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IN THE DISTRICT COURT OF THE SIXTH JUDICIAL DISTRICT OF THE STATE OF IDAHO, IN AND FOR THE COUNTY OF BANNOCK

DALLIN CAUDLE, an individual; and DALLIN J. CAUDLE, LLC, an Idaho limited liability company Plaintiffs, vs. ARDENT HEALTH PARTNERS, INC., a Delaware corporation doing business in Idaho; POCATELLO HOSPITAL, LLC, d/b/a PORTNEUF MEDICAL CENTER, an Idaho limited liability company; ROGER PASSMORE, an individual; NATE CARTER, an individual; DEBRA SCHNEIDER, an individual; LORA DEANNE HEIKKINEN, (as to Count III only); JASON EHRLINSPIEL, (as to Count III only) ; ALEIGHA WORTHAM-BROWN, (as to Count III only) Defendants.	CASE NO. CV03-26-00199 **FIRST AMENDED COMPLAINT AND DEMAND FOR JURY TRIAL UNDER I.R.C.P. 38**

COMES NOW Dallin Caudle, by and through his attorneys of record, May Rammell & Wells, Chtd., and hereby files this Complaint against Defendants as follows

JURISDICTION AND PARTIES

1. At all times relevant to this cause of action, Plaintiff Dallin Caudle was a resident of Bannock County, State of Idaho.

2. Plaintiff Dallin J. Caudle, LLC is an Idaho limited liability company with its principal place of business in Bannock County, State of Idaho.
3. Defendant Ardent Health Partners, Inc. is a foreign corporation authorized to do business in the State of Idaho and conducts business in Bannock County, Idaho, through its ownership, operation, and/or control of Pocatello Hospital, LLC d/b/a Portneuf Medical Center.
4. Defendant Pocatello Hospital, LLC, d/b/a Portneuf Medical Center, is an Idaho limited liability company with its principal place of business located in Bannock County, State of Idaho.
5. Defendant Roger Passmore is an individual residing in Bannock County, State of Idaho, and at all times relevant was acting within the course and scope of his employment or agency with Portneuf Medical Center and/or Ardent Health Partners, Inc.
6. Defendant Nate Carter is an individual residing in Bannock County, Idaho, and at all times relevant was acting within the course and scope of his employment or agency with Portneuf Medical Center and/or Ardent Health Partners, Inc.
7. Defendant Debra Schneider is an individual residing in Bannock County, Idaho, and at all times relevant was acting within the course and scope of her employment or agency with Portneuf Medical Center and/or Ardent Health Partners, Inc..
8. Jurisdiction in the Sixth Judicial District, in and for the County of Bannock, State of Idaho, is proper pursuant to Idaho Code § 5-404, as the acts and omissions giving rise to this action occurred within this judicial district and the Defendants reside or conduct business herein.

9. For purposes of this Complaint, when the word "Defendants" is used, unless specified otherwise, all named Defendants are intended to be included, **except** those Defendants expressly limited to Count III.

10. The following individuals are named in this action **solely** with respect to Count III, and are referred to herein as the Defamation-Only Defendants:

    a. Lora Deanne Heikkinen, Ardent Purchasing Line Director

    b. Jason Ehrlinspiel, Ardent Chief Compliance Officer

    c. Aleigha Wortham-Brown, Sterile Processing Department ('SPD') employee

11. Plaintiffs expressly allege that each of the Defamation-Only Defendants committed one or more of the defamatory acts described in Count III while acting within the course and scope of their employment with Portneuf Medical Center and/or Ardent Health Partners, Inc., or while acting with apparent authority to speak on behalf of those entities. Accordingly, Ardent and Portneuf are vicariously liable for those defamatory acts.

12. Venue is appropriate with this Court pursuant to Idaho Code § 5-404 by reason of the physical presence of the Defendants in the jurisdictional district of this Court and because a substantial part of the events and omissions giving rise to these claims occurred in Bannock County.

13. Plaintiffs reserve the right to amend this Complaint to substitute or add any additional entities that, upon discovery, are found to have owned, operated, managed, or controlled Portneuf Medical Center or were otherwise responsible for the conduct alleged herein.

FACTUAL ALLEGATIONS

14. Plaintiff Dallin J. Caudle ("Dallin") is the owner and managing member of Dallin J. Caudle, LLC (Caudle LLC).

15. Dallin J. Caudle, LLC is a medical device distributorship in Bannock County, Idaho.
16. Dallin and his company provide assistance to surgeons and other medical providers, particularly providing spinal and neurosurgical products and assistants in Idaho.
17. Dallin and his LLC operate as an independent distributor and sales agent for several national and international medical device manufacturers.
18. Dallin's work involves supplying surgical implants, instruments, and biologic materials used by neurosurgeons and orthopedic surgeons.
19. At all times relevant, Dallin J. Caudle LLC held valid distribution or sales-agency agreements with multiple manufacturers whose products were used by neurosurgeons practicing at Portneuf Medical Center in Pocatello, Idaho.
20. Those agreements included contracts with Bioplate, Inc., Sophysa USA, Inc., Xtant Medical, Inc., Zavation Medical Products, LLC, Centinel Spine, LLC, and Kuros Biosciences USA, Inc.
21. Under these agreements, Dallin J. Caudle LLC was responsible for promoting, selling, and supporting medical devices within defined geographic territories in Idaho.
22. Beginning in approximately 2023, Dallin provided in-room technical support, surgical instrumentation, and device expertise for procedures performed by Dr. Jonathan Morgan and other neurosurgeons.
23. The hospital's neurosurgical program relied heavily on Dallin's specialized knowledge and reputation for reliability.
24. His role was not merely commercial; it was professional and clinical in nature, governed by contracts that required him to attend surgeries, deliver and set up instrumentation,

educate operating room personnel, and ensure that all product sets were properly processed and available for patient use.

25. The credibility and trust that surgeons, manufacturers, and hospital staff placed in Dallin were therefore essential to his livelihood and to his ability to meet the obligations of his distribution and agency contracts.
26. Dallin's business depended heavily on maintaining credentialed access to the operating rooms and Sterile Processing Department ('SPD') of hospitals, including Portneuf Medical Center.
27. Credentialing at Portneuf Medical Center was essential to Dallin's ability to perform his professional duties and to maintain his standing within the medical device industry.
28. Through this credentialing, the hospital formally authorized Dallin to enter restricted areas, attend surgical procedures, and interact directly with operating room and Sterile Processing Department ('SPD') personnel.
29. That access allowed him to fulfill his contractual obligations by providing in-room technical support, coordinating sterilization and inventory of implant systems, and ensuring that surgical instruments and devices were properly prepared for patient use.
30. Beginning in approximately 2023, Dallin regularly provided case coverage and product support for neurosurgeon Dr. Jonathan Morgan at Portneuf Medical Center.
31. Dr. Jonathan Morgan led and achieved the development of Portneuf Medical Center's neurosurgical program into a higher-tier facility capable of performing complex spinal and cranial procedures.
32. Dallin and his company provided the surgical device support and technical expertise necessary to carry out those procedures.

