

IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF COLORADO

Civil Action No. 06-cv-

LISA M. ROHRBOUGH,

Plaintiff,

v.

UNIVERSITY OF COLORADO HOSPITAL AUTHORITY, a body corporate and political subdivision of the State of Colorado; and  
MARGARET FRUEH, in individually and in her official capacity,

Defendants

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**COMPLAINT AND JURY DEMAND**

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Plaintiff Lisa M. Rohrbough (“Rohrbough”) submits the following complaint against defendants.

**PARTIES**

1. Rohrbough is an individual with an address of 21324 Colonist Way, Morrison, Colorado.

2. Defendant University of Colorado Hospital Authority (the “Hospital”) is a body corporate and political subdivision of the State of Colorado existing pursuant to C.R.S. § 23-21-503(1). The address of its principal office is 4200 East 9th Avenue, Denver, Colorado.

3. Defendant Margaret Frueh (“Frueh”) is an individual employed by the Hospital. At all relevant times Frueh had a business address of 4200 East 9th Avenue, Denver, Colorado.

## **JURISDICTION AND VENUE**

4. This action arises under the Constitution and laws of the United States and the State of Colorado including Article III, Section 1 of the United States Constitution and 42 U.S.C. § 1983. Jurisdiction is conferred on this Court pursuant to 28 U.S.C. §§ 1331, 1343 and 2201. Jurisdiction supporting Plaintiffs' claim for attorney fees and costs is conferred by 42 U.S.C. § 1988. This Court has supplemental jurisdiction over the pendant state claims pursuant to 28 U.S.C. § 1367.

5. Venue is proper in the District of Colorado pursuant to 28 U.S.C. § 1391(b). All of the events alleged herein occurred within the state of Colorado, and all of the parties are residents of the state.

## **GENERAL ALLEGATIONS**

6. Rohrbough was hired by the Hospital on November 9, 1992. From that time until 1999 Rohrbough worked in the Surgical Intensive Care Department. In 1999 Rohrbough transferred to the Transplant Administration Department, where her job title was "Transplant Administrator - Heart." Rohrbough's employment with the Hospital was involuntarily terminated on June 1, 2004.

7. In the eleven-year period from November 1992 to November 2003 Rohrbough never received an unsatisfactory performance review. Every one of Rohrbough's reviews during this eleven year period stated, at a minimum, that her overall performance met standards, and many of her reviews during this period stated that her overall performance exceeded standards.

8. Notwithstanding her exemplary record over eleven years of employment, six

months after November 2003 Rohrbough was terminated, ostensibly for performance related reasons. In reality, the reasons set forth by Frueh for her decision to terminate Rohrbough were pretexts to cover up the real reason for termination, which was Frueh's decision to retaliate against Rohrbough for the exercise of her First Amendment rights.

### **The Hospital's Staffing Crisis**

9. At all relevant times Frueh was Rohrbough's manager in the Hospital's Heart Transplant Department.

10. At all relevant times Dr. JoAnn Lindenfeld was the program attending physician of the Hospital's Heart Transplant Department. On June 11, 2002 Dr. Lindenfeld sent an email to Frueh in which she stated:

As we discussed yesterday we have a staffing crisis. The coordinators are working 12 hours a day and we are still behind to a great degree it is because our system is incredibly cumbersome our secretary spends over half her time getting insurance approvals and almost 80% of our routine las [*sic*] are done outside UH making retrieval almost impossible. We will shortly have resignations if we don't correct the problem. In addition we will begin making errors. We need a short term fix this week and a quick plan for long term resolution. As you know, in addition to additional secretarial support I believe we need another half time nurse practitioner.

11. Rohrbough agreed with Dr. Lindenfeld's conclusion that there was a staffing crisis in the office which was compromising patient care, and beginning in 2002 she repeatedly made her concerns in this regard clear to Frueh and the office nurse practitioner, Karin Keller ("Keller"). Rohrbough discussed with Dr. Lindenfeld, Frueh, Keller and others the very real danger the short staffing and management issues in the office presented and had caused to the Hospital's patients. Nevertheless, the problems continued.

### **Rohrbough's 2002 Evaluation and Appeal**

12. In July 2002 Rohrbough met with Frueh and informed her that she believed that Keller should not perform Rohrbough's 2002 evaluation, because she feared that Keller would retaliate against her for, among other things, her persistence about the need for additional staff and about patient complaints and negative patient outcomes. Despite Rohrbough's fears of retaliation, Keller performed her annual review in October 2002.

