IN THE UNITED STATES BANKRUPTCY COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ROME DIVISION

IN RE:	)	**CHAPTER 11**
	)	
HUTCHESON MEDICAL CENTER, INC. and HUTCHESON MEDICAL DIVISION, INC.,	)	**Jointly Administered Under CASE NO. 14-42863-pwb**
	)	
	)	
Debtors.	)	

REQUEST FOR ALLOWANCE AND PAYMENT OF
ADMINISTRATIVE EXPENSE CLAIM PURSUANT TO 11 U.S.C. § 503

COMES NOW the claimant identified below and hereby requests the allowance of an administrative expense claim pursuant to Section 503 of the Bankruptcy Code, arising from November 20, 2014 through November 20, 2015, showing the following:

CLAIMANT'S NAME AND ADDRESS: David C. Bosshardt MD
1713 N. Long Hollow Rd
Chickamauga, GA 30707

Amount of 11 U.S.C. § 503 Administrative Expense $ 5219.75

1. The undersigned holds an administrative expense claim pursuant to 11 U.S.C. § 503 in the amount identified above against the following Debtor identified in these bankruptcy cases:

☑ Hutcheson Medical Center, Inc.

☐ Hutcheson Medical Division, Inc.

2. The consideration for this debt (or ground for this liability owed by the Debtor is as follows: Contract for physician patient services provided directly to patients Never Paid

3. The administrative expense is entitled to administrative priority under 11 U.S.C. § 503(b) and 11 U.S.C. § 507(a)(2) because:

The services provided to Hutcheson were essential services of the hospital to provide care for the patients — Never paid

4. A copy of the writing (invoice, purchase order, lease agreement, etc.) on which the administrative expense is founded, if any, is attached hereto or cannot be attached for the reason set forth in the statement attached hereto.

5. The amount of all payments on the administrative expense have been credited and deducted for the purpose of making this request.

6. The undersigned is aware that under 18 U.S.C. §§ 152 and 3571, the penalty for presenting a fraudulent claim in a bankruptcy case includes a fine of up to $500,000 or imprisonment for up to five years, or both.

WHEREFORE, the undersigned requests that the Court allow the administrative expense or expenses requested herein, to be paid in accordance with the priorities set forth in the Bankruptcy Code and based upon availability of funds.

Dated: 1/25/2016.

Name of Claimant: David C. Bosshardt, MD

Signed: _____

By (if appropriate): _____

As Its (if appropriate): _____

INSTRUCTIONS:

Mail the completed form by March 7, 2016, to the Clerk, United States Bankruptcy Court, Northern District of Georgia, Room 339, 600 East First Street, Rome, Georgia 30161, with a copy served on Trustee's Claims Agent: (i) if by overnight or hand delivery: BMC Group, Attn: Hutcheson Medical Center, Inc. Claims Processing, 300 Continental Blvd., #570, El Segundo, CA 90245; (ii) if by first class mail: BMC Group, Attn: Hutcheson Medical Center, Inc. Claims Processing, PO Box 90100, Los Angeles, CA 90009.

Pertinent portion of Contract.

provide the services described herein. The Physicians will use such space, utilities, equipment, supplies and services solely for the purpose of fulfilling the duties outlined in this Agreement.

IV. COMPENSATION & BILLING.

A. **Compensation.** The parties agree that, in consideration for the services provided by Physicians hereunder and the fulfillment by Physician of his duties and obligations hereunder, Hospital shall pay to Physician such fees and compensation as are described as follows:

Payment for Services $4387 for the term not paid

1. **Fee.** The parties agree that in order to make the obligations set forth within this Agreement financially feasible for Physician, Hospital will pay Physician an hourly rate of One Hundred Forty and 00/100 Dollars ($140.00) up to Two Hundred Eight and 00/100 Dollars per hour ($208.00) ("Rate") not to exceed Three Hundred Thousand and No/100 Dollars ($300,000) annually for hours worked. Maximum rate to apply if physician agrees to service with less than 24 hours notice.

2. **Documentation.** Physician shall submit a detailed invoice that identifies (i) the date of the Services were rendered personally by the Physician; (ii) the Schedule of hours; and (iii) a signed attestation confirming that the Physician personally performed the services for the total number of hours worked each month ("Invoice"). The Invoice shall be submitted no later than the fifteenth (15^{th}) day of the month for the Services rendered during the preceding month. Upon review and approval of the detailed invoice, Hospital or Clinic shall issue payment to Physician by the thirtieth (30^{th}) day of the month. The parties have negotiated the hourly rate through arms length negotiation without regard to the volume or value of referrals or generation of business between the parties.

B. **Billing.** The parties acknowledge and agree that Hospital shall be solely responsible for billing any and all charges for the facility and any technical component of the Services rendered by Physician. Physician shall not bill or seek reimbursement from any patient, guarantor, third party payor or federal or state healthcare program for any and all charges related to the facility fees of the Hospital or any technical component. Physician shall be solely responsible for billing and collecting for any and all payments related to the professional services delivered by the Physician within the Hospital. At no time shall Hospital be responsible for the payment of the professional services rendered by the Physician in the Hospital. Physician further acknowledges that Physician shall be solely responsible for completing all records and other documentation necessary to bill patients and third party payers and to collect and receive payment for all services provided by Physician. Physician shall submit such records and documentation, including interpretations provided to Hospital to be contained in the medical records.

