

EXHIBIT 1

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

TEXAS LAUREL RIDGE HOSPITAL, LP)
d/b/a LAUREL RIDGE TREATMENT)
CENTER)

Plaintiff,)

v.)

Case No. 5:26-cv-02701-XR

ROBERT F. KENNEDY, JR., SECRETARY)
OF THE UNITED STATES)
DEPARTMENT OF HEALTH AND)
HUMAN SERVICES,)

DR. MEHMET OZ, ADMINISTRATOR)
OF THE CENTERS FOR MEDICARE)
AND MEDICAID SERVICES,)

AND)

TEXAS HEALTH AND HUMAN SERVICES)
COMMISSION)

Defendants.)

**PLAINTIFF'S EMERGENCY MOTION FOR TEMPORARY RESTRAINING
ORDER AND PRELIMINARY INJUNCTION AND BRIEF IN SUPPORT**

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Plaintiff Texas Laurel Ridge Hospital, L.P., d/b/a Laurel Ridge Treatment Center (“Laurel Ridge,” the “Facility,” or “Plaintiff”), by and through its undersigned counsel, respectfully moves this Court pursuant to [Rule 65 of the Federal Rules of Civil Procedure](#) and Local Rule CV-65 for entry of an emergency temporary restraining order and preliminary injunction restraining and enjoining Defendants from terminating Plaintiff’s Medicare provider agreement on April 30, 2026, or taking any actions on the basis thereof, to preserve the status quo pending resolution of Plaintiff’s administrative appeal rights and subsequent judicial review.

INTRODUCTION

Laurel Ridge is the largest psychiatric hospital in the State of Texas. Located in San Antonio, it has served the community for nearly 40 years, treating thousands of patients annually—including children, adolescents, and active-duty military personnel—and employing more than 650 people. Defendants propose to terminate Laurel Ridge’s Medicare provider agreement on April 30, 2026, based on survey findings that are factually and legally defective and have never been subject to *any* independent review, a decision that came mere weeks after the Facility was found in substantial compliance with all conditions of participation following a full survey (and ten million dollars of improvements). Because termination of Laurel Ridge’s Medicare provider agreement will trigger a cascading loss of virtually all of its payer contracts, the termination will effectively shutter the Facility, displacing all of its patients, eliminating hundreds of jobs, and leaving San Antonio, along with one of the nation’s largest military installations, without its most critical psychiatric care provider. Laurel Ridge brings this emergency motion because the Defendants propose to inflict this irreversible harm without affording Laurel Ridge any meaningful opportunity to be heard, in violation of its

constitutional and statutory rights. Defendants have also deprived Laurel Ridge of its right to a reasonable opportunity to correct alleged deficiencies, in violation of its own regulation.¹

Plaintiff respectfully requests that the Court issue emergency preliminary relief as soon as possible and before April 30, 2026, restraining and enjoining Defendants from terminating Plaintiff's provider agreement, to maintain the status quo and prevent the cascade of irreparable harm that it will suffer, followed by a hearing on Plaintiff's request for a preliminary injunction.

SUMMARY OF THE ARGUMENTS

The arguments in support of this Motion are briefed herein in four parts:

- Section I addresses factual background, establishing the critical role Laurel Ridge plays in the San Antonio community, the catastrophic consequences that will follow if the termination of its Medicare provider agreement is not enjoined, as well as the lack of meaningful process afforded to Laurel Ridge.
- Section II outlines why this Court has subject matter jurisdiction under two independent bases: (a) the collateral-claim exception recognized in *Mathews v. Eldridge*, 424 U.S. 319 (1976), because Laurel Ridge's procedural due process claims are entirely collateral to its substantive claims and cannot be remedied through the administrative appeal process; and (b) requiring exhaustion of administrative remedies would effectively deny judicial review altogether.
- Section III discusses why Laurel Ridge satisfies all factors for issuance of a temporary restraining order and injunctive relief: (1) Laurel Ridge is likely to succeed on the merits of its procedural due process claim because the current termination process deprives it of constitutionally protected liberty and property interests without a meaningful opportunity to be heard; (2) Laurel Ridge (as well as its patients, its employees, and the community at large) will suffer irreparable harm if the termination proceeds; (3) the balance of hardships tips sharply in Laurel Ridge's favor; and (4) the public interest strongly supports maintaining the status quo.
- The requirement for security under [Rule 65\(c\) of the Federal Rules of Civil Procedure](#) is addressed in Section IV.

¹ See 42 C.F.R. § 488.28 and 5 U.S.C. § 706.

ARGUMENT

I. FACTUAL BACKGROUND

A. Background on Laurel Ridge.

Laurel Ridge is the largest psychiatric hospital in the State of Texas. *Verified Complaint* (“Compl.”) at ¶ 15; Declaration of Ashley Sacriste (“Sacriste Dec.”), Exhibit 1 at App. 0002 ¶ 4. Located in San Antonio—the seventh most populous city in the United States—Laurel Ridge has been in continuous operation since 1987 and under its current ownership since 2010. Compl. at ¶¶ 14, 37; Sacriste Dec. App. 0002 at ¶ 3. The Facility holds a total of 330 licensed beds: 208 acute inpatient psychiatric beds, 80 acute inpatient psychiatric beds dedicated to the military community, and 42 residential treatment center (“RTC”) beds for children under 18. Sacriste Dec. App. 0002 at ¶ 6.

Of the 288 acute inpatient psychiatric beds, 26 are for children, 52 are for adolescents, and the remainder are for adults. Sacriste Dec. App. 0002 at ¶ 7.

In 2025, Laurel Ridge’s inpatient admissions totaled 10,340, and it provided outpatient services to 25,484 patients. Sacriste Dec. App. 0003 at ¶ 13. Nearly a third of Laurel Ridge’s patients are part of the military community. Sacriste Dec. App. 0003 at ¶ 14.

Laurel Ridge is an integral part of the mental health service delivery system in Bexar County and surrounding areas. Compl. at ¶ 16; Sacriste Dec. App. 0002 at ¶¶ 5, 58. It is a major employer in San Antonio, with over 659 employees and 22 psychiatrists, and total payroll in excess of \$48.5 million in 2025. Sacriste Dec. App. 0003 at ¶ 19.

In 2025, Laurel Ridge provided \$7,162,493 in uncompensated care to the community. *Id.* at ¶ 16.

The Facility serves as an on-site training location for medical, nursing, and therapy students enrolled in programs through multiple universities, including Galen, University of the Incarnate Word, Chamberlain, University of Texas Arlington, Baylor University, Wayland,

West Carolina University, Texas State University, St. Mary's, and Abilene Christian University. *Id.* at ¶ 20.

Laurel Ridge purchases over \$3 million in services from the local community each year and pays over \$1 million in property, local, and unemployment taxes. *Id.* at App. 0004 ¶¶ 23-24.

The Facility also hosts quarterly and annual training events for the broader mental health community, including the Bexar County Mental Health CIT Training and the JBSA Mental Health Providers Training on Ethics. *Id.* at App. 0003-4 ¶ 21.

B. The Lack of Available but Needed Psychiatric Care in the Community.

The need for inpatient psychiatric services in the San Antonio area far exceeds the available capacity. Apart from Laurel Ridge, there are only three other standalone inpatient psychiatric hospitals in San Antonio, with a combined total of 313 licensed beds—74 of which are exclusively for children—and four general hospitals with a collective total of 130 psychiatric beds. *Sacriste Dec. App. 0004 at ¶ 25.* A report in July 2025 showed that Bexar County adults have a higher prevalence of depressive disorder than state and national estimates. *See Compl. at ¶ 38.* According to Mental Health America, Texas ranks 50th in access to mental health care. *Id. at ¶ 39.* But without Laurel Ridge, San Antonio's total of 731 inpatient psychiatric beds will shrink to 443—a loss of nearly 40%. *Sacriste Dec. App. 0004 at ¶ 25.* The remaining facilities in the area lack the capacity, specialized programming, and staffing to absorb the patient volume currently served by Laurel Ridge, particularly with respect to children, adolescents, and active-duty military personnel. *See Compl. at ¶ 39.*

Indeed, the loss of Laurel Ridge's dedicated 80-bed military unit would be especially acute given the proximity of Joint Base San Antonio, one of the largest military installations in the United States, and the ongoing military engagement in Iran. *Compl. at ¶ 39; Sacriste Dec.*

App. 0009 at ¶ 51. No other facility in the region offers a comparable dedicated military behavioral health program. *See* Compl. at ¶ 39.

C. The Domino Effect of Terminating Laurel Ridge’s Medicare Provider Agreement.

Laurel Ridge’s inpatient psychiatric beds are certified for participation in the Medicare and Medicaid programs. Sacriste Dec. App. 0002 at ¶ 8; *see also* Declaration of Ethan Permenter (“Permenter Dec.”), Exhibit 5 at App. 0021 ¶ 4. In addition to participating in Medicare and Medicaid, Laurel Ridge has contracts with Humana Military and TriWest Healthcare Alliance to provide treatment to individuals covered by Tricare—the healthcare program for active-duty service members, retirees, and their families—through its dedicated 80-bed military unit. Sacriste Dec. App. 0002 at ¶ 10. Both Tricare agreements require that contracted healthcare providers have a Medicare participation agreement. *Id.*

Laurel Ridge also contracts with numerous private commercial payers, all of which require participating providers to be enrolled in Medicare or provide that involuntary termination by Medicare is a cause for termination of those payer contracts. *Id.* at ¶ 11.

Accordingly, termination of Laurel Ridge’s Medicare provider agreement will trigger a cascading loss of virtually all of the Facility’s revenue sources: federal regulations mandate that the state Medicaid program must then terminate the hospital’s Medicaid agreement, [42 C.F.R. § 455.416](#); the Tricare agreements covering approximately one-third of the Facility’s patients will be terminated; and substantially all private payer contracts will be terminated. Sacriste Dec. App. 0009 at ¶ 53. With private pay constituting only approximately 1% of the Facility’s revenue, termination of Medicare participation is catastrophic. *Id.* at ¶ 54.

D. The Medicare Survey and Enforcement Process.

The Medicare survey and enforcement process lacks *any* sufficient procedural safeguards commensurate with the severity of a termination decision. Hospitals participating in Medicare or Medicaid undergo periodic surveys to verify “substantial compliance” with the

Conditions of Participation (“COPs”). *See* Compl. at ¶ 45. The Secretary has contracted with the Texas Health and Human Services Commission (“HHSC”) to conduct these surveys. *Id.* at ¶ 46. Surveys are conducted using methods, procedures, and forms prescribed in the State Operations Manual (“SOM”), a sub-regulatory guidance document that has not undergone notice-and-comment rulemaking.² *Id.* at ¶¶ 49, 52.

The SOM is only one of thousands of guidance documents used by the Centers for Medicare & Medicaid Services (CMS). In a Tenth Circuit decision, now-United States Supreme Court Justice Gorsuch observed that CMS “estimates that it issues literally thousands of new or revised guidance documents (not pages) every single year,” with approximately 37,000 separate guidance documents on its website. *Caring Hearts Pers. Home Servs., Inc. v. Burwell*, 824 F.3d 968, 970 (10th Cir. 2016)). Because of the volume of these guidance documents and the absence of notice-and-comment rulemaking, there are many outdated provisions, drafting errors, and inconsistencies throughout. *See* Compl. at ¶ 53.

Surveyors are often former clinicians, and it is not uncommon for a surveyor to be a rejected applicant or former employee of the very providers they are tasked with surveying. There is no federal regulation prohibiting hospital surveyors from surveying a facility from which they were rejected for employment or terminated, and there is no formal mechanism to provide feedback on state survey agencies or surveyors, or to report surveyor misconduct. *Id.* at ¶¶ 55-56.

