Case No. C20155232
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SUPERIOR COURT FOR THE STATE OF ARIZONA

IN AND FOR THE COUNTY OF PIMA

LINDSEY LECCE, individually and on behalf of all surviving statutory beneficiaries; LINDSEY LECCE, as personal representative of the Estate of Richard Lecce,

Plaintiff,

vs.

SIERRA TUCSON, INC.. a corporation; REINIER J. DIAZ, M.D., an individual; SCOTT R. DAVIDSON, an individual; KELLEY ANDERSON, an individual; XYZ CORP. 1-5; and JOHN DOE 1-5, an individual,

Defendants.

No.

COMPLAINT
(Tort Non-Motor Vehicle)

Assigned to the Honorable

I. Introduction

This wrongful death case arises out of the tragic and needless death of Richard Lecce, a beloved husband and father, inside the campus of Sierra Tucson, a for-profit residential behavioral health hospital. Mr. Lecce's death, on January 23, 2015, was the fifth preventable death that has occurred inside Sierra Tucson as a result of leadership and staff failures to comply with Arizona regulations, its own internal policies and procedures, the standard of care, and basic common sense. Subsequent to Mr. Lecce's death, another individual died under substantially similar circumstances on August 27, 2015, bringing the fatality total to six. Sierra Tucson is in the midst of what the medical literature describes as a "suicide cluster."

Mr. Lecce borrowed money from his extended family and, after seeking support and encouragement from his wife and children, travelled across the country to Sierra Tucson. He sought help and treatment for debilitating neuropathy pain and related depression and brain health problems. He and his family placed their complete trust, and indeed Mr. Lecce's life, in Sierra Tucson and its promises.

The account, from Sierra Tucson's records, is that Mr. Lecce was having thoughts of suicide and feelings of total hopelessness that triggered his transfer to a heightened state of supervision and care. In the days before his death, absent any documentation of clinical evaluation justifying it and in violation of Sierra Tucson's policy, the heightened supervision was terminated.

Later, on January 17, 2015, Mr. Lecce reported thoughts of suicide and feelings of total helplessness. It was ordered that he be provided with increased supervision and care via transfer to the facility's intensive Level 1 hospital. That did not happen. On January 19, Mrs. Lecce called Sierra Tucson concerned about a call from Mr. Lecce where he told her, "I'm just calling to tell you goodbye." She was worried about how he sounded on the phone. Emails suggest Defendant Sierra Tucson placed Mr. Lecce on a "discharge contract" the next day.

On January 23, 2015, the date of his death, no one at Sierra Tucson evaluated Mr. Lecce or engaged with him until he was found, near death, in his bedroom in the afternoon. Sierra Tucson's repeated failures to engage with Mr. Lecce, or even look for him after he was absent at all five of his daily appointments, violates the standard of care and Sierra Tucson's own "Amber Alert" patient tracking policy. The Defendants' irresponsible and unreasonable actions and decisions coupled with a lack of supervision and accountability caused Mr. Lecce's death. This action is based in negligence and violations of the Arizona Consumer Fraud Act (CFA). It seeks compensatory and punitive damages.

II. Parties and Jurisdiction

1. Defendant Sierra Tucson, Inc. is an Arizona corporation wholly owned and controlled by Acadia Healthcare. Sierra Tucson is authorized to do business and does business in the State of Arizona. It is located in Pinal County, and it does business throughout the State of Arizona, including in Pima County, where it has a prominent

presence.

2. Defendant Sierra Tucson is vicariously liable for the acts and omissions of all of the employees and agents, whether party or non-party to this action, done in the course and scope of their employment relationship with Defendant Sierra Tucson.

3. Defendant Reinier J. Diaz, M.D. is a medical doctor practicing in the greater Tucson area. At all times relevant to this action, Dr. Diaz was working as an agent and/or employee of Defendant Sierra Tucson, which is vicariously liable for all acts and omissions complained of herein.

4. At all times relevant to this action, Dr. Diaz was assigned by Sierra Tucson as Mr. Lecce's attending physician.

5. Upon information and belief, Defendant Diaz is not board certified in any medical specialty by the American Board of Medical Specialties.

6. Defendant Diaz is a resident of Pima County, Arizona.

7. At all times relevant to this action, Defendant Scott R. Davidson was an employee and/or agent of Defendant Sierra Tucson, which is vicariously liable for his acts and omissions complained of herein.

