument, but then implicitly concedes that Mercy’s facial challenge to the New Hospital Rule was ripe. MHFRC argues that Mercy’s “as applied” challenge to the rule requires consideration of the facts and thus requires exhaustion of administrative remedies. MHFRC Br. 9.

Both respondents ignore Mercy’s Petition, which explicitly challenges the facial validity of the New Hospital Rule. Mercy’s Count 1 for declaratory judgment is labeled “facial challenges” and alleges that the New Hospital Rule is “facially invalid.” L.F. 20, ¶ 69. The trial court agreed that the validity of a rule was at issue. Its opinion concluded that “St. John’s has failed to show how 19 CSR 60-50.400(4)(F)(1) (the ‘New Hospital Rule’) is invalid.” Mercy Appx. 2. Even Patients First, in seeking dismissal of Mercy’s petition, asserted that Mercy was seeking to invalidate rules: “In short, St. John’s now demands that the Court declare invalid . . . the ‘New Hospital Rule.’” L.F. 80. In its brief in this Court, Patients First casts the substantive issue to be the validity of the New

Hospital Rule. PF Br. 15. There can be no debate that Mercy is challenging the validity of a rule. As a result, exhaustion does not preclude the challenge. Mercy Br. 11-13.

The fact that Mercy challenged the validity of the New Hospital Rule both “facially” and “as applied” (L.F. 22) does not change the applicable principles. The validity of rules and their “threatened application” may be challenged without exhausting administrative remedies. *Premium Standard Farms, Inc. v. Lincoln Township*, 946 S.W.2d 234, 237 (Mo. banc 1997) (citing Rule 87.02(c)). Both MHFRC and Patients First ignore this case and cite *Boot Heel Nursing Center, Inc. v. Missouri Dept. of Social Services*, 826 S.W.2d 14 (Mo. App. W.D. 1992), to support their exhaustion argument. But Mercy demonstrated the inapplicability of *Boot Heel* in its brief. Mercy Br. 12-13. Neither MHFRC nor Patients First addressed Mercy’s arguments on the subject.

Patients First and MHFRC also argue that Mercy does not have standing and that Mercy’s claim is not justiciable because Mercy does not have a legally protectable interest. PF Br. 7-9, 13-14; MHFRC Br. 9-10. This standing argument is based on the inaccurate assertion that Mercy is not challenging an agency rule but is attempting to appeal a ruling by MHFRC. PF Br. 7-8. As shown above, Mercy is in fact challenging the validity of an agency rule. As a member of the industry regulated by the New Hospital Rule and as an economic competitor of those such as Patients First who would invoke this rule, Mercy has standing to make this challenge. See *Missouri Bankers Ass’n v. Dir. of Missouri Div. of Credit Unions*, 126 S.W.3d 360, 365 (Mo. banc 2003). Patients First’s argument about justiciability and protectable interests, although presented in a different part of its brief (PF Br. 13-14), is simply another way of referring to

standing. *Missouri Ass'n of Nurse Anesthetists, Inc. v. State Bd. of Regis.*, 343 S.W.3d 348, 354 (Mo. banc 2011).

Notwithstanding its argument on exhaustion and standing, MHFRC argues that this Court should reach the merits of the validity of the New Hospital Rule. MHFRC Br. 11. Mercy agrees that this Court may and should reach the merits.

## **II. Point on Appeal II – The New Hospital Rule conflicts With the CON Law and Is Invalid**

Now that Respondents have filed their briefs, certain important points are undisputed: (1) the New Hospital Rule is based on the assumption that the new hospital definition of “health care facilities” applies only to sub-part (a) of § 197.305(9); (2) the New Hospital Rule conflicts with the CON Law if the new hospital definition of “health care facilities” applies to the other sub-parts of § 197.305(9); and, (3) the express terms of § 197.366 provide that the new hospital definition of “health care facilities” applies to all of the sub-parts of § 197.305(9). Based on these three undisputed points, Respondents must demonstrate a basis for not applying § 197.366 according to its terms if they are to prevail in this case. They do not do so.