33. During the same period, Dr. Morgan, Dallin, and other surgical staff began noticing serious problems with the hospital's sterilization practices.
34. These concerns included instances in which surgical trays and instruments were returned from the Sterile Processing Department with visible bioburden, residue, or incomplete disassembly, creating serious risks to patient safety and infection control.
35. Dallin and Dr. Morgan's legal, professional, and moral responsibilities are directly connected to the health, safety, and welfare of people who get surgery when either of them is involved.
36. Their contracts actually require that they have adequate insurance to cover any adverse events associated with their care, treatment, or involvement.
37. Defendants knew this and fully understood the legal, professional, and moral significance and importance of ensuring the health, safety, and welfare of the people getting medical services; especially at Pocatello Hospital.
38. Around the beginning of 2023, Morgan, Dallin, and other surgical staff began noticing significant problems with the sterilization of the tools, implements, devices and items used on or in patients.
39. They informed the Defendants of these concerns.
40. Instead of taking any action to address the concerns about the sterilization and the process, the Defendants blamed Dallin and others.
41. The Defendants tried to "pass the buck."
42. The Defendants even misrepresented to Dr. Morgan, Mr. Caudle, and the surgical staff what they had actually done, or were supposedly doing, to fix the sterilization problems they had been warned about.

43. In large measure, because the Defendants appeared to be preparing to blame Dallin, Dr. Morgan or others, and were doing nothing to protect Dallin, Dr. Morgan or others, Dallin began documenting occurrences of improperly cleaned instruments and similar problems.
44. Among other things, Dallin reported visible residue, caked-on blood, and incomplete disassembly of medical implements, tools, and devices.
45. He reported the issues to the hospital's operating room management and administrative leadership.
46. Dallin also engaged in discussions with hospital staff about implementing tray-culture testing to verify instrument sterility and identify sources of contamination.
47. Culture tests ordered by Dr. Morgan to assess sterility were delayed, cancelled, or blocked by hospital administration in several instances.
48. Based on what Dallin learned, this was in retaliation for reporting the problems.
49. This retaliation affected Dallin's work and is part of the basis for this lawsuit.
50. Among other things, Dallin was informed that the hospital's leadership was concerned about the potential implications of positive culture results and, therefore, was essentially ignoring the problems reported.
51. This information and the Defendants' actions further confirmed the Defendant's wrongful behavior and their state of mind, including the reasons for the retaliation for having their lack of sanitation and/or sterilization reported.
52. In early 2025, the hospital's operating room manager, Debra Schneider, Sterile Processing Department supervisors, and certain administrators, including Chief Medical Officer Dr. Roger Passmore and Chief Executive Officer Nate Carter, became directly involved in addressing the concerns reported by Dr. Morgan and Dallin.

53. Following repeated reports from Dr. Morgan, Dallin, and others that instruments were being returned from Sterile Processing Department with visible residue, caked-on blood, or incomplete disassembly, meetings were held between the Sterile Processing Department and hospital leadership.
54. During those meetings, Dr. Morgan and Dallin emphasized that the problem appeared to be systemic and that tray-culture testing was needed to determine the scope of contamination.
55. Ms. Schneider and members of the Sterile Processing Department staff disputed the extent of the issue and expressed clear frustration toward Dallin for raising the concerns.
56. Shortly before this time, at least one person expressing frustration with Dallin had been placed on leave for behavioral issues and later returned to work.
57. Within weeks of that person's return, she complained to management that Dallin had called her "incompetent."
58. Her statement was untrue and was denied by Dallin.
59. The aforementioned complaint was made the day after Dallin discovered bone material inside a micro pituitary instrument that had been processed and cleared for use.
60. Instead of investigating the contamination concerns raised by Dr. Morgan and Dallin, Ms. Schneider called Dallin into her office to interrogate Dallin about allegedly calling a Sterile Processing Department person incompetent.
61. This surprised Dallin because he had been led to believe the meeting was going to address the serious concerns about a lack of proper sterilization processes and practices by the hospital.

62. During that meeting, Ms. Schneider focused entirely on the complaint that Dallin had called a worker incompetent, rather than whether the instrument contamination that Dallin had reported needed follow-up.
63. Dallin reiterated that he had not made the alleged remark and that his only concern was patient safety.
64. Over the next several weeks, Dr. Morgan and Dallin continued to find evidence of incomplete cleaning, including bioburden and residue inside instruments that had already been sterilized and wrapped for surgery.
65. When Dr. Morgan requested that Sterile Processing Department staff disassemble and reprocess the instruments, the same items were returned, still containing human debris.
66. In one instance in late spring of 2025, after a surgery involving a very young immuno-compromised trauma patient, Dallin discovered bioburden and dried blood inside a cannulated instrument that had been certified as sterile.
67. The significance of using such contaminated instruments is enormous.
68. The use of such contaminated instruments on some people can be catastrophic, leading to death or permanent injury.
69. Two identical instruments had been processed together, but only one was found contaminated, indicating inconsistent cleaning practices.
70. These were the very concerns that Dallin had brought to the Defendants' attention on multiple occasions.
71. As a result of this event, Dr. Morgan immediately halted elective surgeries and notified hospital administration that patient safety was at risk and that he could no longer continue performing surgeries under such circumstances.

