

STATE OF MICHIGAN  
CIRCUIT COURT FOR THE 30<sup>TH</sup> JUDICIAL CIRCUIT  
INGHAM COUNTY

COMMISSIONER OF INSURANCE  
FOR THE STATE OF MICHIGAN

Petitioner,

File No. 98-88265-CR

Hon. James R. Giddings

A.G. No. 199805333A

vs.

MICHIGAN HEALTH MAINTENANCE  
ORGANIZATION PLANS, INC., a  
Michigan health maintenance organization,  
Doing business as OmniCare Health Plan  
Respondent.

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**DETROIT MEDICAL CENTER'S BRIEF ON PRIORITY**

The Detroit Medical Center ("DMC") respectfully submits this brief on the issue of claims priority.

**1. The DMC**

The DMC operates several hospitals including the following hospitals in the city of Detroit.

- Harper Hutzell Hospital which provides both general hospital care and maternity care for thousands of Medicaid funded births each year.
- Children's Hospital of Michigan.
- Detroit Receiving Hospital, a Level One trauma center.
- Sinai Grace Hospital, the last community hospital located in Northwest Detroit.

The DMC is by far the largest provider of care to uninsured and underinsured patients in the state of Michigan. Not surprisingly, the DMC is by far Omnicare's largest creditor, and the DMC already has sustained tens of millions of dollars of financial losses as a result of these proceedings.

**2. The DMC's claims filed in this proceeding.**

The DMC has filed the following claims against the OmniCare estate. First, DMC has filed proofs of claim in the total amount of \$14,348,793.37 for unpaid health care claims owed to various DMC hospitals. See Ex. A.

Second, the DMC filed a claim in the amount of \$36,685,911 for OmniCare's underpayment for health care services provided by DMC under the DMC – Omnicare contract. See Ex. B.

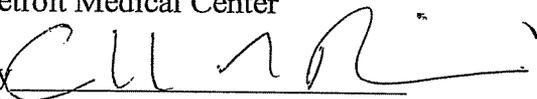
**3. The DMC's position on priority.**

The DMC understands that the question before the Court is whether provider claims are to be considered "priority 2" or "priority 5" claims under MCL 500.8142. However, the DMC also understands that may be an academic question in this proceeding, inasmuch as the vast majority of claims (other than expenses of liquidation) are in fact, provider claims. If correct, the DMC sees no need for this Court to address an academic issue.

It also is the DMC's position that assuming provider claims are accorded priority 2 status, as in The Wellness Plan proceedings, all of the DMC's claims as set forth in Ex 's A and B attached should likewise be accorded priority 2 status. All of the DMC's claims seek payment for health care services rendered to OmniCare members, and, hence, there is no basis for treating any of the DMC's claims differently than other provider claims.

In the event any argument to the contrary is made, DMC will want an opportunity to respond.

Detroit Medical Center

By 

Charles Raimi (P29746)  
3990 John R, 7 Brush West  
Detroit, MI 48201  
(313) 887-5381

June 13, 2005



Michigan Health Maintenance  
Organization Plans, Inc. (in Liquidation)  
Formerly OmniCare Health Plan in Rehabilitation

Ingham County Circuit Court File No. 98-88265-CR

**For Office Use Only:**  
Date Proof Received: \_\_\_\_\_  
Proof of Claim #: \_\_\_\_\_

**"PROOF OF CLAIM"**

**MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (in LIQUIDATION)  
(FORMERLY OMNICARE HEALTH PLAN IN REHABILITATION)**

**DEADLINE FOR FILING: MARCH 31, 2005**

PLEASE READ CAREFULLY BEFORE COMPLETING THIS FORM. EACH SECTION MUST BE FULLY COMPLETED. INSTRUCTIONS ARE ATTACHED. IF ADDITIONAL COPIES ARE NEEDED, PLEASE PHOTOCOPY OR DOWNLOAD FORM: WWW.OCHP.COM. FILE A SEPARATE "PROOF OF CLAIM" FOR EACH BATCH OF CLAIMS.

