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

NOTE: This form should only be used to make a claim for an Administrative Expense arising or accruing from October 10, 2018 through and including April 30, 2019. IT SHOULD NOT BE USED FOR CLAIMS ARISING PRIOR TO OCTOBER 10, 2018.

Name of Creditor (The person or other entity to whom the debtor owes money or property):
BRIFFIN HEALTH CARE Services LLC

Name and address where notices should be sent:
13163W Sandalwood Cove
Port St Lucie FL. 34986

Name and address where payment should be sent (if different):

Telephone number: 860-227-7797

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

☐ Check box if you have never received any notices from the bankruptcy court in this case.

☐ Check box if the address differs from the address on the envelope sent to you by the court.

Last four digits of account or other number by which creditor identifies debtor:

1. Basis for Administrative Claim
- ☐ Goods sold
- ☒ Services performed
- ☐ Money loaned
- ☐ Personal injury/wrongful death
- ☐ Taxes
- ☐ Other

☐ Retiree benefits as defined in 11 U S C. § 1114(a)

☐ Wages, salaries, and compensation (fill out below)
Last four digits of your SS #:
Unpaid compensation for services performed
from _____ (date) to _____ (date)

RECEIVED
JUN 12 2019
GROUP

2. Date(s) debt was incurred:
Oct 10, 2018 thru Dec 19, 2018

3. If court judgment, date obtained:

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 3,088.00

If all or part of your claim is secured, also complete Item 5 below.

☐ Check this box if claim includes interest or other charges in addition to the principal amount of the claim. Attach itemized statement of all interest or additional charges.

5. Please identify the property of the Debtor that secures the claim.

Description of Property: _____

Basis for Perfection: _____

Value of Property: _____

6. Offsets, Credits and Setoffs:

☐ All Payments made on this claim by the Debtor have been credited and deducted from the amount claimed herein

☒ This claim is not subject to any setoff or counterclaim.

☐ This claim is subject to setoff or counterclaim as follows:

7. This Administrative Proof of Claim:

☒ is the first filed proof of claim evidencing the claim asserted herein.

☐ amends/supplements a proof of claim _____ filed on _____ or

☐ replaces/suspends a proof of claim filed on _____.

8. Assignment

☐ If the claimant has obtained this claim by Assignment, a copy is attached hereto.

9. Supporting Documentation:

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.

Date: June 10, 2019

Sign and 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):

PAUL T GLANG

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.

FMHA POC
00196

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

IN RE:	)	
	)	Case No. 18-07762-JJG-11
FAYETTE MEMORIAL HOSPITAL	)	
ASSOCIATION, INC. d/b/a FAYETTE	)	
REGIONAL HEALTH SYSTEMS,	)	
Debtor.	)	
	)	

NOTICE OF DEADLINE FOR FILING ADMINISTRATIVE CLAIMS ARISING DURING THE PERIOD BETWEEN OCTOBER 10, 2018 AND APRIL 30, 2019

PLEASE TAKE NOTICE. The United States Bankruptcy Court for the Southern District of Indiana, Indianapolis Division, has entered an Order Establishing Claims Bar Date (the "**Bar Date Order**") setting **June 12, 2019** (the "**Claims Bar Date**") as the deadline for all persons and entities, including individuals, partnerships, corporations, estates, trusts and governmental units (except those persons and entities described below), who have or may have any claim against Fayette Memorial Hospital Association, Inc., d/b/a Fayette Regional Health Systems (the "**Debtor**") that arose **during the period between October 10, 2018 and April 30, 2019** to file a request for allowance and/or payment of such claim pursuant to 11 U.S.C. § 503 (an "**Administrative Expense Claim**").

Pursuant to 11 U.S.C. § 503, "after notice and a hearing, there shall be allowed, administrative expenses, other than claims allowed under section 502(f) of [title 11], including – the actual, necessary costs and expenses of preserving the estate. . ."

Any person or entity asserting an Administrative Expense Claim against the Debtor's bankruptcy estate shall file such claim on or before the Claims Bar Date. Each proof of claim must substantially conform to the Administrative Proof of Claim Form attached to this Notice. Proofs of Claim may be filed by sending them to Debtor's Claims Agent, BMC Group, Inc., either: (1) by regular mail to BMC Group, Inc., Attn: FMHA Claims Processing, PO Box 90100, Los Angeles, CA 90009 or (2) by messenger or overnight delivery to BMC Group, Inc., Attn: FMHA Claims Processing, 3732 West 120th Street, Hawthorne, CA 90250, **so as to be RECEIVED on or before June 12, 2019.** Facsimile, email or other electronic submission will not be accepted. Proofs of claim shall be deemed filed when actually received by BMC Group, Inc. Timely filed proofs of claim that are entitled to prima facie validity will be deemed allowed unless and until objected to by the Debtor or other party in interest. Should an objection be filed, you will receive notice and an opportunity to respond.

If you have previously filed an Administrative Expense Claim with the Bankruptcy Court seeking allowance and/or payment of a claim against the Debtor for the period between October 10, 2018 and April 30, 2019, or if the Bankruptcy Court has entered an order allowing or otherwise resolving your claim against the Debtor, you do NOT need to file anything further unless you have an additional or different claim.

ANY PERSON OR ENTITY THAT IS REQUIRED TO FILE A CLAIM ON OR BEFORE THE CLAIMS BAR DATE, BUT FAILS TO DO SO, MAY BE FOREVER BARRED, ESTOPPED AND ENJOINED FROM (A) ASSERTING ANY SUCH CLAIM AGAINST THE DEBTOR AND/OR ITS BANKRUPTCY ESTATE AND (B) RECEIVING PAYMENT FROM THE DEBTOR'S ESTATE OR A DISTRIBUTION ON ACCOUNT OF SUCH CLAIM UNDER ANY PLAN CONFIRMED IN THIS CASE.

