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 18-7762-JJG-11

RECEIVED
JUN 12 2019
BMC GROUP

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?

Dallas A. Holmes
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?

Name: Dallas A. Holmes
Number Street: 1809 Virginia Ave.
City State ZIP Code: Connersville, IN. 47331
Contact phone: 765.265.3286
Contact email: dallasaholmes@comcast.net

Where should payments to the creditor be sent? (if different)

Name ____
Number Street ____
City State ZIP Code ____
Contact phone ____
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

00199

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: ___ ___ ___ ___

TAY-ID / EIN - 35-0900741 / Case # 18-07762-JJG-11

7. How much is the claim?

$ 23,503.00

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.

Unpaid Medical Expenses

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 06 / 12 / 2019
MM / DD / YYYY

Dallas A. Holmes
Signature

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

Name: Dallas (First name) A. (Middle name) Holmes (Last name)

Title: out Patient therapist

Company: Fayette Regional Hospital
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 1809 (Number) Virginia Ave (Street)
Connersville (City), IN (State) 47331 (ZIP Code)

Contact phone: 765.265.3286

Email: dallsaholmes@comcast.net dallash@fayetteregional.org

AmeriPath

REQUEST FOR PAYMENT

STATEMENT

▶ IMPORTANT MESSAGE

Your physician chose Ameripath to diagnose and interpret the lab/pathology specimen collected at the time of your physician and /or hospital visit. Professional and Technical Services are in addition to those billed by your physician and /or hospital. Any amount not covered by your insurance is your responsibility. If the insurance information below is inaccurate or incomplete, please contact us at 800-890-6220. The CPT codes provided are based on AMA guidelines and without regard to specific payor requirements.

▶ PATIENT INFORMATION

Patient Name: DALLAS HOLMES
Account Number: UM39 26947958

▶ QUESTIONS

For **automated payment options** 24 hours a day please call: **800-890-6220**

Billing questions or inquiries please call: **800-890-6220**
Mon - Thurs **8:30am - 5:00pm** CST; Fri **9:00am - 4:00pm** CST

▶ INSURANCE INFORMATION

Primary insurance: SIHO
Name of Insured: DALLAS HOLMES
Policy Number: XXXXX2201
Insured Date of Birth: 03/26/XX

Secondary Insurance: None on file
Name of Insured:
Policy Number:
Insured Date of Birth:

▶ ACCOUNT SUMMARY

DATE	INVOICE #	DESCRIPTION	CPT-MOD	ACTIVITY	PATIENT BALANCE
	62047936323	**REFERRING PHYSICIAN: GOODRICH MD,SARAH KAY**			
08/06/18		PATH CONS DURNG SU	88331-26 x 1	306.00	
04/30/19		SIHO PAYMENT		0.00	
		CONTRACTUAL ADJUST		0.00	
		INVOICE BALANCE			306.00
		EXPENSES INCURRED AFTER COVERAGE TERMINATED.			
	62047936324	**REFERRING PHYSICIAN: GOODRICH MD,SARAH KAY**			
08/06/18		IMHISTOCHEM/CYTCHM	88341-26 x 3	363.00	
08/06/18		IMHISTOCHEM/CYTCHM	88342-26 x 1	121.00	
04/30/19		SIHO PAYMENT		0.00	
		CONTRACTUAL ADJUST		0.00	
		INVOICE BALANCE			484.00

Continued on Next Page

ONLINE CREDIT CARD PAYMENT (Lab Code = AMP)

To pay online by credit card, visit www.ameripath.com/pay invoice, select Make a payment then click on Submit a Payment. Lab Code = AMP

PLEASE RETAIN THIS PORTION FOR YOUR RECORDS
PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

AmeriPath

P.O. BOX 525033 • EL DORADO HILLS, CA 95762-9033

Called 06.12.19

Valerie 4055 months

AB 01 000902 61843 B 3 A

DALLAS HOLMES
1809 VIRGINIA AVE
CONNERSVILLE IN 47331-2831

Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side

Please write your account # on your check.
Make your check payable to the address below.

DUE DATE	STATEMENT DATE	ACCOUNT #
	06/04/19	UM39 26947958

	AMOUNT BEING PAID
$2,021.00	$

To pay by check, please indicate the amount being paid and place check in the enclosed envelope

TO PAY ONLINE, WE ACCEPT THE FOLLOWING CREDIT CARDS:

VISA DISCOVER

Website: AmeriPath.com/PayMyBill Phone: 800-890-6220

AMERIPATH INDIANAPOLIS
AMERIPATH INDIANAPOLIS, PC
PO BOX 740975
CINCINNATI OH 45274-0975

01UM39000026947958002021000604190DALLASOHOLMES0000000000008

ST VINCENT HEALTH

Guarantor Name	Dallas [illegible] Holmes
Patient Account #	55664379[illegible]
Statement Date	[illegible]

Your Account Status

Southeastern IN Health Org notified us that you were not covered under their plan. This balance is your responsibility. If this is incorrect, contact your insurer.