V. INSURANCE AND INDEMNIFICATION

A. During the Term of this Agreement, Employer shall reimburse Physician for maintaining professional liability insurance coverage insuring Employer and Physician for professional errors, omissions, negligence, incompetence, and malfeasance with the limits of

Reimbursement for Malpractice Insurance - $832.75/4 for the terms worked

EXHIBIT "A"

OFFICIAL TIME RECORD: David Bosshartd, MD **Department** Hospitalist

Document Purpose: This time record shall be used to account for time spent fulfilling the Services.

Instructions: Fill in the boxes below each instance of time spent fulfilling Services, including the date and shift and hours incurred.

This record covers one month of Services. Upon completion of a month, please send this record to Administration and maintain a copy for your records.

Month: March 2015

Date(s)	Activity/Location	Total Hours Incurred	
3/19/15	Hmc - Records Hospitalist	0.5 hrs @185	92.50
3/21/15	Hmc 10A - 3:30p	5.5 hrs @209	1149.50
3/30/15	Hmc 7:30 - 12:30p	5 hrs @ 185	925.
3/31/15	Hmc 7:15 - 11:15	4 hrs @ 185	740
4/1/15	Hmc 7:15 - 11:15	4 hrs @ 185	740
4/2/15	Hmc 10-11 + 12-3	4 hrs @ 185	740
	Total from back (if applicable)		
	Grand Total	23	

(Include time on reverse if needed)

4387

Attestation:
I, the above noted Independent Contractor, attest that the hours shown "incurred" were actually worked by me. Also, the hours shown are for Services consistent with those required by Clinic in Agreement.

Independent Contractor's Signature: DC Bosshartd MD Date: 4/2/15

MAG MUTUAL®
MAG MUTUAL INSURANCE COMPANY

Eight Piedmont Center, Suite 600 | 3525 Piedmont Road
Atlanta, Georgia 30305-1533 | www.magmutual.com
404.842.5600 | 800.282.4882 | FAX 404.842.5614

David C. Bosshardt, M.D.
1713 N. Long Hollow Rd.

Chickamauga, GA 30707

DETAIL ACCOUNT ACTIVITY (Policy Level) **Report Through Date: 2/09/15**

Policy Number: PSL 1205472 01
Policy Effective Date: 02/01/15

Activity Report	Enter Date	Effective Date	Transaction Amount
Renewal Business	11/30/14	02/01/15	2,291.00
Dividend	12/11/14	02/01/15	49.00-
Payment Received	02/06/15	02/01/15	523.75-
Policy Balance.....:			1,718.25

Policy 2/1/15 – 2/1/16

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DETAIL ACCOUNT ACTIVITY (Policy Level) **Report Through Date: 2/09/15**

Policy Number: PSL 1205472 00
Policy Effective Date: 02/01/14

Activity Report	Enter Date	Effective Date	Transaction Amount
New Business	01/31/14	02/01/14	1,236.00
Payment Received	03/03/14	02/01/14	309.00-
Payment Received	04/21/14	05/02/14	309.00-
Payment Received	07/22/14	07/31/14	309.00-
Payment Received	10/27/14	10/29/14	309.00-
		Policy Balance.....:	.00

Policy 2/1/14 — 2/1/15

MagMutual®
Insurance Company

3535 Piedmont Road, Suite 1000
P.O. Box 52979 | Atlanta, GA 30355-0979
800-282-4882 | fax 404-842-5614
MagMutual.com

Physician & Surgeons Professional Liability
Policyholder: David C. Bosshardt, M.D.

Policy Type	Policy Number	Coverage Period
PSL	1205472 00 01	2/1/2014 - 2/1/2015

Billing Address
David C. Bosshardt, M.D.
1713 N. Long Hollow Rd.
Chickamauga, Georgia 30707

BILLING NOTICE

Billing Date: 10/10/2014

Thank you for selecting MAG Mutual Insurance Company as your provider for insurance protection. We value your business and ask that you remit your payment promptly to ensure continuance of your coverage.

Your Installment Plan is Quarterly - 4 payments: 25% is due on effective date of policy. The remaining 3 installments are billed and due every 90 days thereafter. No service charge applies.

INSTALLMENT NUMBER	TRANSACTION DATE	TRANSACTION DESCRIPTION	AMOUNT
03	7/13/2014	Previous Balance	$309.00
	7/22/2014	Payments since last bill	-309.00
04	10/10/2014	Installment	309.00

MINIMUM AMOUNT DUE: $309.00
DUE DATE 10/29/2014
TOTAL UNPAID PREMIUM: $309.00

RETURN THIS PORTION WITH YOUR REMITTANCE

1/23/15
Mail + Pay This

2/3/15
Pay +523.75

832.75