**PERSON OR ENTITY MAKING CLAIM AGAINST MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (formally OmniCare Health Plan in Rehabilitation):**

1. NAME: CHILDREN'S HOSPITAL OF MI  
2. MAILING ADDRESS: 3901 Beaubien, Detroit, MI 48201  
4. TELEPHONE NUMBER (DAYTIME): (313) 578-3240  
5. CLAIM IS FROM: (Check "X" or specify below)  
A.  Member Provide Social Security or OmniCare ID No: \_\_\_\_\_  
B.  Provider Federal tax I.D. No. of Payee: 38-1357994  
Social Security No. of Payee: \_\_\_\_\_ (if applicable)

**Providers Note:** Each member claim must be submitted on UB 92 or CMS 1500 (HCFA 1500) claim forms. Also see "Instructions" (No. 1) about the "Proof of Claim" process for already adjudicated member claims.

- C.  Trade Creditor for amounts owed on open account Social Security or Federal Tax I.D. No: \_\_\_\_\_  
D.  All other claims - please explain and provide Social Security or Federal Tax I.D. No. : \_\_\_\_\_

6. In the space below give a CONCISE STATEMENT of the FACTS giving rise to your claim. Attach additional sheets if required.  
Approved claims

7. NUMBER OF CLAIMS: 589 AND TOTAL AMOUNT OF YOUR CLAIM(S): \$731,117.69. If amount of claim is unknown, insert words "Unstated Amount." Provider claims amount would be based on 'charges'. You may amend your timely filed claim up until the final date of adjudication. Please attach all documents, contracts and invoices. If they are voluminous, please attach a summary.  
8. No part of the debt has been paid, except \_\_\_\_\_  
9. There are no setoffs or counterclaims to the debt, except \_\_\_\_\_  
10. There is no security for the debt, except \_\_\_\_\_

The undersigned claimant affirms that the representations and information contained in this "Proof of Claim" are true and correct to the best of your knowledge. You also understand that any statements or representations contained herein which knowingly present a false claim is a criminal offense punishable under Michigan Law.

Dated: 3/21/05

Andie Tinsley  
Claimant's Name (please print or type)  
Signature Andie Tinsley  
Title (if applicable) Dr. PT. FIN SVCS (PMC)

Ex. A

Michigan Health Maintenance  
Organization Plans, Inc. (in Liquidation)  
Formerly OmniCare Health Plan in Rehabilitation

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**PERSON OR ENTITY MAKING CLAIM AGAINST MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (formally OmniCare Health Plan in Rehabilitation):**

1. NAME: CHILDREN'S HOSPITAL OF MI  
2. MAILING ADDRESS: 3901 Beaubien, Detroit, MI 48201  
4. TELEPHONE NUMBER (DAYTIME): (313) 578-3240  
5. CLAIM IS FROM: (Check "X" or specify below)

- A.  Member Provide Social Security or OmniCare ID No: \_\_\_\_\_  
B.  Provider Federal tax I.D. No. of Payee: 38-1357994  
Social Security No. of Payee: \_\_\_\_\_

applicable) \_\_\_\_\_ (if

**Providers Note:** Each member claim must be submitted on UB 92 or CMS 1500 (HCFA 1500) claim forms. Also see "Instructions" (No. 1) about the "Proof of Claim" process for already adjudicated member claims.

- C.  Trade Creditor for amounts owed on open account Social Security or Federal Tax I.D. No: \_\_\_\_\_  
D.  All other claims - please explain and provide Social Security or Federal Tax I.D. No. : \_\_\_\_\_

6. In the space below give a CONCISE STATEMENT of the FACTS giving rise to your claim. Attach additional sheets if required. OTHER

7. NUMBER OF CLAIMS: 233 AND TOTAL AMOUNT OF YOUR CLAIM(S): \$896,372.50 If amount of claim is unknown, insert words "Unstated Amount." Provider claims amount would be based on 'charges'. You may amend your timely filed claim up until the final date of adjudication. Please attach all documents, contracts and invoices. If they are voluminous, please attach a summary.