² More than 10 years before the Supreme Court overruled *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984) in *Loper Bright Entr. v. Raimondo*, 144 S. Ct. 2244 (2024), the Fifth Circuit recognized multiple “problematic outcomes” that result from granting deference to CMS’s interpretations of the SOMs: first, “it would make it possible for agencies not only to issue ambiguous regulations, but also to write and enforce ambiguous interpretations of them”; second, “granting deference to CMS’s interpretation of the SOM would leave no role for the courts” and “could effectively insulate agency action from judicial review”; and third, doing so would allow agencies to punish “wrongdoers” without first giving fair notice of the wrong to be avoided.” *Elgin Nursing & Rehab. Ctr. v. United States HHS*, 718 F.3d 488, 493 (5th Cir. 2013). “That final concern is particularly troubling considering the monetary penalties at stake and the potential repercussions of a finding of deficiency, including, in this case, losing all access to Medicare and Medicaid reimbursement.” *Id.*

Surveyors draft a “Statement of Deficiencies,” setting forth their factual findings and legal conclusions, and CMS imposes sanctions based on that Statement of Deficiencies *before a provider is ever given an opportunity to contest it*. There is no evidentiary hearing, neutral decision-maker, or opportunity to present witnesses, cross-examine surveyors, or submit evidence before CMS imposes sanctions. Providers are required to submit a plan of correction (42 C.F.R. § 488.28); however, providers are not permitted to contest the Statement of Deficiencies in a plan of correction. Notably, this regulation requires that CMS allow providers “a reasonable period of time” to correct the alleged deficiencies, which did not occur here.³

The statutory and regulatory scheme distinguishes deficiencies that “immediately jeopardize the health and safety of its patients.” *See generally*, 42 U.S.C. § 1395cc. Under 42 C.F.R. § 489.3, immediate jeopardy is defined as “a situation in which the provider’s or supplier’s non-compliance with one or more requirements, conditions of participation, conditions for coverage, or conditions for certification *has caused, or is likely to cause*, serious injury, harm, impairment, or death to a resident or patient.” (Emphasis added). Surveyors determine immediate jeopardy using Appendix Q in the SOM, “Core Guidelines for Determining Immediate Jeopardy.” But as with deficiencies, once a surveyor determines immediate jeopardy exists, the provider does not get an opportunity to contest such determination before the implementation of sanctions (which are not stayed if an administrative appeal is filed).

If CMS sanctions a hospital by terminating its participation in Medicare, federal law entitles the hospital to a hearing before an administrative law judge (“ALJ”), followed by review by the Department of Health & Human Services (HHS) Departmental Appeals Board

³ As described further below, the Statement of Deficiencies for the survey ending on February 23, 2026, was not sent to Laurel Ridge until March 11, 2026, after which HHSC permitted only five days to prepare a plan, and only 15 days to fully implement the plan. There was then a revisit survey on April 2, the findings of which were not conveyed until April 15, at which point CMS did not provide Laurel Ridge any opportunity to correct the alleged deficiencies.

(“DAB”), then judicial review of the DAB’s decision. *See* Compl. at ¶ 69. However, initiation of this administrative appeal process does not stay the termination, and, as described above, there is no process for review of survey findings *before* a termination goes into effect.

A review of ALJ decisions issued from 2025 reveals that it takes, on average, 3.3 years from the close of a survey to issuance of an ALJ decision; in one case, the ALJ decision came 5.5 years after the close of the survey. *Id.* at ¶ 71.

The administrative appeal process is also systematically deferential to the agency: CMS need only make a *prima facie* showing of non-compliance—satisfied simply by entering the Statement of Deficiencies into the record—after which the burden shifts to the provider to prove its substantial compliance by a preponderance of the evidence. *Id.* at ¶ 75. A review of ALJ and DAB decisions reveals that they are overwhelmingly in favor of CMS: in 2025, 30 of 34 decisions involving a challenge to survey deficiencies were ruled in CMS’s favor. *Id.* at ¶ 72. Because an appeal does not stay the termination, the provider’s Medicare participation would end, and its other payer contracts would terminate, effectively closing the provider for years while the appeal is pending and leaving the community without a significant health care provider. *Id.* at ¶ 73.

E. Surveys at Laurel Ridge, Survey Findings, and Plans for Abatement.

From 2010 to 2024, Laurel Ridge had never been cited for any deficiencies at the immediate jeopardy level and had only two prior surveys involving higher-level deficiencies, both of which were promptly remediated, with the last one occurring almost eight years ago. *Sacriste Dec. App. 0006* at ¶ 29. Then, during the 2025 calendar year, Laurel Ridge underwent numerous surveys. Laurel Ridge’s committed response included over \$10 million invested in the Facility to address cited deficiencies. *Sacriste Dec. App. 0006* at ¶ 30; *Permenter Dec. at App. 0021-22* ¶¶ 5, 13.

A full survey was conducted by CMS in October 2025, and while deficiencies were cited, a revisit from January 5-7, 2026, found the Facility was in substantial compliance with the Medicare COPs. Sacriste Dec. App. 0006 at ¶ 30; Permenter Dec. App. 0022 at ¶¶ 8-9.

Then, less than a month later, from February 4-23, 2026, HHSC performed a complaint survey (the “February 23 Survey”). Sacriste Dec. App. 0006 at ¶ 31. During this survey, the surveyors alleged multiple deficiencies were causing “immediate jeopardy”—despite the Facility having cleared a full survey only weeks before. Compl. at ¶ 80; Sacriste Dec. App. 0006 at ¶ 32. The Facility submitted written immediate jeopardy abatement plans, all of which were accepted as written, but the surveyors indicated they could not confirm that the plans were fully implemented and that the immediate jeopardy had been removed, without further explanation. Sacriste Dec. App. 0006 at ¶ 32.⁴ Laurel Ridge has filed an administrative appeal disputing the accuracy of the surveyors’ factual findings and misapplication of legal standards. Compl. at ¶¶ 81-82.

F. CMS Terminates Laurel Ridge.

By letter dated March 11, 2026, CMS formally notified the Facility of the survey findings and stated that the Facility’s Medicare agreement would be terminated on April 3, 2026, unless the immediate jeopardy was removed. Sacriste Dec. App. 0006 at ¶ 33; *see also* March 11 Letter attached as Exhibit 2 at App. 0011-0013. The letter required submission of a plan of correction by March 16, 2026, with corrections completed by March 26, 2026. App. 0011-0013.

The Facility timely submitted its plan of correction on March 16, 2026. Sacriste Dec. App. 0007 at ¶ 35. But, on March 18, 2026, HHSC rejected the plan and required a revised

⁴ Laurel Ridge disputes the accuracy of the surveyors’ factual findings and contends that the surveyors applied incorrect legal standards. In addition, one of the surveyors bragged about causing the Medicare termination and subsequent closure of another psychiatric hospital in Texas, and another surveyor was a former employee of a sister facility of Laurel Ridge. *See* Compl. at ¶¶ 81-83.

submission by March 19, 2026. *Id.* at ¶ 36. The Facility submitted an addendum on March 19, 2026. *Id.* at ¶ 37.

The plan of correction and addendum contained 19 action items addressing the alleged deficiencies, including comprehensive staff training on emergency behavioral interventions; restraint and seclusion documentation; and abuse, neglect, and exploitation recognition; revision of camera review processes and safety huddle procedures; creation of new policies for level-of-care transitions and informed consent; development of Spanish-language admissions materials and interpreter service protocols; and termination of a staff member for use of inappropriate and excessive force. *Sacriste Dec. App.* 0007-8 at ¶ 38.

On March 23, 2026, HHSC formally rejected the addended plan of correction. *Sacriste Dec. App.* 0008 at ¶ 39.⁵

From March 31 to April 2, 2026, HHSC performed a revisit survey, which included a surveyor who was not even part of the original survey team. *Sacriste Dec. App.* 0008 at ¶ 40. At the exit conference, HHSC notified the Facility that the immediate jeopardy had not been abated and recommended that the termination proceed. *Id.* at ¶ 41.

On April 2, 2026, CMS extended the projected termination date to April 17, 2026, to allow itself time to review the revisit survey reports. *Id.* at ¶ 42; *see also* April 2 Letter attached as Exhibit 3, at *App.* 0014-15. Counsel for the Facility then contacted CMS on April 3, April 9, and April 13, 2026, requesting the opportunity to discuss the survey issues and providing updates on ongoing improvements. *Sacriste Dec. App.* 0008 at ¶¶ 43-45.

On April 15, 2026, counsel for the Facility shared with CMS information concerning the capital improvements and other changes made, to address the concerns raised in the two most recent surveys. *Id.* at ¶ 46. Nevertheless, approximately an hour later, CMS emailed a letter formally notifying the Facility that its Medicare provider agreement would be terminated

⁵ Laurel Ridge contends that HHSC applied incorrect legal standards in its review and rejection of both the original and addended plans of correction. *See Compl.* at ¶¶ 88, 92.

on April 30, 2026, and which did not permit any further opportunity for correction of alleged deficiencies. *Id.* at ¶ 47; *see also* April 15 Letter attached as Exhibit 4, at App. 0016-0019. CMS posted a public notice of the termination on its website the same day. Sacriste Dec. App. 0008 at ¶ 48. Since then, the Facility has experienced a precipitous drop in patients, from approximately 175 on April 15, to only 96 as of the filing of the Complaint. Sacriste Dec. App. 0009 at ¶ 49.

G. Capital Improvements, Investments and Expenditures at Laurel Ridge.

Beginning in 2025, the Facility initiated comprehensive capital improvements to sustain and exceed compliance with applicable regulatory standards, among other goals. These improvements included:

- the addition of 29 full-time equivalent positions in 2025;
- removal of unit walls to improve visibility and patient monitoring;
- replacement of seclusion room doors, interior doors, hinges, and windows;
- modifications to nursing stations to enhance line-of-sight supervision;
- upgrades to ligature-resistant fixtures throughout patient care areas;
- replacement of patient furniture;
- installation of secure storage for patient belongings;
- reconstruction of patient unit patios;
- installation and replacement of perimeter fencing;
- replacement of exhaust ventilation systems; and
- upgrades to camera surveillance systems.

Sacriste Dec. App. 0004-5 at ¶ 26; Permenter Dec. at App. 0022-25.

As of April 2, 2026, the Facility initiated significant additional staffing and structural improvements, including:

- the addition of weekend unit coordinator coverage,
- increased milieu leadership,
- appointment of an Associate Chief Nursing Officer,
- transition of admissions assessors from therapist roles to registered nurses,
- commissioning of a Safety Committee and new Risk Initiative,
- implementation of evening senior leadership rounds,
- increased staffing for one-to-one supervision,
- 100% camera review of all emergency behavioral interventions, and
- ordering of Relay Pro communication devices with integrated panic button functionality.

Sacriste Dec. App. 0005-6 at ¶ 27; Permenter Dec. at App. 0025.

Additional improvement projects—including increasing the height of nursing stations, reconfiguring door access points, installing additional door hinges, and replacing and modifying windows across all patient care units—were scheduled to begin imminently. Sacriste Dec. App. 0006 at ¶ 28.

Despite these significant investments and its obligation under 42 C.F.R. § 488.28 to give providers a reasonable opportunity to correct alleged deficiencies, CMS indicated at an April 21, 2026, meeting that the decision to terminate was final and that it would not entertain any alternative solution. *See* Compl. at ¶ 105.

H. The Consequences of Termination if a TRO is not Granted.

The consequences of termination of Laurel Ridge’s Medicare participation will be catastrophic and irreversible. Laurel Ridge will be forced to close the entirety of its inpatient services—a facility that has served the San Antonio community for nearly 40 years. Sacriste Dec. App. 0009 at ¶ 58.

The closure will result in the layoff of nearly all of the Facility’s 659 employees and 22 psychiatrists, the loss of approximately \$48.5 million in annual payroll, and the lost benefit of over \$10 million in capital improvements made since 2025. Sacriste Dec. App. 0009 at ¶¶ 55, 62, 64. Many of these employees and their dependents will lose health care coverage through the Facility’s employer-sponsored health insurance plan. *Id.* at App. 0010 at ¶ 62. The 42-bed residential treatment center for children will likely be shuttered as well. *Id.* at App. 0009 at ¶ 57. Outpatient services will be drastically reduced, if not fully eliminated. *Id.* at ¶ 56.

The closure will interrupt the care and treatment of individuals, force the displacement of patients—including children, adolescents, and active-duty military personnel—and significantly jeopardize patient access to inpatient psychiatric services because the remaining beds in the San Antonio area will be insufficient to meet the community’s needs. *Id.* at App.

0009-10 at ¶¶ 59-60. The San Antonio community will lose millions of dollars in charity care. Eight universities will lose a significant training site. The State of Texas will lose its largest inpatient psychiatric provider. *Id.* at ¶¶ 58, 61, 63.

There is no adequate remedy at law because Laurel Ridge would be unable to recover millions of dollars in lost revenue, as CMS and HHSC are shielded by sovereign immunity. *See Compl.* at ¶ 126.

On April 23, 2026, the Facility timely filed an appeal and request for hearing before an ALJ of the HHS Departmental Appeals Board to formally contest the factual findings and misapplication of legal standards—but that appeal does not stay the termination. *See Compl.* at ¶¶ 70, 106.

II. THE COURT HAS JURISDICTION

A. Laurel Ridge's Claims Are Collateral and Cannot Be Remedied Through Administrative Review.

The Medicare Act, through [42 U.S.C. §§ 405\(g\) and \(h\)](#), generally channels claims “arising under” the Act through the administrative process before a provider may seek federal court review. However, the exhaustion requirement is subject to well-established exceptions to channeling requirements, enabling the Court to waive exhaustion of administrative remedies and giving this Court jurisdiction.

