Fill in this information to identify the case:	
Debtor 1	FAYETTE MEMORIAL HOSPITAL ASSOCIATION, INC.
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?

Reid Hospital & Healthcare Services, Inc.
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)**
Jeffrey A. Hokanson, Ice Miller LLP Name	Name
2900 One American Square Number Street	Number Street
Indianapolis IN 46282 City State ZIP Code	City State ZIP Code
Contact phone 317-236-2236	Contact phone
Contact email jeff.hokanson@icemiller.com	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
00156

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: ____ ____ ____ ____

7. **How much is the claim?** $ 376,162.03 . **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.

Goods and services

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: _____

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: _____

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 05/09/2019
MM / DD / YYYY

/s/ Jeffrey A. Hokanson
Signature

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

Name: Jeffrey A. Hokanson
First name Middle name Last name

Title: Sr. Counsel

Company: Ice Miller. LLP
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 2900 One American Square
Number Street

Indianapolis IN 46282
City State ZIP Code

Contact phone 317-236-2236 Email jeff.hokanson@icemiller.com

Print | Save As... | Add Attachment | Reset

IN THE UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

In re:	)	Chapter 11
FAYETTE MEMORIAL HOSPITAL ASSOCIATION, INC.,	)	Case No. 18-07762-JJG-11
Debtor.	)	

ADDENDUM TO PROOF OF CLAIM OF
REID HOSPITAL & HEALTHCARE SERVICES, INC.

1. This Proof of Claim is being submitted on behalf of claimant, **Reid Hospital & Healthcare Services, Inc.** (the **"Claimant"**), against **Fayette Memorial Hospital Association, Inc.** (the **"Debtor"**).

2. The basis for the claim arises from a certain transactions by and between Claimant and Debtor, specifically:

a. Debtor is indebted to Claimant in the amount of **$364,909.23** for the value of services provided by Claimant to Debtor for hospital services (See: summary of charges attached hereto as Exhibit 1, redacted to obscure information protected by obscure information protected by the Health Insurance Portability and Accountability Act; and

b. Debtor is indebted to Claimant in the amount of **$11,252.80** for the value of pharmaceutical goods provided by Claimant to Debtor for hospital services (See: invoice attached hereto as Exhibit 2.

TOTAL CLAIM: $376,162.03

3. Claimant hereby reserves and retains the right to supplement, amend and/or modify this Proof of Claim, in accordance with 11 U.S.C. § 502, Fed. R. Bankr. P. 3001, and applicable law. Claimant further reserves and retains the right to pursue any and all rights available at law or at equity, including its right to seek recovery of any claims as an administrative expense, assert setoff rights and/or other such rights and remedies.

ACCOUNT ID	ACCT STATUS	TOT ACCT BALANCE	ADMIT DATE	DISCHG DATE	ACCT FINANCIAL	PATIENT CLASS	PATIENT NAME	DEPT NAME
[redacted]	Billed	$ 112,838.67	4/5/2019	4/7/2019	Commercial	[redacted]		RHH CCU
	Billed	$ 74,742.90	6/25/2018	7/11/2018	Commercial			RHH ONC/DIALYSIS/HOSP
	Billed	$ 52,342.09	3/11/2019	3/11/2019	Commercial			RHH CATH LAB
	Billed	$ 44,213.00	8/1/2018	8/3/2018	Commercial			RHH MED SURG/ORTHO/URO
	Billed	$ 41,234.10	3/18/2019	3/22/2019	Commercial			RHH MED/GEN SURG/PED
	Billed	$ 14,526.77	7/13/2018	7/17/2018	Commercial			RHH PROGRESSIVE CARE
	Billed	$ 7,983.20	7/21/2018	7/22/2018	Commercial			RHH EMERGENCY
	Billed	$ 7,142.93	7/24/2018	7/24/2018	Commercial			RHH EMERGENCY
	Billed	$ 5,286.86	7/26/2018	7/26/2018	Commercial			RHH ROSE ENDOSCOPY
	Billed	$ 3,149.81	6/21/2018	6/21/2018	Commercial			RHH EMERGENCY
	Billed	$ 460.00	3/29/2019	3/29/2019	Commercial			RPA REID OB/GYN
	Billed	$ 334.03	7/25/2018	7/25/2018	Commercial			RHH OP IMG DIAGNOSTIC
	Billed	$ 331.27	1/22/2019	1/22/2019	Commercial			RHH LAB
	Billed	$ 208.63	10/4/2018	10/4/2018	Commercial			RHH LAB
	Billed	$ 114.97	11/3/2018	11/3/2018	Cigna			RHH PCC LAB
	Total	**$ 364,909.23**						

Reid Health PHARMACY

INVOICE

1100 Reid Parkway
Richmond, Indiana 47374
(765) 983-3014

INVOICE DATE | 17-Oct-18

SOLD TO:
Fayette Regional Heath PHARMACY
Attn: Accounts Payable
1941 Virginia Avenue
Connersville, IN 47331

Date of Service		Price
See Attached	UnpaidCharges from July through August 2018	2,963.42
See Attached	New Charges from September 2018	8289.38
	PAY THIS AMOUNT:	$11,252.80

DIRECT ALL INQUIRES TO:
Cathy Sherer
(765) 983-3000 ext. 2615
email: cathy.sherer@reidhealth.org

MAKE ALL CHECKS PAYABLE TO:
Reid Health Pharmacy
Attn: PHARMACY
1100 Reid Parkway
Richmond, Indiana 47374

THANK YOU FOR YOUR BUSINESS!

****

* M E D I C A L E X P E N S E S BGN DTE:07/31/2018 END DTE:05/03/2019 *

****

FOR: FAYETTE REGIONAL, HOSPITA
CARE OF:
1941 VIRGINIA AVE
FAYEMEM CONNERSVILLE, IN 47331
Store PH # - 765-983-3305
Birth Date - 01/01/2001

REID HOSPITAL PHARMACY
1100 REID PARKWAY
RICHMOND, IN 47374
PHARMACIST - PHARMACIST,
Store NPI# - 1508895863
Pat. Sex - M

****

DATE	RX#	DRUG (ITEM) NAME	QTY	PRESCRIBER	PRICE	PR TYPE
	N/R	NDC# MFG#	D/S	DEA#		GEN IND
07/31/18	07515403	SAMSCA 15 MG TABLE 6	TAB	REID,HEALTH	2812.72	Rx
	NEW	59148-0020-50	6DAYS	AR2689000		BRAND
08/07/18	07516557	GEMCITABINE 2 GRAM 52.60ML		REID,HEALTH	37.80	Rx
	NEW	00409-0182-01	53DAYS	AR2689000		GENERIC
08/07/18	07516556	CISPLATIN 200 MG/2 200 ML		REID,HEALTH	112.90	Rx
	NEW	44567-0511-01	200DAYS	AR2689000		GENERIC
09/10/18	07522742	ACTIVASE 100 MG VI 1	VIA	REID,HEALTH	8289.38	Rx
	NEW	50242-0085-27	1DAYS	AR2689000		BRAND

11252.80 TOTAL