72. In response to the Plaintiffs' concerns, hospital leadership began restricting communication between Dr. Morgan's team (which included Dallin) and Sterile Processing Department personnel.
73. Additionally, requests by Dr. Morgan to culture surgical trays for testing and verification purposes were "cancelled" or denied within the hospital's Infection Control Department.
74. When Dr. Morgan and Dallin asked to review the culture reports that had been requested and which they expected to be performed, they were told that the results were confidential and could not be shared.
75. This was a bizarre response, since the Defendants had never taken such a position in the past with respect to cultures involving their tools or instruments.
76. Given the nature of the need for them to have this information, the Defendants' position was inappropriate.
77. Despite the defendants' stated position, they did test some instrument pans.
78. The secretive testing was likely to avoid reporting the full scope of the problem, and an attempt to keep the scope and depth of the problem under the Defendants' exclusive, subjective, and arbitrary control.
79. Nevertheless, it was later learned that approximately seventy percent of instrument pans tested had returned positive for waterborne bacteria.
80. These rates far exceed acceptable rates.
81. Despite those findings, hospital administration continued elective surgeries.
82. Defendants actually demanded that Dr. Morgan increase the number of elective surgeries he was performing, and advised Dr. Morgan that all equipment was "clean".
83. They informed Dr. Morgan that operations should resume as normal.

84. Dr. Morgan was threatened with an action for breach of contract if he didn't do additional elective surgeries at that time.

85. The hospital's statements and explanation conflicted with photographic and physical evidence collected by Dr. Morgan and Dallin.

86. Their in-person and "eyes on" view showed visible contamination in multiple trays, including a Midas Rex drill and a pneumatic Kerrison.

87. When these concerns were reported again, Dr. Passmore and Ms. Schneider claimed and argued that the issues had nothing to do with the hospital or its practices, but were instead the result of improper handling by vendors, like Dallin.

88. The Defendants' position over the source of contamination and the appropriate response created significant stress and tension between Dr. Morgan's surgical team (which included Dallin) and hospital administration.

89. Dr. Morgan insisted that elective procedures be paused until Sterile Processing Department practices were corrected.

90. Concerned about their loss of revenue, the Defendants opposed further investigation or reduction in surgical scheduling.

91. During this same time period, vendors and people like Dallin who were part of a surgical team, especially in relation to Dr. Morgan's cases, began experiencing intense scrutiny and unwarranted suspicion.

92. Staff reported being instructed not to communicate or cooperate with representatives, including Dallin.

93. They also reported being told to minimize communication with Dr. Morgan's team.

94. All of this was done knowing the potential risks and consequences of a lack of sterile equipment and infections on patients.

95. The defendants' actions and lack of care and concern for patients and the Plaintiff can be explained through their financial arrangements and kickbacks.

96. For example, Portneuf Medical Center maintained an "earn-out" arrangement with Medtronic, Inc.

97. This arrangement allowed the hospital to receive and benefit from massive financial incentives or discounts based on maintaining specified usage levels of Medtronic implants.

98. When Dr. Morgan and Dallin began using alternative implant systems from other manufacturers, administrators expressed concern that reduced Medtronic usage would affect those payments.

99. Dr. Morgan and Dallin's choice of implant systems was based on what was best for each patient, instead of financial considerations for using Medtronic, even if the devices were not the best choice (in Dr. Morgan's professional opinion) for a specific patient.

100. Additionally, the Defendants themselves had called into question concerns about the devices as being a source of infection, and Dr. Morgan and his team had confidence in the systems and devices they used.

101. Following these developments, Portneuf personnel began directing surgeons and staff that only"Medtronic-approved representatives" were permitted to attend certain neurosurgical procedures.

102. This directive had the practical effect of excluding Dallin from surgeries involving competing implant systems.

103. It also interfered with Dallin's fulfilling his contractual duties.

104. In the months following, hospital employees and administrators made several statements either directly stating or implying that Dallin was difficult to work with.

105. Some of the claims were that he was unreachable and/or had violated vendor policies.

106. Defendants also made statements to outside manufacturers, falsely claiming that Dallin had improperly solicited surgeons for certain products for personal gain, had smuggled in unapproved vendors, and lacked understanding of his own equipment.

107. These statements were untrue.

108. They were made for the purpose of discrediting Dallin and his reporting that the hospitals' sterilization processes were inadequate and/or dangerous to patients undergoing surgery at the hospital.

109. The false statements and communications were shared with hospital employees, surgeons, and representatives of the companies whose products Dallin distributed.

110. Dallin was not even given an opportunity to respond to or correct the Defendants' statements, made through their agents and representatives, who began circulating them.

111. In May 2025, after Dr. Morgan and Dallin again raised concerns regarding contaminated instruments, Dallin's access credentials to Portneuf Medical Center were suddenly revoked.

112. No formal explanation was given to Dallin for that revocation

113. Dallin's exclusion from the hospital prevented him from performing in-room case coverage and product support, which were essential functions of his distribution contracts.

114. As a result, he was unable to meet sales quotas, maintain surgeon relationships, or earn commissions owed under his manufacturer agreements.

115. Following the revocation of access, hospital staff and administration continued to communicate with surgeons and manufacturers that the infections and equipment problems were caused by Dallin.

116. After his credentials were revoked, Dr. Morgan informed Dallin that internal oversight had finally investigated and had confirmed multiple deficiencies within the Sterile Processing Department.

117. The findings include evidence of contamination in instrument trays.

118. The contamination findings were essentially the same as those raised and reported by Dallin.

119. Dallin's actions and those he reported the problems to were all appropriate and consistent with the Defendants' own claimed procedures and practices.

120. Before Dallin's access was revoked, hospital administrators and staff had repeatedly assured Dallin that his actions regarding reporting his concerns and his participation in surgeries were authorized and that he remained in good standing as a vendor representative.

121. Relying on those assurances, he continued to prepare surgical trays, coordinate inventory, and report for scheduled cases.

122. In May of 2025, he was unexpectedly informed that he was no longer welcome or credentialed to continue working, including preparing surgical trays, coordinating inventory, and reporting for scheduled cases

123. Dallin's inability to do the work he was required to do as part of his job at Portneuf Medical Center resulted in tremendous financial and other damages and losses.

124. Among those damages caused by the Defendants were the loss of business income, disruption of his ongoing contractual relationships, damage to his professional reputation among surgeons and manufacturers, general damages such as humiliation, depression, anxiety, stress, and more.

125. He is entitled to compensation sufficient to make him whole from any losses or damages caused by the Defendants' wrongful actions.

126. Plaintiff is entitled to recover attorney's fees and pursuant to Idaho law, including because Defendants have acted in bad faith and forced Plaintiff to incur unnecessary litigation expenses.

COUNT I

(Whistleblower Protection Idaho Code § 54-1301 et seq.)

127. Dallin qualifies as a "health care provider" within the meaning of Idaho Code § 54-1303(7) because he is a "health care professional" under § 54-1303(6).