8. No part of the debt has been paid, except \_\_\_\_\_  
9. There are no setoffs or counterclaims to the debt, except \_\_\_\_\_  
10. There is no security for the debt, except \_\_\_\_\_

The undersigned claimant affirms that the representations and information contained in this "Proof of Claim" are true and correct to the best of your knowledge. You also understand that any statements or representations contained herein which knowingly present a false claim is a criminal offense punishable under Michigan Law.

Dated: 3/21/05

Andre Tinsley  
Claimant's Name (please print or type)  
Andre Tinsley  
Signature  
Dr PT FIN SVCS(DMC)  
Title (if applicable)

Michigan Health Maintenance  
Organization Plans, Inc. (in Liquidation)

Formerly OmniCare Health Plan in Rehabilitation

Ingham County Circuit Court File No. 98-88265-CR

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**MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (in LIQUIDATION)  
(FORMERLY OMNICARE HEALTH PLAN IN REHABILITATION)**

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**PERSON OR ENTITY MAKING CLAIM AGAINST MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (formerly OmniCare Health Plan in Rehabilitation):**

1. NAME: Detroit Receiving Hospital

2. MAILING ADDRESS: 4201 ST ANTOINE, DETROIT, MI 48201

4. TELEPHONE NUMBER (DAYTIME): (313) 578-3240

5. CLAIM IS FROM: (Check "X" or specify below)

A.  Member Provide Social Security or OmniCare ID No: \_\_\_\_\_

B.  Provider Federal tax I.D. No. of Payee: 38-2320476  
Social Security No. of Payee: \_\_\_\_\_

applicable) **Providers Note:** Each member claim must be submitted on UB 92 or CMS 1500 (HCFA 1500) claim forms. Also see "Instructions" (No. 1) about the "Proof of Claim" process for already adjudicated member claims.

C.  Trade Creditor for amounts owed on open account Social Security or Federal Tax I.D. No: \_\_\_\_\_

D.  All other claims - please explain and provide Social Security or Federal Tax I.D. No. : \_\_\_\_\_

6. In the space below give a CONCISE STATEMENT of the FACTS giving rise to your claim. Attach additional sheets if required. Approved Claims

7. NUMBER OF CLAIMS: 383 AND TOTAL AMOUNT OF YOUR CLAIM(S): \$1,658,893.77 If amount of claim is unknown, insert words "Unstated Amount." Provider claims amount would be based on 'charges'. You may amend your timely filed claim up until the final date of adjudication. Please attach all documents, contracts and invoices. If they are voluminous, please attach a summary.

8. No part of the debt has been paid, except \_\_\_\_\_

9. There are no setoffs or counterclaims to the debt, except \_\_\_\_\_

10. There is no security for the debt, except \_\_\_\_\_

The undersigned claimant affirms that the representations and information contained in this "Proof of Claim" are true and correct to the best of your knowledge. You also understand that any statements or representations contained herein which knowingly present a false claim is a criminal offense punishable under Michigan Law.

Dated: 3/21/05

Andie Tinsley  
Claimant's Name (please print or type)

Signature Andie Tinsley

Title (if applicable) Dir. PT FIN SVCS (DME)

Michigan Health Maintenance  
Organization Plans, Inc. (in Liquidation)  
Formerly OmniCare Health Plan in Rehabilitation

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(FORMERLY OMNICARE HEALTH PLAN IN REHABILITATION)**

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**PERSON OR ENTITY MAKING CLAIM AGAINST MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (formally OmniCare Health Plan in Rehabilitation):**

1. NAME: Detroit Receiving Hospital

2. MAILING ADDRESS: 4201 ST ANTOINE, Detroit, MI 48201

4. TELEPHONE NUMBER (DAYTIME): (313) 578-3240

5. CLAIM IS FROM: (Check "X" or specify below)

A.  Member Provide Social Security or OmniCare ID No: \_\_\_\_\_

B.  Provider Federal tax I.D. No. of Payee: 38-2320476  
Social Security No. of Payee: \_\_\_\_\_

applicable) **Providers Note:** Each member claim must be submitted on UB 92 or CMS 1500 (HCFA 1500) claim forms. Also see "Instructions" (No. 1) about the "Proof of Claim" process for already adjudicated member claims. (if