8. On January 23, 2015, the day of Mr. Lecce's death, Defendant Davidson was the nurse assigned to the care of Mr. Lecce.

9. Defendant Davidson is a resident of Pima County, Arizona.

10. At all times relevant to this action, Defendant Kelley Anderson was an agent and/or employee of Defendant Sierra Tucson, which is vicariously liable for her

acts and omissions complained of herein.

11. On January 23, 2015, Defendant Anderson was the Clinical Technician assigned to provide Patient Care Assistance to Mr. Lecce.

12. Defendant Anderson is a resident of Pima County, Arizona.

13. Plaintiff Lindsey Lecce is the widow and surviving statutory beneficiary of Richard Lecce. The two had been married for 28 years when Richard Lecce died inside Sierra Tucson on January 23, 2015.

14. Mrs. Lecce brings this action on her own behalf, and on behalf of their two children, son Garrett Lecce and daughter Morgan Lecce. She also brings this action on behalf of the Estate of Richard Lecce.

15. Venue and jurisdiction is proper in this Court.

III. Factual Allegations

A. Defendant Sierra Tucson

16. Plaintiff incorporates and realleges paragraphs 1 through 15 as if fully set forth herein.

17. At all times relevant to this action, Defendant Sierra Tucson markets itself as a "World Class Facility" and "The Premier Treatment Center for Individuals Struggling with Alcohol and Drug Addiction, Chronic Pain, Eating Disorders, Compulsive Behaviors, Depression and Other Mental Health Issues."

18. Defendant Sierra Tucson advertises that it provides "personalized" services and adheres to the "highest professional standards."

19. Defendant Sierra Tucson advertises that it provides holistic treatment geared toward the "spirit, mind, and the body." It advertises that this approach allows it to provide very individualized treatment.

20. Defendant Sierra Tucson promises that its "Dynamic Patient Centered Process" will overcome mental health and/or addiction disorders. Perspective patients, and their families, are told "With effective treatment or you or your loved one can enjoy the life you were meant to live."

21. Defendant Sierra Tucson promises that "When you enter treatment with us, you can rest assured that you will receive the quality medical care that you deserve every single day. The team of skilled and dedicated full-time medical professionals communicates and collaborates with the entire treatment team. This ensures that patient care is always provided in a comprehensive and highly coordinated manner."

22. Defendant Sierra Tucson holds itself out as specializing in the treatment of co-occurring or co-morbid disease and disorders.

23. In October 2014, Acadia Health Care announced it would acquire Sierra Tucson, along with a portfolio of other behavioral health facilities that were assets of CRC health group for 1.8 billion dollars.

24. At all times relevant to this action, Defendant Sierra Tucson, under the ownership of Acadia, held itself out as being an appropriate – if not the best – facility for the treatment of anxiety and depression co-occurring with pain.

25. Defendant Sierra Tucson held itself out as an appropriate – if not the best –

facility to address the needs of severely depressed individuals who expressed either past or recent suicidal ideation.

26. Defendant Sierra Tucson charges patients, including Mr. Lecce and others, upward of $1,300 per day for their room and treatment.

27. The Sierra Tucson campus is made up of two separate facilities. There is a Level One psychiatric hospital, which operates under license SH3764. There is also a residential facility that operates under license BH3923.

28. During the course of a patient's stay on the Sierra Tucson campus, a patient is initially admitted into the Level One facility for evaluation and close observation.

29. If and when appropriate, the patient is discharged from the Level One facility and admitted into the Level Two facility.

30. Both facilities operate under the name Sierra Tucson.

31. During a patient's stay inside the Sierra Tucson gates, they can be admitted, discharged and readmitted between a Level One and Level Two facility on an as-needed basis, depending on clinical and observational factors and professional judgment.

32. Because the two license holding entities are distinct and separate and operate under distinct and separate licenses, a patient must be admitted and discharged with corresponding paperwork, chart entries and documentation.

B. The State of Arizona Department of Health Services Enforcement Actions

33. Subsequent to Mr. Lecce's death, the State of Arizona Department of Health Services commenced two separate investigations. One investigation centered on

Sierra Tucson's Level One facility (SH3764), and the other centered on Sierra Tucson's Level Two facility (BH3923).

34. Both investigations found deficiencies including violations of Arizona regulations and violations of Sierra Tucson's professional bylaws, policies, and procedures.