128. Dallin regularly participated in and assisted with neurosurgical medical procedures by providing intraoperative product support, preparing and verifying surgical instruments and implant systems, identifying and reporting contaminated or improperly processed instruments, and ensuring correct implantation of neurosurgical devices.

129. Because § 54-1303(9) defines "participate" broadly, "to take part in any way in providing any medical procedure", Dallin falls squarely within the statutory definition.

130. Beginning in 2023 and continuing through 2025, Dallin repeatedly disclosed to Portneuf Medical Center leadership, Sterile Processing Department personnel, the OR

Manager, and other hospital administrators information that he reasonably believed demonstrated:

a. violations of laws, rules, and regulations governing hospital sterilization, reprocessing, and patient-safety standards;

b. violations of ethical guidelines governing the provision of surgical and neurosurgical procedures;

c. gross mismanagement of Sterile Processing Department operations;

d. abuse of authority by hospital personnel seeking to impose vendor restrictions tied to Medtronic's earn-out agreement rather than patient safety;

e. practices placing patient health at substantial risk, including routine delivery of contaminated and unsterile neurosurgical instruments; and

f. substantial and specific danger to public health and safety due to systemic instrument-cleaning failures and concealment of adverse findings.

131. Dallin also refused to participate in neurosurgical procedures when he discovered instruments that were visibly contaminated, improperly disassembled, or otherwise unsafe for patient use.

132. After Dallin made the protected disclosures and conscience-based refusals described above, Defendants took direct retaliatory and discriminatory action against him, including but not limited to:

a. revoking Dallin's access to Portneuf Medical Center without explanation;

b. blocking him from covering neurosurgical cases he previously supported;

c. making or endorsing false allegations of incompetence;

d. damaging his professional reputation among hospital staff and vendors;

e. attempting to replace him with financially preferred vendors tied to the hospital's Medtronic earn-out agreement;

f. causing other hospitals to drop Dallin as a medical provider

133. These actions constitute "discrimination" under Idaho Code § 54-1303(2), which includes any adverse action taken or threatened as a result of the exercise of protected rights.

134. Defendants' actions were taken *because of* Dallin's protected disclosures and conscience-based objections, in direct violation of Idaho Code § 54-1305(2).

135. As a direct and proximate result of Defendants' statutory violations, Dallin suffered:

a. loss of income and commissions;

b. loss of business;

c. reputational harm;

d. emotional distress;

e. diminished future earning capacity; and

f. additional economic and non-economic damages.

136. Under Idaho Code § 54-1307(1)–(3), Dallin is entitled to:

a. injunctive relief, including reinstatement of access and prohibition of further retaliation;

b. actual damages for all injuries suffered;

c. reasonable attorney fees and costs; and

d. all other relief the Court deems just and proper.

COUNT II
(Tortious Interference with Contract)

137. Plaintiff re-alleges and incorporates by reference all preceding paragraphs as though

fully set forth herein.

138. During all relevant times, Dallin Caudle, through his company, had active and legally binding agreements with several medical device manufacturers whose products were regularly used by neurosurgeons in Southeast Idaho, including at Portneuf Medical Center. Those agreements included, among others:

a. Bioplate Inc. Distributor Agreement covering customers in Southeast Idaho, including Portneuf Medical Center;

b. Sophysa USA, Inc. Confidential Representative Agreement appointing Dallin to promote and sell Sophysa products within defined Idaho territories and customers;

c. Centinel Spine, LLC Distributor Agreement appointing Dallin as exclusive distributor for PRODISC products to specified Idaho surgeons, including Dr. Jonathan Morgan and Dr. Robert Cach, with quota and commission terms;

d. Xtant Medical, Inc., Independent Agent Distribution Agreement granting Dallin non-exclusive rights in Idaho with stated commissions on biologics and hardware;

e. Zavation Medical Products, LLC Distributor Commission Agreement appointing Dallin as distributor for spinal products in the specified territory with commission schedule; and

f. Kuros Biosciences USA Inc. Sales Agency Agreement appointing Dallin to solicit orders for MagnetOs products for identified Idaho surgeons, including Cach, Morgan, Blair, O'Holloran, and Woodbury.

139. Defendants, including Portneuf Medical Center and its administrators and agents, had actual knowledge of Dallin's contracts with multiple medical-device manufacturers and his ongoing case-coverage duties at Portneuf Medical Center.

140. They were aware that Plaintiff's work required credentialed access to the Operating Room and Sterile Processing Department areas in order to deliver, set, and support the contracted products used by Dr. Morgan and other neurosurgeons.

141. Defendants also knew that this access was essential for Dallin to fulfill his contractual obligations, maintain manufacturer compliance, and support patient care during surgical procedures.

142. Defendants were further aware of the legal, ethical, and moral importance of Plaintiff's role within the surgical setting.

143. They understood that Dallin's responsibilities were directly tied to maintaining sterile surgical conditions, ensuring patient safety, and upholding the professional and regulatory standards governing neurosurgery and hospital operations.

144. Despite this knowledge, Defendants ignored and concealed ongoing sterile-processing failures, cancelled or obstructed culture testing that would have revealed contamination, and retaliated against Plaintiff for reporting these deficiencies.

145. In so doing, Defendants knowingly violated the ethical principle to "do no harm," disregarded the hospital's legal duties of care, and demonstrated willful indifference to both patient safety and the professional integrity of those who sought to uphold it.

146. The Defendants went out of their way to push Dallin out.

147. Defendants knew that by cutting off his access to the hospital and blocking him from the operating rooms, he wouldn't be able to do his job or meet his obligations to the medical companies he represented.

148. Defendants' actions include, but are not limited to:

a. Blocking/Revoking access and credentialing necessary for Dallin to provide

in-room case coverage and fulfill manufacturer obligations at PMC, following Caudle's involvement in raising safety concerns about sterile processing;

b. Directing surgeons to limit representatives to "Medtronic-approved reps" only, thereby excluding Dallin from cases and product selections covered by Caudle's contracts with competing manufacturers; and

c. Implementing or enforcing implant-usage directives tied to a purported Medtronic "earn-out" arrangement, pressuring product choices in a manner that displaced Caudle's contracted products and prevented Caudle's performance.

149. Defendants' interference was intentional and without justification, undertaken to advance PMC's economic interests (including vendor-usage commitments) and to suppress competing vendors and representatives such as Caudle, rather than for any legitimate patient-care objective.

150. Each of Dallin's contracts, with Bioplate, Sophysa, Centinel, Xtant, Zavation, and Kuros, was a valid and active agreement.

