IN THE CIRCUIT COURT OF WASHINGTON COUNTY, ARKANSAS
CIVIL DIVISION

JESSICA MOUNCE, Individually, and Behalf of all others Similarly Situated Plaintiffs,	)	**CLASS ACTION COMPLAINT**
	)	**Jury Trial Demanded**
Plaintiff,	)	
vs.	)	**Case No.** CV15-934-1
COMMUNITY HEALTH SYSTEMS, INC. A Delaware Corporation; CHSPSC, LLC, A Delaware Corporation, and NORTHWEST ARKANSAS HOSPITALS, LLC, a Delaware Corporation d/b/a/ NORTHWEST MEDICAL CENTER, PROFESSIONAL ACCOUNT SERVICES, INC., a Tennessee Corporation and JOHN DOES I – X.	)	
Defendants.	)	

FILED FOR RECORD
2015 JUN -3 AM 8:17
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CLASS ACTION COMPLAINT

Comes Now **Plaintiff, JESSICA MOUNCE,** by and through her attorneys of record, individually and on behalf of all other similarly situated, and alleges as follows:

PARTIES, JURISDICTION AND VENUE

1. Plaintiff, Jessica Mounce, individually and as representative of a proposed class, is a resident of Lowell, Benton County, Arkansas.

2. **Defendant, Community Health Systems, Inc.** (hereinafter referred to as "CHS") is a Delaware corporation with its principle place of business in Tennessee. CHS conducts business in the State of Arkansas and elsewhere. Upon information and belief, CHS is the parent company that owns and/or operates subsidiaries which in turn operate general care hospitals in

numerous states, including Northwest Medical Center in Springdale, Arkansas. In its 10-K filed with the United States Securities & Exchange Commission, CHS represented:

> We are one of the largest publicly-traded hospital companies in the United States and a leading operator of general acute care hospitals in communities across the country. We were originally founded in 1986 and were reincorporated in 1996 as a Delaware corporation. We provide healthcare services through the hospitals that we own and operate and affiliated businesses in non-urban and selected urban markets throughout the United States. As of December 31, 2014, we owned or leased 197 hospitals included in continuing operations, comprised of 193 general acute care hospitals and four stand-alone rehabilitation or psychiatric hospitals. These hospitals are geographically diversified across 28 states, with an aggregate of 30,137 licensed beds. We generate revenues by providing a broad range of general and specialized hospital healthcare services and other outpatient services to patients in the communities in which we are located. Services provided through our hospitals and affiliated businesses include general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic, psychiatric and rehabilitation services. We also provide additional outpatient services at urgent care centers, occupational medicine clinics, imaging centers, cancer centers, ambulatory surgery centers and home health and hospice agencies. An integral part of providing these services is our relationship and network of affiliated physicians at our hospitals and affiliated businesses. As of December 31, 2014, we employed approximately 3,300 physicians and an additional 900 licensed healthcare practitioners.

3. Defendant **CHSPSC, LLC,** formerly known as Community Health Systems Professional Services Corporation (hereinafter "CHSPSC") is a Delaware Corporation with its principal place of business in Tennessee. Upon information and belief, CHSPSC does business in Arkansas and other states and has responsibility for billing of patients and liens filed within the State of Arkansas. .

4. Defendant **Professional Account Services, Inc.** ("PAI") is a Tennessee corporation with its principal place of business in Tennessee. PAI has no registered agent in and lacks a certificate of authority authorizing it to do business in Arkansas, it nevertheless does business in Arkansas, including filing a Notice Lien against Plaintiff with the Circuit Court of Washington County, Arkansas.

5. **Defendant, Northwest Arkansas Hospitals, LLC d/b/a Northwest Medical Center ("Northwest Medical Center")** is a Delaware Corporation with its principal place of business at 4800 Tennyson Parkway, Plano, Texas 75024. Northwest Medical Center operates, among other health care facilities, the following general care hospitals in Arkansas: Forrest City Medical Center, Forrest City, Arkansas; Northwest Medical Center, Bentonville, Arkansas; Sparks Medical Center, Van Buren, Arkansas; Helena Regional Medical Center, Helena, Arkansas; Northwest Medical Center, Springdale, Arkansas; Sparks Regional Medical Center, Fort Smith, Arkansas; Medical Center of South Arkansas, El Dorado, Arkansas; Siloam Springs Regional Hospital, Siloam Springs, Arkansas; and Willow Creek Women's Hospital, Johnson, Arkansas.

