

B10 (Official Form 10) (04/13)

UNITED STATES BANKRUPTCY COURT		Northern District of Georgia	FILED IN CLAIMANT'S OFFICE U.S. BANKRUPTCY COURT PROOF OF CLAIM 15 NOV 23 PM 1:05 M. KEDON - CLERK BY _____ DEPUTY CLERK						
Name of Debtor: HUTCHESON MEDICAL CENTER, INC		Case Number: 14-42863	COURT USE ONLY <input type="checkbox"/> Check this box if this claim amends a previously filed claim. Court Claim Number: _____ (If known) Filed on: _____						
NOTE: Do not use this form to make a claim for an administrative expense that arises after the bankruptcy filing. You may file a request for payment of an administrative expense according to 11 U.S.C. § 503. Name of Creditor (the person or other entity to whom the debtor owes money or property): US DEPT OF LABOR O/B/O HUTCHESON MED CENTER, INC. 403(b) RETIREMENT PLAN									
Name and address where notices should be sent: U.S. DEPARTMENT OF LABOR, EBSA 81 FORSYTH STREET S.W., SUITE 7B54 ATLANTA, GEORGIA 30303 Telephone number: (404) 302-3911 email: _____			<input type="checkbox"/> Check this box if you are aware that anyone else has filed a proof of claim relating to this claim. Attach copy of statement giving particulars.						
Name and address where payment should be sent (if different from above): VALIC RETIREMENT SERVICES O/B/O HUTCHESON MEDICAL CENTER 403(b) PLAN 2919 Allen Parkway, L13-10 Houston, TX 77019-2155 Telephone number: _____ email: _____									
1. Amount of Claim as of Date Case Filed: \$ <u>0.00</u> If all or part of the claim is secured, complete item 4. If all or part of the claim is entitled to priority, complete item 5. <input type="checkbox"/> Check this box if the claim includes interest or other charges in addition to the principal amount of the claim. Attach a statement that itemizes interest or charges.									
2. Basis for Claim: <u>Unremitted employee contributions</u> (See instruction #2)									
3. Last four digits of any number by which creditor identifies debtor:	3a. Debtor may have scheduled account as: (See instruction #3a)	3b. Uniform Claim Identifier (optional): (See instruction #3b)							
4. Secured Claim (See instruction #4) Check the appropriate box if the claim is secured by a lien on property or a right of setoff, attach required redacted documents, and provide the requested information. Nature of property or right of setoff: <input type="checkbox"/> Real Estate <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Other Describe: _____ Basis for perfection: _____ Value of Property: \$ _____ Amount of Secured Claim: \$ _____ Annual Interest Rate _____ % <input type="checkbox"/> Fixed or <input type="checkbox"/> Variable (when case was filed) Amount Unsecured: \$ _____									
5. Amount of Claim Entitled to Priority under 11 U.S.C. § 507 (a). If any part of the claim falls into one of the following categories, check the box specifying the priority and state the amount.									
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Domestic support obligations under 11 U.S.C. § 507 (a)(1)(A) or (a)(1)(B). </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Wages, salaries, or commissions (up to \$12,475*) earned within 180 days before the case was filed or the debtor's business ceased, whichever is earlier – 11 U.S.C. § 507 (a)(4). </td> <td style="width: 33%; vertical-align: top;"> <input checked="" type="checkbox"/> Contributions to an employee benefit plan – 11 U.S.C. § 507 (a)(5). </td> </tr> <tr> <td style="vertical-align: top;"> <input type="checkbox"/> Up to \$2,775* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use – 11 U.S.C. § 507 (a)(7). </td> <td style="vertical-align: top;"> <input type="checkbox"/> Taxes or penalties owed to governmental units – 11 U.S.C. § 507 (a)(8). </td> <td style="vertical-align: top;"> <input type="checkbox"/> Other – Specify applicable paragraph of 11 U.S.C. § 507 (a)(). </td> </tr> </table>				<input type="checkbox"/> Domestic support obligations under 11 U.S.C. § 507 (a)(1)(A) or (a)(1)(B).	<input type="checkbox"/> Wages, salaries, or commissions (up to \$12,475*) earned within 180 days before the case was filed or the debtor's business ceased, whichever is earlier – 11 U.S.C. § 507 (a)(4).	<input checked="" type="checkbox"/> Contributions to an employee benefit plan – 11 U.S.C. § 507 (a)(5).	<input type="checkbox"/> Up to \$2,775* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use – 11 U.S.C. § 507 (a)(7).	<input type="checkbox"/> Taxes or penalties owed to governmental units – 11 U.S.C. § 507 (a)(8).	<input type="checkbox"/> Other – Specify applicable paragraph of 11 U.S.C. § 507 (a)().
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Amount entitled to priority: \$ <u>0.00</u>									
*Amounts are subject to adjustment on 4/01/16 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.									
6. Credits. The amount of all payments on this claim has been credited for the purpose of making this proof of claim. (See instruction #6)									