151. The Defendants knew about these contracts and knew that Dallin's ability to perform them depended on having access to the operating rooms and staff at Portneuf Medical Center. Despite that knowledge, the Defendants intentionally stepped in and interfered.

152. By blocking Dallin's credentials, spreading false information, and steering surgeons toward other vendors, Defendants caused those contracts to fall apart.

153. As a direct result, Dallin lost his income, his professional relationships, and the business he had worked for years to build.

154. Dallin has sustained economic damages, including lost commissions and sales revenue under the above contracts, loss of business expectancy with PMC surgeons,

reputational harm with manufacturers, and consequential losses arising from Defendants' wrongful interference.

155. Defendants' conduct was willful, wanton, and in bad faith, entitling Dallin to all remedies available under Idaho law, including sufficient compensation to make Dallin and his business whole, and including an award of punitive damages.

COUNT III

(Intentional Interference with a Prospective Economic Advantage)

156. Plaintiff re-alleges and incorporates by reference all preceding paragraphs as though fully set forth herein.

157. At all times material, Dallin had strong, ongoing business relationships and a clear expectation that his work would continue to grow.

158. He regularly provided case support and product assistance for neurosurgeons at Portneuf Medical Center and nearby hospitals in Southeast Idaho, and he reasonably expected that those same surgeons would keep choosing his products and referring new cases.

159. He also anticipated that his sales would expand as those doctors scheduled more surgeries and new patients.

160. Defendants were aware of Dallin's prospective economic advantage and his ongoing expectation of continued business with those surgeons and facilities.

161. Defendants interacted with those same surgeons and were aware that Dallin's role required credentialed OR access, in-person case coverage, and sterile-processing coordination to enable continued product utilization and sales growth in Southeast Idaho.

162. Defendants intentionally interfered with Dallin's expected business opportunities by taking deliberate steps to shut him out of both current and future surgeries and to steer

work away from the companies he represented.

163. Defendants' steps include, but are not limited to:

a. Blocking or revoking Dallin's access/credentialing necessary to attend, support, and supply upcoming neurosurgical cases, thereby foreclosing future sales opportunities that flow from in-OR support and surgeon preference capture;

b. Issuing or enforcing directives limiting reps to "Medtronic-approved" personnel, thereby prospectively excluding Dallin from future product selections and case coverage with PMC neurosurgeons; and

c. Pressuring usage patterns tied to a Medtronic "earn-out" arrangement, a policy choice aimed at vendor loyalty and quotas, thereby diverting future implant usage and associated commission opportunities away from Dallin's contracted manufacturers on a going-forward basis.

164. Dallin had a clear and valid expectation that his business with surgeons at Portneuf Medical Center and nearby hospitals would continue to grow.

165. He had already established relationships, repeat case coverage, and ongoing opportunities to expand his sales territory through honest work and reliable service.

166. The Defendants knew about this economic expectancy and how valuable it was to his business and livelihood.

167. Despite that knowledge, the Defendants intentionally interfered and caused that future business to collapse.

168. They blocked Dallin's hospital credentials, spread damaging rumors, and pressured surgeons to use only "approved" vendors connected to the hospital's financial interests.

169. Defendants' actions were not taken for any legitimate medical or safety reason.

170. Defendants' actions were done to punish Dallin for raising concerns about unsafe sterilization practices and to eliminate competition that stood in the hospital's way.

171. The Defendants' interference was wrongful by more than just the fact that they interfered.

172. Defendants violated basic standards of fairness and honesty, using hospital power for retaliation and profit instead of patient care.

173. By acting with this improper purpose and through improper means, the Defendants destroyed Dallin's business relationships, blocked future sales, and damaged his reputation with manufacturers and surgeons who once trusted him.

174. As a direct result, Dallin lost the future income and opportunities he reasonably expected to earn.

175. Dallin's commissions stopped, his professional reputation was tarnished, and years of effort building his business were wiped out.

176. Defendants' conduct was willful and in bad faith, entitling Dallin to all remedies available under Idaho law, including sufficient compensation to make Dallin and his business whole, and including an award of punitive damages.

COUNT IV
(Defamation)

177. Plaintiff re-alleges and incorporates by reference all preceding paragraphs as though fully set forth herein.

178. At all times material hereto, Plaintiff Dallin J. Caudle and Plaintiff Dallin J. Caudle, LLC were engaged in the professional business of providing neurosurgical and spinal implants, biologics, instrument sets, in-room case support, and technical expertise at Portneuf Medical Center and across Southeast Idaho. Plaintiff's reputation for honesty,

competence, safety, and reliability was central to his ability to maintain hospital access, meet manufacturer requirements, and serve surgeons and patients.

179. On or about May through June 2025, Defendant Lora Deanne Heikkinen, Ardent's Purchasing Line Director, published in writing to a shunt manufacturer representative, and orally to Portneuf administrative personnel, that Plaintiff was "hard to work with" and "unreachable," despite never having attempted to contact Plaintiff.

180. These statements were false and were published in the course of her employment with Ardent. These publications constitute libel and slander.

181. On or about August 18 through August 28, 2025, Defendant Heikkinen told hospital administrators, biologics manufacturers, and neurosurgeons including Dr. Morgan and Dr. Cach that Plaintiff was "petitioning doctors" and "improperly soliciting surgeons," specifically regarding MagnetOs biologics.

182. The statements were false. MagnetOs had been requested by the surgeons themselves and was already approved at other Ardent facilities.

183. These statements were published orally and through written communications and constitute slander and libel.

184. On or about June through July 2025, Sterile Processing Department personnel, under the authority of OR Manager Debra Schneider, stated orally to OR nurses, scrub techs, and administrative staff that Plaintiff had "snuck in a shunt company" or "smuggled" a vendor into the hospital without authorization.

185. These statements were false. Plaintiff had written authorization from the hospital's Chief Financial Officer, John Abreu. These publications constitute slander.

186. On or about May through July 2025, Defendant hospital administrators including

Chief Medical Officer Dr. Roger Passmore told OR nurses, physicians, and other staff members that Plaintiff "did not know how his equipment operated," that he was "creating equipment problems," and that he lacked the technical competency expected of a device representative.

187. These statements were false, as Plaintiff had successfully supported more than 1,200 neurosurgical procedures without incident. These publications constitute slander.

188. On or about March 2025, Defendant OR Manager Debra Schneider reported orally to hospital management and Human Resources that Plaintiff had called sterile-processing employee Aleigha Wortham-Brown "incompetent." This accusation was false.