13. In her review of Rohrbough's performance, Keller stated that Rohrbough had exceeded standards in six of seven rating categories. Nevertheless, Keller gave Rohrbough an overall rating of only "meets standards." Keller told Rohrbough that she could not give her an overall rating of "exceeds standards" because no employee in her department would receive that rating for the year. This was untrue. Keller gave her good friend, Nancy Ireland ("Ireland"), an overall rating of "exceeds standards," and Keller herself received such a rating.

14. Rohrbough appealed Keller's decision to Frueh. Frueh denied Rohrbough's appeal, even though she acknowledged that there was merit to Rohrbough's contention that there were management concerns.

15. Ultimately, Rohrbough appealed her evaluation to the hospital's chief nursing officer, Colleen Goode, and finally all the way to the Hospital's Executive Vice President, Joyce Cashman. In a January 29, 2003 letter to Cashman, Rohrbough told Cashman that she had informed Frueh after Dr. Lindenfeld's June 11, 2002 email that the staff could not handle their daily or weekly workflow and could not keep up with remote labs, annual scheduling, UNOS reporting or following their inpatients. Rohrbough also told Frueh that patients were complaining about delays in getting calls on results and that the staff was starting to miss a lot of things and make mistakes because they were too

busy. Rohrbough also told Frueh that the staff was afraid they were going to make a “big error” that could really hurt a patient. Rohrbough then expressed her concern about the inadequate response to the staffing crisis in the office. Rohrbough also informed Cashman that she had informed Frueh that she believed Keller and Ireland had been involved in a cover-up of an error with respect to patient “John Doe” that put the patient in extreme risk of a negative outcome.

16. In her January 29, 2003 letter Rohrbough also informed Cashman that Keller had repeatedly instructed the staff that any errors committed in the office must be “kept to ourselves” and that especially errors should not be disclosed to Dr. Lindenfeld. Rohrbough also informed Cashman that Keller worked part time as a nurse practitioner at Dr. Lindenfeld’s private clinic, and that Keller was complicit in an arrangement pursuant to which the office secretary, Tammy Gunnick, who was a public employee, had been directed to spend many hours of her time scheduling patients for Dr. Lindenfeld’s private clinic, which was a misappropriation of public resources.

17. On January 31, 2003 Cashman denied Rohrbough’s appeal.

### **The Heart Switch Cover up**

18. In September, 2002, Rohrbough was the on-call nurse for the heart transplant program. This was a part of her regularly scheduled duties as a heart transplant coordinator. The nurse on-call is responsible for numerous duties including returning calls from patients who have questions or problems, calling UNOS when a patient needed to be listed for a heart or needed a change made in their transplant status when it could not wait to be done during normal business hours, and for making the necessary phone calls to coordinate a transplant once a heart has been accepted by the physician on-call.

19. Federal regulations govern heart transplantation priorities. Each hospital involved in heart transplants has a “Status 1” list of potential recipients which include patients who are in serious jeopardy of imminent death if they do not receive an immediate transplant. Each hospital also has a “Status 2” list of candidates, each of whom needs a new heart but not with the urgency of the “Status 1” list candidates. There are very specific criteria which determine a patient's listing status. When a heart becomes available, the central registry goes from hospital to hospital looking for a “Status 1” list candidate. If no “Status 1” list candidate at any hospital matches a donor heart, the registrar goes back through the hospital lists and makes inquiry regarding “Status 2” list matches.

20. In September, 2002, Rohrbough received a page from Dr. Ronald Zolty, the attending physician on-call for the heart transplant program. She called Dr. Zolty back and when he answered he told Rohrbough that the Hospital had been offered a heart and stated that he was “going to tell a lie.” Rohrbough asked him what he was going to lie about. He told her that he had been offered a heart for a “Status 1” list candidate, but that he was going to give the heart instead to a “Status 2” list patient and that he wanted Rohrbough to call in the “Status 2” list patient and then make the other phone calls necessary to facilitate the transplant.