Hutcheson Med POC



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7. Documents: Attached are redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, security agreements, or, in the case of a claim based on an open-end or revolving consumer credit agreement, a statement providing the information required by FRBP 3001(c)(3)(A). If the claim is secured, box 4 has been completed, and redacted copies of documents providing evidence of perfection of a security interest are attached. If the claim is secured by the debtor's principal residence, the Mortgage Proof of Claim Attachment is being filed with this claim. (See instruction #7, and the definition of "redacted".)

DO NOT SEND ORIGINAL DOCUMENTS. ATTACHED DOCUMENTS MAY BE DESTROYED AFTER SCANNING.

If the documents are not available, please explain:

8. Signature: (See instruction #8)

Check the appropriate box.

- ☐ I am the creditor. ☒ I am the creditor's authorized agent. ☐ I am the trustee, or the debtor, or their authorized agent. ☐ I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)
(See Bankruptcy Rule 3004.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: ISABEL COLON
Title: REGIONAL DIRECTOR
Company: U.S. DEPT OF LABOR, EBSA
Address and telephone number (if different from notice address above):
61 FORSYTH STREET S.W., STE. 7B54
ATLANTA, GA. 30303


(Signature)

11-17-2015
(Date)

Telephone number: (404) 302-3900 email:

Penalty for presenting fraudulent claim: Fine of up to \$500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571.

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The instructions and definitions below are general explanations of the law. In certain circumstances, such as bankruptcy cases not filed voluntarily by the debtor, exceptions to these general rules may apply.

Items to be completed in Proof of Claim form

Court, Name of Debtor, and Case Number:

Fill in the federal judicial district in which the bankruptcy case was filed (for example, Central District of California), the debtor's full name, and the case number. If the creditor received a notice of the case from the bankruptcy court, all of this information is at the top of the notice.

Creditor's Name and Address:

Fill in the name of the person or entity asserting a claim and the name and address of the person who should receive notices issued during the bankruptcy case. A separate space is provided for the payment address if it differs from the notice address. The creditor has a continuing obligation to keep the court informed of its current address. See Federal Rule of Bankruptcy Procedure (FRBP) 2002(g).

1. Amount of Claim as of Date Case Filed:

State the total amount owed to the creditor on the date of the bankruptcy filing. Follow the instructions concerning whether to complete items 4 and 5. Check the box if interest or other charges are included in the claim.

2. Basis for Claim:

State the type of debt or how it was incurred. Examples include goods sold, money loaned, services performed, personal injury/wrongful death, car loan, mortgage note, and credit card. If the claim is based on delivering health care goods or services, limit the disclosure of the goods or services so as to avoid embarrassment or the disclosure of confidential health care information. You may be required to provide additional disclosure if an interested party objects to the claim.

3. Last Four Digits of Any Number by Which Creditor Identifies Debtor:

State only the last four digits of the debtor's account or other number used by the creditor to identify the debtor.

3a. Debtor May Have Scheduled Account As:

Report a change in the creditor's name, a transferred claim, or any other information that clarifies a difference between this proof of claim and the claim as scheduled by the debtor.

3b. Uniform Claim Identifier:

If you use a uniform claim identifier, you may report it here. A uniform claim identifier is an optional 24-character identifier that certain large creditors use to facilitate electronic payment in chapter 13 cases.