C.  Trade Creditor for amounts owed on open account Social Security or Federal Tax I.D. No: \_\_\_\_\_

D.  All other claims - please explain and provide Social Security or Federal Tax I.D. No. : \_\_\_\_\_

6. In the space below give a CONCISE STATEMENT of the FACTS giving rise to your claim. Attach additional sheets if required.

7. NUMBER OF CLAIMS: 89 AND TOTAL AMOUNT OF YOUR CLAIM(S): \$1,160,652.40. If amount of claim is unknown, insert words "Unstated Amount." Provider claims amount would be based on 'charges'. You may amend your timely filed claim up until the final date of adjudication. Please attach all documents, contracts and invoices. If they are voluminous, please attach a summary.

8. No part of the debt has been paid, except \_\_\_\_\_

9. There are no setoffs or counterclaims to the debt, except \_\_\_\_\_

10. There is no security for the debt, except \_\_\_\_\_

The undersigned claimant affirms that the representations and information contained in this "Proof of Claim" are true and correct to the best of your knowledge. You also understand that any statements or representations contained herein which knowingly present a false claim is a criminal offense punishable under Michigan Law.

Dated: 3/21/05

Archie Tinsley  
Claimant's Name (please print, or type)

Signature Archie Tinsley

Title (if applicable) Dir PT FIN SVCS (DMC)

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Organization Plans, Inc. (in Liquidation)  
Formerly OmniCare Health Plan in Rehabilitation

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**PERSON OR ENTITY MAKING CLAIM AGAINST MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (formally OmniCare Health Plan in Rehabilitation):**

1. NAME: Harper - Hospital

2. MAILING ADDRESS: 3990 John R, Detroit, MI 48201

4. TELEPHONE NUMBER (DAYTIME): (313) 578-3240

5. CLAIM IS FROM: (Check "X" or specify below)

A.  Member Provide Social Security or OmniCare ID No: \_\_\_\_\_

B.  Provider Federal tax I.D. No. of Payee: 38-2391907  
Social Security No. of Payee: \_\_\_\_\_

applicable) **Providers Note:** Each member claim must be submitted on UB 92 or CMS 1500 (HCFA 1500) claim forms. Also see "Instructions" (No. 1) about the "Proof of Claim" process for already adjudicated member claims. (if

C.  Trade Creditor for amounts owed on open account Social Security or Federal Tax I.D. No: \_\_\_\_\_

D.  All other claims - please explain and provide Social Security or Federal Tax I.D. No. : \_\_\_\_\_

6. In the space below give a CONCISE STATEMENT of the FACTS giving rise to your claim. Attach additional sheets if required. Approved claims

7. NUMBER OF CLAIMS: 890 AND TOTAL AMOUNT OF YOUR CLAIM(S): \$ 3,296,785.03 If amount of claim is unknown, insert words "Unstated Amount." Provider claims amount would be based on 'charges'. You may amend your timely filed claim up until the final date of adjudication. Please attach all documents, contracts and invoices. If they are voluminous, please attach a summary.

8. No part of the debt has been paid, except \_\_\_\_\_

9. There are no setoffs or counterclaims to the debt, except \_\_\_\_\_

10. There is no security for the debt, except \_\_\_\_\_

The undersigned claimant affirms that the representations and information contained in this "Proof of Claim" are true and correct to the best of your knowledge. You also understand that any statements or representations contained herein which knowingly present a false claim is a criminal offense punishable under Michigan Law.