189. The alleged statement had never been made by Plaintiff and was made the day after Plaintiff discovered bone material and other contamination inside a processed neurosurgical instrument. This publication constitutes slander.

190. Between May and July 2025, Defendants, including Passmore and Schneider, stated orally and in internal written communications to surgeons, OR nurses, and staff that Plaintiff was responsible for equipment contamination, that vendor mishandling by Plaintiff was the source of infection risks, and that Plaintiff was the cause of surgical safety problems. These statements were false.

191. The hospital's own later internal findings showed that approximately seventy percent of surgical pans tested were contaminated due solely to Portneuf's failures. These publications constitute libel and slander.

192. Between May and August 2025, Defendants, including Ardent Chief Compliance Officer Jason Ehrlinspiel, Passmore, Schneider, and other staff acting within the scope of their employment, told hospital employees, surgeons, and vendor representatives that

Plaintiff was “misrepresenting” or “misreporting” the cause of sterile-processing failures and contamination.

193. These statements implied dishonesty and unprofessional behavior and were false. The photographic and physical evidence documented by Plaintiff and Dr. Morgan confirmed sterile-processing failures. These publications constitute libel and slander.

194. On October 29, 2025, Portneuf Medical Center publicly issued a written statement to East Idaho News for publication in an article titled “Portneuf Medical Center makes changes after investigation into dirty surgical tools.”

195. In that article, Portneuf stated: “Earlier this year we self-identified an isolated issue with reprocessing certain specialized surgical instruments provided by an outside vendor.”

196. The phrase “outside vendor” was widely understood within the medical community and by many in the public to refer specifically to Plaintiff, who had been a primary neurosurgical vendor at Portneuf for years and who had been publicly connected to the neurosurgical instrument systems at issue.

197. This public statement was false, defamatory, and misleading. It falsely implied that Plaintiff was responsible for the contamination, sterilization failures, or instrument defects identified in the investigation.

198. The hospital’s statement was knowingly misleading because the same contamination issues Plaintiff had repeatedly reported were later confirmed in the hospital’s own investigation, showing that the failure was internal to Portneuf and not attributable to Plaintiff or any vendor.

199. This publication constitutes libel per se because it was a written, public allegation

suggesting Plaintiff caused patient-safety hazards, professional incompetence, and regulatory violations, all of which directly injure Plaintiff in his trade and profession.

200. In July 2025, during an interview conducted by Idaho Division of Occupational and Professional Licenses Investigator M'Lissa McCloud, surgical PA David McDonald was asked whether "the same medical device [vendor] was involved in the concerns about specific patient care."

201. McDonald reasonably understood this inquiry to mean that DOPL had already been told, or had been led to believe, that Plaintiff was responsible for infections or patient harm, and that defamatory statements about Plaintiff had been repeated or circulated to state regulators.

202. The repetition of Defendants' slander to or within a regulatory agency constitutes republication and is attributable to Defendants because such repetition was foreseeable and a natural consequence of the defamatory statements initially circulated by Defendants.

203. The implication that Plaintiff was responsible for patient infections constitutes defamation per se because it directly alleges professional incompetence, unsafe practices, and unfitness to work in the medical-device field.

204. Each of the statements identified above was false, unprivileged, and published with knowledge of falsity, reckless disregard for the truth, or negligence.

205. The statements constitute defamation per se because they accuse Plaintiff of professional unfitness, incompetence, policy violations, unethical behavior, and causing risks to patient safety.

206. Independently, Defendants are liable for defamation by implication because they

juxtaposed facts, omitted critical context, concealed known sterile-processing failures, and created the materially false impression that Plaintiff caused contamination and safety problems.

207. As a direct and proximate result of Defendants' defamation, Plaintiff suffered loss of business income, loss of manufacturer relationships, loss of professional standing, emotional distress, humiliation, and severe reputational harm within the medical and surgical community.

208. All defamatory statements were made by employees, agents, and officers of Defendants Ardent Health Partners, Inc. and Pocatello Hospital, LLC dba Portneuf Medical Center in the course and scope of their employment. Ardent and Portneuf are therefore vicariously liable for the statements.

209. Defendants acted jointly and in furtherance of a common plan to shift blame for the contamination away from themselves, retaliate against Plaintiff's safety reporting, and protect Portneuf's economic interests. Defendants are jointly and severally liable.

COUNT V

(Violation of the Idaho Racketeering Act – I.C. §§ 18-7801–7805)
(Racketeering Predicate: I.C. § 18-1906 – Fraudulent Reports by Corporate Officers)

210. Plaintiff re-alleges and incorporates by reference all preceding paragraphs as though fully set forth herein.

211. At all times relevant, Defendants Pocatello Hospital, LLC d/b/a Portneuf Medical Center ("PMC"), Ardent Health Partners, Inc., and their officers and agents including but not limited to Chief Medical Officer Dr. Roger Passmore, CEO Nate Carter, OR Manager Debra Schneider, and Chief Compliance Officer Jason Ehrlinspiel, constituted an "enterprise" within the meaning of Idaho Code § 18-7803(c).

212. The enterprise functioned as a continuing unit with a common purpose of managing

and controlling PMC's operations and protecting its financial and reputational interests.

213. Each Defendant participated, directly and indirectly, in the conduct of the enterprise's affairs through a pattern of racketeering activity, consisting of multiple violations of Idaho Code § 18-1906, which is expressly defined as a racketeering predicate under Idaho Code § 18-7803(a)(16).

214. On October 29, 2025, PMC issued a written public statement asserting that the hospital had "self-identified an isolated issue" with instrument reprocessing and that the issue had been "successfully addressed," despite knowing that:

a. contamination was widespread;

b. culture results had been concealed;

c. corrective measures had not been sufficiently taken; and

d. Joint Commission had identified multiple deficiencies.

215. This written report was a "statement of its affairs or pecuniary condition" and contained material falsehoods knowingly published by corporate officers, constituting a violation of Idaho Code § 18-1906.

216. Between March and August 2025, Defendants knowingly published false internal statements and summaries of surgical tray culture tests, including:

a. falsely representing cultures as "negative";

b. concealing positive results;

c. delaying processing to invalidate findings;

d. providing inconsistent and mutually contradictory versions of reports.

217. These written and verbal communications constituted "reports" or "statements" of the corporation's affairs, knowingly made false in violation of Idaho Code § 18-1906.