21. Rohrbough told Dr. Zolty that she had previously confirmed with the program director, Dr. Lindenfeld, that the attending physician on-call has the authority to list patients, make changes to their status, and to make the decision regarding the patient for whom to accept a heart, and that the nurse on-call is obligated to follow the physician's orders on these matters. Rohrbough told Dr. Zolty that if his order was to call

in the “Status 2” list patient, then she would do that. She also told him, however, that UNOS does careful follow-up of the allocation of all transplanted hearts and that if he lied to them it would certainly come back and he would have to answer for it. Dr. Zolty told Rohrbough to go ahead and call in the “Status 2” list patient.

22. After hanging up the phone and before Rohrbough had called in the patient Dr. Zolty called her back and told her not to make any phone calls until he called her back. A short while later, Dr. Zolty called Rohrbough back and told her that he had cleared it and that she should now call in the “Status 2” list patient and make the other necessary phone calls. Rohrbough asked if he had cleared it and could accept the heart for the “Status 2” patient and Dr. Zolty told her that he had. Rohrbough then called in the patient and made the other phone calls as per Dr. Zolty’s orders. The Status 2 patient did in fact, receive a heart transplant at this time.

23. Rohrbough was troubled by what had transpired and spoke with Karin Keller and Nancy Ireland about the conversations she had had with Dr. Zolty. She was told that she had done the right thing to question Dr. Zolty about his initial decision to lie to UNOS and both Keller and Ireland confirmed that the sequence of allocation is always followed up on by UNOS and that it was a good thing for the program that Dr. Zolty had changed his initial decision and proceeded to follow proper protocol.

24. On approximately January 15, 2003, the office received a fax from Lindenfeld asking for follow-up on correspondence that she had received from UNOS about a possible policy violation in regard to the allocation of a specific heart. This correspondence from the UNOS Compliance Department requested explanation for why a heart that was originally accepted for a “Status 1” list patient was not transplanted into

that patient. The correspondence then stated that this heart was transplanted to another patient, but no import match run was generated, and UNOS requested an explanation of how allocation proceeded once it was decided that another patient and not the original designee would receive this heart.

25. Rohrbough spoke with both Keller and Ireland and confirmed that this was the heart that Dr. Zolty had called her about in September 2002 as described above.

26. Rohrbough then spoke with Dr. Zolty about the UNOS investigation. He stated that the “Status 2” list patient, even though listed lower in status than the “Status 1” list patient, was sick and would probably have had to wait a long time to get transplanted and that it should not matter since patient “Status 2” received the heart and was doing well.

27. Rohrbough then spoke with Lindenfeld, who stated that she believed the allocation problem was probably the result of a junior attending physician not knowing proper protocol for accepting a heart. Rohrbough corrected Lindenfeld’s mistaken belief and told her what had transpired that night as described above. She told Lindenfeld that Dr. Zolty had assured her that he had obtained approval for the switch. She then told Lindenfeld of her conversation with Dr. Zolty who stated that it should not matter because patient “Status 2” was doing well post-transplant. Lindenfeld thanked Rohrbough for her input and said she would speak with Dr. Zolty about the problem.

28. Rohrbough spoke with Cashman in January of 2003 and told her about the UNOS issue. She stated her concerns that now Lindenfeld was going to lie to UNOS and state – even though she knew differently – that the error was a result of a mistake made by a junior attending physician who did not know better. Rohrbough also followed this

up with a letter to Cashman on January 29, 2003, telling her that an investigation from UNOS was in progress and that she feared that this could harm the transplant program and that the incident was a symptom of systemic problems in the heart transplant office. Rohrbough then spoke with Colleen Goode on 8-4-03 and told her about the UNOS transplant violation. She told Goode about the circumstances involved and expressed her concern of a cover-up involving Dr. Lindenfeld. Rohrbough also reiterated her concerns regarding other patients and policy violations resulting in negative patient outcomes, including death.

29. The incident was discussed at a Transplant Selection Committee meeting in which Lindenfeld told the committee that the Hospital had violated UNOS rules by transplanting a heart into patient "Status 2" which had been accepted for patient "Status 1". In response to questioning about how this had happened and who had made that decision, Lindenfeld responded that it was hard to pin down the person involved and that things like this happen when things get confused, and that she would tell UNOS that the Hospital made a mistake and that it would be discussed with the staff and it would not happen again. She further stated that the Hospital would not have gotten the heart if it had said it intended to take it for patient "Status 2", because it would have been used elsewhere for an "Status 1" list patient at some other hospital.