6. On information and belief, CHS is or was at all relevant times, the parent company of CHSPSC, PAI, and Northwest Medical. On information and belief, CHSPSC, CHS, and PAI exercise control over policies enacted by Northwest Medical Center, including policies related to billing and liens, and CHSPSC, CHS, PAI and Northwest Medical Center committed the acts and omissions described below jointly and in concert.

7. Defendants John Does I through X are other corporations, persons or entities who either own, operate, control, manage or in other ways are responsible or liable parties for the named defendants herein. These John Does defendants are additional tortfeasors but at the time of this pleading the identities are unknown to the Plaintiffs. That John Doe defendants I-X are named herein as yet unidentified tortfeasors pursuant to Ark. Code Ann. § 16-56-125 for the express purpose of tolling the statute of limitations and are intended to include, without limitation,

a. All individual employees, agents or contractors who were performing services of any kind for the Northwest Medical Center during the events described *infra* who are or may be liable in damages;

b. All individuals or business entities other than the Northwest Medical Center who hired, employed or supervised any individual employees, agents or contractors who were performing the duties of accounts receivable/payable services for Northwest Medical Center;

c. All individuals or business entities who own or control the Northwest Medical Center; and

d. All insurers of the Northwest Medical Center and/or any John Doe defendant who raise the issue of non-profit or charitable status, or immunity from suit. An Affidavit of Counsel is attached hereto as Exhibit "A" and made a part hereof by reference in support of the aforementioned John Doe allegations.

8. Jurisdiction and venue is proper in this Court because the acts and/or omissions occurred in Washington County, Arkansas. Defendants do business in the State of Arkansas.

9. Plaintiff brings this action on behalf of herself and all other similarly situated individuals in the State of Arkansas as a Collective and Class Action.

FACTS

10. Defendants screen all patients and make a determination regarding the reason for treatment and whether there may be sources of payment other than health insurance available.

11. Upon information and belief, if the patient is identified as one whose medical bills may be recoverable from another source, Defendants refuse to submit that patient's medical bills to his or her health insurance carrier or submit the bills to health insurance, and sometime thereafter, remit those funds back to health insurance after receiving payment from another source.

12. Defendants engaged in these practices even though Defendants are contractually required to submit said bills to the health insurance carrier, accept the payment from health

insurance in satisfaction of the bill, not seek payments from any additional sources, and hold the patient harmless from any amounts owed other than co-pays and/or deductibles.

13. While refusing to submit medical bills to the patients' health insurance carrier and accept the payment in satisfaction of the bill, Defendants routinely seek payment for the medical bills from those same patients, either directly or indirectly.

14. Defendants seek payment for medical bills through means including demanding cash payment directly from the patients, placing unlawful liens upon patients' third-party tort claims, seeking medical payment benefits from the patients' auto insurers, turning said patients over to collection agencies, and/or reporting said patients to credit bureaus (thereby impairing the patients' credit score), *inter alia*.

15. Defendants pursue such course of conduct despite the patients having health insurance and being contractually entitled to have their medical bills submitted to their health insurance carrier for payment.

16. Upon information and belief, Defendants are required by their contracts with patients' health insurance carriers to submit insured patients' medical bills directly to the carriers. Likewise, Defendants were required to submit Plaintiff's medical bills to her health insurance carrier, Blue Cross Blue Shield.

17. Defendants are required to honor a contractual discount with their patients' health insurance carriers and accept discounted payment from those health insurance carriers in full satisfaction of the patients' debts.

18. Upon information and belief, Defendants are precluded by contracts with private health insurance carriers (such as the named Plaintiff's insurer, Blue Cross Blue Shield) from seeking payment for covered services from other sources, including from the patient directly,

medical payment benefits from the patients' auto insurer, turning the bills over to collections, and/or filing liens against patients' property, including personal injury claims.

19. Defendants fail to inform patients at the time of treatment that they will not honor the patient's health insurance if the circumstances create the possibility of another source of recovery.

20. Defendants represent to patients, including the named Plaintiff in this case, that Defendants will submit the patient's bill to health insurance and will accept that payment in satisfaction of the patient's bill.