Charges	$17,157.00
Previous Payments & Credits	$0.00
Payment Due Upon Receipt	**$17,157.00**

PROFESSIONAL FEES

Charges for services rendered by a provider, such as an examination or explanation of results.

Patient Name	Provider Name	Service Location	
Dallas Holmes	**Janet Rippy, MD**	ST VINCENT HOSPITAL	- 11.58

Date	Description	Charge Status	Charges	Payments/ Credits	Patient Balance
08/03/2018	ELECTROCARDIOGRAM, ROUTINE ECG WITH AT LEAST 12 LEADS; INTERPRETATION AND R		$48.00		
02/02/2019	Insurance Company: Southeastern IN Health Org	Not Elig		$0.00	
	Patient Balance - Misc.				$48.00

Patient Name	Provider Name	Service Location	
Dallas Holmes	**Sarah Goodrich, MD**	**ST VINCENT HOSPITAL**	- 1,4079.91

Date	Description	Charge Status	Charges	Payments/ Credits	Patient Balance
08/06/2018	TLH WITHOUT 250G OR LESS		$4,608.00		
02/02/2019	Insurance Company: Southeastern IN Health Org	Not Elig		$0.00	
	Patient Balance - Misc.				$4,608.00
08/06/2018	LAPAROSCOPY BILATERAL TOTAL PELVIC LYMPHADENECTOMY		$3,651.00		
02/02/2019	Insurance Company: Southeastern IN Health Org	Not Elig		$0.00	
	Patient Balance - Misc.				$3,651.00
08/06/2018	CYSTOURETHROSCOPY		$591.00		
02/02/2019	Insurance Company: Southeastern IN Health Org	Not Elig		$0.00	
	Patient Balance - Misc.				$591.00

Patient Name	Provider Name	Service Location	
Dallas Holmes	**Wendy M Fodstad PA-C**	**ST VINCENT HOSPITAL**	. 210.04

Date	Description	Charge Status	Charges	Payments/ Credits	Patient Balance
08/06/2018	TLH WITHOUT 250G OR LESS		$4,608.00		
02/02/2019	Insurance Company: Southeastern IN Health Org	Not Elig		$0.00	
	Patient Balance - Misc.				$4,608.00
08/06/2018	LAPAROSCOPY BILATERAL TOTAL PELVIC LYMPHADENECTOMY		$3,651.00		
02/02/2019	Insurance Company: Southeastern IN Health Org	Not Elig		$0.00	
	Patient Balance - Misc.				$3,651.00

58,259

2 of 2

121091-4977

Any dispute regarding this statement or any amounts due must be submitted in writing to:
P.O. Box 19000, Belfast, ME 04915-4085
Submitting payment in an amount less than the total on this statement shall not constitute an offer to settle any dispute, regardless of any accompanying communication.

>IMPORTANT INFORMATION

THANK YOU FOR YOUR BUSINESS. PLEASE SEND YOUR PAYMENT WITHIN 10 DAYS.

IF YOU'VE SENT PAYMENT IN FULL, PLEASE ACCEPT OUR THANKS

FOR PROFESSIONAL PATHOLOGY SERVICES RENDERED AT CYTOMETRY SPECIALISTS INC.

>PATIENT INFORMATION

Patient Name	HOLMES,DALLAS A
Your Physician	TOLNAY,GABOR L
Account Number	063258749
Original account#	378279/CSIG

>ACCOUNT SUMMARY

Date	Description	Code	Amount
06/23/18	IMMUNOHISTO ANTB ADDL SLIDE	88341-59x10	2300.00
06/23/18	IMMUNOHISTO ANTB 1ST STAIN	88342-59x2	540.00
06/23/18	TUMOR IMMUNOHISTOCHEM/MANUAL	88360-59x2	700.00
06/27/18	MICROSLIDE CONSULTATION	88323	320.00
	Balance Due		3860.00

>INSURANCE INFORMATION

PRIMARY

Insurance Name	SIHO
Name of Insured	HOLMES,DALLAS A
Policy Number	00069482201

SECONDARY

Insurance Name	None on file
Policy Number	

Called - on 04.02.19 - Said Coding Issue

>QUESTIONS?

Billing questions or changes to insurance coverage? Please contact Patient Accounts at 1-800-274-2158
Monday - Friday 9:00AM-7:00PM

>CREDIT CARD

TO PAY YOUR BILL ONLINE, PLEASE VISIT HTTPS://PAYYOURBILL.APSMEDBILL.COM

THIS IS YOUR BALANCE: $3860.00 -

THANK YOU FOR YOUR PROMPT PAYMENT!