### **A. MHFRC’s First Argument – Ambiguity**

In its brief, Mercy argued that statutes should be interpreted according to their plain meaning and that the New Hospital Rule conflicts with the plain meaning of the CON Law. Mercy Br. 15-16. MHFRC contends that Mercy’s interpretation of the CON Law should be rejected because it “creates ambiguity” between § 197.305(9) and § 197.366. MHFRC Br. 16-17. MHFRC suggests an alternative interpretation of the CON Law that ignores the “new hospital” definition of “health care facilities”: “there is no conflict or ambiguity so long as ‘health care facility’ refers to any of the facilities in § 197.366 except a new hospital . . . Conflict and ambiguity arise in these provisions when the term ‘health care facility’ refers to a new hospital.” MHFRC Br. 17.

The obvious flaw in MHFRC's position is that the CON Law explicitly defines the term "health care facility" to include a new hospital. § 197.366(4). The courts are not free to ignore the statutory language enacted by the legislature. They must apply the plain and ordinary meaning of that statutory language. *Mercy Br. 15*. In the present case, the legislature directed that the term "health care facility" shall include new hospitals. Therefore, every time that "health care facility" as used in the CON Law appears in the various sub-parts of § 197.305(9), it must include new hospitals.

**B. MHFRC's Second Argument – Irreconcilable Inconsistency**

MHFRC's second argument (MHFRC Br. 19-24) is that there is an "irreconcilable inconsistency between the statutes" and that "§ 197.305(9) trumps § 197.366 in resolving the conflict between these statutes." *Id.* at 20, 22. The alleged "irreconcilable inconsistency" is that *Mercy's* reading of the statute purportedly would render "meaningless" sub-part (a) of § 197.305(9). MHFRC contends that this would be "an absurd result that constitutes irreconcilable inconsistency." *Id.* at 20. MHFRC seems to have combined separate principles involving "absurd results" and "irreconcilable inconsistency" into a single argument. But there is no need to resolve whether this combination of legal principles is appropriate because the premise of the combined argument – that the plain meaning of the statute renders sub-part (a) meaningless – is incorrect in any event.

After 1997, any new "health care facility" that cost more than \$1 million triggered the sub-part (a) definition of "new institutional health service." The legislature's amendment of "health care facility" did not go into effect until 2002, so there were

several years in which the original broad definition of “health care facility,” which included ambulatory surgical centers and other facilities, was subject to this \$1 million expenditure minimum. The expenditure minimum was in no way meaningless to the facilities that were subject to the CON Law at that time. Since 2002, those facilities are no longer “health care facilities,” and so are not subject to the provision. But sub-part (a) continues to apply to nursing homes, long term care facilities, and new hospitals. Those facilities trigger sub-part (a) if they cost more than \$1 million. If so, a certificate of need is required and there is no need for further analysis of other sub-parts. If, however, such a facility costs less than \$1 million, then the plain language of the statute requires consultation of the other sub-parts. A certificate of need is required if the facility triggers another sub-part. Under the plain meaning of the statute, sub-part (a) was not meaningless in the 1997 to 2002 time period; nor is it meaningless in the time period since 2002.

It may be that a new hospital will almost always trigger the “new beds” or “new services” sub-parts (e) and (f) of § 197.305(9). But this does not render sub-part (a) meaningless. The fact that a facility might cost less than \$1 million, but still trigger a certificate of need under another sub-part, simply means that the provisions of § 197.305(9) are disjunctive. A facility that does not trigger one sub-part is not immune from the others. *McKnight Place Extended Care, L.L.C. v. MHFRC*, 142 S.W.3d 228, 232-34 (Mo. App. W.D. 2004). Regardless of whether a facility costs less than the expenditure minimum in sub-part (a), (b), (c), or (d), § 197.305(9) “creates seven separate

definitions and an entity that meets any of the definitions is deemed a ‘[n]ew institutional health service’ and requires a certificate of need.” *Id.* at 232.