Under the collateral-claim exception articulated in [Mathews v. Eldridge](#), 424 U.S. 319, 330, (1976), the Court has jurisdiction over claims (a) that are “entirely collateral” to a substantive agency decision; and (b) for which “full relief cannot be obtained at a post-deprivation hearing.” *Id.* at 330-32. Thus, “when a plaintiff asserts a collateral challenge that cannot be remedied after the exhaustion of administrative review,” exhaustion is waived. [Family Rehab., Inc. v. Azar](#), 886 F.3d 496, 501 (5th Cir. 2018) (citation omitted); *see also Oak Park Health Care Ctr., LLC v. Johnson*, No. 09 CV 217, 2009 WL 331563, at *2 (W.D. La. Feb. 10, 2009) (noting Fifth Circuit’s recognition of waiver of exhaustion in collateral

challenges, and granting a nursing home a TRO based on procedural due process violations in termination by CMS). Laurel Ridge's claims meet both requirements to qualify for the exception. Laurel Ridge's procedural due process and constitutional claims (as well as its claim under the APA) are entirely collateral to questions that will be presented to and decided by the ALJ, e.g., issues surrounding the survey findings. And Laurel Ridge cannot obtain full relief at a post-deprivation hearing.

1. Laurel Ridge asserts procedural claims that are collateral to the underlying administrative dispute.

A claim is collateral where it does not require the court to “immerse itself” in the substance of the underlying Medicare dispute or seek the substantive, permanent relief that the agency appeals process is designed to provide. *Family Rehab.*, 886 F.3d at 501. Claims that “sound only in constitutional or procedural law...and request that benefits be maintained temporarily until the agency follows the statutorily or constitutionally required procedures” are within the district court's jurisdiction. *Id.* at 503 (citing cases).

In *Family Rehab.*, the court held that a provider's procedural due process claims were “plainly collateral” when the provider sought “only a hearing”—not substantive relief on the merits. 886 F.3d at 503. Such claims “only require the court to determine how much process is required under the Constitution and federal law” and do “not require the court to wade into the Medicare Act or regulations.” *Id.* The distinction between asking that an agency action be temporarily stayed pending process and asking that substantive benefits be permanently granted is not a matter of labeling, but a distinction of jurisdictional significance. *Id.* at n.13 (noting that “the fact that [the provider] seeks only the temporary abatement of [CMS's actions] is far from a labeling act”). The Supreme Court drew this same distinction in finding that claims challenging “the Secretary's failure to follow the applicable regulations”—rather than seeking benefits—are collateral. *Bowen v. City of New York*, 476 U.S. 467, 483 (1986) (procedural challenge against Social Security Administration concerning disability benefits). *See also*

Supreme Home Health Servs., Inc. v. Azar, 812 F. App'x 229 (5th Cir. 2020) (finding district court had jurisdiction over plaintiff's procedural due process and ultra vires claims, which were ultimately dismissed on the merits under summary judgment analysis).

Under this framework, federal courts have exercised jurisdiction to consider injunctive relief in Medicare termination matters where the provider's claims are collateral to the underlying merits determination or a claim to benefits—that is, where the provider does not challenge the substance of the Secretary's *decision to terminate*, but rather *the process* by which that decision was reached. *See, e.g., Family Rehab.*, 886 F.3d at 503; *see also Aurora Chicago Lakeshore Hosp. v. Azar*, 356 F. Supp. 3d 749, 758 (N.D. Ill. 2018) (finding due process and APA claims challenging pre-termination procedures collateral to underlying administrative challenge to termination) (*vacated on other grounds*, No. 18 C 8162, 2019 WL 6911965 (N.D. Ill. Dec. 19, 2019)); *Oak Park Health Care Ctr*, 2009 WL 331563, at *2 (granting TRO in provider's due process challenge to pre-termination procedures); *Symphony Hospice, Inc. v. Becerra*, No. ED CV 25-2498-JFW (PVCx), 2025 WL 3050054 (C.D. Cal. Oct. 3, 2025) (granting TRO enjoining termination of Medicare provider agreement where provider raised due process challenge based on CMS's failure to afford any opportunity to be heard before termination); *Ridgeview Manor of the Midlands, L.P. v. Leavitt*, No. 3:07-CV-861-JFA, 2007 WL 1110915, at *4-5 (D.S.C. Apr. 9, 2007) (granting a TRO and preliminary injunction where provider sought stay of revocation of Medicare billing privileges pending administrative appeal); *Mediplex of Mass., Inc. v. Shalala*, 39 F. Supp. 2d 88, 93 (D. Mass. 1999) (granting injunctive relief where provider's challenge to Secretary's authority to impose Medicare termination raised issues of statutory construction and equitable concerns, not benefits claims); *Libbie Rehab. Ctr., Inc. v. Shalala*, 26 F. Supp. 2d 128, 131 (D.D.C. 1998)

(finding jurisdiction and granting injunctive relief where nursing facility challenged the Secretary's refusal to conduct additional surveys before terminating facility).⁶

Laurel Ridge's claims fall within this same rubric. Laurel Ridge does not seek to enjoin CMS from ever terminating its participation based on the survey findings, nor does it ask the Court to wade into the substantive merits, but only to preserve the status quo until Laurel Ridge has a meaningful opportunity to challenge those findings through the administrative process. This is especially important given that the survey process affords no assurance of accuracy or reliability, as described *supra*.

Cases finding claims non-collateral and denying jurisdiction are readily distinguishable. As just one example, the Tenth Circuit in *Blue Valley Hospital, Inc. v. Azar* considered a Medicare termination of a hospital and found the provider's claims non-collateral. But the plaintiff there based its due process claim on CMS's use of newly-adopted definitions to terminate the plaintiff from the program. Such a claim would have required the court to immerse itself in how CMS promulgated and applied its new definitions. 919 F.3d 1278, 1285 (10th Cir. 2019). The Tenth Circuit acknowledged that *Family Rehab.* involved a different scenario: one where, as here, a provider challenged only "how much process is required under the Constitution and federal law" without requiring the court to "wade into the Medicare Act or regulations." *Id.* at n. 5.

2. Full relief cannot be obtained through a post-deprivation hearing.

Laurel Ridge cannot obtain full relief post-deprivation. Laurel Ridge will go out of business and it will have suffered irreparable harm long before the administrative appeal process, which averages over three years, is completed. Reinstatement of the Medicare provider agreement will not make Laurel Ridge whole, nor will it remedy the harm incurred by Laurel

⁶ Laurel Ridge likewise asserts that CMS is not following its own regulation, 42 C.F.R. § 488.28, by not permitting a reasonable opportunity for Laurel Ridge to correct the purported deficiencies, which constitutes a violation of the Administrative Procedure Act ("APA"), 5 U.S.C. § 706. *See also Aurora*, 356 F. Supp. 3d at 760-61.

Ridge (and its employees and patients) as a result of Laurel Ridge's closure. *See Eldridge*, 424 U.S. at 331 (at jurisdictional stage, plaintiff need only raise "at least a colorable claim" that the challenged action would "damage him in a way not recompensable through retroactive payments."); *see also Family Rehab.*, 886 F.3d at 504 (stating courts must "be especially sensitive to irreparable injury where the Government seeks to require claimants to exhaust administrative remedies merely to enable them to receive the rights they should have been afforded in the first place.") (internal quotations and citations omitted); *Supreme Home Health Servs., Inc.* 812 F. App'x at 233 (provider's allegations that it would be "force[d] out of business" and that its closing would harm its patients raised a cognizable claim of irreparable harm to establish jurisdiction, although claim was ultimately dismissed on summary judgment).

As shown, Laurel Ridge is the largest psychiatric hospital in the State of Texas, with 330 licensed beds, including 208 acute inpatient beds, 80 beds dedicated to the military community, and 42 residential treatment center beds for children under the age of 18. *Sacriste* Dec. App. 0002 at ¶¶ 4, 6, 7. In 2025, the Facility's inpatient admissions totaled 10,340, and it provided outpatient services to 25,484 patients. *Id.* at App. 0003 ¶ 13. Once this Facility closes and its staff and patients disperse, no administrative ruling can reconstitute its current level or provide compensation for the incalculable losses Laurel Ridge (and others) will suffer in the interim. Inpatient psychiatric care for acutely ill patients, children, and active-duty military personnel is not a commodity service with readily available substitutes. Texas already ranks 50th in access to mental health care, and the remaining facilities in the area lack the capacity, specialized programming, and staffing to absorb the patient volume currently served by Laurel Ridge. *Cf. True Health Diagnostics, LLC v. Azar*, 392 F. Supp. 3d 666, 681 (E.D. Tex. 2019) (no disruption where "over 3,500 diagnostic laboratories nationwide" provided similar services).

D&G Holdings, LLC v. Burwell, 156 F. Supp. 3d 798, 815 (W.D. La. 2016) is instructive. There, the court deemed the plaintiff's procedural due process claim collateral to its substantive claim to Medicare benefits. The court also found the plaintiff had raised "at least a colorable claim" that the damage from recoupment would not be compensable through retroactive benefits where the plaintiff had alleged that recoupment would deprive it of 95% of its total revenues, forcing it out of business; that its patients "will not be able to receive care from other providers;" and where the court noted awareness that plaintiff's closure would inflict harm on its employees. These potential harms "are not compensable through [] a retroactive payment" and thus satisfied the second prong of *Eldridge*. The harm to Laurel Ridge as described above is, if anything, more severe.

This case presents nothing like the situation in *Tex. Cypress Creek Hosp., LP v. Leavitt*, No. CIV A H-07-2590, 2007 WL 2402347, at *3 (S.D. Tex. Aug. 20, 2007). There, the court declined to waive exhaustion because a provider's parent entity was "capable of bearing the expense of operating" the facility "during the few weeks" before the ALJ's decision and any temporary income loss could be reimbursed through retroactive benefits. By contrast, Laurel Ridge faces years (not weeks) of delay in the administrative appeal process and would not be entitled to anything retroactively to make it whole. And it would not be facing a mere temporary income loss but rather existential threat.

Similarly distinguishable are *Cathedral Rock of North College Hill, Inc. v. Shalala*, 223 F.3d 354 (6th Cir. 2000), *Varandani v. Bowen*, 824 F.2d 307 (4th Cir. 1987), and *Northlake Community Hosp. v. United States*, 654 F.2d 1234 (7th Cir. 1981). In *Cathedral Rock*, the Sixth Circuit rejected the nursing facility's due process claim because the facility failed to demonstrate that *full relief would be unavailable* through a post-deprivation hearing. 223 F.3d at 364. Laurel Ridge, by contrast, cannot achieve full relief in post-deprivation litigation. In *Varandani*, the doctor had received notice of the impending suspension, an opportunity to

respond in writing, and an opportunity to respond in person at an informal hearing. 824 F.2d at 324. Not so here. In *Northlake*, the provider did not have a colorable constitutional claim because it could still obtain revenue from private patients. 654 F.2d at 1243. Laurel Ridge has demonstrated the contrary.⁷ Further, none are controlling, unlike *Family Rehab.*, in which the court confirmed that business closure combined with patient disruption can give rise to waiver of exhaustion. *Id.*, 886 F.3d at 504. For all of these reasons, Laurel Ridge’s claims satisfy both prongs of the *Mathews v. Eldridge* exception. The Court has jurisdiction.

B. The Court also Has Jurisdiction Because Practical Roadblocks Effectively Deny Review if Termination Is Not Stayed Pending Review.

Requiring Laurel Ridge to exhaust administrative remedies would be tantamount to the practical denial of judicial review. The irreparable harm Laurel Ridge imminently faces cannot be remedied through the administrative process. Courts have recognized that exhaustion may be excused where the administrative process cannot provide the relief sought. *See, e.g., Frontier Health Inc. v. Shalala*, 113 F. Supp. 2d 1192, 1193 (E.D. Tenn. 2000) (granting injunction sought by psychiatric hospital facing termination of its Medicare participation, and finding jurisdiction to do so under “practical effect of totally denying judicial review” argument: “If Woodridge Hospital were forced to close down before its administrative remedies had been exhausted, it would not be in a position to seek judicial review at the close of the administrative process.”); *Pathfinder Healthcare, Inc. v. Thompson*, 177 F. Supp. 2d 895, 896–97 (E.D. Ark. 2001) (reaffirming jurisdiction under “practical equivalent of total denial of judicial review” exception and converting TRO to preliminary injunction to enjoin termination of provider’s Medicare and Medicaid provider agreements during administrative

⁷ All of these decisions also pre-date *Loper Bright Enters. v. Raimondo*, 603 U.S. 369 (2024) and *Azar v. Allina Health Servs.*, 587 U.S. 566, 139 S. Ct. 1804 (2019), which reflect a significant turning of the tide in administrative law. Indeed, under these new standards for reviewing agency decisions, this Court no longer owes deference to the determinations made by CMS with respect to Laurel Ridge.

appeal); *Intensiva Hosp. of Greater St. Louis, Inc. v. Johnson*, No. 09-0210-CV-W-SOW, 2009 WL 10704985 (W.D. Mo. Apr. 15, 2009).