- 1,248.00
6.23.18
- Next Bill -
$2,440.00 -
1,136.00 -
No Deductible

MAKE CHECKS PAYABLE TO

CYTOMETRY SPECIALISTS INC.
5700 SOUTHWYCK BLVD
TOLEDO,OH 43614-1509

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NUMBER
03/26/19	3860.00	063258749
SHOW AMOUNT PAID HERE $	PASS CODE CSIG	

FORWARDING SERVICE REQUESTED
ADDRESSEE

DALLAS A HOLMES
1809 VIRGINIA AVE
CONNERSVILLE IN 47331-2831

REMIT TO

CYTOMETRY SPECIALISTS INC.
5700 SOUTHWYCK BLVD
TOLEDO,OH 43614-1509

☐ Please check box if address is incorrect or insurance information has changed and indicate change(s) on reverse side.

Please detach and return this portion with payment.

6100 W 96TH ST
STE 125
INDIANAPOLIS, IN 46278

Statement Date	02/12/19
Account Number	46978
Payment Due Date	02/26/19
Pay This Amount	$5667.00

Billing Questions? Call (866) 771-5257 or (317) 715-1800

Dallas A Holmes
1809 VIRGINIA AVE
CONNERSVILLE, IN 47331-2831

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Language assistance available: Español, Kreyol Ayisien, Tiếng Việt, Português, 中文, français, Tagalog, русский, اردو, Italiano, Deutsche, 한국어, Polskie, Gujarati, ไทย, 日本語, فارسی

STATEMENT - CANCER CARE GROUP PC

Date	Description	Amount	Insurance Balance	Patient Balance	Balance
10/09/18	**ENCOUNTER 459234 FOR DALLAS WITH LIEBROSS MD, ROBERT**				
10/05/18	99205 - OFFICE/OUTPATIENT VISIT, NEW	465.00		465.00	
	ENCOUNTER TOTAL	465.00		465.00	465.00
10/17/18	**ENCOUNTER 460196 FOR DALLAS WITH DUGAN MD, THOMAS**				
10/12/18	57156 - INSERTION OF VAGINAL RAD AFTERLOAD APP FOR BRACHY	320.00		320.00	$181.87
10/12/18	7777026 - HDR INTERSTITIAL INTRACAVITARY 1 CHANNEL	425.00		425.00	
	ENCOUNTER TOTAL	745.00		745.00	745.00
10/17/18	**ENCOUNTER 460197 FOR DALLAS WITH TUMATI MD, VASU**				
10/10/18	77263 - RADIATION THERAPY PLANNING	496.00		496.00	
10/10/18	7747026 - PROF SPECIAL RADIATION TREATMENT	395.00		395.00	
10/10/18	57156 - INSERTION OF VAGINAL RAD AFTERLOAD APP FOR BRACHY	320.00		320.00	
10/10/18	7777026 - HDR INTERSTITIAL INTRACAVITARY 1 CHANNEL	425.00		425.00	
10/10/18	7731626 - PROF BRACHY ISODOSE PLAN SIMPLE	445.00		445.00	
	ENCOUNTER TOTAL	2081.00		2081.00	2081.00
10/23/18	**ENCOUNTER 460764 FOR DALLAS WITH DUGAN MD, THOMAS**				
10/17/18	57156 - INSERTION OF VAGINAL RAD AFTERLOAD APP FOR BRACHY	320.00		320.00	
10/17/18	7777026 - HDR INTERSTITIAL INTRACAVITARY 1 CHANNEL	425.00		425.00	

Please pay your balance as indicated at the bottom of this statement. Thank you for your prompt payment
Mon-Thur 8am-5:00pm Friday 8am-4:30pm

PLEASE DETACH AT THE PERFORATION AND MAIL THIS PORTION WITH YOUR PAYMENT

☐ Please check box if above address is incorrect or if insurance information has changed and indicate change(s) on reverse

☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMEX

CARD NUMBER	3 DIGIT CODE	AMOUNT PAID
SIGNATURE		EXP DATE
NAME: Dallas A Holmes		STATEMENT ID: 69547835
AMOUNT DUE: $5667.00	ACCOUNT NUMBER: 46978	PAYMENT DUE DATE: 02/26/19

Cancer Care Group is pleased to announce Bill Payment online; please go to:

https://patients.availity.com/

Statement ID: 69547835
Access Code: 2E2160

Please remit payments to:
CANCER CARE GROUP
DEPT 78725
PO BOX 78000
DETROIT, MI 48278-0725

Didn't pay Robert - LieBROSS - MD