Dated: 3/21/05

Andee Tinsley  
Claimant's Name (please print or type)

Signature Andee Tinsley

Title (if applicable) D.I.R. PT FIN SVCS (DMC)

Michigan Health Maintenance  
Organization Plans, Inc. (in Liquidation)

Formerly OmniCare Health Plan in Rehabilitation

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**PERSON OR ENTITY MAKING CLAIM AGAINST MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (formally  
OmniCare Health Plan in Rehabilitation):**

1. NAME: Harper-Hospital

2. MAILING ADDRESS: 3990 John R, Detroit, MI 48201

4. TELEPHONE NUMBER (DAYTIME): (313) 578-3240

5. CLAIM IS FROM: (Check "X" or specify below)

A.  Member Provide Social Security or OmniCare ID No: \_\_\_\_\_

B.  Provider Federal tax I.D. No. of Payee: 38-2391907  
Social Security No. of Payee: \_\_\_\_\_ (if applicable)

**Providers Note:** Each member claim must be submitted on UB 92 or CMS 1500 (HCFA 1500) claim forms. Also see "Instructions" (No. 1) about the "Proof of Claim" process for already adjudicated member claims.

C.  Trade Creditor for amounts owed on open account Social Security or Federal Tax I.D. No: \_\_\_\_\_

D.  All other claims - please explain and provide Social Security or Federal Tax I.D. No. : \_\_\_\_\_

6. In the space below give a CONCISE STATEMENT of the FACTS giving rise to your claim. Attach additional sheets if required.

7. NUMBER OF CLAIMS: 341 AND TOTAL AMOUNT OF YOUR CLAIM(S): \$1,985,936.85 If amount of claim is unknown, insert words "Unstated Amount." Provider claims amount would be based on 'charges'. You may amend your timely filed claim up until the final date of adjudication. Please attach all documents, contracts and invoices. If they are voluminous, please attach a summary.

8. No part of the debt has been paid, except \_\_\_\_\_

9. There are no setoffs or counterclaims to the debt, except \_\_\_\_\_

10. There is no security for the debt, except \_\_\_\_\_

The undersigned claimant affirms that the representations and information contained in this "Proof of Claim" are true and correct to the best of your knowledge. You also understand that any statements or representations contained herein which knowingly present a false claim is a criminal offense punishable under Michigan Law.

Dated: 3/21/05

Andee Tinsley  
Claimant's Name (please print or type)

Andee Tinsley  
Signature

Title (if applicable) Dir. PT Fin Svcs (PMC)

Michigan Health Maintenance  
Organization Plans, Inc. (in Liquidation)  
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**PERSON OR ENTITY MAKING CLAIM AGAINST MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (formally OmniCare Health Plan in Rehabilitation):**

1. NAME: Swa Grace Hospital

2. MAILING ADDRESS: 6071 W. Outer Drive, Detroit, MI 48235

4. TELEPHONE NUMBER (DAYTIME): (313) 578-3240

5. CLAIM IS FROM: (Check "X" or specify below) \_\_\_\_\_

A.  Member Provide Social Security or OmniCare ID No: \_\_\_\_\_

B.  Provider Federal tax I.D. No. of Payee: 38-1416522  
Social Security No. of Payee: \_\_\_\_\_

applicable) **Providers Note:** Each member claim must be submitted on UB 92 or CMS 1500 (HCFA 1500) claim forms. Also see "Instructions" (No. 1) about the "Proof of Claim" process for already adjudicated member claims. (if

C.  Trade Creditor for amounts owed on open account Social Security or Federal Tax I.D. No: \_\_\_\_\_

D.  All other claims - please explain and provide Social Security or Federal Tax I.D. No. : \_\_\_\_\_

6. In the space below give a CONCISE STATEMENT of the FACTS giving rise to your claim. Attach additional sheets if required.  
Approved Claims

7. NUMBER OF CLAIMS: 455 AND TOTAL AMOUNT OF YOUR CLAIM(S): \$2474,156.34 If amount of claim is unknown, insert words "Unstated Amount." Provider claims amount would be based on 'charges'. You may amend your timely filed claim up until the final date of adjudication. Please attach all documents, contracts and invoices. If they are voluminous, please attach a summary.