21. Defendants enter into contracts with patients, including the named Plaintiff in this case, which assigns and authorizes payment to Defendants by the patient' health insurance carrier. This agreement also indicates that Defendants will submit the patient's charges to health insurance and that the patient will only be responsible for charges not covered by the assignment of insurance benefits (i.e. co-pays and deductibles).

22. Such patients are unable to submit their medical bills directly to their health insurance carrier as Defendants are the entities responsible for such submission. Defendants are the only entities in possession of the information required to make such a submission, and Defendants are the entities that have a contract with the health insurance carrier for a reduced compensation for treating patients with health insurance.

23. Through Defendants' bill collection practices, they attempt to optimize the amount received for services rendered by seeking from patients the full amount billed (or more than Defendants are entitled to for the covered treatment), rather than accepting the discounted amount it has agreed to accept from the patient's health insurance carrier.

24. By employing such a policy and business model, Defendants have unlawfully violated the rights of Plaintiff and the Class Members as described more particularly below.

25. Further, such conduct of Defendants and their agents, for which they are directly and indirectly responsible, is outrageous, intentional, willful, wanton, and malicious, and otherwise shows a complete indifference to or conscious disregard of the rights of Plaintiff and the Class Members such that punitive damages are appropriate and warranted.

26. On or about November 30, 2013, Plaintiff Jessica Mounce presented to Defendants for emergency medical services as a result of an automobile accident.

27. Plaintiff's treatment resulted in medical charges for the treatment she received from Defendant totaling $6,104.96.

28. At the time of treatment, Plaintiff had valid health insurance coverage with Blue Cross Blue Shield.

29. At the time of treatment, Defendants did not inform Plaintiff that Defendants would not accept Plaintiff's health insurance. Nor did Defendants explain they would be seeking the balance of Plaintiff's medical bills from her personally, by billing her medical payments coverage, or by placing a lien against her third-party tort claim.

30. Defendants did not inform Plaintiff that Defendants would be pursuing a third-party lien against her personal injury recovery.

31. Defendants are required by contracts with Plaintiff's health insurance carrier, Blue Cross Blue Shield, to submit medical bills of insured patients directly to the carrier for payment.

32. Plaintiff was entitled to a contractual reduction in the amount of her medical bills charged by Defendants pursuant to her insurance carrier's agreement with Defendants, and to have those bills paid by her health insurance carrier.

33. Defendants are precluded by their contracts with Plaintiff's health insurance company from seeking payment for covered benefits from other sources, including seeking payment directly from Plaintiff, seeking medical payment benefits from Plaintiff's auto insurer, turning the bills over to collections, and/or filing a lien on Plaintiff's property, such as a third-party tort claim.

34. Despite the fact that Plaintiff did not owe Defendants any debt, on January 9, 2014 Defendant sent Notice of Statutory Lien in the amount of $6,104.96 to Plaintiff.

35. Defendants sought payment and/or asserted a lien on the third-party motorist claim through the auto insurer, Horace Mann Insurance.

36. Defendants did not inform Plaintiff and/or Horace Mann Insurance that Defendants had a contract with Blue Cross that required Plaintiff's charges be submitted to Blue Cross for payment and that Defendants were precluded from pursuing any charges from Plaintiff and/or any asset of Plaintiff, including, but not limited to, by filing a lien on Plaintiff's third-party personal injury recovery.

37. Defendants were paid $3,052.48 to satisfy Defendants' lien in January, 2015.

38. Any amount paid to Defendants to satisfy the lien was paid based on the wrongful conduct of Defendants.

39. Neither Plaintiff nor Horace Mann Insurance had full knowledge of the facts surrounding Defendants' improper lien.

CLASS ACTION ALLEGATIONS

40. Plaintiff incorporates the preceding allegations of her Class Action Complaint by reference.

41. This action is brought as a Plaintiff's Class pursuant to Rule 23 of the Arkansas Rules of Civil Procedure. Plaintiff brings this action on her own behalf and all others similarly situated, as representative of the following Class:

> All Arkansas residents who, since April 30, 2010, received any type of healthcare treatment from any entity located in Arkansas that is owned or affiliated with Defendant Community Health Systems, while being covered by valid commercial health insurance, and whose medical bills resulting from that treatment were either not submitted to health insurance for payment or were submitted and thereafter Defendants refunded those payments to their health insurance carriers and Defendants obtained payment for those bills directly from the patient, from an auto insurer, and/or from the patient's third-party tort recovery (hereinafter "Class Members" or "the Class ").