218. In August 2025, PMC officers knowingly misrepresented the findings of an unscheduled Joint Commission inspection by reporting internally that the inspection resulted in “less than five conditions,” then “three conditions,” and finally “three suggestions,” despite knowing the actual findings consisted of approximately twenty deficiencies and multiple serious conditions of noncompliance.

219. These knowingly false reports constitute violations of Idaho Code § 18-1906.

220. The predicate acts above constitute at least two incidents of racketeering conduct under Idaho Code § 18-7803(d).

221. The predicate acts were related in purpose (concealing contamination), method (false reporting), result (misleading staff, regulators, and the public), and participants (PMC officers acting jointly), and occurred over a continuous period from early 2025 through at least October 2025. They were not isolated incidents but part of an ongoing pattern.

222. Each Defendant participated in directing, authorizing, or publishing false reports and statements regarding PMC’s contamination problems, sterile-processing failures, Joint Commission findings, and the Plaintiff’s role.

223. These acts were taken through the enterprise and for the enterprise’s benefit, and constitute participation in the conduct of the enterprise’s affairs through racketeering activity.

224. As a direct and foreseeable result of Defendants’ false reports and statements, including those blaming Plaintiff and those concealing systemic failures, Plaintiff’s hospital access was revoked, his professional reputation was damaged, his business relationships were interfered with, and his income was destroyed.

225. These injuries were caused “by reason of” Defendants’ pattern of racketeering

activity.

226. Pursuant to Idaho Code § 18-7805, Plaintiff is entitled to treble damages, attorney fees, and all other civil remedies available under the Idaho Racketeering Act.

227. Defendants are jointly and severally liable for all damages.

COUNT VI
(False Light Invasion of Privacy)

228. Plaintiff re-alleges and incorporates by reference all preceding paragraphs as though fully set forth herein.

229. At all times material hereto, Defendants Pocatello Hospital, LLC d/b/a Portneuf Medical Center, through its officers, agents, and employees, made and disseminated false statements and omissions to hospital staff, medical professionals, manufacturers, and others in the community regarding Dallin's professional conduct.

230. Through these communications, Defendants created and promoted a false narrative about Dallin.

231. They portrayed him as unprofessional, difficult to work with, and dishonest.

232. They claimed he smuggled vendors into the hospital, violated policies, and was responsible for equipment and infection problems.

233. Each of these accusations was false and intended to shift blame away from the hospital’s own failures in the Sterile Processing Department.

234. These statements were public disclosures, widely communicated within the local community and to key industry partners in Idaho and beyond.

235. By spreading this misinformation to Dallin’s professional network, Defendants effectively published the story of “what happened” at Portneuf and cast Dallin as the cause of it.

236. That portrayal was highly offensive. It damaged Dallin's reputation not just as a businessperson but as someone who worked in surgical rooms where trust and integrity mean everything.

237. Any reasonable person would find it deeply humiliating and professionally devastating to be labeled as the source of infection risks in a hospital setting.

238. The Defendants either knew these statements were false or acted with reckless disregard for the truth.

239. They were fully aware that the contamination problems came from the hospital's own sterile-processing failures, yet they chose to blame Dallin instead of accepting responsibility.

240. The hospital's leadership had every opportunity to correct the record once they knew the truth.

241. They could have told staff, surgeons, and manufacturers that Dallin had acted properly. They did not. Instead, they allowed the false narrative to continue because it protected the hospital's image and shifted scrutiny away from their own misconduct.

242. By making public disclosures that portrayed Dallin as dishonest and incompetent, Defendants placed him in a false light that any reasonable person would find highly offensive.

243. They acted knowingly and with reckless disregard for the truth of what they said and for the harm those lies would cause.

244. As a direct result, Dallin's professional reputation and livelihood were destroyed. Years of hard-earned credibility in the operating room were wiped away. Dallin suffered humiliation, emotional distress, and loss of income injuries that are the foreseeable and

natural result of being publicly blamed for something he did not do.

COUNT VII
(Quasi Estoppel)

245. Plaintiff re-alleges and incorporates by reference all preceding paragraphs as though fully set forth herein.

246. Idaho recognizes quasi-estoppel where a party takes a position inconsistent with one previously taken and, as a result, either gains an advantage or causes a disadvantage, induces the other party to change position, or where allowing the inconsistency would be unconscionable.

247. Portneuf Medical Center and its administrators repeatedly told staff, including Dallin, that concerns about patient safety, infection control, and sterile-processing procedures should be reported through internal channels without fear of retaliation.

248. These statements were made in staff meetings, compliance trainings, and vendor-credentialing materials that emphasized the hospital's "speak-up" culture and duty to report safety risks.

249. Relying on those assurances, Dallin acted exactly as the hospital said he should. He documented contamination problems, reported them to supervisors, and worked with surgeons to find solutions that would protect patients.

250. His reporting was consistent with hospital policy, federal patient-safety regulations, and basic medical ethics.

251. After receiving and benefiting from his cooperation, Defendants reversed course. Instead of addressing the problems he reported, they retaliated against him by revoking his credentials, spreading false accusations, and blaming him for the very issues he tried to correct.

252. Having encouraged employees and vendors to report safety concerns, the hospital cannot now take the opposite position and punish someone for doing so.

253. This inconsistency is precisely what the doctrine of quasi estoppel forbids. Portneuf gained the benefit of projecting compliance and accountability to regulators, surgeons, and patients by promoting a no-retaliation reporting policy.

254. It then used its power to silence and punish the person who relied on that policy in good faith. Allowing the hospital to do so would be unconscionable.

255. As a result of Defendants' inconsistent and retaliatory conduct, Dallin suffered the loss of his hospital access, damage to his professional reputation, and substantial financial and emotional harm. Quasi estoppel bars Defendants from denying the very rights and protections they promised to those who report patient-safety violations.

COUNT VIII

(Fraud; and in the alternative, Constructive Fraud)

256. Plaintiff re-alleges and incorporates by reference all preceding paragraphs as though fully set forth herein.

257. Beginning in February 2025 and continuing through June 2025, Defendants Pocatello Hospital, LLC d/b/a Portneuf Medical Center ("PMC") and its senior administrators (including Chief Medical Officer Dr. Roger Passmore, Operating Room Manager Debra Schneider, and Chief Executive Officer Nate Carter) made a series of false statements and material omissions to Dallin regarding the condition and safety of Portneuf's Sterile Processing Department and his authorization to continue providing in-room surgical support and vendor services.