At best, MHFRC’s argument is that a new hospital will always constitute a “new institutional health service” under sub-parts (e) and (f), and that renders the expenditure minimum distinction in sub-part (a) redundant as applied to new hospitals. Even if this is true, MHFRC cites no authority that this constitutes a basis for ignoring the language of § 197.366. In fact, when the legislature adopts provisions that contain overlapping language, the courts will not change the meaning of those words in order to avoid a perceived redundancy. *State v. Carouthers*, 714 S.W.2d 867, 870 (Mo. App. E.D. 1986). Moreover, the solution that MHFRC suggests is that the courts deem § 197.366(4) to apply only to one sub-part of § 197.305(9), while the rest of § 197.366 applies to all of § 197.305(9). This “solution” is far worse than the claimed problem, as it would constitute an impermissible re-writing of a statute by the courts. *Turner v. Sch. Dist. of Clayton*, 318 S.W.3d 660, 668 (Mo. banc 2010); *State v. Rowe*, 63 S.W.3d 647, 650 (Mo. banc 2002) (“this Court, under the guise of discerning legislative intent, cannot rewrite the statute.”).

### **C. Invalidity of New Hospital Rule due to Sub-parts (b), (c), and (d)**

In the course of making its ambiguity argument, MHFRC included a footnote addressing Mercy’s argument about sub-parts (b), (c), and (d) of § 197.305(9). MHFRC Br. 17 n. 8. Mercy had demonstrated that the New Hospital Rule is invalid because it fails to account for these sub-parts. Mercy Br. 20-22. MHFRC claims that the “costs referenced” in these sub-parts are included in the expenditure minimum in sub-part (a)

and therefore the sub-parts do not apply to new hospitals. The argument appears to be that, for new hospitals, sub-parts (a), (b), (c), and (d) have redundant expenditure minimums so only sub-part (a) applies. MHFRC's argument is flawed. The first clause of subpart (b) contains no expenditure minimum applicable to the "acquisition of a health care facility." The expenditure minimum referenced in sub-part (c) applies to expenditures "on behalf of a health care facility" and is thus broader than sub-part (a). Finally, sub-part (d) is triggered when pre-development expenses exceed \$150,000. Regardless of whether this amount is included in the sub-part (a) expenditure minimum, as MHFRC suggests, it certainly could be triggered even if sub-part (a) is not.

Patients First does not even address the fact that sub-parts (b), (c), and (d) prove the invalidity of the New Hospital Rule. There is no basis for concluding that these sub-parts do not or should not apply to new hospitals. The lack of a coherent rebuttal to Mercy's arguments on this point demonstrates that the New Hospital Rule is invalid because it conflicts with the CON Law, including sub-parts (b), (c), and (d) of § 197.305(9).

**D. Patients First's Argument Based on § 197.305(9)(a)**

Using somewhat different analysis than MHFRC, Patients First also argues that the 1997 amendment of § 197.305(9)(a) proves the validity of the New Hospital Rule. PF Br. 18-23. Patients First argues that the expenditure minimum in sub-part (a) illustrates that "the legislature never intended for every new hospital, regardless of cost, to obtain a CON." *Id.* at 20. According to Patients First, Mercy's plain-meaning interpretation of the CON Law is based on the "belief that every new hospital, regardless

of cost, is required to obtain a CON.” *Id.* at 18. Therefore, because it is inconsistent with legislative intent, Mercy’s interpretation of the CON Law must be incorrect, asserts Patients First. Each step of Patients First’s argument on this point is incorrect.

First, the amendment to sub-part (a) does not reflect the legislative intent that Patients First asserts. The amendment to sub-part (a) simply added an expenditure minimum to one of seven statutory definitions of “new institutional health service.” A “health care facility” could thereafter trigger sub-part (a) only if it cost more than \$1 million. But a “health care facility” could still trigger any one of the other sub-parts regardless of whether it triggered sub-part (a). The legislature gave no indication that this 1997 amendment was intended to preclude the definition of “health care facilities” in § 197.366 from applying to all sub-parts of § 197.305(9).

Even if Patients First accurately divined the legislature’s intent regarding the sub-parts to which § 197.366(4) should apply, that does not warrant ignoring the plain language of the statute. In *State v. Rowe*, 63 S.W.3d 647 (Mo. banc 2002), this Court addressed a statute that made driving with a revoked license a felony. The Court determined that the legislature likely intended this statute to apply regardless of which state had revoked a driver’s license. But the terms of the statute read otherwise. Those terms applied to licenses “revoked under the laws of this state . . .” *Id.* at 648. Therefore, the statute did not cover the defendant, whose license was revoked in Iowa. “Courts do not have the authority to read into a statute a legislative intent that is contrary to its plain and ordinary meaning.” *Id.* at 650. Similarly, in the present case, § 197.366 explicitly

indicates that it applies to all sub-parts of § 197.305(9) and the courts, under the guise of statutory construction, may not rewrite those terms.