35. The State entered Enforcement Actions against both of Sierra Tucson's licenses and required the facility to come forward with acceptable Plans of Correction.

a. The Level Two Investigation

36. Defendant Sierra Tucson entered into an informal dispute process with state regulators with regard to the Level Two findings.

37. As a result of those private negotiations, Sierra Tucson convinced state regulators to modify at least one Survey Finding in the final report.

38. The initial subject Survey Finding, published on www.azcarecheck.com on April 20, 2015, read:

> Based on document reviews and interviews, the administrator failed to ensure that the policy and procedure for behavioral health services of tracking residents was implemented to protect the health and safety of five out of five sampled residents and **contributing the death of one out of five sampled residents.**" [Emphasis added.]

39. In the April 20, 2015 version, the State made a finding that Sierra Tucson's failures contributed to Mr. Lecce's death.

40. Through the informal dispute resolution process, Defendant Sierra Tucson agreed to certain sanctions and actions.

41. In exchange, state regulators agreed to remove the phrase that Sierra Tucson's failures "contribut[ed] to the death of one [Mr. Lecce] of five sampled residents."

42. The State's Enforcement Action, dated June 10, 2015, imposed an agreed to $7,500 civil fine and issued the facility a provisional license through October 31, 2015. The Enforcement Action says:

> LICENSEE AGREED TO PAY $7500 IN CIVIL PENALTIES FOR FAILURE TO IMPLEMENT POLICIES AND PROCEDURES THAT COVER RESIDENT OUTINGS. IF RESIDENTS DO NOT ATTEND, EITHER AN AUTOMATIC SAFETY CHECK OR A CHECK AFTER A 15-MINUTE DELAY SHOULD HAVE BEEN IMPLEMENTED; TREATMENT PLANS WERE NOT ESTABLISHED FOR RESIDENTS WHEN THEY MOVED FROM THE HOSPITAL TO THE RESIDENTIAL FACILITY FOR FIVE RESIDENTS; AND TREATMENT PLANS WERE NOT REVIEWED BY A BEHAVIORAL HEALTH PROFESSIONAL WITHIN 24 HOURS OF COMPLETION FOR FIVE RESIDENTS. THE DEPARTMENT ISSUED A PROVISIONAL LICENSE EFFECTIVE FROM JUNE 10, 2015 TO OCTOBER 31, 2015. LICENSEE AGREED TO RETURN THE ORIGINAL STATEMENT OF DEFICIENCIES WITH THE SIGNED AND DATED ACCEPTABLE PLAN OF CORRECTION TO THE DEPARTMENT WITHIN 10 WORKING DAYS OF RECEIPT OF THE ENFORCEMENT AGREEMENT.

43. In its survey leading to the June 10, 2015 Enforcement Action, state investigators interviewed Sierra Tucson employees, including but not limited to Scott Davidson, Mr. Lecce's assigned nurse on the date of his death, and Kelley Anderson, his assigned Patient Care Tech, along with the residential staff and program staff responsible for leading group activities and group sessions.

44. Per the State's investigation, on January 23, 2015, Mr. Lecce did not have a mandatory morning meeting with Defendant Davidson, his assigned nurse. Defendant Davidson described these meetings as "very important because they bring him contact with the resident and he can see how they are feeling each day."

45. When asked why he did not track down Mr. Lecce, or any resident who misses the morning meeting, Defendant Davidson replied, "It is not in my job description to track down people. The patient comes to the nurse. We have too many other things to do that only the nurse can do."

46. Per the State's investigation, on January 23, 2015, Mr. Lecce was absent and/or there was no documentation as to his attendance at breakfast, his 0715 Exercise Mood and Trauma session, his 0800 Getting Motivated for Change session, his 1000 Mind over Mood session, and his 1200 lunch.

47. State investigators concluded that Sierra Tucson records contained no documentation that the facility's locating procedure was implemented.

48. Defendant Davidson and Defendant Anderson, and other Sierra Tucson employees, reported to state investigators that Mr. Lecce had not been seen on the day of his death and there was "no urgency" in looking for him.

49. Defendant Anderson, in particular, told investigators that she "assumed" Mr. Lecce had been located by his 1000 session because she never received word that he was absent.

50. In connection with Sierra Tucson losing track of Mr. Lecce and his

subsequent death, Sierra Tucson staff have stated that the attendance and reporting policy is simply a "loose program."