30. After this meeting, Rohrbough spoke to Dr. Zolty and told him that she believed that this was a cover-up. Dr. Zolty stated that Dr. Lindenfeld was going to falsely claim that it was a mistake. Rohrbough told Dr. Zolty that when he had her call in patient "Status 2" he had assured her that he had been cleared to accept the heart for that patient and that that was not the truth. Dr. Zolty replied that Donor Alliance had told him

that this is done all of the time and that there were no other centers and no other “Status 1” list patients to offer the heart to anyway.

31. Rohrbough continued to be concerned about the ethical issues involved and called UNOS and spoke with a representative who was investigating the misallocation of the heart. The representative told Rohrbough that UNOS received two conflicting reports of what had happened and appreciated the information that Rohrbough was providing. Rohrbough provided the representative her pager number in case UNOS needed further involvement on her part.

#### **Rohrbough’s “Incidence Reports”**

32. At all relevant times Dennis Brimhall (“Brimhall”) was the President and Chief Executive Officer of the Hospital. On April 7, 2003 Rohrbough contacted Brimhall about her concerns regarding the Heart Transplant Department. Brimhall met with Rohrbough on April 21, 2003 to discuss her concerns. Rohrbough also told Brimhall that Frueh, Goode, and Cashman had declined to look at Rohrbough's documentation of negative patient outcomes. The following day Brimhall directed Rohrbough to contact Susan West, head of the Hospital’s Risk Management Department.

33. On May 15, 2003 Rohrbough met with West to express her concerns about patient care. West instructed Rohrbough that any concerns she had with patient care should be reported to Risk Management for review. She instructed her to write “occurrence reports” at any time an event occurred that gave her concerns about patient safety, even if the event had occurred in the past. West requested occurrence reports of past problems to see if there was a pattern to the problems.

34. Heart transplant patients are part of a very unique and specific patient

population. These patients are routinely on two to three immunosuppressive medications to keep their heart from being rejected. Other medications they may be on include steroids, lipid decreasing agents, antihypertensives, medication and vitamins to increase or stabilize bone density, anti-fungal, anti-viral, anti-ulcer, and diabetes medications. The immunosuppressive medications have many potential serious even life-threatening side effects. These include increased risk of infection, increased risk of cancer, renal failure, hypertension, and neurotoxicity. Other potential side effects of heart transplant patients' medical regime include electrolyte imbalances, diabetes, hypotension, osteoporosis, and a serious muscle breakdown syndrome. Heart transplant patients are also at risk for hyperacute, acute, and chronic rejection as well as accelerated coronary artery disease.

35. Because of these factors, heart transplant patients need to have intense medical follow-up. Some of this follow up includes biopsies, echocardiograms, lab work, heart catheterizations, and bone density studies. Because of the potentially life threatening results if abnormalities are not seen and treated immediately, the Hospital's heart transplant office standards included same day follow up of results on labs drawn at the Hospital, next day follow up on labs drawn elsewhere, and next day follow up on biopsies, echocardiograms, and preliminary results on heart catheterizations.

36. In response to West's instructions Rohrbough wrote eleven occurrence reports, which are summarized in the following paragraphs.

37. Occurrence Report One: Patient A. Annual testing was done in April 2001 which showed coronary artery disease. Patient A had a clinic visit in May 2001 at which time medication changes were made and follow up labs and testing were ordered. No follow up on the labs or testing was documented. In fact, the next documentation on this

patient was not until the middle of August, 2002. Patient A then had a clinic visit with labs approximately six days later. Annual testing was done one week later, which showed left ventricular hypertrophy and a change in hemodynamics. Further work-up was then needed. The office standard was to check fasting lipids on all patients a minimum of every three months. Patient A had documented fasting lipids checked only in mid-January, 2000, late August, 2000, late August, 2002, and in the beginning of May, 2003.

38. Occurrence Report Two: Patient B. Patient B had a low white blood cell count (WBC) at the end of January, 2003 of 3.3. Twelve days later the WBC remained low at 3.1. No changes were made. Patient B had a clinic visit in the end of March, 2003 at which time the WBC was 3.2. The physician ordered a medication change with a repeat WBC ordered for approximately two weeks later. This WBC result, however, was not seen until nine days after it was drawn and it was 2.0. The following day the WBC was 2.7. Two days later, the WBC was 2.1. Approximately 11 days later the WBC was 1.7. At this time additional medication was ordered for the patient.