YOUR RIGHTS MAY BE AFFECTED BY THIS NOTICE and you should read these papers carefully and consult with your attorney. If you do not have an attorney, you may wish to consult one.

Dated: May 8, 2019

/s/ Wendy D. Brewer

Wendy D. Brewer (#22669-49)
FULTZ MADDOX DICKENS PLC
333 N. Alabama Street, Ste. 350
Indianapolis, IN 46204
Tel: (317) 215-6220
E-Mail: wbrewer@fmdlegal.com

-and-

Laura M. Brymer (#30989-10)
FULTZ MADDOX DICKENS PLC
101 S. Fifth Street, Ste. 2700
Louisville, KY 40202
Tel: (502) 588-2000
E-mail: lbrymer@fmdlegal.com
Attorneys for the Debtor

Griffin Healthcare Services, LLC

1316 SW Sandalwood Cove
FL 34986

Invoice

Date	Invoice #
10/22/2018	2330

Bill To
Fayette Regional Health System 1941 Virginia Avenue Connersville, IN 47331

P.O. No.	Terms	Project

Quantity	Description	Rate	Amount
40	Scrub Tech - Wilson, L	48.00	1,920.00
16	On Call	2.00	32.00
	Amount due after Fayette Regional Bankruptcy		
		Total	$1,952.00

URSING OPTIONS
HEALTHCARE STAFFING

[illegible] Healthcare, dba
Nursing Options, LLC
970-673-8916 -- Jeff's Office
PAYROLL fax
877-669-8357

Timesheets must be faxed no later than 10 a.m., EST, each Monday to ~~888-223-8189~~ 877-669-8357
IMPORTANT: TIMESHEETS MUST BE SIGNED BY YOU, AND BY A SUPERVISOR,
IN ORDER TO BE PROCESSED FOR PAYMENT. *THANK YOU FOR YOUR HARD WORK!!*

Employee: Lisa Lewton
Specialty: SCRUB
Unit Worked: OR
Facility: Fayette Regional
City & State: Connersville Indiana

Day of Week	Date (MM/DD/YY)	Shift Begin	Break	Shift End	Regular Hours	On-Call Hours	Call Back Hours	Charge Hours	Comments (Sick, low census, etc.)
SUNDAY	10-14-18								
MONDAY	10-15-18	645	~~30m~~ 30m	315	8				
TUESDAY	10-16-18	645	30m	315	8				
WEDNESDAY	10-17-18	645	30m	315	8	16			
THURSDAY	10-18-18	645	30m	315	8				
FRIDAY	10-19-18	645	30m	315	8				
SATURDAY	10-20-18								
				TOTAL	40	16			

In accordance with the Agreement between the Facility, Employee & Agency, the hours worked as indicated above are correct and were completed in a satisfactory manner.

Employee Signature: Lisa Lewton
Date: 10-19-18

Facility Authorized Signature: Kimberly A Collins
Title: Charge RN Date: 10/19/18

PLEASE...TOTAL YOUR HOURS!
We will check your math...we promise!!

Additional Comments:
Last days !!!

Please fax your SIGNED timesheet to 877-669-8357
by **Monday** each week, **before 10 a.m. Eastern Time.**
Please, TOTAL YOUR HOURS! Thanks!

Invoice

Griffin Healthcare Services, LLC

1316 SW Sandalwood Cove
FL 34986

Date	Invoice #
10/15/2018	2310

Bill To

Fayette Regional Health System
1941 Virginia Avenue
Connersville, IN 47331

P.O. No.	Terms	Project

Quantity	Description	Rate	Amount
23	Scrub Tech - Wilson, L	48.00	1,104.00
16	On Call	2.00	32.00
	Amount due after Fatette Regional Bankruptcy		

Total $1,136.00

Griffin Healthcare, dba
Nursing Options, LLC
970-673-8916 -- Jeff's Office
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HEALTHCARE STAFFING

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IN ORDER TO BE PROCESSED FOR PAYMENT. *THANK YOU FOR YOUR HARD WORK!!*

Employee: Lisa L. Wilson
Specialty: Scrub
Unit Worked: OR
Facility: Fayette Reg
City & State: Connersville Indiana

Day of Week	Date (MM/DD/YY)	Shift Begin	Break	Shift End	Regular Hours	On-Call Hours	Call Back Hours	Charge Hours	Comments (Sick, low census, etc.)
SUNDAY	10-7-18								
MONDAY	10-8-18	0645	30 m	315	8				
TUESDAY	10-9-18	0645	30m	315	8				
WEDNESDAY	10 10-18	0645	30m	315	8	16			
THURSDAY	10-11-18	0645	30m	315	8				
FRIDAY	10-12-18	0745	30m	315	7				
SATURDAY	10-13-18		30m						
				TOTAL	39	16			

In accordance with the Agreement between the Facility, Employee & Agency, the hours worked as indicated above are correct and were completed in a satisfactory manner.

Employee Signature: Lisa Wilson
Date: 10-12-18
Facility Authorized Signature:
Title: Date

PLEASE...TOTAL YOUR HOURS!
We will check your math...we promise!!

Additional Comments:

Please fax your SIGNED timesheet to 877-669-8357
by **Monday** each week, **before 10 a.m. Eastern Time.**
Please, TOTAL YOUR HOURS! Thanks!