Second, Mercy's argument is not based on the abstract proposition that every new hospital must have a certificate of need. It is based on the proposition that a statute must be interpreted according to its plain meaning. It may be that the plain meaning of § 197.366, as applied to § 197.305(9), ends up requiring virtually all new hospitals to get a certificate of need. But it is the application of the plain meaning of the statute that drives that result, not some otherwise-derived legislative intent.

Finally, Patients First's conclusion that the plain meaning of the statute is inconsistent with legislative intent does not follow from its argument. To be valid, the New Hospital Rule must be consistent with the CON Law. The rule is therefore valid only if sub-parts (b) through (g) of § 197.305(9) are inapplicable to new hospitals. Based on § 197.366(4), it is clear that the legislature intended "health care facilities" to include newly-constructed hospitals. Sub-parts (b) through (g) use the phrase "health care facilities." So, sub-parts (b) through (g) certainly purport to apply to new hospitals. Patients First's contention that sub-part (a) reflects a different legislative intent would change this result only if sub-part (a) implicitly and partially repealed § 197.366, an argument that Patients First does not make.

Next, Patients First tries to refute Mercy's argument about the possible reason for the 1997 amendment to sub-part (a). PF Br. 21. Mercy argued that the 1997 amendment to sub-part (a) likely was intended to allow certain facilities that would to be partially deregulated in 2002 – kidney disease treatment centers, diagnostic imaging centers, etc. –

to be built without a CON in the four years or so before § 197.366 went into effect.

Mercy Br. 25. Patients First complains that Mercy's argument "is not supported by any evidence whatsoever." PF Br. 21.

Patients First's complaint loses sight of what Mercy's argument was addressing. Patients First and the lower courts had taken the position that there was no reason for the 1997 amendment to sub-part (a) if new hospitals could trigger other provisions of § 197.305(9) beginning in 2002. Mercy was pointing out that there was indeed a plausible reason for the amendment even if new hospitals would later be subject to other provisions of the statute. The existence of this plausible alternative refutes the lower courts' reasoning. Mercy did not need to offer evidence of legislators' subjective intent. The fact that the statutory language had the effect that Mercy suggested was sufficient to disprove Patients First's "no other reason" argument.

Patients First also offers a straw man argument. According to Patients First, Mercy argues that the amended sub-part (a) was only to be in effect until 2002. PF Br. 21. This, of course, is not what Mercy contends. Like the other provisions of § 197.305(9), sub-part (a) continues to be in effect and should be applied according to its terms. If a health care facility is developed costing in excess of the expenditure minimum, then it constitutes a "new institutional health service" and requires a certificate of need. If a health care facility does not trigger sub-part (a), then it may still constitute a "new institutional health service" under one of the other six sub-parts of § 197.305(9). This was true before 2002 and it continues to be true today.

Patients First next argues that Mercy ignores the principle that a later-enacted statute prevails over an earlier-enacted statute. PF Br. 21-22. In fact, Mercy addressed this later-enacted statute rule in its brief. Mercy Br. 19. What Patients First ignores is that one statute prevails over another only when the statutes conflict. Patients First has not demonstrated any conflict between the plain meaning of sub-part (a) of § 197.305(9) and § 197.366. The putative conflict was between sub-parts (e), (f), and (g) and § 197.366. Mercy Appx. 3; Slip Op. at 11-12. Mercy has demonstrated that there is no irreconcilable conflict between these provisions. Mercy Br. 17-19.