8. No part of the debt has been paid, except \_\_\_\_\_

9. There are no setoffs or counterclaims to the debt, except \_\_\_\_\_

10. There is no security for the debt, except \_\_\_\_\_

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Dated: 3/21/05

Andie Tinsley  
Claimant's Name (please print or type)  
Signature Andie Tinsley  
Title (if applicable) Dir. PT FIN SVCS (DMC)

Michigan Health Maintenance  
Organization Plans, Inc. (in Liquidation)  
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**PERSON OR ENTITY MAKING CLAIM AGAINST MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (formally OmniCare Health Plan in Rehabilitation):**

- 1. NAME: SIDA - Grace Hospital
- 2. MAILING ADDRESS: 6571 W. Outer Drive, Detroit, MI 48235
- 4. TELEPHONE NUMBER (DAYTIME): (313) 578-3240
- 5. CLAIM IS FROM: (Check "X" or specify below)

- A.  Member Provide Social Security or OmniCare ID No: \_\_\_\_\_
- B.  Provider Federal tax I.D. No. of Payee: 38-1416522  
Social Security No. of Payee: \_\_\_\_\_

**Providers Note:** Each member claim must be submitted on UB 92 or CMS 1500 (HCFA 1500) claim forms. Also see "Instructions" (No. 1) about the "Proof of Claim" process for already adjudicated member claims.

- C.  Trade Creditor for amounts owed on open account Social Security or Federal Tax I.D. No: \_\_\_\_\_
- D.  All other claims - please explain and provide Social Security or Federal Tax I.D. No. : \_\_\_\_\_

6. In the space below give a CONCISE STATEMENT of the FACTS giving rise to your claim. Attach additional sheets if required.

7. NUMBER OF CLAIMS: 262 AND TOTAL AMOUNT OF YOUR CLAIM(S): \$1,954,267.75 If amount of claim is unknown, insert words "Unstated Amount." Provider claims amount would be based on 'charges'. You may amend your timely filed claim up until the final date of adjudication. Please attach all documents, contracts and invoices. If they are voluminous, please attach a summary.

- 8. No part of the debt has been paid, except \_\_\_\_\_
- 9. There are no setoffs or counterclaims to the debt, except \_\_\_\_\_
- 10. There is no security for the debt, except \_\_\_\_\_

The undersigned claimant affirms that the representations and information contained in this "Proof of Claim" are true and correct to the best of your knowledge. You also understand that any statements or representations contained herein which knowingly present a false claim is a criminal offense punishable under Michigan Law.

Dated: 3/21/05

Andie Tinsley  
Claimant's Name (please print or type)  
Signature Andie Tinsley  
Title (if applicable) Dir. PT FN SVCS (DMC)

Michigan Health Maintenance  
Organization Plans, Inc.  
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**PERSON OR ENTITY MAKING CLAIM AGAINST MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (formally OmniCare Health Plan in Rehabilitation):**

1. NAME: REHABILITATION INSTITUTE OF MICHIGAN - DEPT-64947

2. MAILING ADDRESS: PO Box 67000 DETROIT, MI. 48267-0947

4. TELEPHONE NUMBER (DAYTIME): (313) 578-3269

5. CLAIM IS FROM: (Check "X" or specify below)

A. ( ) Member Provide Social Security or OmniCare ID No: \_\_\_\_\_

B.  Provider Federal tax I.D. No. of Payee: 381-417-366  
Social Security No. of Payee: \_\_\_\_\_ (if applicable)

**Providers Note:** Each member claim must be submitted on UB 92 or CMS 1500 (HCFA 1500) claim forms. Also see "Instructions" (No. 1) about the "Proof of Claim" process for already adjudicated member claims.

C. ( ) Trade Creditor for amounts owed on open account Social Security or Federal Tax I.D. No: \_\_\_\_\_

D. ( ) All other claims - please explain and provide Social Security or Federal Tax I.D. No. : \_\_\_\_\_

6. In the space below give a CONCISE STATEMENT of the FACTS giving rise to your claim. Attach additional sheets if required.

