Fill in this information to identify the case:

Debtor 1: Fayette Memorial Hosp. Assoc., Inc. d/b/a Fayette Region

Debtor 2 (Spouse, if filing): _____

United States Bankruptcy Court for the: Southern District of Indiana

Case number: 18-07762-JJG-11

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Official Form 410

Proof of Claim

04/19

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. **Do not send original documents;** they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) **that you received.**

Part 1: Identify the Claim

1. **Who is the current creditor?**

   Centers for Medicare & Medicaid Services (CMS), U.S. Dept. of Health and Human Services
   Name of the current creditor (the person or entity to be paid for this claim)

   Other names the creditor used with the debtor: _____

2. **Has this claim been acquired from someone else?**

   ☑ No
   ☐ Yes. From whom? _____

3. **Where should notices and payments to the creditor be sent?**

   Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)

Where should notices to the creditor be sent?	**Where should payments to the creditor be sent? (if different)**
Chung-Han Lee, Assistant Reg'l Counsel, OGC Name	Veronica Moore, CMS Name
233 N. Michigan Ave., Suite 700 Number Street	P.O. Box 7520 Number Street
Chicago IL 60601 City State ZIP Code	Baltimore MD 21207 City State ZIP Code
Contact phone (312) 886-1705	Contact phone (410) 786-6479
Contact email Chung-Han.Lee@hhs.gov	Contact email _____

Uniform claim identifier for electronic payments in chapter 13 (if you use one):

_____

4. **Does this claim amend one already filed?**

   ☑ No
   ☐ Yes. Claim number on court claims registry (if known) _____ Filed on _____ MM / DD / YYYY

5. **Do you know if anyone else has filed a proof of claim for this claim?**

   ☑ No
   ☐ Yes. Who made the earlier filing? _____

FMHA POC
00152

Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. **Do you have any number you use to identify the debtor?**
   - ☐ No
   - ☑ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 0 0 6 4

7. **How much is the claim?** $ 26,839.66 . **Does this amount include interest or other charges?**
   - ☑ No
   - ☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. **What is the basis of the claim?**
   Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.
   Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).
   Limit disclosing information that is entitled to privacy, such as health care information.
   Medicare Overpayments

9. **Is all or part of the claim secured?**
   - ☐ No
   - ☑ Yes. The claim is secured by a lien on property.

   Nature of property:
   - ☐ Real estate. If the claim is secured by the debtor's principal residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410-A) with this *Proof of Claim*.
   - ☐ Motor vehicle
   - ☑ Other. Describe: 11 USC 506(a)(1), 553; secured to extent of any setoff rights

   Basis for perfection: _____
   Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)

   Value of property: $_____
   Amount of the claim that is secured: $_____
   Amount of the claim that is unsecured: $_____ (The sum of the secured and unsecured amounts should match the amount in line 7.)

   Amount necessary to cure any default as of the date of the petition: $_____

   Annual Interest Rate (when case was filed)_____%
   - ☐ Fixed
   - ☐ Variable

10. **Is this claim based on a lease?**
    - ☑ No
    - ☐ Yes. **Amount necessary to cure any default as of the date of the petition.** $_____

11. **Is this claim subject to a right of setoff?**
    - ☐ No
    - ☑ Yes. Identify the property: Medicare pay'ts to extent subj. to setoff per, e.g., 42 CFR 405.371

12. **Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?**

A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.

☑ No

☐ Yes. *Check one:*

	Amount entitled to priority
☐ Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	$_____
☐ Up to $3,025* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	$_____
☐ Wages, salaries, or commissions (up to $13,650*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).	$_____
☐ Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	$_____
☐ Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	$_____
☐ Other. Specify subsection of 11 U.S.C. § 507(a)(__) that applies.	$_____

* Amounts are subject to adjustment on 4/01/22 and every 3 years after that for cases begun on or after the date of adjustment.

Part 3: Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Check the appropriate box:

☑ I am the creditor.
☐ I am the creditor's attorney or authorized agent.
☐ I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 5/31/2019
MM / DD / YYYY

Charlotte G. Foster
Signature

Print the name of the person who is completing and signing this claim:

Name: Charlotte (First name) G. (Middle name) Foster (Last name)

Title: Associate Regional Administrator, DFMFFSO

Company: Centers for Medicare & Medicaid Services (CMS)
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: DHHS/CMS, 801 Market Street, Suite 9400
Number Street

Philadelphia (City) PA (State) 19107 (ZIP Code)

Contact phone: (215) 861-4219 Email: Charlotte.Foster@cms.hhs.gov

CENTERS FOR MEDICARE & MEDICAID SERVICES
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Region III – Philadelphia Regional Office
801 Market St., Ste. 9400
Philadelphia, Pennsylvania 19107

DECLARATION IN SUPPORT OF PROOF OF CLAIM

Debtor Name & Address: Fayette Memorial Hospital Association, Inc. d/b/a Fayette Regional Health System
1941 Virginia Avenue
Connersville, Indiana 47331

Total debt due the Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services as of the filing date: $26,839.66, plus unliquidated, contingent claims

Charlotte G. Foster, in the City of Philadelphia, County of Philadelphia, State of Pennsylvania, declares and says that:

1. I am the Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Centers for Medicare & Medicaid Services, United States Department of Health and Human Services, Region III (CMS-III, HHS), and am duly authorized to make this claim.