51. Sierra Tucson staff admitted that they were "not aware" of requirements to take attendance and report absence.

52. Multiple staff interviewed by state regulators confirmed that they "were not sure who was responsible" for taking attendance, reporting absences, and calling for a search.

b. The Level One Investigation

53. On October 1, 2015, the State entered an Enforcement Action against Sierra Tucson's Level One license for violations related to Mr. Lecce's care and ultimate death.

54. The State assessed an agreed to $1,000 fine, along with the following statement:

> LICENSEE AGREED TO PAY $1000 IN CIVIL PENALTIES. THE MEDICAL STAFF MEMBER FAILED TO COMPLY WITH THE BY-LAWS OF THE PROFESSIONAL STAFF IN PROVIDING QUALITY PATIENT CARE, WHEN A PATIENT WHO PRESENTED WITH A HISTORY OF SUICIDAL IDEATION RELATED TO MOOD AND PAIN, DID NOT RECEIVE A PAIN CONSULT TIMELY; AND THE NURSE EXECUTIVE FAILED TO ENSURE THE RN WHO FACILITATED THE TRANSFER OF A PATIENT TO A LOWER LEVEL OF CARE, WHILE ON A 1:1 FOR SAFETY DUE TO RISK OF SUICIDE, DID NOT NOTIFY THE PHYSICIAN OF THE PATIENT'S STATUS REQUIRING 1:1 OBSERVATION PRIOR TO THE TRANSFER. LICENSEE AGREED TO RETURN THE ORIGINAL STATEMENT OF DEFICIENCIES WITH THE SIGNED AND DATED ACCEPTABLE PLAN OF CORRECTION TO THE DEPARTMENT WITHIN 10 WORKING DAYS OF RECEIPT OF THE ENFORCEMENT AGREEMENT.

55. In a survey of the Level One facility dated July 22, 2015, state regulators determined that Sierra Tucson failed to insure that medical staff provide quality care to Mr. Lecce as evidenced by, among other things, its failing to conduct a psychiatric evaluation of him before discharging him from the Level One facility to the lower level of care Level Two facility shortly before his death.

56. This undocumented discharge was in violation of Sierra Tucson's own hospital policy/procedure titled "Admission Criteria."

57. This undocumented discharge was done even though Mr. Lecce was documented to be at a high risk of suicide at the time he was transferred to the residential facility.

c. The Amber Alert Policy

58. Sierra Tucson's Level Two facility operates under a "Resident Tracking Plan – Amber Alert," Policy Number NR0006.

59. Per the Arizona Department of Health Services Survey Findings, Sierra Tucson's tracking policy states, "It is the policy of Sierra Tucson to ensure resident safety…by tracking resident movement 24 hours a day, 7 days a week."

60. The policy requires staff be responsible for knowing the whereabouts of their residents, which includes the responsibility to monitor resident movement, locate residents when not accounted for, and participate in Amber Alert searches.

61. The policy requires staff take attendance for each activity on the day's schedule. If a resident is not in attendance as scheduled, the locating procedure, also

defined in the policy, is triggered.

62. The policy contains strict, easy to understand, clear and unambiguous guidance to employees in the event that a patient is absent from a scheduled activity.

63. Per the policy, if a resident is absent from two consecutive activities, the Treatment Team will be notified to discuss the implementation of behavioral interventions.

64. On January 23, 2015, Mr. Lecce was absent from all of his scheduled activities of the day, and his assigned nurse did not have his required morning engagement with Mr. Lecce.

65. On January 23, 2015, Defendant Sierra Tucson, through its staff, including but not limited to the named defendants, failed to act in accord with its Amber Alert policy.

66. The failures alleged herein are alleged against Sierra Tucson, independently, and against several of those hired by Sierra Tucson to care for Mr. Lecce.

67. The failures alleged herein caused and contributed to Mr. Lecce's death on January 23, 2015, but they are examples of a much larger, ongoing pattern of negligence and conscious disregard of substantial risk of catastrophic harm to a very vulnerable population, their own patients and their families.

