Proof of 503(b)(9) Claim Form

Debtor: Fayette Memorial Hospital Association, Inc. Case No. 18-07762-JJG-11

11 U.S.C. § 503(b)(9) provides that "[a]fter notice and a hearing, there shall be allowed administrative expenses. . . including . . . the value of any goods received by the debtor within 20 days before the date of commencement of a [bankruptcy case] in which the goods have been sold to the debtor in the ordinary course of such debtor's business."

The Debtor's case commenced on October 10, 2018. Your receipt of this form does not mean you hold a valid 503(b)(9) claim.

Claimants should submit a signed original of this form in order to assert a claim pursuant to section 503(b)(9) of the Bankruptcy Code, together with the accompanying documentation required pursuant to the order of the Bankruptcy Court establishing procedures for the assertion, resolution, allowance and satisfaction of any claims asserted pursuant to section 503(b)(9) of the Bankruptcy Code to the following address:

If by regular mail to: BMC Group, Inc., Attn: FMHA Claims Processing, PO Box 90100, Los Angeles, CA 90009

If by messenger or overnight delivery: BMC Group, Inc., Attn: FMHA Claims Processing, 3732 West 120th Street, Hawthorne, CA 90250

NOTE: This form must be delivered to BMC Group, Inc. at the above-referenced address **on or before to June 12, 2019.** This form may be submitted in person or by mail, hand delivery, or overnight courtier. Facsimile, email or other electronic submission will not be accepted. Proofs of claim shall be deemed filed when actually received by BMC Group, Inc.

Name of Creditor *(the person or other entity to whom the debtor owes money or property)*:

Aya Healthcare, Inc.

Name and Address Where Notices and Payment Should Be Sent:

Aya Healthcare, Inc.
Legal Department
5930 Cornerstone Court West, Suite 300
San Diego, CA 92121

Telephone No.: 858-333-6884

☐ Check this box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach a copy of statement giving particulars.

☐ Check this box if you have asserted a reclamation demand for any of the Goods referenced on this claim form. Attach statement identifying any such goods.

☒ Check this box if you have filed any other claim against any of the Debtors regarding the goods underlying your claim asserted herein.

☐ Check this box if the alleged value of the goods underlying your claim asserted herein represents a combination of goods and services. If you checked this box, provide the percentage of alleged value related to services and to goods on the following line ____________

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR ______

Check here if this claim ☐ replaces ☐ amends a previously filed claim, dated ______

1. TOTAL AMOUNT OF SECTION 503(b)(9) CLAIM: $ 5,145.00

RECEIVED
JUN 12 2019
BMC GROUP

2. DATE GOODS WERE RECEIVED BY DEBTOR: October 11, 2018

3. BRIEF DESCRIPTION OF CLAIM AND GOODS

Healthcare Staffing Services provided to debtor through invoices attached have not been paid.

Attach particular invoices for which any of the amounts described in this form was applied.

4. SUPPORTING DOCUMENTS Attach copies of supporting documents, such as invoices, receipts, bills of lading and the like, identifying the goods for which the claim is being asserted, the date such goods were received by the Debtor, and the alleged value of such goods. DO NOT SEND ORIGINAL DOCUMENTS. If the documents are not available, explain. Any attachments must be 8-1/2" by 11".

5. DATE-STAMPED COPY To receive an acknowledgement of the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim.

6. ORDINARY COURSE CERTIFICATION By signing this claim form, you are certifying that the goods, for which payment is sought hereby, were sold to the Debtor in the ordinary course of the Debtor's business and were received by the Debtor within twenty days prior to October 10, 2018, as required by 11 U.S.C. § 503(b)(9).