Requiring Laurel Ridge to suffer permanent injury in order to obtain process it should have received before termination is not merely “delay-related hardship” or “added inconvenience or cost in an isolated, particular case.” *Contra Shalala v. Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 13, 22 (2000). And where § 405(h) “would not simply channel review through the agency, but would mean no review at all,” federal question jurisdiction is available under 28 U.S.C. § 1331. *Id.* at 19.

Further, Laurel Ridge’s administrative appeal does not stay the termination. So by the time Laurel Ridge’s appeal is heard, the consequences and harm of termination will have long since come to fruition. As the Fifth Circuit has recognized:

Providers...are mired in years of review....For many others who lack the necessary will or resources, such challenges are undoubtedly cost-prohibitive, and capitulation, even for meritorious objections, presents a more attractive option.

Maxmed Healthcare, Inc. v. Price, 860 F.3d 335, 345-46 (5th Cir. 2017).⁸

III. LAUREL RIDGE MEETS ALL REQUIREMENTS FOR THE COURT TO ISSUE AN EMERGENCY TEMPORARY RESTRAINING ORDER AND INJUNCTIVE RELIEF.

“The purpose of a preliminary injunction is to preserve the status quo and thus prevent irreparable harm until the respective rights of the parties can be ascertained during a trial on the merits.” *Exhibitors Poster Exch., Inc. v. Nat’l Screen Serv. Corp.*, 441 F.2d 560, 561 (5th Cir. 1971) (citations omitted).

The standard governing a motion for a TRO is the same as the standard governing a motion for a preliminary injunction. *See, e.g., Clark v. Prichard*, 812 F.2d 991, 993 (5th Cir.

⁸ *Maxmed* involves the Medicare payment process, and the provider ultimately lost. But the opinion’s important closing comment on the process of Medicare administrative appeals is no less applicable to alleged survey deficiencies. It is, in fact particularly acute here, where the harshest possible penalty (termination) is being imposed and there is no stay available administratively during the long pendency of the matter, while the harm is long-since suffered.

1987). Four factors must be satisfied: (1) a substantial likelihood of success on the merits; (2) a substantial threat that the plaintiff will suffer irreparable injury if the injunction is not granted; (3) the threatened injury to the plaintiff outweighs any threatened damage the injunction might cause the defendant; and (4) granting the injunction will not disserve the public interest. *Canal Auth. of Fla. v. Callaway*, 489 F.2d 567, 573 (5th Cir. 1974); *Janvey v. Alguire*, 647 F.3d 585, 595 (5th Cir. 2011).

Although a preliminary injunction is an extraordinary remedy, a movant who “has clearly carried the burden of persuasion” on these four factors is entitled to the relief. *Mississippi Power & Light Co. v. United Gas Pipe Line Co.*, 760 F.2d 618, 621 (5th Cir. 1985). The four factors are not considered in isolation, but rather are weighed together on a sliding scale. “None of the four requirements has a fixed quantitative value,” and therefore “in applying the four-part test, a sliding scale is utilized, which takes into account the intensity of each in a given calculus.” *Med-Cert Home Care, LLC v. Azar*, 365 F. Supp. 3d 742, 749 (N.D. Tex. 2019) (citations omitted). Determining whether to grant preliminary injunctive relief requires balancing the probabilities of success at final hearing with the consequences of immediate irreparable injury without preliminary relief. *Id.* Accordingly, “[w]hen the other factors weigh strongly in favor of an injunction, a showing of some likelihood of success on the merits will justify temporary injunctive relief.” *Id.* (citations omitted). As shown below, each factor is satisfied here.

A. Laurel Ridge is Likely to Succeed on the Merits of Its Due Process Claim.

To demonstrate a likelihood of success on the merits, a plaintiff “must present a prima facie case, but need not prove that [it is] entitled to summary judgment.” *Daniels Health Scis., L.L.C. v. Vascular Health Scis., L.L.C.*, 710 F.3d 579, 582 (5th Cir. 2013)). The movant’s likelihood of success must only be more than negligible. *Compact Van Equipment Co., Inc. v. Leggett & Platt, Inc.*, 566 F.2d 952, 954 (5th Cir. 1978). In the context of termination of a

Medicare or Medicaid provider agreement, where the plaintiff seeks only to prevent termination until it receives constitutionally required procedures, the “likelihood of success on the merits” inquiry focuses on whether certain procedures are required before the government takes a specific action; it does not require showing that the outcome of those procedures will likely be favorable. See *Family Rehab.*, 886 F.3d at 504 n.14 (citing *Eldridge*, 424 U.S. at 335).

Here, CMS will terminate Laurel Ridge’s Medicare provider agreement without affording Laurel Ridge *any* opportunity to challenge the survey results underlying the termination. As shown below, Laurel Ridge has constitutionally protected liberty and property interests at stake. And the Constitution guarantees Laurel Ridge due process before being deprived of these interests. U.S. CONST. amend V; U.S. CONST. amend XIV; *Eldridge*, 424 U.S. at 333 (“This Court consistently has held that some form of hearing is required before an individual is finally deprived of a property interest.”).

1. Laurel Ridge Has a Constitutionally Protected Liberty Interest.

The Fifth Amendment provides that no person shall be deprived of “life, liberty, and property, without due process of law” (the “Due Process Clause”). U.S. CONST. amend V. “[A] liberty interest is infringed, and the right to notice and an opportunity to clear one’s name arises,” when the government discharges or terminates a party “in a manner that creates a false and defamatory impression about [it] and thus stigmatizes [it] and forecloses him from other...opportunities.” *Bledsoe v. City of Horn Lake*, 449 F.3d 650, 653 (5th Cir. 2006) (quoting *White v. Thomas*, 660 F.2d 680, 684 (5th Cir. 1981)). This protection operates through the “stigma-plus” doctrine, under which “stigma to reputation” plus an additional factor (*i.e.*, failure to rehire, reengage, a discharge) is sufficient to state a claim for a due process liberty interest. *Dennis v. S & S Consol. Rural High Sch. Dist.*, 577 F.2d 338, 342 (5th Cir. 1978). The doctrine exists precisely to ensure that the government cannot inflict reputational devastation through official action and then deny the injured party an opportunity to be

heard. Critically, the “plus” element does not require an independent property interest in continued participation. *Id.* A provider has a protected liberty interest where the government’s charges were “(1) false, (2) publicized, and (3) stigmatizing to either [its] standing or reputation in [its] professional community or [its] ability to find other [business] opportunities.” *Felder v. Hobby*, No. 99-20111, 1999 WL 1067892 at *4 (5th Cir. 1999); *see also Symphony Hospice, Inc. v. Becerra*, No. ED CV 25-2498-JFW(PVCX), 2025 WL 3050054, at *4 (C.D. Cal. Oct. 3, 2025) (discussing liberty interest in the context of provider termination).

Here, CMS has posted on its web page that Laurel Ridge “failed to substantially comply with Medicare and Medicaid health and safety participation requirements” and that its provider agreement is being terminated. *See* Compl. at ¶ 102; Sacriste Dec. App. 0008 at ¶ 48; Notice to the Public of Laurel Ridge Treatment Center Involuntary Termination, *available at* <https://www.cms.gov/medicare/health-safety-standards/certification-compliance/public-notices/laurel-ridge-treatment-center> (last visited Apr. 26, 2026). Laurel Ridge disputes these findings. The charges are plainly stigmatizing. Laurel Ridge is already suffering a diminution in its patient population. Sacriste Dec. App. 0009 at ¶ 49. And as for the “plus” element, CMS’s termination of Laurel Ridge’s provider agreement will force the closure of the facility owing to the loss of 99% of its payer sources.

2. Laurel Ridge Has a Constitutionally Protected Property Interest.

Laurel Ridge also possesses a constitutionally protected property interest at stake. In direct response to deficiencies and concerns identified by CMS during the survey and compliance process in 2025, Laurel Ridge spent approximately \$10 million in significant facility improvements and remediation measures. *See* Permenter Dec. at App. 0020-0026. These expenditures were not speculative or unilateral; they were undertaken in reliance on CMS’s own directives and in furtherance of the ongoing regulatory relationship between Laurel Ridge and the agency. *Id.*; *see also* Sacriste Dec. at App. 0004-0008. Where, as here, a provider

makes substantial, concrete capital investments at the government’s direction and in reliance on the continuation of a regulatory relationship, due process protects the provider’s interest in those expenditures from arbitrary destruction. *See Eldridge*, 424 U.S. at 335 (weighing the private interest at stake in determining what process is due). CMS’s termination of Laurel Ridge’s provider agreement without meaningful pre-termination process under the circumstances here would render \$10 million in capital expenditures a total loss, effecting a deprivation of property without due process of law.⁹

3. Laurel Ridge is Entitled to Procedural Due Process.

“The fundamental requirement of due process is the opportunity to be heard ‘at a meaningful time and in a meaningful manner.’” *Eldridge*, 424 U.S. at 333 (citation omitted). Due process “is flexible and calls for such procedural protections as the particular situation demands.” *Id.* at 334 (citation omitted). The Court determines what process is due by balancing “the risk of an erroneous deprivation, the state’s interest in providing specific procedures and the strength of the individual’s interest.” *Cassim v. Bowen*, 824 F.2d 791, 797 (9th Cir. 1987) (quoting *United States v. Crozier*, 777 F.2d 1376, 1383 (9th Cir. 1985)); *see also Eldridge*, 424 U.S. at 335.

Here, the risk of erroneous deprivation is significant, warranting a pre-termination hearing. The Government’s interest in expeditious termination is arguably substantial, but it is diminished here. *See Northlake Community Hosp.*, 654 F.2d at 1242. Although CMS has

⁹ Laurel Ridge further submits that its Medicare provider agreement itself constitutes a protected property interest. Although courts have generally held that providers lack a property interest in continued Medicare participation, *see, e.g., Shah v. Azar*, 920 F.3d 987, 997-98 (5th Cir. 2019), that line of authority does not account for the reality that Medicare enrollment has become a *de facto* prerequisite for participation in virtually every other healthcare payer program. Medicare participation is not a mere government benefit that a provider may take or leave—modernly, it is a practical necessity, without which an inpatient psychiatric facility like Laurel Ridge cannot operate. Under these circumstances, Laurel Ridge contends the provider agreement gives rise to a legitimate claim of entitlement sufficient to constitute a property interest protected by the Due Process Clause. *See Bd. of Regents of State Colls. v. Roth*, 408 U.S. 564, 577 (1972) (property interests arise from “legitimate claim[s] of entitlement” created by “existing rules or understandings”). Further, *Shah v. Azar* involved physicians challenging the revocation of their billing privileges after conceding to submitting claims for services provided when they were out of the country, and after which the physicians had a full panoply of administrative process, including corrective action plans, ALJ review, DAB appeal, and judicial review. The case is therefore easily distinguishable.

alleged that deficiencies at the Facility constitute immediate jeopardy, Laurel Ridge strongly contests this. Further, the survey process is such that the results are not inherently reliable, and there are indicia of unreliability here, described *supra*. Notably, Laurel Ridge was determined to be in substantial compliance mere weeks before these new findings. *See* Sacriste Dec. App. 0006 at ¶¶ 30-32. And nothing in Laurel Ridge’s patient satisfaction results suggests that immediate and highly punitive action is warranted. *See* Compl. at ¶¶ 28-29. Further, Laurel Ridge has implemented significant improvements at the Facility to address the identified concerns, despite its disagreement with the findings (investments which will all be for naught if the termination proceeds). *Permenter* Dec. App. 0020-0026.

