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 May 1, 2019 through August 31, 2019 ONLY.

Name of Creditor (The person or other entity to whom the debtor owes money or property):
Cytometry Specialists INC.

☐ 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.

Name and address where notices should be sent:

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

Name and address where payment should be sent (if different):
Cytometry specialist INC.
5700 Southwyck Blvd.
Toledo, OH 43614-1509

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

Telephone number: 765-265-1941

Last four digits of account or other number by which creditor identifies debtor: 7307

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 ______________ - to ______________
(date) (date)

RECEIVED
SEP 24 2019
KMC GROUP

2. Date(s) debt was incurred: 6/18/19

3. If court judgment, date obtained:

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 1050.00

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 no payments have been paid

☐ 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: 9/17/19

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):
Peggy Turney Peggy Turney

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
00227

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 MAY 1, 2019 AND AUGUST 31, 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 **October 18, 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 May 1, 2019 and August 31, 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 October 18, 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, 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: September 6, 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

> IMPORTANT INFORMATION

SIHO FILED 07/09/2019

WE BILLED YOUR INSURANCE COMPANY FOR THIS ACCOUNT. TO DATE,
THERE IS STILL AN OPEN BALANCE ON YOUR ACCOUNT.
FINAL RESPONSIBILITY FOR PAYMENT TO SETTLE THIS ACCOUNT IS
YOURS. PLEASE CONTACT YOUR INSURANCE CARRIER TO EXPEDITE
PAYMENT. THANK YOU.
IF YOU'VE SENT PAYMENT IN FULL, PLEASE DISREGARD THIS NOTICE

FOR PROFESSIONAL PATHOLOGY SERVICES RENDERED AT CYTOMETRY SPECIALISTS INC.

> PATIENT INFORMATION

Patient Name	TURNEY,PEGGY S
Your Physician	TOLNAY,GABOR L
Account Number	068607307
Original account#	254250/CSIG

> INSURANCE INFORMATION

PRIMARY

Insurance Name	SIHO
Name of Insured	TURNEY,PEGGY S
Policy Number	00085364201

SECONDARY

Insurance Name	None on file
Policy Number	

> 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

> ACCOUNT SUMMARY

Date	Description	Code	Qty	Amount
06/18/19	FLOWCYTOMETRY/ TC 1 MARKER	88184		150.00
06/18/19	FLOWCYTOMETRY/TC ADD-ON	88185	x8	720.00
06/18/19	FLOWCYTOMETRY/READ 9-15	88188		180.00
	Balance Due			1050.00

Mon Aug 26 06:35:13 2019
acc1146-20190826063013-1-451683695
110005b

THIS IS YOUR BALANCE: $1050.00

THANK YOU FOR YOUR PROMPT PAYMENT!

MAKE CHECKS PAYABLE TO

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

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NUMBER
08/25/19	1050.00	068607307
SHOW AMOUNT PAID HERE $	PASS CODE CSIG	

* FORWARDING SERVICE REQUESTED
ADDRESSEE

PEGGY S TURNEY
527 W 20TH ST
CONNERSVILLE IN 47331-2222

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.

PLEASE READ THE FRONT OF THIS FORM CAREFULLY BEFORE YOU COMPLETE ANY OF THIS INFORMATION!

CORRECTION OF PERSONAL INFORMATION

NAME		
ADDRESS		
CITY	STATE	ZIP
SOC. SEC. NUMBER	PHONE ( )	
EMPLOYER'S NAME		
EMPLOYMENT ADDRESS		
CITY	STATE	ZIP
PHONE ( )		

INSTRUCTIONS FOR FILING HEALTH INSURANCE CLAIMS

1. If you wish our assistance in filing a claim for your health insurance benefits, please complete the form below and return it to our office. Failure to return the form automatically makes you responsible for payment in full.
2. If you need another claim filed for a second insurance company, please make a photocopy of the front and back of this statement, then complete one form for each insurance carrier Return all forms to our office.
3. Be sure to sign the appropriate authorization(s) below for each form submitted.

Complete all items below and return to our office.

Insurance Company ______________ Insurance Co. Telephone No. ______________

Claim Office Address ______________

Policy Number ______________ Group Number ______________

Name of Insured ______________ Home Telephone No. ______________

Social Security No. ______________ Medicare No. ______________ Medicaid No. ______________

Employer of Insured ______________ Employer's Telephone No. ______________

Employer's Address ______________

Relation of Patient to Insured ______________ Patient's Date of Birth ______________

Was condition related to ☐ Employment ☐ Auto Accident Date of accident/injury ______________

Referring Physician ______________

AUTHORIZATION: I HEREBY AUTHORIZE AND DIRECT MY INSURANCE CARRIER TO PAY DIRECTLY TO THE PROVIDER SHOWN ON THE REVERSE SIDE OF THIS FORM ANY BENEFITS DUE ME UNDER MY INSURANCE PLAN. I AGREE TO PAY THE BALANCE OF EXPENSES NOT PAID UNDER THIS PLAN.
I FURTHER AUTHORIZE THE RELEASE TO MY INSURANCE COMPANY ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

x ______________________________

AUTHORIZED SIGNATURE DATE