MHFRC also briefly argues that Mercy's later-enacted statute argument is flawed. According to MHFRC, § 197.305(9) was repealed in its entirety and replaced with a new statute in 1997. MHFRC Br. 21.<sup>1</sup> In fact, the only amendment to § 197.305(9) in 1997 was the addition of an expenditure minimum to sub-part (a). The reenactment of the remainder of § 197.305(9), unchanged from its prior version, does not give those sub-sections a new "born on" date for purposes of evaluating conflicts among statutes. *See*

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<sup>1</sup> MHFRC erroneously suggests that § 197.366 was repealed and reenacted in 1996. MHFRC Br. 21. In fact, § 197.366 was first enacted in 1996. There was no previous statute with that citation, as the prior definition of "health care facilities" was at § 197.305(7), which was repealed in 2010 by H.B. 1516 and 1965 (2010). Those same bills made corresponding changes to § 197.366, with no indication that the legislature intended to change the statutes to which the definition in § 197.366 applies.

*State v. Ward*, 40 S.W.2d 1074, 1078 (Mo. 1931). Section 197.366 is the later-enacted statute in relation to the sub-parts of § 197.305(9) that purportedly conflict with it.

As they address this later-enacted statute issue, both Patients First and MHFRC make brief arguments that § 197.305(9) is the more specific statute. MHFRC Br. 21-22; PF Br. 22. They are incorrect. Section 197.366 is more specific because it provides a definition of words used in § 197.305(9). Section 197.366 is more specific for the further reason that the dispositive issue in this case is whether the definition in § 197.366(4) applies to all of the sub-parts in § 197.305(9). Section 197.366 is the only statute that specifically addresses this point. It states that “the term ‘health care facilities’ in sections 197.300 to 197.366 shall mean . . .” When a term is specially defined by statute, that definition must be given effect and is binding on the courts. *St. Louis Country Club v. Administrative Hearing Comm.*, 657 S.W.2d 614, 617 (Mo. banc 1983); *Labor’s Education & Political Club Independent v. Danforth*, 561 S.W.2d 339, 346 (Mo. banc 1978).

Patients First next addresses *McKnight Place Extended Care, L.L.C. v. MHFRC*, 142 S.W.3d 228 (Mo. App. 2004). PF Br. 22-23. According to Patients First, *McKnight* held only that the sub-parts to § 197.305(9) are disjunctive definitions, not exclusions, which provides no support for Mercy’s argument regarding the effect of the expenditure minimum language in sub-part (a). Patients First is incorrect. First, the fact that the sub-parts are disjunctive is an important part of Mercy’s argument – a new hospital can trigger any one of the sub-parts defining a “new institutional health service.”

Second, *McKnight's* holding was not merely that the sub-parts are disjunctive. The appellant's argument in *McKnight* focused on the effect of the expenditure minimum in sub-part (c). According to the appellant, the expenditure minimum requirement in sub-part (c) reflected legislative intent not to require a certificate of need for projects that cost less than the expenditure minimum. 142 S.W.3d at 233-234. The appellant argued that there would be a conflict with legislative intent if the court adopted any other interpretation. *Id.* The Western District rejected the appellant's argument, holding that the expenditure minimum in sub-part (c) simply means that if appellant's project costs less than that expenditure minimum, then it does not trigger sub-part (c), but the appellant may still trigger any one of the other sub-parts regardless of the expenditure minimum in sub-part (c). *Id.*

The appellant in *McKnight* was making an argument very similar to the argument that Patients First and the lower courts are making. The difference is that the expenditure minimum at issue here is the one in sub-part (a) instead of the one in sub-part (c). The Western District's rejection of that argument in the context of sub-part (c) applies equally to Patients First's argument about the expenditure minimum in sub-part (a). The fact that a health care facility may be below the expenditure minimum in sub-part (a) does not mean that the sub-part is rendered meaningless if the facility satisfies the definition of "new institutional health service" set forth in another sub-part. There is no substantive difference in issues between the present case and *McKnight*.

### **E. Patients First's Arguments Based on Sub-Parts (e), (f), and (g)**

Patients First next argues that the plain and ordinary meanings of sub-parts (e), (f), and (g) demonstrate that they do not apply to new hospitals. PF Br. 23-26. According to Patients First, “the lower courts did not conclude that the two statutes were in conflict with one another.” *Id.* at 25. Rather, they found that the statutes were not in “complete harmony” and construed them “beyond their simple text” in order to avoid an “absurd result.” *Id.* at 26. Patients First does not recognize the inconsistency in claiming to advocate both that of the language of the statutes be given its plain meaning and that the statutes must be read “beyond their simple text.” Nor does Patients First harmonize its position with MHFRC’s argument that the New Hospital Rule is valid because there is an irreconcilable conflict between the relevant statutes. MHFRC Br. 20, 22.