By contrast, Laurel Ridge’s interest is overwhelming. Medicare termination will cripple it irreparably. It will eliminate Laurel Ridge’s 288 inpatient psychiatric beds, nearly 40% of the San Antonio area’s inpatient psychiatric bed capacity; and leave psychiatric patients, including children and active-duty military personnel, who receive treatment from Laurel Ridge, with limited alternative options. The closure of the inpatient beds has a high likelihood of causing the closure of all outpatient services, as well as the 42-bed residential treatment center. The damage inflicted by this action without review under any meaningful process, is catastrophic and irreversible. The “entire purpose to be served by a preliminary injunction in this case is to permit the ALJ to engage in ‘more deliberative investigation,’” and therefore “injunctive relief is appropriate.” *See Int’l Long Term Care, Inc. v. Shalala*, 947 F. Supp. 15, 19-20 (D.D.C. 1996) (internal quotation marks omitted).¹⁰

¹⁰ Laurel Ridge is also likely to succeed on its claim that CMS did not afford Laurel Ridge a reasonable opportunity to correct the alleged deficiencies, as its own regulations require under 42 C.F.R. § 488.28, and that its failure to comply with its own regulation is in violation of the Administrative Procedure Act. 5 U.S.C. § 706(2)(A); *see also Aurora*, 356 F. Supp. 3d at 760-61. Much like the hospital in *Aurora*, Laurel Ridge was given only 15 days to fully implement a plan of correction with respect to the alleged deficiencies, and, then, after a revisit survey on April 2, 2026, it was given no further opportunity. Laurel Ridge is disputing the cited deficiencies from both surveys and the finding of immediate jeopardy in the administrative appeal process, but argues that CMS is also required to give it the opportunity to submit a plan of correction in response to the April 15, 2026, notice under 42 C.F.R. § 488.28. This claim likewise meets the channeling exception, as it will be no remedy at all if Laurel Ridge is determined to have received inadequate opportunity to correct the alleged deficiencies after a multi-year

B. Laurel Ridge Will Suffer Irreparable Harm.

To establish irreparable injury, the movant must establish “a significant threat of injury from the impending action, that the injury is imminent, and that money damages would not fully repair the harm.” *Humana, Inc. v. Jacobson*, 804 F.2d 1390, 1394 (5th Cir. 1986). “An injury is irreparable only if it cannot be undone through monetary remedies.” *Deerfield Med. Ctr. v. City of Deerfield Beach*, 661 F.2d 328, 338 (5th Cir. 1981) (internal quotation marks omitted) Where the government enjoys sovereign immunity from damages claims, economic injury that cannot be recovered constitutes irreparable injury. *See, e.g., Clarke v. Commodity Futures Trading Comm’n*, 74 F.4th 627, 643 (5th Cir. 2023) (citation omitted).

1. Termination Will Irreparably Harm Laurel Ridge.

In the Medicare and Medicaid context, courts recognize that a termination or recoupment which will effectively put the facility out of business satisfies the irreparable harm standard. *Family Rehab.*, 886 F.3d at 504. *See also Humana*, 804 F.2d at 1394; *Med-Cert Home Care*, 365 F. Supp. 3d at 757; *Aurora*, 356 F. Supp. 3d at 759; *New Orleans Home for Incurables, Inc. v. Greenstein*, 911 F. Supp. 2d 386, 408-09 (E.D. La. 2012) (granting preliminary injunction where termination of Medicaid provider agreement “would destroy [the facility’s] business before its appeal on the license revocation can be heard”); *Mediplex of Mass., Inc. v. Shalala*, 39 F. Supp. 2d 88, 100 (D. Mass. 1999) (“termination would likely cause irreparable harm to Mediplex because it would likely lead to closure of the facility, which could wipe out the company”) (citation omitted). “The combined threats of going out of business and disruption to Medicare patients are sufficient for irreparable injury.” *Family Rehab.*, 886 F.3d at 504.

As shown, if the termination is not immediately enjoined, the termination triggers the cascading loss of Laurel Ridge’s Medicaid participation, Medicare Advantage contracts,

administrative review process during which time virtually all of its payer contracts will have been terminated and its business will have been shuttered. *See supra*, pp. 19-20.

Tricare agreements covering approximately one-third of the Facility's patients, and substantially all private payer contracts—forcing the closure of the largest psychiatric hospital in Texas. With private pay constituting only approximately 1% of the Facility's revenue, Laurel Ridge will be forced to close the entirety of its inpatient services—a facility that has served the San Antonio community for nearly 40 years. The closure will result in the layoff of over 650 employees, the loss of approximately \$48.5 million in annual payroll, and the forfeiture of over \$10 million in capital improvements made since 2025. *See* Sacriste Dec. at App. 0009-0010. Laurel Ridge has already received letters of termination from private insurers following CMS's public notification of the Medicare termination on April 15, 2026. *Id.* at App. 0009 ¶ 53. Even a temporary closure would be devastating, as the Facility's staff would certainly seek employment elsewhere and many would no longer be available for rehire in the midst of a national healthcare staffing crisis.

The Fifth Circuit has confirmed the principle that while potential harm that is “strictly financial” is generally insufficient, “an exception exists where the potential economic loss is so great as to threaten the existence of the movant's business.” *Atwood Turnkey Drilling, Inc. v. Petroleo Brasileiro, S.A.*, 875 F.2d 1174, 1179 (5th Cir. 1989) (citations omitted).

2. Laurel Ridge Has No Adequate Remedy at Law.

The administrative appeal process does not provide Laurel Ridge an adequate remedy at law. Although a facility that is terminated from the Medicare program has a statutory and administrative right to appeal the termination decision and present its case before an ALJ, the ALJ is without stay authority. *See* 42 U.S.C. § 1395cc(h)(1); 42 C.F.R. part 498. Because there is no stay of the termination, such a hearing does not occur until well after termination is implemented and the cascading effect of the termination causes closure of the facility. Significantly, a review of recent ALJ decisions shows it takes, on average, 3.3 years to get an ALJ decision.

Assuming a provider prevails at either the administrative hearing or on judicial review of the final administrative decision, no adequate remedy exists to make Laurel Ridge whole. “A judgment for damages, acquired years after [the movant’s] business has been obliterated would not be a meaningful remedy.” *Atwood*, 875 F.2d at 1179; *see also New Orleans Home for Incurables, Inc.*, 911 F. Supp. 2d at 409 (finding irreparable harm where facility would be “essentially out of business” the day after Medicaid funding ceased). Because the state and federal government have sovereign immunity, no monetary relief would even be available to compensate Laurel Ridge for the multi-year loss in revenue, the loss of its \$10 million dollar investment in capital improvements, or the loss of its good standing in the community. *See, e.g., Clarke*, 74 F.4th at 643.

C. The Balance of Hardships and Public Interest Favor Laurel Ridge.

When the government is the opposing party, the balancing of the equities and the public interest factors merge. *Clarke*, 74 F.4th at 643. The court is required to weigh the potential harm on each side. *Id.* The movant must show its injury without injunctive relief is greater than the defendant’s injury if the relief is granted. *Med-Cert Home Care*, 365 F. Supp. 3d at 757.

If the TRO is denied and the termination proceeds on April 30, 2026, Laurel Ridge will suffer the catastrophic and irreversible consequences described throughout this Motion. The State of Texas will lose its largest inpatient psychiatric provider, which has been an integral part of the mental health service delivery system for nearly 40 years. The resulting pressure on an already strained mental health system would effectively render services unavailable to many patients in the region and preclude seriously ill psychiatric patients from access to necessary treatment, as addressed *supra*.

Termination will mean thousands of patients, including children, adolescents, and active-duty military personnel that rely on Laurel Ridge for critical psychiatric treatment, will be unable to receive such care at Laurel Ridge. Without Laurel Ridge, the total number of

inpatient psychiatric beds in San Antonio will shrink by nearly 40%, in a community where adults have a higher prevalence of depressive disorder, and where Texas ranks 50th in access to mental health care (even with Laurel Ridge). The remaining facilities in the area lack the capacity, specialized programming, and staffing to absorb the patient volume currently served by Laurel Ridge. The loss of Laurel Ridge's dedicated 80-bed military unit would be especially acute given the proximity of Joint Base San Antonio and the ongoing military engagement in Iran, and no other facility in the region offers a comparable dedicated military behavioral health program.

Continuity of treatment is especially important in behavioral health settings. Patients establish relationships with nurses, therapists, staff, physicians, and others that are essential to their therapy and recovery. Disruption of these relationships would cause harm that could not be repaired. In similar situations, courts have recognized that this constitutes irreparable harm. *See New Orleans Home for Incurables, Inc.*, 911 F. Supp. 2d at 409-10 (crediting testimony regarding "the recognized effects of transfer trauma and the likely harm that could result to the residents' physical and mental well-being" and finding irreparable harm to patients).

The harm from termination will extend from Laurel Ridge's vulnerable patient population to its employees. CMS's actions will also cause the hospital personnel to lose their jobs, adding substantial financial harm and stress to them and their families that cannot be retroactively remedied. Many of these employees and their dependents will lose health care coverage through the Facility's employer-sponsored health insurance plans. *Sacriste Dec.* at App. 0010 ¶ 62.

These harms are not compensable through retroactive payments or administrative relief rendered years after the Facility has closed.

Under these circumstances, the balance tips sharply in favor of granting injunctive relief pending further proceedings. While Laurel Ridge recognizes that CMS has an interest in

expeditious termination, neither the Secretary nor the public interest will suffer if the status quo is maintained and the Facility continues to participate in the Medicare and Medicaid programs while it is afforded process. This is particularly noteworthy where Laurel Ridge has made millions of dollars in significant expenditures and implemented significant new improvements to address deficiencies, subject to its disagreement with the survey findings and was found to be in substantial compliance with all conditions of participation just weeks before the February 23 survey was initiated.

The potential harm to the government is minimal compared to the potential harm to the Facility and others. See *Family Rehab., Inc. v. Azar*, No. 3:17-CV-3008-K, 2018 WL 3155911 at *7 (N.D. Tex. June 28, 2018) (balancing of harms and public interest favored allowing the facility to continue providing services while pursuing its procedural claims); see also *Med-Cert Home Care*, 365 F. Supp. 3d at 758 (granting injunctive relief after weighing the public interest in keeping a facility in business).

The public interest also supports granting injunctive relief. The public benefits from ensuring that government agencies do not act arbitrarily and capriciously in enforcing their requirements, and that they follow proper procedures. *Clarke*, 74 F.4th at 643-44 (noting public interest is served when administrative agencies comply with their procedural obligations); *Aurora* 356 F. Supp. 3d at 760-61 (injunctive relief to preserve status quo until CMS followed required procedures was appropriate even if CMS's allegations of substantial shortcomings at the facility were true); *New Orleans Home for Incurables*, 911 F. Supp. 2d at 412 (“[E]nsuring that a thorough and constitutionally required hearing is had before the provider agreement is terminated aids the Secretary [in] making a comprehensive and correct decision before its action forces [the facility] out of business.”).

IV. NO SECURITY OR NOMINAL SECURITY SHOULD BE IMPOSED.

Rule 65(c) of the Federal Rules of Civil Procedure provides that a court may issue a temporary restraining order “only if the movant gives security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongfully enjoined or restrained.” Fed. R. Civ. P. 65(c). The Fifth Circuit has held that the amount of security required is a matter within the discretion of the trial court, and that a nominal bond—or no bond at all—may be appropriate. *Kaepa, Inc. v. Achilles Corp.*, 76 F.3d 624, 628 (5th Cir. 1996).

Here, the TRO would merely maintain Laurel Ridge’s existing Medicare provider agreement pending further proceedings. Defendants will not incur any costs or damages from the temporary continuation of the Facility’s participation in the Medicare program—a program in which Laurel Ridge has participated for decades. Accordingly, Laurel Ridge respectfully requests that the Court set the bond at a nominal amount or waive the bond requirement entirely.

V. CONCLUSION

For all of the foregoing reasons, and those set forth in its Verified Complaint, Laurel Ridge respectfully requests that this Court enter an emergency temporary restraining order and preliminary injunction restraining and enjoining Defendants from terminating Laurel Ridge from Medicare on April 30, 2026, or thereafter, for as long as such TRO and preliminary injunction remain in effect to preserve the status quo pending the outcome of Laurel Ridge’s administrative challenge to the termination of its Medicare provider agreement and subsequent judicial review, and for such other and further relief to which it may be entitled.

Dated: April 26, 2026

Respectfully submitted,

HUSCH BLACKWELL LLP

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LAUREL RIDGE TREATMENT
CENTER**

CERTIFICATE OF SERVICE

I certify that on April 26, 2026, a copy of the foregoing was electronically filed with the Court's CM/ECF System.

/s/ *Emily M. Solum*

Emily M. Solum

UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

TEXAS LAUREL RIDGE HOSPITAL, LP)
d/b/a LAUREL RIDGE TREATMENT)
CENTER)

Plaintiff,)

v.)

Civil Action No. 5:26-cv-2701-XR

ROBERT F. KENNEDY, JR., SECRETARY)
OF THE UNITED STATES)
DEPARTMENT OF HEALTH AND)
HUMAN SERVICES,)

DR. MEHMET OZ, ADMINISTRATOR)
OF THE CENTERS FOR MEDICARE)
AND MEDICAID SERVICES,)

AND)

TEXAS HEALTH AND HUMAN SERVICES)
COMMISSION)

Defendants.)