39. Occurrence Report Three: Patient C. Patient C had labs checked early June, 2003. It was noted that the patient's Sirolimus (anti-rejection medication) level drawn in the beginning of May, 2003 had never been followed up on and was still listed as pending.

40. Occurrence Report Four: Patient D. Patient D had a medication change done in late February, 2003. The anti-rejection medication, Cellcept, was increased at that time with a repeat lab including WBC scheduled to be checked two weeks later. At the end of April, 2003, upon checking the "blue book" (which lists pending labs and tests) it

was noted that this lab had not been followed up on and was still listed as pending. Upon calling the lab for results, Rohrbough was told that the patient had not shown up to have labs drawn. Patient D was called and labs were then done.

41. Occurrence Report Five: Patient E. Patient E had stable labs mid-February, 2002. Patient E was next due for annual testing in April or May of 2002. Late April, 2002, documentation was made in the patient's chart that patient had lost insurance coverage and the plan was to call the patient in two weeks to check on status of insurance and to schedule annual testing. The next documentation is in mid-December, 2002 stating that patient has insurance. A clinic visit with labs was scheduled for January 2003 and the annual testing was done in March 2003.

42. Occurrence Report Six: Patient F. Patient F had a medication change in early May, 2003. Patient's medication Lisinopril was increased and their potassium supplement was discontinued. To follow up on these changes, labs were ordered to be drawn five days later. The order was not faxed to the lab so the lab draw date was changed to two days later. On June 10, 2003, upon checking the blue book for pending labs and tests, it was noted that that follow up lab had not been followed up on and was still listed as pending. The lab was called and results obtained which showed a decrease in the patient's potassium from 4.9 (end of April, 2003) to 3.8 (currently checked lab).

43. Occurrence Report Seven: Patient G. Patient G had a lab drawn in early May, 2003. On June 10, 2003, upon checking the blue book for pending labs and tests, this lab had not been followed up on and was still listed as pending. These labs had been ordered secondary to a medication change, and patient G had a history of increased potassium levels.

44. Occurrence Report Eight: Patient H. Patient H had annual testing with full fasting labs done on end of May, 2003. On June 10, 2003, upon checking the blue book for pending labs and tests, it was found that patient H had full fasting labs end of February, 2003, which had never been followed up on and which were still listed as pending. Patient H's last documented labs before this were mid-December, 2002. The office standard is to check full fasting labs every three months.

45. Occurrence Report Nine: Patient I. Patient I was on Cytoxan, a medication that can cause an adverse effect known as hematuria, which can lead to potentially fatal hemorrhagic cystitis. The office standard was to check a urinalysis once a month on every patient receiving Cytoxan to check for hematuria. During the past year, patient I only had documented urinalysis checks end of June, 2002, end of July, 2002, beginning of October, 2002, mid-February, 2003, beginning of April, 2003 and beginning of July, 2003.

46. Occurrence Report Ten: Patient J. Patient J had an abdominal ultrasound beginning of August, 2000 that showed an abdominal aortic aneurysm. No follow up serial ultrasounds were done to evaluate the aneurysm until the patient was seen at a clinic visit mid-June, 2003 and a physician ordered one. The office standard is to check serial abdominal ultrasounds once every six months on patients with existing abdominal aortic aneurysms. Patient J had an abdominal ultrasound done end of June, 2003 and was referred to a vascular surgeon for further follow up.

47. Occurrence Report Eleven: Patient K. Patient K had labs done beginning of May, 2003 ordered by the office to be done locally at their primary doctor's office. Results were not followed up on or received until mid-June, 2003. The labs showed an

increased CK level of 283 (normal is 24-195). This patient was on Pravachol at the time. The lab was rechecked six days later.

### **Rohrbough's 2003 Evaluation and Termination**

48. As noted above, in her 2002 evaluation Rohrbough received an "exceeds standards" rating in six of seven rating categories, prompting Cashman to state that Rohrbough's performance score was "very high." This was consistent with the Rohrbough's reviews in the previous ten years.

49. In September 2003 three of Rohrbough's colleagues, Nancy Ireland, Linda Stepien ("Stepien"), and Rhonda Frisk ("Frisk"), submitted "peer review" evaluations of Rohrbough's performance to Frueh. Each of these evaluations concluded that Rohrbough either met standards or exceeded standards.