42. The particular members of the Class are capable of being described without difficult managerial or administrative problems. The members of the Class are readily identifiable from the information and records in the possession or control of Defendants.

43. The Class consists of hundreds and perhaps thousands of individual members and is, therefore, so numerous that individual joinder of all members is impractical.

44. There are questions of law and fact common to the Class, which questions predominate over any questions affecting only individual members of the Class and, in fact, the wrongs suffered and remedies sought by Plaintiff and the other members of the Class are premised upon an unlawful scheme perpetuated uniformly upon all the Class Members. The only material difference between the Class Members' claims is the exact monetary amount to which each member of the Class is entitled. The principal common issues include, but are not limited to the following:

(a) Whether Defendants entered into express and/or implied agreements with various health insurance carriers providing, among other things, that health insurance claims should be promptly submitted to the carriers for payment;

(b) Whether Defendants violated their contracts with various health insurance carriers by not submitting medical bills to the carrier;

(c) Whether Defendants violated their contracts with various health insurance carriers by pursuing recovery for services rendered by placing liens upon patients' property (such as third-party tort claims), pursuing medical payment benefits from auto insurers, pursuing payment directly from the patients, and/or turning patients' accounts over to collections;

(d) Whether Defendants violated their contracts with various health insurance carriers by not offering a contractually agreed discount to patients covered by said policies;

(e) Whether Defendants have violated their contracts with Plaintiff and the Class Members by seeking payment for charges that were covered by valid commercial health insurance;

(f) Whether Defendants improperly refused to submit the Plaintiff's and the Class Members' medical bills to Plaintiff's and the Class Members' health insurance carriers for payment;

(g) Whether Defendants profited by refusing to submit said medical bills to said health insurance carriers for payment;

(h) Whether Defendants have been unjustly enriched at the Plaintiff's and the Class Member's expense through the above described misconduct;

(i) Whether Defendants breached their duty of good faith and fair dealing to the Plaintiff and the Class through the above described misconduct;

(j) Whether Defendants are liable to Plaintiff and the Class Members based on a claim on money they have received;

(k) Whether Defendants should be enjoined from continuing their improper and unlawful billing practices as described above.

45. Plaintiff's claims are typical of those of the Class and are based on the same legal and factual theories as outlined above.

46. Plaintiff and her counsel will fairly and adequately represent and protect the interests of the members of the Class. Plaintiff has no claims antagonistic to those of the Class. Plaintiff has retained competent and experienced counsel who have prosecuted dozens of complex class actions within Arkansas and across the nation. Undersigned counsel is committed to the vigorous prosecution of this action.

47. Certification of a plaintiff Class is appropriate in that Plaintiff and the Class Members seek monetary damages, common questions predominate over any individual questions, and a plaintiff class action is superior for the fair and efficient adjudication of this controversy. A plaintiff class action will cause an orderly and expeditious administration of the Class Members' claims. Economies of time, effort and expense will be fostered, and uniformity of decisions will be ensured by certification of the class. Moreover, the individual Class Members are unlikely to be aware of their rights and are not in a position (either through experience or financially) to commence individual litigation against Defendants and their vast resources.

48. Alternatively, certification of a plaintiff Class is appropriate in that inconsistent or varying adjudications with respect to individual members of the class would establish incompatible standards of conduct for Defendants. In addition, as a practical matter, adjudications with respect to individual members of the Class would be dispositive of the interests of the other members not parties to the adjudications, or would at the very least substantially impair or impede their ability to protect their interests.

49. Defendants have acted or refused to act on grounds generally applicable to the Class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the Class as a whole.

COUNT I
(Violation of Arkansas Deceptive Trade Practices Act)

50. Plaintiff incorporates the preceding allegations of her Class Action Complaint by reference.

51. Defendants' actions and the actions of persons under Defendants' direct and indirect control, violated the Arkansas Deceptive Trade Practices Act ("ADTPA"), Ark. Code Ann. § 4-88-101 *et seq*. Those actions include a refusal to submit valid bills to patients' private health insurance and instead asserting liens or otherwise taking payment from patients.

52. Defendants and persons under their direct or indirect control engaged in unconscionable, false, deceptive and consumer-oriented acts or practices in business, commerce, or trade by refusing to submit valid health insurance claims and instead asserting liens, taking a patient's medical payments coverage or taking money directly from patients in violation of their agreements with health insurance companies.