**APPENDIX IN SUPPORT OF PLAINTIFF’S EMERGENCY MOTION FOR
TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION
AND BRIEF IN SUPPORT**

Plaintiff, Texas Laurel Ridge Hospital, LP d/b/a Laurel Ridge Treatment Center (“Laurel Ridge” or “Plaintiff”) files this Appendix in Support of Laurel Ridge’s Emergency Motion for Temporary Restraining Order and Preliminary Injunction and Brief in Support containing the items as follows:

APPENDIX

EXHIBIT	DESCRIPTION	APP. PG. RANGE
1.	Declaration of Ashley Sacriste, Chief Executive Officer of Laurel Ridge Treatment Center	App. 0001 – App. 0010
2.	March 11, 2026 Letter to Laurel Ridge Treatment Center from Centers for Medicare & Medicaid Services	App. 0011 – App. 0013
3.	April 2, 2026 Letter to Laurel Ridge Treatment Center from Centers for Medicare & Medicaid Services	App. 0014 – App. 0015
4.	April 15, 2026 Letter to Laurel Ridge Treatment Center from Centers for Medicare & Medicaid Services	App. 0016 – App. 0019
5.	Declaration of Ethan Permenter, Divisional Senior Vice President and employee of UHS of Delaware, Inc.	App. 0020 – App. 0026

DATED: April 26, 2026

Respectfully submitted,

/s/ Jody Rudman

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LAUREL RIDGE TREATMENT CENTER**

CERTIFICATE OF SERVICE

I certify that on April 26, 2026, a copy of the foregoing was electronically filed with the Court's CM/ECF System.

/s/ Emily Solum
Emily M. Solum

EXHIBIT 1

DECLARATION OF ASHLEY SACRISTE

CHIEF EXECUTIVE OFFICER OF LAUREL RIDGE TREATMENT CENTER

I, Ashley Sacriste, am over the age of eighteen years and competent to testify in this matter. I have personal knowledge of the facts stated in this Declaration.

PERSONAL BACKGROUND

1. I have been the Chief Executive Officer of Laurel Ridge Treatment Center (“Laurel Ridge” or the “Facility”) and employee of UHS of Delaware, Inc. (“UHSD”).
2. In my role, I am responsible for overseeing the operations of Laurel Ridge.

LAUREL RIDGE BACKGROUND

3. Laurel Ridge has been in operation since 1987, and under its current ownership since 2010.
4. Laurel Ridge is the largest psychiatric hospital in Texas.
5. Laurel Ridge provides mental health services in Bexar County, Texas, and surrounding areas.
6. Laurel Ridge has a total of 330 licensed beds: 208 acute inpatient psychiatric beds; 80 beds dedicated to the military community; and 42 residential treatment center beds for children under the age of 18.
7. Of the 288 acute inpatient psychiatric beds, 26 are for children (ages 5-12); 52 are for adolescents (ages 13-17), and the remainder are for adults.
8. Laurel Ridge’s inpatient psychiatric beds are certified for participation in the Medicare and Medicaid programs.
9. Laurel Ridge has numerous contracts with Medicare Advantage plans.
10. In addition to participating in Medicare and Medicaid, Laurel Ridge has 80 beds dedicated to the military community pursuant to contracts with Humana Military and TriWest Healthcare Alliance, the contractors responsible for management and delivery of services for Tricare, the healthcare program for active-duty service members, retirees, and their families. Both agreements require that contracted healthcare providers have a Medicare participation agreement.
11. In addition to participating in Medicare, Medicaid, and Tricare, Laurel Ridge also contracts with numerous private commercial payers. All of its contracts with private commercial payers require Laurel Ridge to be enrolled in Medicare or indicate that involuntary termination by Medicare is a cause for termination of those payer contracts.
12. In addition to the inpatient services that Laurel Ridge provides to children, adolescents, and adults, Laurel Ridge also provides outpatient services.

13. In 2025, Laurel Ridge's inpatient admissions totaled 10,340, and it provided outpatient services to a total of 25,484 patients.

14. Nearly a third of Laurel Ridge's patients are part of the military community.

15. Laurel Ridge treats individuals requiring care regardless of ability to pay.

16. In 2025, Laurel Ridge provided the community \$7,162,493 in uncompensated care.

17. Laurel Ridge performs well against the Texas and national Inpatient Psychiatric Facility Quality Reporting (IPFQR) measures. In 10 of 15 categories analyzed, Laurel Ridge scored at or better than the Texas or national average.

18. Laurel Ridge patients complete surveys upon completion of their admission. In these surveys, from July 2025 through December 2025, patients report overall satisfaction with their care at the Facility as a 4.4 out of 5. Additionally, patients were asked to score on the statement "I feel better than when I was admitted," and rated at a 4.43 out of 5. Similar scores were also achieved for these same metrics in a survey from January through June 2024, showcasing consistent positive patient encounters. Laurel Ridge's Net Promoter Score is 48. This score ranges from -100 to +100, with metrics determined by industry benchmarks for customer satisfaction. Overall, a score above 20 is considered good and above 50 is excellent. Laurel Ridge's score of 48—is almost meeting excellence. Lastly, ninety-three percent (93%) of patients indicated improvement on patient reported outcome measurements based upon symptom severity. These results show Laurel Ridge is achieving a high degree of patient satisfaction when it comes to meeting positive outcomes for patients following discharge.

19. Laurel Ridge is a major employer in San Antonio. It has over 659 employees and 22 psychiatrists. In 2025, its total payroll was in excess of \$48.5 million. Many of these employees and their dependents are covered through facility-sponsored health insurance plans.

20. In addition to being a major employer, Laurel Ridge supports the community in addressing the significant healthcare workforce shortage by serving as an on-site training location for medical, nursing, and therapy students enrolled in programs through multiple universities, including Galen, University of the Incarnate Word, Chamberlain, University of Texas Arlington, Baylor University, Wayland, West Carolina University, Texas State University, St. Mary's, and Abilene Christian University.

21. Laurel Ridge also provides training and education for the community at large to improve the mental health service delivery system. On a quarterly basis, Laurel Ridge hosts the Bexar County Mental Health CIT Training and Children's Crisis Intervention Training. Annually, Laurel Ridge hosts the JBSA Mental Health Providers Training on Ethics, Texas Association of School Resources Conference, and National Case Management Conference. Special training hosted by Laurel Ridge from 2023 to 2026 has included the following:

- a. Genetics and Mental Health
- b. Understanding the Impact of Trauma in Memory Formulation and the Development of PTSD

- c. Male Survivors – Breaking the Gender Stereotypes with MST & The Autonomic Nervous System
- d. Parenting Seminar – Back to School Anxiety
- e. Recognizing Eating Disorders & Utilizing Effective Treatment Modalities
- f. Treatment of Substance Use Disorders
- g. Hope Restored 2 – ECT Therapy CEU
- h. Principals of Ethics and Morals
- i. Ethics of Self-Care for Mental Health Professionals
- j. Genetics and Mental Health
- k. Understanding Neurofeedback
- l. Sculpting and Letter Writing to Address Unspoken Resistance in Couple and Family Therapy
- m. Music Therapy Vs. Music IN Therapy: How to Incorporate Music in Your Practice
- n. Ethical Decision Making, Awareness & Sensitivity, Trauma Memory

22. On top of hosting these community events, Laurel Ridge contributes hundreds of thousands of dollars sponsoring many other community and national mental health events.

23. Laurel Ridge purchases over \$3 million in services from the local community each year, which includes building maintenance services, utilities, medical supplies, and printing for community education and outreach.

24. Laurel Ridge is also a significant taxpayer in San Antonio, paying over \$1 million in property, local, and unemployment taxes in 2025.

25. Apart from Laurel Ridge, there are only three other standalone inpatient psychiatric hospitals in San Antonio. Collectively, those three facilities have a total of 313 licensed beds (74 of which are exclusively for children). Apart from these standalone psychiatric hospitals, there are four general hospitals in San Antonio that have a collective total of 130 psychiatric beds. Without Laurel Ridge, San Antonio's total of 731 beds will shrink to a total of 443 beds (a loss of nearly 40% in available inpatient psychiatric beds).

LAUREL RIDGE IMPROVEMENTS

26. Beginning in 2025, the Facility initiated comprehensive capital improvements to sustain and exceed compliance with applicable regulatory standards, strengthen the environment of care, and enhance patient safety across the campus. Specifically, the Facility made the following staffing improvements, capital improvements, and environmental modifications:

- a. Beginning in 2025, the Facility added 29 additional full time equivalent (“FTE”) positions, further increasing the nursing and patient care workforce. These staffing enhancements included additional patient care staff and training and education resources to optimize patient safety and regulatory compliance. The filing of the Verified Complaint for Declaratory and Injunctive Relief, Civil Action No. 5:26-cv-2701, contained a statement about the number of FTEs at the facility that I misunderstood when I read it. For clarity, the facility added 29

FTEs in 2025 but, while already employing the additional FTEs in 2026, did not add additional FTEs in 2026

- b. Removed unit walls separating day rooms to improve visibility and patient monitoring, with corresponding flooring replacement and electrical and telecommunications reconfiguration.
- c. Replaced seclusion room doors, interior doors, door hinges, and windows as an upgrade to current safety standards.
- d. Made modifications to nursing stations to enhance line-of-sight supervision and staff accessibility.
- e. Upgraded existing ligature-resistant fixtures throughout patient care areas, including door hardware and stoppers, toilet paper holders, faucets and plumbing fixtures, ceiling tiles, and water dispensers.
- f. Replaced patient furniture and installed secure storage, in the form of safes, for patient belongings.
- g. Removed and replaced landscaping materials to improve patient safety.
- h. Reconstructed patient unit patios to improve safe patient access.
- i. Replaced multiple concrete slabs across the campus.
- j. Installed and replaced perimeter fencing to enhance security.
- k. Replaced exhaust ventilation systems.
- l. Upgraded camera surveillance systems to support patient monitoring and incident prevention.
- m. Installed protective materials, including Lexan, in designated areas to improve safety.
- n. Replaced patient lobby light fixtures to eliminate identified risks and improve the therapeutic environment.

27. As of April 2, 2026, the Facility initiated significant additional staffing and structural improvements. Specifically, it has:

- a. Added weekend unit coordinator coverage to ensure consistent operational oversight and support seven days a week.
- b. Increased Milieu leadership by adding a third Milieu Manager to each unit.
- c. Reconfigured Milieu Manager schedules to include rotating weekend coverage, ensuring leadership presence seven days per week.
- d. Appointed an Associate Chief Nursing Officer (“ACNO”) to strengthen nursing clinical leadership, supervision, and accountability.
- e. Transitioned Admissions Assessors from therapist roles to registered nurses (“RNs”) to enhance clinical assessment accuracy, timeliness, and patient safety.
- f. Commissioned a Safety Committee and implemented a new Risk Initiative, (RSQ — Risk, Safety, and Culture).
- g. Implemented evening senior leadership rounds to increase executive visibility, reinforce accountability, and proactively address safety concerns in real time.
- h. Increased staffing to ensure that dedicated staff are always available for one-to-one supervision when clinically indicated.
- i. Increased reviews of camera footage to 100% of Emergency Behavioral Interventions (“EBIs”), with random reviews of all footage occurring across all shifts.

- j. Ordered Relay Pro communication devices, equipping staff with real-time communication capabilities, integrated panic button functionality to immediately summon assistance during emergencies, and enhanced coordination across units to support rapid response and de-escalation.

28. The Facility is currently undertaking the following improvement projects to further enhance the safety and quality of care provided to its patients. Specifically, implementation is scheduled to begin imminently for the following initiatives:

- a. Increasing the height of standard nursing stations to further enhance patient observation and staff safety.
- b. Reconfiguring door access points to ensure controlled entry and exit.
- c. Installing additional door hinges in the admissions area to meet safety specifications.
- d. Replacing and modifying windows across all patient care units.

LAUREL RIDGE'S SURVEYS

29. From 2010 to 2024, Laurel Ridge had never been cited for any deficiencies at the immediate jeopardy level and had only had two prior surveys involving higher level deficiencies that were promptly remediated, with the last one almost eight years ago.

30. During the 2025 calendar year, Laurel Ridge underwent numerous surveys. As a result of those surveys, over \$10 million was invested in the facility and numerous improvements were implemented. A full survey was conducted by CMS in October 2025, and while deficiencies were cited as a result of that survey, a revisit performed from January 5-7, 2026 found that the Facility was in substantial compliance with the Medicare COPs.

31. Less than a month later, from February 4, 2026, to February 23, 2026, HHSC performed a survey related to several complaints (the "February 23 Survey").

32. During the course of this survey, the surveyors alleged multiple deficiencies were causing "immediate jeopardy". The facility submitted written immediate jeopardy abatement plans, all of which were accepted as written, but the surveyors indicated that they could not confirm that the plans were fully implemented and that the immediate jeopardy had been removed, without any further explanation.