258. Specifically, in multiple meetings and conversations between February and May 2025, Dr. Passmore and Ms. Schneider assured Dallin that the Sterile Processing

Department had been investigated and was "fully compliant," that there were "no material concerns," and that he "should proceed as normal" with case coverage and product provisioning.

259. These statements were made in person at Portneuf Medical Center, often in the administrative conference area adjacent to the operating suite, and later repeated by email from the hospital's vendor management office to confirm his continued authorization.

260. At the same time, Defendants concealed material facts:

a. That multiple tray-culture tests ordered by Dr. Morgan had been cancelled or blocked by hospital leadership at Dr. Passmore's direction;

b. That internal audits showed noncompliance with infection-control benchmarks; and

c. That regulatory findings from outside inspectors had identified contamination issues the hospital had not disclosed.

261. Each of these representations and omissions concerned facts that were false, material, and critical to Dallin's work. The truth, that instruments were returning from sterile processing contaminated with bioburden and that leadership was hiding the problem, would have immediately changed his professional decisions and his willingness to continue supporting surgeries at Portneuf.

262. Defendants knew their statements were false or acted with reckless disregard for the truth.

263. They had personal knowledge of positive culture results, documented equipment contamination, and complaints from multiple surgeons, yet they continued to insist that ther Sterile Processing Department was safe and that operations should proceed.

264. Defendants made these statements and omissions with the intent to induce Dallin's reliance.

265. They wanted him to keep attending surgeries, supplying inventory, and maintaining normal operations to protect the hospital's surgical volume and reputation during a period of mounting internal scrutiny.

266. Dallin was ignorant of the falsity of these statements.

267. He could not independently access the hospital's internal testing data, incident reports, or culture results. Those systems were entirely controlled by Portneuf administrators and infection-control staff.

268. Dallin reasonably relied on the hospital's representations. He continued performing surgical case support, maintaining his credentialing, preparing and sterilizing inventory, and dedicating his professional time and resources to Portneuf.

269. His reliance was justified because these assurances came directly from the hospital's highest-ranking officials, who held themselves out as responsible for patient safety and compliance.

270. As a direct and proximate result of Defendants' fraudulent statements and concealment, Dallin suffered substantial injuries, including:

a. loss of income and manufacturer commissions;

b. loss of professional relationships with surgeons and vendors;

c. reputational harm in the medical-device community; and

d. emotional and financial distress caused by the sudden destruction of his business and credibility.

271. All nine elements of fraud are met:

a. Defendants made statements of fact about sterile-processing safety and authorization;

b. Those statements were false;

c. The truth was material to Dallin's work;

d. Defendants knew the statements were false;

e. They intended Dallin to rely;

f. Dallin was unaware of the falsity;

g. He relied by continuing his work;

h. That reliance was justified; and

i. He was injured as a result.

272. In the alternative, even if intent to deceive cannot be shown, the same facts constitute constructive fraud.

273. The hospital and its administrators occupied a position of trust and confidence over Dallin, controlling his credentialing, access, and the safety information necessary for him to lawfully perform his job.

274. They owed a duty of full candor and transparency regarding conditions that directly affected patient safety and his compliance obligations.

275. By concealing material facts and making half-truths in this relationship of dependence and reliance, Defendants breached that duty.

276. Under Idaho law, a plaintiff alleging constructive fraud need not prove intent or knowledge of falsity when there is a breach of a duty arising from a relationship of trust.

277. Here, the hospital's concealment of contamination and revocation of Dallin's credentials after he relied on their assurances exemplify that breach.

278. Defendants' conduct was willful, wanton, and in conscious disregard of Dallin's rights and professional safety.

279. He is entitled to recover all compensatory damages proximately caused by the fraud, and punitive damages to punish and deter similar misconduct in the future.

COUNT IX
(Intentional Infliction of Emotional Distress)

280. Plaintiff re-alleges and incorporates by reference all preceding paragraphs as though fully set forth herein.

281. At all times relevant, Defendants Pocatello Hospital, LLC d/b/a Portneuf Medical Center and its administrators and agents owed Dallin a duty to act honestly and fairly, and to conduct hospital operations in accordance with professional standards that protect patients, vendors, and clinical personnel who support surgical care.

282. Defendants engaged in extreme and outrageous conduct, including, but not limited to:

a. Knowingly disregarding serious sterile-processing failures while continuing operations and pressuring increased case volume despite known risks to patients and those supporting surgeries.

b. Cancelling or blocking culture testing that would have revealed contamination, concealing material safety information, and undermining those who raised safety concerns.

c. Retaliating against Dallin's protected safety reporting by revoking or blocking access and credentialing necessary for case support, and by circulating false narratives about Plaintiff's professionalism and policy compliance to justify exclusion.

283. Defendants further acted outrageously by threatening or jeopardizing Dallin's

professional standing and livelihood if Dallin did not acquiesce to unsafe practices or vendor restrictions that served Defendants' financial interests rather than patient care.

284. Defendants' conduct was undertaken intentionally or with reckless disregard of the high probability that it would cause Dallin severe emotional distress. Defendants knew that excluding a credentialed in-room surgical representative, discrediting his professionalism, and impugning his integrity in the local medical community would foreseeably cause profound emotional harm.

285. As a direct and proximate result of Defendants' extreme and outrageous conduct, Dallin has suffered severe emotional distress, including anxiety, humiliation, and loss of professional purpose, which has substantially disrupted Plaintiff's daily functioning and business operations.

286. Defendants' conduct was malicious, willful, and in conscious disregard of Dallin's rights, warranting the imposition of punitive damages to deter similar misconduct in the future.

WHEREFORE, Plaintiff respectfully prays for judgment against Defendants as follows:

1. For general and special damages exceeding $10,000 and in sufficient amounts to make the Plaintiff whole
2. For treble damages, enhanced damages, attorney's fees and all other increased damage remedies available under Idaho law, including but not limited to those arising from Defendants' civil conspiracy and statutory violations, including under Idaho Code §18-7805 ;

3. For reasonable attorney fees and costs of suit, including under Idaho Code §§ 12-120(3), 12-121, Idaho Code § 18-7805, Idaho Code § 54-1307(2)(c), and any other statutory or equitable authority entitling Dallin to fees and costs;
4. For equitable relief as necessary to do complete justice for the Plaintiff
5. Plaintiff demands a trial by jury in this matter pursuant to I.R.C.P. 38.

DATED this 21st day of January, 2026.

/s/ Bron Rammell
BRON RAMMELL