2. The Debtor named above, namely Fayette Memorial Hospital Association, Inc. d/b/a Fayette Regional Health System (referred to hereafter as "Debtor"), filed for bankruptcy protection under Title 11 of the United States Code in *Fayette Memorial Hospital Association, Inc. d/b/a Fayette Regional Health System,* Docket No. 18-07762-JJG-11 (Bankr. S.D. Ind.) on October 10, 2018,

3. I certify that records of the Centers for Medicare & Medicaid Services, Region III, Philadelphia, show that the Debtor is indebted to CMS in the amount stated above under the Medicare program, Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.*, as amended.

4. CMS-III has responsibility for administering and overseeing CMS's interests in bankruptcies for a number of States, including the State of Indiana, where a provider has filed for bankruptcy and participates in the Medicare program, 42 U.S.C. § 1395 *et seq.*

The Medicare Program

5. Under the Medicare program, a provider or supplier of services submits claims to Medicare in order to receive reimbursement from the Medicare program for covered services furnished to Medicare beneficiaries.

6. Debtor, a hospital, enrolled in the Medicare program as a provider of inpatient hospital services. *See* 42 U.S.C. § 1395x(b),(e).

7. To be eligible to participate in the Medicare program and receive reimbursement for services, a hospital, as a provider of Part A services, must enter into a provider agreement with the Secretary of HHS, under which the hospital agrees to comply with Medicare requirements. *See* 42 U.S.C. § 1395cc(a)(1).

8. The Secretary has delegated the administration of the Medicare program to CMS, a component HHS agency.

9. On behalf of the Secretary of HHS, CMS also contracts with private organizations and agencies (usually insurance companies) for performance of certain routine Medicare claim processing and payment activities. Such contractors were formerly known as "fiscal intermediaries" under Part A and "carriers" under Part B, but the Medicare Act now collectively refer to them as "Medicare administrative contractors" ("MACs"). 42 U.S.C. §§ 1395kk-1; 42 U.S.C. §§ 1395h(a) & 1395u(a) (cross-referencing § 1395kk-1).

10. In this case, the MAC assigned to process the Debtor's claims was Wisconsin Physicians Service Insurance Corporation (WPS).

11. As relevant to this proof of claim, Medicare overpayment debts may arise at the level of individual Medicare claim reimbursement determinations adjustments or at the broader periodic Medicare cost report level.

12. CMS has rights of recoupment and setoff per 42 C.F.R. § 405.371. *See also* 42 U.S.C. §§ 1395g(a), 1395cc(j)(6), 1395ddd.

Medicare Cost Report Process

13. Under Medicare Part A, CMS regulations provide for "interim payments" to be made to hospitals during a twelve month cost reporting period, based on estimates of the provider's projected costs for the entire period, which may be adjusted to approximate actual costs as nearly as practicable to minimize any subsequently determine overpayment or underpayment. Such interim rate adjustments may result in overpayment determinations.

14. After the end of the cost reporting period, the hospital or other Part A provider must file a "cost report." A cost report represents the provider's analysis on whether it has been overpaid or underpaid on Medicare claims during that period, and it also addresses other Medicare reimbursements (as applicable to various types of providers). For example, for certain hospitals, the cost report may provide information to support reimbursement for costs of graduate medical education programs.

15. The cost report must state (and support) the amount that the provider claims to be due for that entire year. Without the cost report, Medicare payments for the cost year are not adequately supported and therefore constitute an overpayment. 42 C.F.R. § 405.378(c)(1)(v); *see* 42 U.S.C. § 1395g(a).

16. Once the cost report is filed, the MAC performs a "desk review" of the cost report, which itself may result in an overpayment determination, and may perform a full audit of the cost report. The MAC then issues a Notice of Program Reimbursement (NPR), which is the MAC's final determination of the total reasonable cost payable for the year together with any overpayment.

17. The NPR determination is subject to administrative and judicial review pursuant to 42 U.S.C. § 1395oo. The Medicare Act requires proper presentment of claims for administrative review and appropriate exhaustion of administrative remedies before hospitals and other providers may seek judicial review of claims that are inextricably intertwined with claims arising under the Medicare Act. 42 U.S.C. §§ 405(h) & 1395ii.

18. WPS has completed its review of Debtor's cost report for fiscal year 2016, and it determined an overpayments of **$2,549.00** (*see* NPR letter attached as Exhibit A).

19. On March 19, 2018, WPS accepted the Debtor's cost report for fiscal year 2017, and on March 22, 2019, WPS accepted the Debtor's cost report for fiscal year 2018.

20. To, date, however, WPS has not completed either a desk review or a full review of the 2017 and 2018 cost reports and thus has not determined the extent of overpayments, if any, for those years. Until cost reports are filed and audits completed for all pre-petition periods, CMS will not know the full extent of its pre-petition claim.