33. By letter dated March 11, 2026 (the "March 11 Letter"), CMS formally notified the Facility of the survey findings from the February 23 Survey. The March 11 Letter stated that the Facility's Medicare agreement would be terminated on April 3, 2026 unless the immediate jeopardy was removed. Specifically, it indicated that termination could only be avoided through submission of acceptable plans of correction and subsequent verification of compliance by HHSC.

34. The March 11 Letter stated that a plan of correction must be submitted by March 16, 2026, and the corrections had to be completed by March 26, 2026, to ensure a timely revisit survey.

35. On March 16, 2026, the Facility submitted its plan of correction to HHSC in response to the statement of deficiencies, as required, indicating that the deficiencies cited during the February 23 Survey would be corrected by March 26, 2026.

36. On March 18, 2026 HHSC sent the Facility an email rejecting the Facility's plan of correction. HHSC required the Facility to submit a revised or addended plan of correction by March 19, 2026.

37. On March 19, 2026, the Facility submitted an addendum to its plan of correction to HHSC.

38. The Facility's plan of correction, including the addendum, contained 19 different action items the Facility was taking to address the alleged deficiencies:

- a. Education by the Facility's medical director on Emergency Behavioral Intervention ("EBI") orders and packets;
- b. Revision of the Weekday Safety Huddle process;
- c. Comprehensive training of all staff by the Chief Nursing Officer ("CNO") on Facility policies concerning EBIs and documentation;
- d. Additional training for nurses on restrictive intervention documentation and escalation protocols;
- e. Additional training for nurses on restraint and seclusion use and documentation requirements, along with competency assessments by return demonstration;
- f. Revision of the Facility's camera review process by the CEO, Chief Nursing Officer, and Risk Management/Performance Improvement Director, to increase executive oversight;
- g. Updates by the leadership team to the Senior Leadership Rounding process to ensure daily rounding by leadership;
- h. Update to the Special Communication Needs policy with respect to interpreter services;
- i. Development of a Spanish version of the admissions consent packet, along with monitoring until 100% compliance was sustained;
- j. Creation of laminated visual tip sheets outlining the process for accessing the AMN Healthcare Video Remote Interpreting Device, along with daily monitoring of availability of the device and staff awareness;
- k. Training of admission staff, social services, therapists, and direct care staff on interpreter services, along with written competency assessment post-training;
- l. Creation of a new policy (Residential Services: Transition of Care) outlining the process for transitioning patients from residential treatment to acute care;
- m. Creation of a checklist to use for informed consent when transitioning patients from residential treatment to acute care, along with implementation of a monitoring process to verify documentation;
- n. Training of all clinical and nursing leadership and therapists on informed consent for level-of-care transitions and discharge planning;
- o. Revision to the Facility's policy on Reporting Abuse, Neglect, and Exploitation to include additional leadership oversight requirements and state requirements for 8 hours of training annually;

- p. Creation of a decision-tree to assist staff in recognizing and escalating possible abuse, neglect, and exploitation, with competency assessment;
- q. Creation of an 8-hour in-person training curriculum on abuse, neglect, and exploitation, with 100% of employees trained and competency assessed via written test;
- r. Revision to the new hire orientation and annual training to include the 8-hour abuse, neglect, and exploitation training;
- s. Termination of a staff member for use of inappropriate and excessive force.

39. On March 23, 2026, HHSC sent the Facility an email formally rejecting the Facility's addended plan of correction on the grounds that the POC did not include sufficient detail about the actions the facility was taking and requesting it verify whether it was prepared for a revisit survey.

40. From March 31, 2026 to April 2, 2026 HHSC performed a revisit survey (the "April 2 Survey"). The survey team conducting the revisit included a surveyor who was not a part of the original survey team.

41. At the exit conference for the April 2 Survey, HHSC notified the Facility that the immediate jeopardy had not been abated and that it was recommending that the termination proceed.

42. On April 2, 2026, CMS sent the Facility a letter stating that the date of projected termination was extended to April 17, 2026 to grant CMS sufficient time to review the revisit survey report.

43. On April 3, 2026, counsel for the Facility contacted CMS requesting the opportunity to discuss the survey issues with CMS before any statement of deficiency was finalized or final decisions made.

44. On April 9, 2026, counsel for the Facility contacted CMS, again requesting the opportunity to discuss the survey issues with CMS.

45. On April 13, 2026, counsel for the Facility contacted CMS again, updating CMS on the ongoing improvements at the Facility and requesting clarification on the timeline and possible extension of the termination date.

46. On April 15, 2026, counsel for the Facility shared with CMS information concerning the capital improvements and other changes and investments made to improve the Facility and address the concerns raised in the two most recent surveys.

47. An hour later, CMS emailed a letter dated April 15, 2026 ("April 15 Letter"), formally notifying the Facility of HHSC's deficiency findings from the April 2 Survey. The April 15 Letter informed the Facility that its Medicare provider agreement would now be terminated on April 30, 2026.

48. CMS posted a public notice on its web page on April 15, 2026, indicating the Facility was being terminated on April 30, 2026.

49. Since then, the Facility has had a precipitous drop in patients, from approximately 175 on April 15 to only 96 at the time of filing of the Verified Complaint for Declaratory and Injunctive Relief, Civil Action No. 5:26-cv-2701 (expecting to decrease to 85 by end of the day on April 23, 2026).

TERMINATION'S EFFECT ON LAUREL RIDGE

50. Upon termination, the Facility will no longer be able to accept any patients covered by Medicare or Medicare Advantage for inpatient treatment.

51. Laurel Ridge's contract to provide treatment to individuals covered by Tricare requires that providers participate in Medicare. Therefore, the agreement covering one-third of the Facility's patients will be terminated and all active-duty military and veterans will no longer be able to receive inpatient or outpatient treatment through Laurel Ridge's dedicated 80-bed military unit at a time when the United States has an active military engagement in Iran.

52. Laurel Ridge will no longer be able to accept or treat Medicaid patients.

53. Because substantially all private payer contracts held by Laurel Ridge require Medicare participation or provide that involuntary termination from Medicare is grounds for termination, and because the remaining contracts contain provisions that effectively condition continued participation on Medicare certification, every contract held by Laurel Ridge will inevitably be terminated. Laurel Ridge has already received letters of termination from private insurers following CMS's public notification on April 15 of Laurel Ridge's Medicare termination.

54. Because all of its payer sources for inpatient services will be eliminated, except private pay (which makes up only 1%), Laurel Ridge will be forced to close the entirety of its inpatient services that has been open and available to the San Antonio community for nearly 40 years.

55. The closure of Laurel Ridge's inpatient psychiatric hospital will result in the layoff of nearly all of the Facility's 659 employees and 22 psychiatrists. These employees and psychiatrists will seek employment elsewhere and many will no longer be available for re-hire in the event Laurel Ridge were to later be re-opened.

56. Without the corresponding inpatient services, outpatient services will be drastically reduced, if not fully eliminated.

57. The 42-bed residential treatment center for children will likely be closed since those services are part of the contracts that the Facility has with its private payers, which are subject to termination as a result of the inpatient unit's Medicare termination, and loss of staff due to the closure of the inpatient psychiatric hospital.

58. Texas will lose its largest inpatient psychiatric provider that has been an integral part of the mental health service delivery system for 40 years.

59. The closure of Laurel Ridge's inpatient psychiatric hospital will interrupt the care and treatment of hundreds of individuals in the San Antonio community and surrounding areas.

60. The closure of Laurel Ridge significantly jeopardizes patient access to inpatient psychiatric services because the number of beds in the San Antonio area without Laurel Ridge will be insufficient to meet the community's needs.

61. The San Antonio community will be without the millions of dollars in charity care provided by Laurel Ridge.

62. The employees of Laurel Ridge and the San Antonio community will lose approximately \$48.5 million in payroll as a result of CMS's action, and, with it, health care coverage through the Facility's employer-sponsored health insurance plan.

63. Eight different universities with medical, nursing, and therapy programs will lose a significant training site, exacerbating the national healthcare workforce shortage.

64. Laurel Ridge will have lost the benefit of over \$10 million in capital improvements it has made at Laurel Ridge since 2025.

I declare under the penalty of perjury that the foregoing is true and correct and is based upon my personal knowledge.

Date: 4/24/24

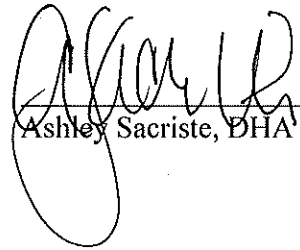

Ashley Sacriste, DHA

EXHIBIT 2

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
CMS Survey & Operations Group
Division of Dallas Survey & Enforcement
1301 Young Street, Room 106-900
Dallas, Texas 75202



March 11, 2026

Our Reference: CCN 454060, Complaint Intake #TX00559067, TX00559340, TX00559451,
TX00559932

Ashley Sacriste, CEO
Laurel Ridge Treatment Center
17720 Corporate Woods Drive
San Antonio, TX 78259

Dear Ms. Sacriste:

Section 1865 of the Social Security Act (the Act) and Centers for Medicare & Medicaid Services (CMS) regulations provide that a provider entity accredited by a CMS-approved Medicare accrediting organization will be "deemed" to meet all of the applicable Medicare conditions and requirements.

Section 1864 of the Act requires the State Agency to conduct a survey of a deemed hospital on a selective sampling basis, in response to a substantial allegation of noncompliance, or when CMS determines that a full survey is required after a substantial allegation survey identifies substantial noncompliance. CMS uses such surveys as a means of validating the accrediting organization's survey and accreditation process.

We have reviewed the February 23, 2026, survey reports and determined that Laurel Ridge Treatment Center no longer meets the requirements for participation in the Medicare program because of deficiencies that represent **immediate jeopardy** to patient health and safety. Enclosed is the form CMS-2567 with the findings that show the following Medicare Conditions of Participation were out of compliance:

42 CFR 482.12 Governing Body
42 CFR 482.13 Patient Rights
42 CFR 482.62 Special Staff Requirements for Psychiatric Hospitals

Psychiatric hospitals must meet all provisions of Section 1861(e) and (f) of the Social Security Act, be in compliance with each of the applicable Medicare Conditions of Participation, and be free of hazard to patient health and safety in order to participate as providers of services in the Medicare program.

The deemed status of your hospital was removed on March 11, 2026.

Unless the immediate jeopardy to patient health and safety is removed, the Medicare agreement of your hospital will be terminated on **April 3, 2026**. Termination can only be averted by correction of the deficiencies, through submission of acceptable plans of correction (PoC) and subsequent verification of compliance by the Texas Health and Human Services Commission (HHSC).

You must send acceptable plans of correction to **Brad Brew, Texas Health and Human Services Commission, via email at Brad.Brew@hhs.texas.gov by March 16, 2026**, in order to ensure a timely revisit. Also send the PoC's to Laura Christian-Gonzalez, email Laura.ChristianGonzalez@hhs.texas.gov, and to Jeanette Salinas, email Jeanette.Salinas@hhs.texas.gov.

The criteria for acceptable plans of correction are as follows:

1. The plan for correcting the specific deficiency cited;
2. The plan for improving the processes that lead to the deficiency cited, including how the hospital is addressing improvements in its systems in order to prevent the likelihood of recurrence of the deficient practice;
3. The procedures for implementing the acceptable plans of correction for each deficiency cited;
4. A completion date for the implementation of the plans of correction for each deficiency cited;
5. The monitoring and tracking procedures that will be implemented to ensure that the plan of correction is effective and the specific deficiency cited remain corrected and in compliance with regulatory requirements; and
6. The title of the person responsible for implementing the acceptable plan of correction.

The completion date for your corrective action can be no later than **March 26, 2026**.

Copies of the Form CMS-2567, including copies containing the hospital's PoC, are releasable to the public in accordance with the provisions of Section 1864(a) of the Act and 42 CFR 401.133(a). As such, the PoC should not contain personal identifiers, such as patient and staff names. However, it must be specific as to what corrective action the hospital will take to achieve compliance.

In accordance with section 1865(b) of the Social Security Act, the HHSC will conduct a full Medicare survey of your facility to assess compliance with all the applicable Medicare Conditions of Participation for hospitals.

If you remain out of compliance at the time of your revisit, or fail to submit acceptable plans of correction, you will receive a notice from our office advising you of your termination and your appeal rights.

You may contact Tiffany Curtis Baird at 214-767-4404 or by email at tiffany.curtis@cms.hhs.gov, if you have questions regarding this matter.