IV. Count One – Medical Negligence, A.R.S. 12-561, et seq. (All Defendants)

68. Plaintiff realleges paragraphs 1-67 as though fully set forth herein.

69. At all times relevant to this action, Defendants owed to patients and their

families, including Mr. Lecce and his family, a duty to use due care in their diagnosis, treatment, documentation of care and supervision of him. Additionally, Defendants owed Mr. Lecce a duty to use due care in their education, training, instruction and supervision of employees as relates to the care and treatment of patients, the creation and maintenance of records and compliance with government statutes and/or regulations and the policies and procedures of the Sierra Tucson facility.

69. At all times relevant to this action, Defendants owed patients and their families, including Mr. Lecce and his family, a duty to exercise reasonable care in keeping him, as a vulnerable patient entrusted to their care, safe, sound, secure and with access to appropriate treatment and interventions.

70. At all times relevant to this action, Defendants owed patients and their families, including Mr. Lecce and his family, at duty to exercise reasonable care in their search efforts to locate him in a timely manner once his whereabouts became unknown.

71. At all times relevant to this action, Defendants acted unreasonably with regard to Mr. Lecce and failed to meet the standard of care requirements.

72. Mr. Lecce's death is a direct result of Defendants' failures. His death has caused, and will forever cause, injury and damage to his surviving beneficiaries.

73. Pursuant to the provisions of A.R.S. 12- 613 in an action for wrongful death, the jury shall give such damages as it deems fair and just with reference to the injuries resulting in the death of the decedent, Richard Lecce, to the surviving parties who may be entitled to recover having regard for the "aggravating circumstances" attending

the wrongful acts, neglect or default of the Defendants and/or their employees and agents.

V. Count Two – Negligence *Per Se.* (All Defendants)

74. Plaintiff incorporates paragraphs 1-73 as though fully set forth herein.

75. At all times relevant to this action, Defendants, all of them, were obligated to follow Arizona law, including statutes and regulations, governing the operation of a Level One psychiatric hospital and a Level Two residential behavioral health facility.

76. Plaintiff's decedent, Richard Lecce, was in the class of people whom these statutes and regulations were designed to protect.

77. At all times relevant to this action, Defendants violated Arizona law governing the safe, lawful, reasonable, and appropriate operation of a Level One psychiatric hospital and a Level Two residential behavioral health facility, including but not limited to, violations of Arizona Administrative Code R9-20-201, et seq.

78. Richard Lecce's death is a direct and proximate result of Defendants' violations of these safety laws, and Mr. Lecce's surviving statutory beneficiaries have suffered and will continue to suffer injury and damage as a result.

VI. Count Three – Consumer Fraud Act Violations (Defendant Sierra Tucson)

79. Plaintiff incorporates paragraphs 1-78 as though fully set forth herein.

80. The Arizona Consumer Fraud Act, A.R.S. §44-1522 et seq, prohibits "any deception, deceptive or unfair act or practice, fraud, false promise, [or] misrepresentation" in connection with "the sale of any merchandise."

81. The CFA defines merchandise to include, among other things, intangibles, services, and health care.

82. The CFA provides consumers with an implied private cause of action against those who violate the act.

83. The elements of a private claim are a false promise, omission, or misrepresentation, made in connection with the sale or advertisement of merchandise, and the plaintiff's consequent and proximate injury from reliance on such a misrepresentation.

84. Plaintiff's reliance need not be reasonable.

85. At all times relevant to this action, Defendant Sierra Tucson acted in violation of the CFA through its false, deceptive, and unfair affirmative advertisements in print and online, including but not limited to on its owned and controlled website, www.sierratucson.com.

86. At all times relevant to this action, Defendant Sierra Tucson acted in violation of the CFA though its material concealment, suppression, and/or omission of material fact including the concerning number of suicides inside its facility, and the related enforcement actions the State of Arizona Department of Health Services had taken against its licenses.

87. At all times relevant to this action, Plaintiffs relied on the statements and advertisements of Sierra Tucson in selecting Sierra Tucson as the best place for the care and treatment of their vulnerable husband and father.

88. Once in the care and custody of Defendant Sierra Tucson, Mr. Lecce did not receive the promised services. Indeed, Defendant Sierra Tucson knew and/or should have known that it was unable or unwilling to provide the promised services.

89. As a direct and proximate result of Plaintiff's reliance on Sierra Tucson's false and misleading statements and the absence and concealment of material facts, Mr. Lecce suffered the ultimate injury – death – and Plaintiff, individually and on behalf of all statutory beneficiaries, has suffered injury including economic injury for expenses charged by Defendant Sierra Tucson and associated expenses such as travel costs.