53. Defendants and persons under Defendants' direct or indirect control have breached the ADTPA by their actions, which include but are not limited to the following:

a. Failing to submit bills to and/or honor contractual discounts from health insurance carriers despite a contractual obligation to do so;

b. Concealing, suppressing, and/or omitting the fact that Defendants will not submit bills to or accept payments from health insurance carriers despite contractual obligations to do so;

c. Concealing, suppressing, and/or omitting the fact that Defendants will not honor agreed-to balance adjustments, or "discounts," despite obligations to offer said adjustments to insured patients;

d. Misrepresenting Defendants' health care centers as businesses that will accept and submit bills to valid health insurance carriers with whom Defendants have provider agreements;

e. Deceiving their patients to believe their bills are covered by health insurance when Defendants intend to seek payment for services from other sources, including directly from patients, via medical payment benefits from patients' auto insurer, by placing liens on patients' property, or by submitting patients' bills to collection agencies;

f. Violating the duty of good faith in performing health care services by failing to disclose their unfair billing practices to patients and prospective patients;

g. Committing an unfair practice by violating the public policy and/or common laws of this state.

54. Defendants knew or reasonably should have known of the existence of facts by reason of which Defendants should have known persons under their direct and indirect control committed violations of the ADTPA.

55. Defendants' conduct as set forth herein proximately caused Plaintiff and the Class Members, who are consumers, actual injuries and damages.

56. Plaintiff and the Class Members are entitled to their actual damages, prejudgment interest, and attorney's fees and costs incurred herein in amount which exceeds that required for federal diversity jurisdiction.

COUNT II
(Tortious Interference with Contractual Relationship/Business Expectancy)

57. Plaintiff incorporates all preceding allegations of her Class Action Complaint as though fully set forth herein.

58. Plaintiff and the Class Members enjoyed a valid business expectancy and/or contractual relationship with their own health insurance providers by virtue of an express or implied contract that Plaintiff and each individual Class Member had with their health insurance carrier.

59. Defendants were informed and had actual knowledge of the above-described business expectancies and contractual relationships involving Plaintiff, the Class Members, and their respective health insurance carriers.

60. Defendants intentionally and improperly interfered with and caused a disruption of the business expectancies and contractual relationships of Plaintiff and the Class Members by preventing them from receiving the benefit of their contractual business relationships with their respective health insurance carriers. Defendants did so without justification or privilege in a malicious attempt to procure additional monies that it was not entitled to, and with reckless disregard for the damage and harm such action would have on Plaintiff and the Class Members.

61. Defendants' actions resulted in Plaintiff and the Class Members having paid premiums but receiving no benefit, the premiums effectively wasted and the would-be coverage rendered illusory. Defendant's actions thus proximately caused Plaintiff and the Class Members damages.

62. Plaintiff and the Class Members are entitled to compensatory damages, punitive damages, and prejudgment interest in amount that exceeds that which is required for federal diversity jurisdiction.

COUNT III
(Unjust Enrichment)

63. Plaintiff incorporates all preceding allegations of her Class Action Complaint though fully set forth herein.

64. As alleged above, Defendants have engaged in a pattern of subverting the financial interests and contractual agreements of Plaintiff and the Class Members-patients of the Defendants' hospitals-for their own pecuniary gain.

65. Defendants have been unjustly enriched in that they received and retained the benefits of proceeds to which it was not entitled to and received in violation of Arkansas law.

66. Said benefits were conferred on Defendants by Plaintiff and the Class Members, and unlawfully obtained to the detriment of Plaintiff and the Class Members.

67. Defendants' retention of these funds is unjust because payment for the services provided should have come from Plaintiff's and the Class Members' health insurance carriers, and the reasonable value for Defendants' services determined by the contracts between Defendant and the carriers.

68. Allowing Defendants to retain the aforementioned benefits violates fundamental principles of justice, equity, and good conscience.

COUNT IV
(Injunctive Relief)

69. Plaintiff incorporates the preceding allegations of her Class Action Complaint as though fully set forth herein.

70. Upon information and belief, Defendants were required by their contracts with Blue Cross Blue Shield to submit Plaintiff's medical bills to her health insurers for payment.