4. Secured Claim:

Check whether the claim is fully or partially secured. Skip this section if the

claim is entirely unsecured. (See Definitions.) If the claim is secured, check the box for the nature and value of property that secures the claim, attach copies of lien documentation, and state, as of the date of the bankruptcy filing, the annual interest rate (and whether it is fixed or variable), and the amount past due on the claim.

5. Amount of Claim Entitled to Priority Under 11 U.S.C. § 507 (a).

If any portion of the claim falls into any category shown, check the appropriate box(es) and state the amount entitled to priority. (See Definitions.) A claim may be partly priority and partly non-priority. For example, in some of the categories, the law limits the amount entitled to priority.

6. Credits:

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.

7. Documents:

Attach redacted copies of any documents that show the debt exists and a lien secures the debt. You must also attach copies of documents that evidence perfection of any security interest and documents required by FRBP 3001(c) for claims based on an open-end or revolving consumer credit agreement or secured by a security interest in the debtor's principal residence. You may also attach a summary in addition to the documents themselves. FRBP 3001(c) and (d). If the claim is based on delivering health care goods or services, limit disclosing confidential health care information. Do not send original documents, as attachments may be destroyed after scanning.

8. Date and Signature:

The individual completing this proof of claim must sign and date it. FRBP 9011. If the claim is filed electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what constitutes a signature. If you sign this form, you declare under penalty of perjury that the information provided is true and correct to the best of your knowledge, information, and reasonable belief. Your signature is also a certification that the claim meets the requirements of FRBP 9011(b). Whether the claim is filed electronically or in person, if your name is on the signature line, you are responsible for the declaration. Print the name and title, if any, of the creditor or other person authorized to file this claim. State the filer's address and telephone number if it differs from the address given on the top of the form for purposes of receiving notices. If the claim is filed by an authorized agent, provide both the name of the individual filing the claim and the name of the agent. If the authorized agent is a servicer, identify the corporate servicer as the company. Criminal penalties apply for making a false statement on a proof of claim.

ADDENDUM TO PROOF OF CLAIM

The Secretary of the U.S. Department of Labor is charged with responsibility for the enforcement of the fiduciary requirements of Title I of the Employee Retirement Income Security Act, 29 U.S.C. §1001, et. seq. (ERISA), including the institution of actions in federal district court for injunctive relief and restitution to employee benefit plans pursuant to ERISA §502(a), 29 U.S.C. § 1132(a).

The Secretary, under his statutory authority, has initiated an investigation of the Hutcheson Medical Center, Inc. The Secretary's investigation concerns the Hutcheson Medical Center, Inc. 403(b) Retirement Plan (the "Plan"), an employee benefit plan covered by ERISA. The Secretary's investigation is ongoing. The information obtained by the Secretary to date indicates that the Hutcheson Medical Center, Inc. is a fiduciary under § 3(21) of ERISA to the Plan.

Between January 1, 2015 and November 13, 2015, Hutcheson Medical Center, Inc. may have failed to timely forward an undisclosed amount of employee contributions (the "Employee Contributions") to the Plan. The Department is investigating whether there were unpaid employee contributions and lost earnings due to the Plan.

Based on preliminary results from his investigation, the Secretary is asserting an unsecured priority claim.

The Secretary files this Proof of Claim to protect his interests and those of the Plan, particularly the participants' rights, with regards to the assets owed to the Plan by the debtor on behalf of the Plan. Penalties may be assessed in this matter pursuant to section 502(l) of ERISA.

The Secretary files this Proof of Claim on behalf of the Plan. **Any distribution resulting from this Proof of Claim should be paid directly to the Plan, not the Secretary of Labor. The undersigned can provide additional information about the means of doing so upon request.** As noted above, the Secretary's investigation is ongoing. The Secretary may need to amend this proof of claim based on the ongoing results of his investigation. The Secretary recognizes that this proof of claim may overlap claims filed by individual Participants and Beneficiaries of the Plan. In the event that such overlap occurs, the Secretary may, as appropriate, amend the claim.