Overlooking the inconsistency of these positions, Patients First’s point is not substantively persuasive. The definition of “health care facilities” in § 197.366 clearly indicates that it applies to a range of statutes, including § 197.305(9). *See also* § 1.070.2. Patients First claims that three of the seven sub-parts of § 197.305(9) are not phrased properly to have the new hospital portion of the “health care facilities” definition apply to them. But this putative phrasing inconsistency does not provide a basis for ignoring the language in § 197.366. Instead, both statutes must be applied as they were written. *Turner v. Sch. Dist. of Clayton*, 318 S.W.3d 660, 667 (Mo. banc 2010). Furthermore, the statutory definition of “health care facilities” is binding and must be given effect. *St. Louis Country Club*, 657 S.W.2d at 617; *Labor’s Education & Political Club Independent*, 561 S.W.2d at 346.

Mercy explained in its brief how the new hospital definition of “health care facilities” and the three sub-parts (e), (f), and (g) could be applied as-written. Mercy Br. 16-19. Patients First responds that Mercy’s arguments on this point “are devoid of logic and ignore the plain and ordinary language used in the statutes.” PF Br. 26. But Patients First provides no explanation to support this point. Its conclusory attack does not demonstrate any flaw in Mercy’s arguments. Sub-parts (e), (f), and (g) are simply not irreconcilably inconsistent with the new hospital definition of “health care facilities” and they should all be applied according to their terms.

Patients First and MHFRC note that the court of appeals relied on *United Pharmacal Co. v. Missouri Bd. of Pharmacy*, 208 S.W.3d 907 (Mo. banc 2006), for the proposition that statutes may be construed “beyond their simple text” when needed to avoid an absurd result. PF Br. 26; MHFRC Br. 20. Respondents do not defend the court of appeals’ reliance on this case. Indeed, the case provides little support for the court of appeals’ conclusion. In *United Pharmacal*, the relevant statutes were unclear as to whether dispensing veterinary drugs constituted the “practice of pharmacy.” This Court decided the issue based on the rule of lenity, not any legal principle that allows statutes to be construed “beyond their simple text.” 208 S.W.3d at 913.

#### **F. The Conflict Between Respondents’ Arguments and § 197.315.3**

As Mercy described in its brief, there is a provision of the CON Law that all health care facilities that require a license must have a certificate of need before they can obtain that license. Mercy Br. 27-28. It makes little sense for Respondents to base their arguments on a putative legislative intent not to require all new hospitals to have a

certificate of need to be built when there is a provision that expressly requires them to have one to be licensed. *Id.* MHFRC responds to this point by asserting that § 197.315.3 mandates a certificate of need before a license is granted only in the case of “new institutional health services,” which it contends includes new hospitals only when they trigger sub-part (a). MHFRC Br. 22-23.

The trouble with MHFRC’s argument<sup>2</sup> is that that is not what the statute says. The statute says: “After October 1, 1980, no state agency charged by statute to license or certify **health care facilities** shall issue a license to or certify any **such facility**, or distinct part of **such facility**, that is developed without obtaining a certificate of need.” § 197.315.3 (emphasis added). MHFRC cited to a different statutory section, § 197.315.1, when making its argument. MHFRC provides no basis for concluding that § 197.315.1 limits the scope of § 197.315.3. Therefore, the law is that any “health care facility” that requires a license, new hospitals included, must have a certificate of need before obtaining that license.