71. Upon information and belief, Defendants are required by their contracts with various other health insurance carriers to submit the proposed Class Members' medical bills directly to those carriers for payment.

72. Upon information and belief, Defendants are also required to honor a contractual discount with their patients' health insurance carriers and accept discounted payments from those health insurance carriers in satisfaction of the patients' bills.

73. Upon information and belief, Defendants failed to honor contractually agreed-upon discounts regarding Plaintiff's medical bills at issue in this case and those of the proposed Class Members.

74. Upon information and belief, Defendants failed to honor their contractual commitment to submit the medical bills of insured patients to his/her insurance company.

75. Upon information and belief, Defendants are precluded by their contracts with private health insurance carriers (such as the named Plaintiff's insurer, Blue Cross Blue Shield) from seeking payment for covered services from other sources, including from the patient directly, medical payment benefits from the patients' auto insurer, turning the bills over to collections, and/or filing liens against patients' property, including personal injury claims.

76. Through Defendants' bill collection practices, they attempt to optimize the amount received for services rendered by seeking from patients the full amount billed (or more than they are entitled to for the covered treatment), rather than accepting the discounted amount they have agreed to accept from the patient's health insurance carrier.

77. By employing such a policy and business model, Defendants are violating the terms of their health insurance provider agreements (including the agreement with Blue Cross Blue Shield) and have unlawfully violated the rights of Plaintiff and the Class Members.

78. A real and subsisting controversy exists between the parties hereto concerning the validity of Defendants' policies and procedures.

79. Plaintiff requests this Court declare that Defendants, through their actions, policies, procedures and misconduct as alleged herein, have violated the terms of their agreements with the various health insurance providers and said policies and procedures should be declared invalid and void as a matter of law and enter a permanent injunction enjoining Defendants from engaging in the unlawful billing practices as detailed herein and for such other and further relief as the Court deems just and proper.

JURY DEMAND

90. Plaintiff, on behalf of herself and the Class Members, demands a jury trial.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, on behalf of herself and all Class Members, respectfully prays for judgment against the Defendants as follows:

a) For an Order certifying that this action may be maintained as a class action and appointing Plaintiff and her counsel to represent the class;

b) For a declaration that Defendants' actions violated Plaintiff's and the Class Members' rights under Arkansas law as pleaded in Counts I thru IV;

c) For all actual damages, statutory damages, punitive damages, penalties, and remedies available for the Defendants' violations of Plaintiff's and the Class Members' rights under Arkansas law in an amount which exceeds that required for federal diversity jurisdiction;

d) For a declaration that Defendants, through their actions and misconduct as alleged above, have been unjustly enriched and an order that Defendants disgorge any

unlawfully gained proceeds;

e) For pre-judgment interest as provided by law;

f) For post-judgment interest as provided by law;

g) For declaratory relief and a permanent injunction enjoining Defendants from engaging in the unlawful billing practices as detailed in the paragraphs above;

h) For an award to Plaintiff and the Class Members of their reasonable attorneys' fees;

i) For an award to Plaintiff and the Class Members of their costs and expenses of this action;

j) For such other and further relief as the Court may deem necessary and proper under Arkansas law.

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EXHIBIT
"A"

IN THE CIRCUIT COURT OF WASHINGTON COUNTY, ARKANSAS
CIVIL DIVISION

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	)	**Jury Trial Demanded**
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AFFIDAVIT OF COUNSEL

STATE OF ARKANSAS)
)
COUNTY OF WASHINGTON)

Comes Now Plaintiff's attorney, Shawn B. Daniels, and pursuant to AVA 12-56-125(2)(c) submits this affidavit with the Complaint filed contemporaneously herewith.

1. To the best of Plaintiff's and Plaintiff's attorney's information and belief, there are, or may be, additional tortfeasors, or responsible parties, the identity of which are unknown at this time.
2. That Plaintiff's counsel submits this subject affidavit in support of and per the requirements of ACA 16-56-125.

FURTHER AFFIANT SAYETH NOT.

Dated this 2 day of June, 2015.

BY: _____

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Subscribed and sworn to before the undersigned, a Notary Public, on this 2 day of June, 2015.

_____
Notary Public

MY COMMISION EXPIRES:

7/20/2022

ASHLEE SHARP
Arkansas - Washington County
Notary Public - Comm# 12388625
My Commission Expires Jul 20, 2022