7. NUMBER OF CLAIMS: 10 AND TOTAL AMOUNT OF YOUR CLAIM(S): \$ 91,565.59 . If amount of claim is unknown, insert words "Unstated Amount." Provider claims amount would be based on 'charges'. You may amend your timely filed claim up until the final date of adjudication. Please attach all documents, contracts and invoices. If they are voluminous, please attach a summary.

8. No part of the debt has been paid, except \_\_\_\_\_

9. There are no setoffs or counterclaims to the debt, except \_\_\_\_\_

10. There is no security for the debt, except \_\_\_\_\_

The undersigned claimant affirms that the representations and information contained in this "Proof of Claim" are true and correct to the best of your knowledge. You also understand that any statements or representations contained herein which knowingly present a false claim is a criminal offense punishable under Michigan Law.

Dated: 03-09-05

Jane Ruppman  
Claimant's Name (please print or type)

Signature Jane Ruppman

Title (if applicable) Director of Patient Accounting

**SEE OTHER SIDE FOR "INSTRUCTIONS" TO COMPLETE AND SUBMIT THE "PROOF OF CLAIM" FORM**

Michigan Health Maintenance  
Organization Plans, Inc.  
(in Liquidation)

(Formerly OmniCare Health Plan in Rehabilitation)

Ingham County Circuit Court File No. 98-88265-CR

**For Office Use Only:**

Date Proof Received: \_\_\_\_\_

Proof of Claim #: \_\_\_\_\_

**"PROOF OF CLAIM"**

**MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (in LIQUIDATION)  
(FORMERLY OMNICARE HEALTH PLAN IN REHABILITATION)**

**DEADLINE FOR FILING: MARCH 31, 2005**

PLEASE READ CAREFULLY BEFORE COMPLETING THIS FORM. EACH SECTION MUST BE FULLY COMPLETED. INSTRUCTIONS ARE ATTACHED. IF ADDITIONAL COPIES ARE NEEDED, PLEASE PHOTOCOPY OR DOWNLOAD FORM: WWW.OCHP.COM. FILE A SEPARATE "PROOF OF CLAIM" FOR EACH BATCH OF CLAIMS.

**PERSON OR ENTITY MAKING CLAIM AGAINST MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (formerly OmniCare Health Plan in Rehabilitation):**

1. NAME: REHABILITATION INSTITUTE OF MICHIGAN - DEPT-64947  
2. MAILING ADDRESS: PO Box 67000 DETROIT, MI. 48267-0947  
4. TELEPHONE NUMBER (DAYTIME): (313) 578-3269  
5. CLAIM IS FROM: (Check "X" or specify below)

A. ( ) Member Provide Social Security or OmniCare ID No: \_\_\_\_\_

B. (X) Provider Federal tax I.D. No. of Payee: 381417366  
Social Security No. of Payee: \_\_\_\_\_ (if applicable)

Providers Note: Each member claim must be submitted on UB 92 or CMS 1500 (HCFA 1500) claim forms. Also see "Instructions" (No. 1) about the "Proof of Claim" process for already adjudicated member claims.

C. ( ) Trade Creditor for amounts owed on open account Social Security or Federal Tax I.D. No: \_\_\_\_\_

D. ( ) All other claims - please explain and provide Social Security or Federal Tax I.D. No. : \_\_\_\_\_

6. In the space below give a CONCISE STATEMENT of the FACTS giving rise to your claim. Attach additional sheets if required.

7. NUMBER OF CLAIMS: 1 AND TOTAL AMOUNT OF YOUR CLAIM(S): \$ 402.00. If amount of claim is unknown, insert words "Unstated Amount." Provider claims amount would be based on 'charges'. You may amend your timely filed claim up until the final date of adjudication. Please attach all documents, contracts and invoices. If they are voluminous, please attach a summary.