	Print the name and title, if any, of the creditor or other person authorized to file this claim (attach copy of power of attorney, if any)		
Date: 6/11/2019	Name: Lindsay Watson	Title: Attorney	Signature:

FMHA POC
00186

AYA Healthcare - Open Balance Report

FAYETTE REGIONAL HEALTH SYSTEM-BK

Facility	Invoice Date	Invoice Number	Open Balance	Days Aged
FAYETTE REGIONAL HEALTH SYSTEM	10/11/2018	508485	$2,520.00	47
FAYETTE REGIONAL HEALTH SYSTEM	10/11/2018	508484	$2,625.00	47
		Total Billed	$5,145.00	

5930 Cornerstone Crt W Suite 300
San Diego, CA 92121

Invoice

Invoice #: 508484

Invoice Date: 10/12/2018

TERMS: 30 Days

Fayette Regional Health System - Medefis

1941 Virginia Avenue
Connersville, IN 47331

Unit: Behavioral Health 18561

Caregiver: [redacted] **- Registered Nurse**

Specialty	*Date*	*Shift*	*Lunch*	*Reg. Hours*	*OT/HOL Hours*	*Rate*	*Gross*	*Comment*
RN-Behavioral Health	10/03/2018	06:45 PM-07:15 AM	0.00	12.50	0.00	$70.00	$875.00	
RN-Behavioral Health	10/04/2018	06:45 PM-07:15 AM	0.00	12.50	0.00	$70.00	$875.00	
RN-Behavioral Health	10/05/2018	06:45 PM-07:15 AM	0.00	12.50	0.00	$70.00	$875.00	

Unit Total: **$2,625.00**

Grand Total: **$2,625.00**

Total This Invoice:	**$2,625.00**
Pay This Amount:	**$2,625.00**

If you have any questions about this invoice, CALL (866) 687-7390, EMAIL to billing@ayahealthcare.com

Make Checks Payable To:

Aya Healthcare Inc
Dept 3519
PO Box 123519
Dallas, TX 75312-3519

THANK YOU FOR YOUR BUSINESS!

In accordance with contract provisions, the billing rates shown above include reimbursement for meals and incidental expenses of $357.0000. Amounts paid to the above-named Caregiver for meals and incidental expenses were properly substantiated in accordance with Internal Revenue Code ("IRC") § 274(d) and therefore, not treated as compensation. You acknowledge that (i) you may be subject to a 50% deduction limitation for these costs under IRC § 274(n) and (ii) you have been provided with sufficient substantiation of such costs in accordance with IRC § 274(d) in this Invoice.

Invoice

5930 Cornerstone Crt W Suite 300
San Diego, CA 92121

Invoice #: 508485

Invoice Date: 10/11/2018

TERMS: 30 Days

Fayette Regional Health System - Medefis

1941 Virginia Avenue
Connersville, IN 47331

Unit: Behavioral Health 18561

Caregiver: [redacted] **- Registered Nurse**

Specialty	*Date*	*Shift*	*Lunch*	*Reg. Hours*	*OT/HOL Hours*	*Rate*	*Gross*	*Comment*
RN-Behavioral Health	10/02/2018	05:45 AM-05:45 PM	0.00	12.00	0.00	$70.00	$840.00	
RN-Behavioral Health	10/03/2018	05:45 AM-06:00 PM	0.50	11.75	0.00	$70.00	$822.50	
RN-Behavioral Health	10/04/2018	05:45 AM-06:00 PM	0.00	12.25	0.00	$70.00	$857.50	

Unit Total: **$2,520.00**

Grand Total: **$2,520.00**

Total This Invoice:	**$2,520.00**
Pay This Amount:	**$2,520.00**

If you have any questions about this invoice, CALL (866) 687-7390,
EMAIL to billing@ayahealthcare.com

Make Checks Payable To:

Aya Healthcare Inc
Dept 3519
PO Box 123519
Dallas, TX 75312-3519

THANK YOU FOR YOUR BUSINESS!

In accordance with contract provisions, the billing rates shown above include reimbursement for meals and incidental expenses of $320.0000. Amounts paid to the above-named Caregiver for meals and incidental expenses were properly substantiated in accordance with Internal Revenue Code ("IRC") § 274(d) and therefore, not treated as compensation. You acknowledge that (i) you may be subject to a 50% deduction limitation for these costs under IRC § 274(n) and (ii) you have been provided with sufficient substantiation of such costs in accordance with IRC § 274(d) in this Invoice.