VI. Count Five – Punitive Damages (Defendant Sierra Tucson)

90. Plaintiff incorporates paragraphs 1-89 as though fully set forth herein.

91. In 2006, a patient at Sierra Tucson committed suicide by drowning. Sierra Tucson was a defendant in a wrongful death litigation where the central allegation was a failure to properly supervise a vulnerable patient population.

92. In 2009, Defendants were fined by the State of Arizona in connection with failing to properly supervise patients and violating Arizona law governing the operation of a behavioral health facility.

93. In 2011, a patient with a history of anxiety and depression went missing from Sierra Tucson's Level Two residential facility. Two weeks later he was found dead approximately 400 yards from his room, near the facility's horse stable.

94. State regulators took adverse action against Sierra Tucson's Level Two license and fined the facility as a result of the 2011 death. Sierra Tucson entered into an agreed to Enforcement Action.

95. In January 2014, a patient with a history of anxiety hanged himself inside his Level Two Sierra Tucson room. Earlier that same day, his wife had called Sierra Tucson staff to report that he had expressed suicidal ideation to her.

96. In April 2014, a 20-year-old man, who was in Sierra Tucson for drug rehabilitation, died of acute drug toxicity.

97. In May 2014, state regulators took adverse action against Sierra Tucson's Level Two license and fined the facility. Sierra Tucson entered into an agreed to Enforcement Action.

98. In September 2014, state regulators took adverse action against Sierra Tucson's Level One license and fined the facility. Sierra Tucson entered into an agreed to Enforcement Action.

99. Each of these four prior deaths involve a common issue of Sierra Tucson's ongoing failure to properly monitor and supervise its vulnerable patient population in a manner that causes and/or contributes to their death.

100. Several of these deaths are the result of Sierra Tucson's ongoing failures in properly looking for its vulnerable patients when they are absent from scheduled activities.

101. The importance of proper patient care and supervision has been known to Defendant since it entered the behavioral health care market, and it has known that the consequences of failure to do so can be fatal.

102. In sworn testimony, current and former Sierra Tucson employees, including a medical doctor and primary counselor, testified that they had raised concerns to Sierra Tucson administration, including the risk manager and executive director, about failures in the facilities patient tracking system and Amber Alert system.

103. The dangers of failing to provide reasonable supervision and care, especially in their open, desert campus location, has been known to Defendants since at least 2006.

104. Defendants have known of their own failures to comply with its own policies and state regulations in regard to the supervision and care of patients since at least 2009.

105. Other problems involving missing patients, patient safety, and unreasonable failures to comply with both policies and procedures and the standard of care have been known or should have been known to Defendants long before January 23, 2015.

106. Despite this knowledge, Defendants continued with a business model that placed a vulnerable patient population in danger.

107. Even subsequent to January 23, 2015, Defendant Sierra Tucson continued with a business model that placed vulnerable patients in danger.

108. Just a few months after Mr. Lecce's death, on August 27, 2015, another vulnerable Sierra Tucson patient took his own life inside Sierra Tucson's Level Two residential facility.

109. The circumstances surrounding the August 27 death are tragically similar to those surrounding the prior five deaths.

110. It again involved a patient who had expressed suicidal ideation not being engaged with on the date of his death.

111. It again involved Sierra Tucson's failures to follow its own Amber Alert policy and the standard for care to look for a patient who was absent from scheduled activities.

112. Defendant Sierra Tucson's conduct was such that it was done with an evil mind evidenced by Defendants acting to serve their own interests, having reason to know and consciously disregarding a substantial risk that their conduct might, and in fact did, significantly injure the rights, health, or safety of others and/or consciously pursuing a course of conduct knowing that it created a substantial risk of significant harm to others.

WHEREFORE, Plaintiff Lindsey Lecce prays for judgment in her favor and against Defendants, all of them, as follows:

1. For past and future special damages;

2. For past and future general damages;

3. For punitive/exemplary damages against Defendant Sierra Tucson, only;

4. For prejudgment interest on the liquidated amounts;

5. For post-judgment interest on the entire judgment amount;

6. For taxable costs incurred in the prosecution of this claim; and

7. Any further relief the court deems just and appropriate in this action.

Dated this 16th November, 2015.

KINERK, SCHMIDT & SETHI, P.L.L.C.
and
PANISH, SHEA & BOYLE

By /s/ Dev K. Sethi
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