#### **G. Patients First’s “Judicial Legislation” Argument**

Patients First argues that Mercy wants the Court to engage in “judicial legislation” to remedy an alleged “defect” in § 197.305(9). PF Br. 27-28. This argument strikingly misstates Mercy’s position. According to Patients First, Mercy wants the Court to “write out” sub-part (a) from § 197.305(9). Patients First urges the Court not to do this because the Court “must enforce § 197.305(9) as written . . .” PF Br. 28. Patients First seems to

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<sup>2</sup> Patients First did not even address this point.

be trying to engage in role reversal. Mercy agrees that § 197.305(9) should be applied as-written. But so should § 197.366. The problem for Patients First is that its position inevitably requires ignoring portions of § 197.366. Its attempt to put on the mantle of enforcing statutes as-written is unpersuasive so long as it advocates ignoring the clear language of § 197.366.

#### **H. Patients First’s Argument About the *Turner* Case**

In its next section, Patients First contends that Mercy’s reliance on *Turner v. Sch. Dist. of Clayton*, 318 S.W.3d 660 (Mo. banc 2010), is misplaced. PF br. 28-29. According to Patients First, *Turner* involved implied partial repeal of a statute, whereas the present case involves whether an agency rule conflicts with a statute. *Id.* at 29. It is true that this case involves the validity of an agency rule.<sup>3</sup> But Patients First defends the validity of that rule by arguing euphemistically that there is a lack of “harmony” between two statutes, so the statutes do not have to be applied according to their “simple text.” (At least MHFRC acknowledges that the validity of the New Hospital Rule depends on a conflict between statutes, asserting that one prevails over the other. MHFRC Br. 20, 22.)

Regardless of how Patients First may wish to characterize its position, it can defend the validity of the New Hospital Rule only by arguing that the term “health care facility” in sub-parts (b) through (g) of § 197.305(9) does not include new hospitals.

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<sup>3</sup> At this point in its brief, Patients First seems to have abandoned the argument at page 7 of its brief that this case was not about the validity of a rule.

Since § 197.366 requires that “health care facility” include new hospitals in these sub-parts, Patients First must come up with some justification for ignoring that express statutory language. Mercy and MHFRC agree that the “irreconcilable inconsistency” standard is the basis for evaluating whether the statutes so conflict that parts of one statute may be ignored. Patients First may disagree, but it has not suggested an alternative justification for ignoring the statutory language in § 197.366 that conflicts with its argument.

### **I. Respondent’s Argument About the Loophole**

In the final section of its brief, Patients First addresses the two-step loophole that is created by the New Hospital Rule and described in Mercy’s brief. Mercy Br. 23-24. This loophole allows a hospital developer to build a hospital for less than \$1 million without a certificate of need and later engage in unconstrained expansion also without obtaining a certificate of need, thereby effectively defeating certificate of need review whenever a developer so desires. *Id.* According to Patients First, the loophole does not exist because an existing hospital “may still be required” to get a certificate of need before expanding. PF Br. 30. Patients First does not provide the Court with any explanation of what it is referring to or even a citation to the provision that “may” require a certificate of need. Presumably, if it has a persuasive point, Patients First would have supported it with explanation and citation. Contrary to Patients First’s unsupported assertion, the loophole is real and it illustrates the absurd results that are a consequence of the New Hospital Rule. Mercy Br. 23-24.

MHFRC also addresses the loophole at the end of its brief. MHFRC Br. 23-24. Its argument appears to be that the legislature has cut back on the types of facilities covered by the CON Law, and therefore the loophole identified by Mercy is no loophole at all. It is what the legislature intended when it restricted the scope of the statute. The trouble with MHFRC's argument is that MHFRC does not want to apply the law as the legislature wrote it. That is why MHFRC is arguing that an irreconcilable conflict exists among statutes and that one should prevail over another. It is no answer that the loophole is what the legislature intended when the plain meaning of the words used by the legislature do not create such a loophole.

### **III. Conclusion**

The New Hospital Rule can be valid only if § 197.366 is not applied according to its terms. As demonstrated in Mercy's briefs, neither MHFRC nor Patients First has provided a basis for ignoring those terms. The New Hospital Rule is therefore invalid. Mercy requests that this Court so hold, reverse the trial court's judgment, and remand the case for further proceedings.

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**Certification Pursuant to Rule 84.06(c)**

The undersigned hereby certifies that the foregoing substitute brief complies with the limitations contained in Rule 84.06(b) and contains 5,682 words, as measured by the Microsoft Word software program used to prepare the brief.

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