ISABEL COLON
Regional Director
U. S. Department of Labor
Employee Benefits Security Administration
Atlanta Regional Office

Attachment "E"

UNITED STATES BANKRUPTCY COURT
FOR THE NORTHERN DISTRICT OF GEORGIA

IN RE:

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Case No. 14-42863

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HUTCHESON MEDICAL
CENTER, INC.

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Chapter 11

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Debtor.

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DECLARATION OF ISABEL COLON
IN SUPPORT OF CLAIM OF THE
U. S. DEPARTMENT OF LABOR

I, Isabel Colon, declare the following:

1. I am the Regional Director of the Atlanta Regional Office, Employee Benefits Security Administration, United States Department of Labor, with offices located at 61 Forsyth Street S.W. Suite 7B54, Atlanta, Georgia 30303.
2. The Secretary of the United States Department of Labor (hereafter, the "Department") is charged with responsibility for enforcement of the fiduciary provisions of Title I of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, et seq., as amended (hereinafter known as "ERISA"), including the investigation of employee benefit plans covered by ERISA. 29 U.S.C. § 1134(a); ERISA § 504(a).
3. The Department has determined that the above-referenced Debtor is the sponsor and fiduciary of the **Hutcheson Medical Center, Inc. 403(b) Retirement Plan** ("Plan"), to which the provisions of ERISA apply.
4. Under its investigative authority, the Department has initiated, and is continuing, an investigation of the Plan to determine whether any entity or person has violated or is about to violate any provision of Title I of ERISA.
5. The Department is in the process of investigating whether the Debtor violated ERISA by failing to remit employee contributions owed to the Plan.
6. In addition, the Department is investigating whether the Debtor has committed additional violations of ERISA other than those specified in Paragraph 5. The


Attachment "E"

Department reserves its right to amend this Proof of Claim to assert additional liabilities of the Debtor.

7. Accordingly, the Department is filing this Proof of Claim in an unliquidated amount representing any restitution owed the Plan caused by the Debtor's failure to collect employer contributions owed the Plan, plus interest. This amount is claimed as an unsecured non-priority amount to the extent permitted in accordance with § 507(a) of the Bankruptcy Code.
8. Debtor may be assessed a civil penalty pursuant to § 502(l) of ERISA, 29 U.S.C. § 1132, by the Secretary of Labor, which penalty is owed to the United States Treasury.
9. **The money owed to the Pension Plan should be paid directly to the Pension Plan and not to the Department of Labor.** The Department will amend or withdraw the claim upon the completion of its investigation.

I declare under penalty of perjury that the foregoing statement is true and correct.

Dated: 11-17-2015



ISABEL COLON
Regional Director
U. S. Department of Labor
Employee Benefits Security Administration
Atlanta Regional Office

Northern District of Georgia Claims Register

[14-42863-pwb Hutcheson Medical Center, Inc.](#)

Judge: Paul W. Bonapfel

Chapter: 11

Office: Rome

Last Date to file claims: 05/01/2015

Trustee: Ronald L. Glass

Last Date to file (Govt):

<i>Creditor:</i> (19503475) US Dept of Labor o/b/o Hutcheson Medical Center Inc 403(b) Retirement Plan 61 Forsyth Street SW, Ste 7B54 Atlanta GA 30303	Claim No: 182 <i>Original Filed</i> <i>Date:</i> 11/23/2015 <i>Original Entered</i> <i>Date:</i> 11/23/2015	<i>Status:</i> <i>Filed by:</i> CR <i>Entered by:</i> mrr <i>Modified:</i>
Amount claimed: \$0.00		

History:

Details	182-1	11/23/2015	Claim #182 filed by US Dept of Labor, Amount claimed: \$0.00 (mrr)
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Description:

Remarks: (182-1) Zero dollar amount listed as "Amount Entitled to Priority".

Claims Register Summary

Case Name: Hutcheson Medical Center, Inc.

Case Number: 14-42863-pwb

Chapter: 11

Date Filed: 11/20/2014

Total Number Of Claims: 1

Total Amount Claimed*	\$0.00
Total Amount Allowed*	

*Includes general unsecured claims

The values are reflective of the data entered. Always refer to claim documents for actual amounts.

	Claimed	Allowed
Secured		
Priority		
Administrative		