Sincerely,



Marcus Foster
Manager, Acute & Continuing Care Branch

Enclosure: CMS-2567

cc: Accrediting Organization, HHSC

EXHIBIT 3

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
CMS Survey & Operations Group
Division of Dallas Survey & Enforcement
1301 Young Street, Room 106-900
Dallas, Texas 75202



April 2, 2026

Our Reference: CCN 454060, Complaint Intakes #TX00559067, TX00559340, TX00559451,
TX00559932

Ashley Sacriste, CEO
Laurel Ridge Treatment Center
17720 Corporate Woods Drive
San Antonio, TX 78259

Dear Ms. Sacriste:

The Texas Health and Human Services Commission (HHSC) conducted a survey at your hospital on February 23, 2026, that found noncompliance with the applicable Medicare Conditions of Participation.

We notified you on March 11, 2026, that the date of your projected termination from the Medicare program would be April 3, 2026, based on the noncompliance survey findings. We are extending the termination date to **April 17, 2026**, to allow CMS time to process the revisit survey reports.

Please remember that if you remain out of compliance, you will receive a notice from our office advising you of your termination.

You may contact Tiffany Curtis Baird at 214-767-4404 or by email at tiffany.curtis@cms.hhs.gov if you have questions regarding this matter.

Sincerely,

Rachel

Mccarty -S

Digitally signed by
Rachel Mccarty -S
Date: 2026.04.02
12:21:55 -05'00'

Rachel McCarty
Acting Manager, Acute & Continuing Care Branch

cc: Accrediting Organization, HHSC

EXHIBIT 4

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
CMS Survey & Operations Group
Division of Dallas Survey & Enforcement
1301 Young Street, Room 106-900
Dallas, Texas 75202



April 15, 2026

Our Reference: CCN 454060

Ashley Sacriste, CEO
Laurel Ridge Treatment Center
17720 Corporate Woods Drive
San Antonio, Texas 78259

Dear Ms. Sacriste:

The Centers for Medicare & Medicaid Services (CMS) has determined that Laurel Ridge Treatment Center no longer meets the requirements for participation in the Medicare program because of deficiencies that represent an **immediate jeopardy** to patient health and safety. We have reviewed the State Agency's April 2, 2026, survey reports and we are in agreement with the enclosed findings, which show that the following Medicare Conditions of Participation were out of compliance:

- 42 CFR 482.12 Governing Body**
- 42 CFR 482.13 Patient Rights**
- 42 CFR 482.62 Special Staff Requirements for Psychiatric Hospitals**

Psychiatric hospitals must meet all provisions of Section 1861(e) and (f) of the Social Security Act, be in compliance with all of the applicable Medicare Conditions of Participation, and be free of hazard to patient health and safety in order to participate as providers of services in the Medicare program.

The Medicare provider agreement of your hospital will be terminated on **April 30, 2026**. No payment for patients admitted on or after that date will be made by the Medicare program. For patients admitted prior to **April 30, 2026**, payment may continue to be made for up to 30 days of covered inpatient hospital services furnished on and after **April 30, 2026**.

A list showing the names and health insurance claim numbers of the Medicare patients remaining in your hospital on **April 30, 2026**, must be forwarded immediately to the Centers for Medicare & Medicaid Services, Survey & Operations Group, Attention: Marcus Foster, 1301 Young Street, Room 106-900, Dallas, Texas, 75202.

A legal notice will be published in the CMS Survey & Certification Website at <https://www.cms.gov/medicare/health-safety-standards/certification-compliance/public-notice> to advise the public of your termination from the Medicare program. We will notify the appropriate State officials concerning termination of your provider agreement under Title XVIII because the requirements for participation in the Medicaid program are substantially the same as those for Medicare.

If you believe this determination is not correct, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, *et. seq.*

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A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel to represent you at a hearing (at your own expense). You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than **June 14, 2026**. Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service.

When using DAB e-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB e-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: https://dab.efile.hhs.gov/user_sessions/new to access DAB e-File. A registered user's access to DAB e-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil Remedies Division* on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB e-File on any day on or before 11:59 p.m. EST will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB e-File.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

U.S. Department of Health and Human Services
 Departmental Appeals Board, MS 6132
 Director, Civil Remedies Division
 330 Independence Avenue, SW
 Cohen Building, Room G-644
 Washington, D.C. 20201

Please contact the Civil Remedies Division at 202-565-9462 if you have questions regarding the DAB e-Filing System. If you experience technical issues with the DAB e-Filing System, please contact E-File System at OSDABImmediateOffice@hhs.gov or call 202-565-0146 before 4:00 p.m. EST.

In addition, please forward a copy of your request to:

CMS Division Director
 Centers for Medicare & Medicaid Services
 Survey & Operations Group
 ATTN: Marcus Foster
 1301 Young Street; Room 106-900
 Dallas, Texas 75202

Page 3 – Laurel Ridge Treatment Center

In accordance with the Medicare regulation 42 CFR 489.57, a new Medicare provider agreement will not be accepted until it has been determined that the reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur. The terminated facility will have to operate for a period of time determined by CMS, during which the reasonable assurance requirement has been satisfied. During this period the facility must fulfill, or make satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of the previous agreement.

You may contact Tiffany Curtis Baird at 214-767-4404 or by email at tiffany.curtis@cms.hhs.gov if you have questions regarding this matter.

Sincerely,



Gerardo Ortiz, MHSM
Division Director, CMS - Dallas
Survey & Operations Group (SOG)
Center for Clinical Standards & Quality (CCSG)
Centers for Medicare & Medicaid Services (CMS)

Enclosure: CMS-2567

cc: Accrediting Organization, State Medicaid Agency, HHSC

EXHIBIT 5

DECLARATION OF ETHAN PERMENTER

DIVISIONAL SENIOR VICE PRESIDENT – UHS OF DELAWARE, INC.

I, Ethan Permenter, am over the age of eighteen years and competent to testify in this matter. I have personal knowledge of the facts stated in this Declaration:

1. I am a Divisional Senior Vice President and employee of UHS of Delaware, Inc. (“UHSD”).

2. UHSD provides administrative support services to the subsidiary facilities of Universal Health Services, Inc., including Laurel Ridge Treatment Center (“Laurel Ridge” or the “Facility”).

3. In my role, I provide operational support to Laurel Ridge, an inpatient psychiatric hospital located in San Antonio, Texas, including facilitating budgetary review and approval for certain capital improvements.

4. Laurel Ridge participates in the Medicare program as a Medicare-certified inpatient psychiatric hospital. The Facility holds a Medicare provider agreement with the Centers for Medicare & Medicaid Services (“CMS”) and provides inpatient psychiatric care, including acute psychiatric treatment, to Medicare beneficiaries

5. During calendar year 2025, Laurel Ridge was the subject of multiple surveys (collectively, the “2025 Surveys”) conducted by the Texas Health and Human Services Commission (“HHSC”) acting in its capacity as a state survey agency (“SSA”) pursuant to an agreement with CMS. I am personally familiar with the course and outcome of those surveys.

6. CMS removed the Facility’s deemed status effective July 22, 2025, and issued a notice of proposed termination of the Facility’s Medicare provider agreement.

7. Laurel Ridge disputed the survey findings and immediately undertook comprehensive corrective action across all areas of operations, patient care, physical environment, and staffing.

8. HHSC conducted a revisit survey on September 29–30, 2025, at which surveyors confirmed that the Immediate Jeopardy condition had been abated. An additional HHSC survey was conducted in October 2025, after which the proposed termination date was extended to January 30, 2026, reflecting the Facility’s ongoing and demonstrated progress toward full compliance.

9. HHSC conducted a revisit survey on January 5–7, 2026. That survey confirmed that Laurel Ridge was in substantial compliance with all Medicare Conditions of Participation (“CoP”). No condition-level deficiencies were identified.

10. By letter dated January 27, 2026, the proposed termination was cleared.

11. By letter dated February 6, 2026, CMS fully restored Facility’s deemed status.

12. There are no outstanding restrictions, sanctions, or conditions on the Facility’s Medicare provider agreement arising from the 2025 Surveys.

13. Beginning in 2025 and continuing into 2026, and in direct response to findings from the 2025 Surveys, Laurel Ridge undertook comprehensive corrective actions totaling approximately \$10,287,118 in capital improvements, staffing enhancements, and operational changes.

14. The Facility spent \$4,087,579 for the removal of interior unit walls to open patient day rooms, which directly improved staff sightlines and the ability to monitor patients at all times. The project also included corresponding flooring replacement and electrical and telecommunications reconfiguration throughout the affected units.

15. The Facility replaced seclusion room doors, interior doors, door hinges, and windows across the Facility to bring all door and safety systems up to current regulatory standards. These replacements were made in direct response to findings from the 2025 Surveys identifying deficiencies in seclusion practices and the physical integrity of related safety systems.

16. The Facility conducted a campus-wide upgrade of ligature-resistant fixtures throughout all patient care areas, including door hardware, toilet paper holders, faucets and plumbing fixtures, ceiling tiles, and patient water dispensers. These upgrades addressed specific environmental hazard findings from the 2025 Surveys and were implemented throughout every patient-facing area of the Facility.

17. The Facility replaced components of its camera surveillance systems across patient care units to support enhanced patient monitoring and incident prevention. The replaced systems also support the Facility's new operational requirement mandating review of camera footage for 100% of Emergency Behavioral Interventions, as well as random reviews across all shifts.

18. The Facility assessed and replaced patient furniture in need of repair in patient care areas. The Facility installed new secure personal storage units for patient belongings. These improvements enhanced the therapeutic environment, addressed environmental safety concerns identified during the surveys, and provided patients with secure storage for personal property during their course of treatment.

19. The Facility installed protective Lexan materials to cover glass lightbulbs in designated areas of the campus to address environmental hazards identified during the 2025 Surveys, including findings related to compromised materials in seclusion areas.

20. The Facility undertook a series of exterior and structural improvements in response to survey findings that identified outdoor areas and common spaces as presenting patient safety risks. These improvements included the removal and replacement of all landscaping materials campus-wide to eliminate potential hazards, reconstruction of patient unit patios to improve safe patient access, and replacement of multiple concrete slabs across the campus.

21. The Facility installed and replaced perimeter fencing to enhance security. This improvement was made in response to survey findings concerning the adequacy of the Facility's physical perimeter to protect its patient population.

22. The Facility replaced exhaust ventilation systems across the campus and replaced patient lobby light fixtures to eliminate identified risks and improve the therapeutic environment. These mechanical and systems upgrades were made in response to survey findings concerning the adequacy of the physical plant and environment of care.

23. In addition to the completed capital improvements identified above, approved capital authorizations—totaling \$5,668,846—have been issued for additional ongoing work. The Facility has committed an estimated additional \$1,300,000 in capital improvements currently being implemented, bringing total capital expenditures to approximately \$6,968,846. These ongoing projects include increasing the height of standard nursing station counters throughout the Facility to further enhance patient observation and staff safety, reconfiguring door access points at nursing stations, installing additional door hinges in the admissions area, and replacing and modifying windows across all patient care units.

24. In addition to physical plant modifications, Laurel Ridge implemented significant staffing increases in direct response to survey findings identifying inadequate registered nurse coverage and staffing levels that failed to account for patient census and acuity.

25. Beginning in 2025, the Facility added 29 additional full time equivalent positions, further increasing the nursing and patient care workforce. These positions included weekend unit coordinator coverage, a third Milieu Manager added to each patient care unit, and a reconfiguration of Milieu Manager schedules to include rotating weekend coverage, ensuring consistent leadership presence on every unit seven days per week.

26. The Facility appointed an Associate Chief Nursing Officer to strengthen nursing clinical leadership and accountability and transitioned its Admissions Assessors from therapist roles to registered nurses to enhance clinical assessment accuracy, timeliness, and patient safety.

27. The total incremental staffing expenditure for positions added in 2025 through the present is \$3,318,272.

28. Beyond capital and staffing improvements, the Facility implemented a series of operational and governance enhancements in direct response to the 2025 Surveys. These include the commissioning of a Safety Committee and a new Risk Initiative focused on risk, safety, and culture; implementation of evening senior leadership rounds to increase executive visibility and reinforce accountability to proactively address safety concerns in real time; ensuring dedicated staff are always available for one-to-one patient supervision when clinically indicated; and requiring review of camera footage for 100% of Emergency Behavioral Interventions, with random footage reviews occurring across all shifts.

29. In total, the capital improvements, staffing enhancements, communication systems, and operational changes made by Laurel Ridge in direct response to the 2025 Surveys

total \$10,287,118. The Facility has not limited its efforts to the minimum requirements of any Plan of Correction. Rather, Laurel Ridge has pursued a comprehensive and sustained program of improvement to address underlying systemic issues, strengthen clinical leadership, and ensure enduring compliance with all CoPs.

I declare under penalty of perjury that the foregoing is true and correct and is based upon my personal knowledge.

Dated: 4/24/2026

Ethan Permenter
Ethan Permenter