21. In addition, CMS regulations also provide for reopening of cost report determinations, which may result in overpayment or underpayment determinations as to prior periods. 42 C.F.R. §§ 405.1885, 405.1887.

22. Thus, **CMS has an unliquidated contingent claim against the Debtor to the extent an audit of the Debtor's cost reports reveal any overpayments.**

Medicare Claims Accounts Receivable Debts

23. During the year, the hospital may submit a stream of claims for Medicare services on behalf of its patients to the MAC, which determines whether each patient is enrolled in Medicare and whether the claims for services furnished to them are covered and otherwise payable.

24. If the MAC determines that these claims meet conditions for coverage and payment of under Title XVIII, Medicare regulations, and guidance issued to the MACs by CMS, the MAC pays claims subject to adjustments for prior overpayments and potential further review and further overpayment determinations.

25. After the MAC has processed a claim for payment, the MAC may subsequently review the correctness of that payment and, based on additional information, may determine that the payment was incorrect.

26. Medicare regulations provide for prior payment determinations to be reopened, which may result in pre-petition debts being identified. *See* 42 C.F.R. § 405.980 (explaining that the MACs may reopen previous determinations).

27. In addition, other adjustments to previously paid claims may be made based upon information received from the provider, such as if the provider itself reports an error in payment.

28. To the extent permitted by 42 U.S.C. § 1395ff and CMS regulations, Medicare beneficiaries and providers may seek administrative and judicial review of such determinations. As with the broader cost report determinations discussed above, the Medicare Act requires proper presentment of claims and appropriate exhaustion of administrative remedies before the provider may seek judicial review. 42 U.S.C. §§ 405(h) & 1395ii.

29. As individual payment amounts are adjusted by the system, the system generates Medicare debts that WPS refers to as Medicare claims accounts receivable ("AR").

30. WPS, as the MAC, has identified pre-petition Medicare accounts receivable debts for Part A claims by Debtor totaling **$23,952.51** and Part B claims by Debtor totaling **$338.15**.

CMS's Claim

31. Based on the facts set forth above, the Debtor named above was indebted to the United States of America and CMS for a total of at least **$26,839.66** at the time it filed for bankruptcy, plus the above-referenced unliquidated, contingent claims for potential cost report and claims A/R debts:

Debt	Amount
Part A Claims A/R	$23,952.51
Part B Claims A/R	$338.15
FY2016 NPR Debt	$2,549.00
Total	**$26,839.66**

32. CMS's claims are secured by its rights of recoupment and setoff per 42 C.F.R. § 405.371.

33. No note or other negotiable instrument has been received for the claims presented in this Certificate or for any part thereof. No judgment has been rendered thereon.

34. The filing of the claim recited in this Certificate is not to be construed as a waiver of the right of the United States, or any agency or instrumentality thereof, to follow any property, or the proceeds thereof, into the hands of whomever the same may be, including the receiver or trustee in bankruptcy, or as a waiver of any other claim or right of action or setoff or recoupment or of any other right whatsoever, that the United States or any agency or instrumentality thereof has or may have against the bankrupt, the Debtor, the trustee, or any other person. The filing of

this claim shall also not be construed as a waiver of the United States' claims concerning jurisdiction based on 42 U.S.C. § 405(h) and 1395ii.

35. The United States and CMS also reserve the right to amend this proof of claim as additional evidence regarding Debtor's submission of claims and receipt of payments from Medicare becomes available. The United States and CMS further reserves its right to amend this proof of claim to assert subsequently discovered liabilities, and also reserves its right to assert that any amended claim is secured by rights or recoupment and/or setoff to the extent there are any underpayments owing to the Debtor.

CERTIFICATION: Pursuant to 28 U.S.C. § 1746, I certify under penalty of perjury that the foregoing is true and correct to the best of my knowledge and information.

Charlotte G. Foster
Associate Regional Administrator
Division of Financial Management and
Fee for Service Operations
Centers for Medicare & Medicaid Services, Region III
(215) 861-4219

Date: May 31, 2019

U.S. Department of Justice

United States Attorney
Southern District of Indiana

10 West Market Street
Suite 2100
Indianapolis, IN 46204-3048

(317) 226-6333
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FAX NUMBERS:
Criminal (317) 226-6125
Administration (317) 226-5176
Civil (317) 226-5027
FLU (317) 226-6133
OCDETF (317) 226-5953

June 3, 2019

BMC Group, Inc.
Attn: FMHA Claims Processing
3732 West 120th Street
Hawthorne, CA 90250

Re: ***In re Fayette Memorial Hospital Assoc. Inc.,***
No. 18-07762-JJG-11(Bankr. S.D. Ind.)

Dear Sir or Madam:

Enclosed please find the Proof of Claim of creditor Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services.

Please contact me at (317) 229-2457 or taylor.kirklin@usdoj.gov with any questions.

Very truly yours,

J. Taylor Kirklin
Assistant United States Attorney

Enclosure