50. Rohrbough was on leave pursuant to the Family Medical Leave Act ("FMLA") from August 2003 to November 2003. While Rohrbough was on FMLA leave she spoke with Stepien by telephone. Stepien informed her that her occurrence reports were being investigated and that "your name is mud" in the office.

51. On February 17, 2004 Frueh delivered Rohrbough's 2003 performance evaluation to her. For the first time in Rohrbough's twelve-year career at the Hospital, her evaluation stated that her overall performance had not met expectations. Frueh stated that Rohrbough's main problems were with her communications, even though in her previous evaluation "communication" had been listed as one of her greatest strengths.

52. At the same time she delivered Rohrbough's evaluation to her, Frueh established a 90-day performance improvement plan for Rohrbough, and scheduled a second evaluation for May 17, 2004.

53. Frueh told Rohrbough that her evaluation was based in part on one written peer review and three verbal peer reviews. Frueh told Rohrbough that the three persons who gave verbal peer reviews had done so because they feared Rohrbough would retaliate against them.

54. In Rohrbough's department there were four and only four persons who were eligible to submit "peer review" evaluations of Rohrbough's performance. These four persons were Keller, Stepien, Frisk and Ireland.

55. Stepien informed Rohrbough that Frueh had approached her in or about February 2004 concerning Rohrbough's evaluation and that Stepien told her to use her written September 2003 evaluation report.

56. Frisk told Rohrbough that she never did any evaluation for her 2003 performance other than the September 2003 written evaluation.

57. It is obvious, therefore, that Frueh lied to Rohrbough when she told her that three of her four peer review evaluations had been verbal. Frueh told this lie to cover up the fact that she completely disregarded the positive September 2003 reviews Rohrbough had received in order to give her a bad review as part of her plan to terminate her in retaliation for her First Amendment protected speech activities.

58. On March 4, 2003 Keller, Stepien, Frisk, Ireland, and the office secretary went to the office of Kathleen Doderro to complain that Rohrbough had created a "hostile work environment." On this same day Rohrbough was placed on administrative leave pending an investigation of this complaint. The complaint against Rohrbough was without merit.

59. On June 1, 2004 Frueh fired Rohrbough in retaliation for Rohrbough's First

Amendment speech activities described above.

**FIRST CLAIM FOR RELIEF  
(Violation of First Amendment Rights)**

60. Rohrbough incorporates the allegations paragraphs 1 through 59 as if fully set forth herein.

61. Rohrbough engaged in speech activities protected by the First Amendment regarding several matters of public concern all involving health care and life and death matters in a governmentally owned and operated facility, whose primary purpose as a hospital is to provide medical and surgical care to sick or injured persons.

62. There was no disruption of the Hospital's activities, and thus Rohrbough's interest in commenting on these matters of public concern outweighed any interest the Hospital might have had in promoting efficient government services. Indeed, many of Rohrbough's comments were intended to assist the Hospital to increase the effectiveness of its patient care.

63. Retaliation against Rohrbough's speech activities was a substantial or motivating factor in Frueh's decision to terminate Rohrbough.

64. Rohrbough's job performance at the Hospital was excellent. Therefore, the Hospital would not have terminated Rohrbough if she had not engaged in the protected speech activities.

65. Defendant's actions in terminating Plaintiff from her employment were intentional, knowing, willful and wanton, designed to punish and retaliate against her for the exercise of her constitutionally protected speech.

65. Rohrbough has been damaged by the defendants' violation of her Constitutional right to freedom of speech.

## **PRAYER FOR RELIEF**

66. Rohrbough respectfully requests the Court to enter judgment in her favor against defendants and to award her the following relief:

- (a) Appropriate relief at law and equity;
- (b) Compensatory and consequential damages, including damages for emotional distress, humiliation, loss of enjoyment of life, and other pain and suffering on all claims allowed by law in an amount to be determined at trial;
- (c) Punitive damages on all federal claims allowed by law and in an amount to be determined at trial;
- (d) Attorneys fees and the costs of this action, including expert witness fees, on all claims allowed by law;
- (e) Pre- and post-judgment interest at the lawful rate;
- (f) Any further relief that this court deems just and proper, and any other relief as allowed by law.

PLAINTIFF REQUESTS A JURY ON ALL MATTERS SO TRIABLE.

Respectfully submitted on this the 24<sup>th</sup> day of May, 2006.

KILLMER & LANE, LLP

s/ David A. Lane

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