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):
Riverview Health

☐ 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:
Kay Dee Baird, Esq., Krieg DeVault LLP, One Indiana Square, Suite 2800, Indianapolis, IN 46204

☐ 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):

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

Telephone number: (317)238-6306

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

1. Basis for Administrative Claim

- ☐ Goods sold
- ☒ Services performed (invoices attached)
- ☐ 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)

2. Date(s) debt was incurred: May 20, 2019 - June 30, 2019

3. If court judgment, date obtained:

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 13,695.82

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: 10/15/19

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):

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.

Invoice	INV6521
Date	6/6/2019

Riverview Hospital
Attn: Terry Harp
395 Westfield Road
Noblesville, IN 46060

Bill To:	Ship To:
FAYETTE REGIONAL HEALTH SYSTEM ATTN: PAUL HUMMEL 1941 VIRGINIA AVE CONNERSVILLE, IN 47331	FAYETTE REGIONAL HEALTH SYSTEM ATTN: PAUL HUMMEL 1941 VIRGINIA AVE CONNERSVILLE, IN 47331

Qty	Description	Rate	Price
	LAB SERVICES: 5.20.19 – 5.26.19		
50	TESTS	VARIABLE	$2,143.93
		Total	$2,143.93

Invoice	INV6522
Date	6/6/2019

Riverview Hospital
Attn: Terry Harp
395 Westfield Road
Noblesville, IN 46060

Bill To:

FAYETTE REGIONAL HEALTH SYSTEM
ATTN: PAUL HUMMEL
1941 VIRGINIA AVE
CONNERSVILLE, IN 47331

Ship To:

FAYETTE REGIONAL HEALTH SYSTEM
ATTN: PAUL HUMMEL
1941 VIRGINIA AVE
CONNERSVILLE, IN 47331

Qty	Description	Rate	Price
	LAB SERVICES: 5.27.19 – 6.2.19		
59	TESTS	VARIABLE	$2,356.45
		Total	$2,356.45

Invoice	INV6523
Date	6/12/2019

Riverview Hospital
Attn: Terry Harp
395 Westfield Road
Noblesville, IN 46060

Bill To:

FAYETTE REGIONAL HEALTH SYSTEM
ATTN: PAUL HUMMEL
1941 VIRGINIA AVE
CONNERSVILLE, IN 47331

Ship To:

FAYETTE REGIONAL HEALTH SYSTEM
ATTN: PAUL HUMMEL
1941 VIRGINIA AVE
CONNERSVILLE, IN 47331

Qty	Description	Rate	Price
	LAB SERVICES: 6.3.19 – 6.9.19		
64	TESTS	VARIABLE	$2,234.84
		Total	$2,234.84

6-12 Emailed Paul
cc Sarah

Invoice	INV6524
Date	7/3/2019

Riverview Hospital
Attn: Terry Harp
395 Westfield Road
Noblesville, IN 46060

Bill To:

FAYETTE REGIONAL HEALTH SYSTEM
ATTN: PAUL HUMMEL
1941 VIRGINIA AVE
CONNERSVILLE, IN 47331

Ship To:

FAYETTE REGIONAL HEALTH SYSTEM
ATTN: PAUL HUMMEL
1941 VIRGINIA AVE
CONNERSVILLE, IN 47331

Qty	Description	Rate	Price
	LAB SERVICES: 6.10.19 – 6.16.19		
72	TESTS	VARIABLE	$2,891.95
		Total	$2,891.95

Invoice	INV6525
Date	7/3/2019

Riverview Hospital
Attn: Terry Harp
395 Westfield Road
Noblesville, IN 46060

Bill To:	Ship To:
FAYETTE REGIONAL HEALTH SYSTEM ATTN: PAUL HUMMEL 1941 VIRGINIA AVE CONNERSVILLE, IN 47331	FAYETTE REGIONAL HEALTH SYSTEM ATTN: PAUL HUMMEL 1941 VIRGINIA AVE CONNERSVILLE, IN 47331

Qty	Description	Rate	Price
	LAB SERVICES: 6.17.19 – 6.23.19		
54	TESTS	VARIABLE	$1,861.85
		Total	$1,861.85

Invoice	INV6526
Date	7/8/2019

Riverview Hospital
Attn: Terry Harp
395 Westfield Road
Noblesville, IN 46060

Bill To:

FAYETTE REGIONAL HEALTH SYSTEM
ATTN: PAUL HUMMEL
1941 VIRGINIA AVE
CONNERSVILLE, IN 47331

Ship To:

FAYETTE REGIONAL HEALTH SYSTEM
ATTN: PAUL HUMMEL
1941 VIRGINIA AVE
CONNERSVILLE, IN 47331

Qty		Description	Rate	Price
		LAB SERVICES: 6.24.19 – 6.30.19		
43		TESTS	VARIABLE	$2,206.80
			Total	$2,206.80

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, Indianapolis Division

Case number 18-07762-JJG-11

E-Filed on 10/17/2019
Claim # 248

Modified Form 410

Proof of Claim

04/16

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?

Riverview Health
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)
Name: Kay Dee Baird	Name:
Number Street: c/o Krieg DeVault LLP One Indiana Square, #2800	Number Street:
City: Indianapolis State: IN ZIP Code: 46107	City: State: ZIP Code:
Contact phone: (317) 636-4341	Contact phone:
Contact email: kbaird@kdlegal.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? ______

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?** $ 13,695.82 . **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.

   Services Performed

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.** $ 0.00

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).	$ 0.00
	☐ Up to $2,850* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	$ 0.00
	☐ Wages, salaries, or commissions (up to $12,850*) 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).	$ 0.00
	☐ Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	$ 0.00
	☐ Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	$ 0.00
	☐ Other. Specify subsection of 11 U.S.C. § 507(a)(__) that applies.	$ 0.00
	* Amounts are subject to adjustment on 4/01/19 and every 3 years after that for cases begun on or after the date of adjustment.	
13. **Is all or part of the claim entitled to administrative priority pursuant to 11 U.S.C. § 503(b)(9)?**	☑ No ☐ Yes. **Indicate the amount of your claim arising from the value of any goods received by the Debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.**	$ 0.00

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 10/17/2019
MM / DD / YYYY

Nicole Swiney
Signature

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

Name: Nicole Swiney
First name | Middle name | Last name

Title: VP of Ambulatory, Sports and Lab Services

Company: Riverview Health
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: ______
Number Street

______
City State ZIP Code

Contact phone ______ Email ______

Attachment 1 - Administrative Expense Claim.pdf
Description -