8. No part of the debt has been paid, except \_\_\_\_\_

9. There are no setoffs or counterclaims to the debt, except \_\_\_\_\_

10. There is no security for the debt, except \_\_\_\_\_

The undersigned claimant affirms that the representations and information contained in this "Proof of Claim" are true and correct to the best of your knowledge. You also understand that any statements or representations contained herein which knowingly present a false claim is a criminal offense punishable under Michigan Law.

Dated: 3/9/05

Jane Buppman  
Claimant's Name (please print or type)

Jane Buppman  
Signature

Director of Patient Accounting  
Title (if applicable)

**SEE OTHER SIDE FOR "INSTRUCTIONS" TO COMPLETE AND SUBMIT THE "PROOF OF CLAIM" FORM**

Michigan Health Maintenance  
Organization Plans, Inc.  
(in Liquidation)

(Formerly OmniCare Health Plan in Rehabilitation)

Ingham County Circuit Court File No. 98-88265-CR

**For Office Use Only:**

Date Proof Received: \_\_\_\_\_

Proof of Claim #: \_\_\_\_\_

**"PROOF OF CLAIM"**

**MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (in LIQUIDATION)  
(FORMERLY OMNICARE HEALTH PLAN IN REHABILITATION)**

**DEADLINE FOR FILING: MARCH 31, 2005**

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**PERSON OR ENTITY MAKING CLAIM AGAINST MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (formally OmniCare Health Plan in Rehabilitation):**

1. NAME: REHABILITATION INSTITUTE OF MICHIGAN - DEPT 64947

2. MAILING ADDRESS: P.O. BOX 67000 DETROIT MI 48267-0947

4. TELEPHONE NUMBER (DAYTIME): (313) 578-3269

5. CLAIM IS FROM: (Check "X" or specify below)

A. ( ) Member Provide Social Security or OmniCare ID No: \_\_\_\_\_

B. (X) Provider Federal tax I.D. No. of Payee: 381417366  
Social Security No. of Payee: \_\_\_\_\_ (if applicable)

**Providers Note:** Each member claim must be submitted on UB 92 or CMS 1500 (HCFA 1500) claim forms. Also see "Instructions" (No. 1) about the "Proof of Claim" process for already adjudicated member claims.

C. ( ) Trade Creditor for amounts owed on open account Social Security or Federal Tax I.D. No: \_\_\_\_\_

D. ( ) All other claims - please explain and provide Social Security or Federal Tax I.D. No.: \_\_\_\_\_

6. In the space below give a CONCISE STATEMENT of the FACTS giving rise to your claim. Attach additional sheets if required.

7. NUMBER OF CLAIMS: 44 AND TOTAL AMOUNT OF YOUR CLAIM(S): \$ 94,193.68. If amount of claim is unknown, insert words "Unstated Amount." Provider claims amount would be based on 'charges'. You may amend your timely filed claim up until the final date of adjudication. Please attach all documents, contracts and invoices. If they are voluminous, please attach a summary.

8. No part of the debt has been paid, except \_\_\_\_\_

9. There are no setoffs or counterclaims to the debt, except \_\_\_\_\_

10. There is no security for the debt, except \_\_\_\_\_

The undersigned claimant affirms that the representations and information contained in this "Proof of Claim" are true and correct to the best of your knowledge. You also understand that any statements or representations contained herein which knowingly present a false claim is a criminal offense punishable under Michigan Law.

Dated: 3/2/05

Jane Ruppman

Claimant's Name (please print or type)

Signature Jane Ruppman

Title (if applicable) Director of Patient Accounting

SEE OTHER SIDE FOR "INSTRUCTIONS" TO COMPLETE AND SUBMIT THE "PROOF OF CLAIM" FORM

Michigan Health Maintenance  
Organization Plans, Inc. (in Liquidation)  
Formerly OmniCare Health Plan in Rehabilitation

Ingham County Circuit Court File No. 98-88265-CR

**For Office Use Only:**

Date Proof Received: \_\_\_\_\_

Proof of Claim #: \_\_\_\_\_

**"PROOF OF CLAIM"**

**MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (in LIQUIDATION)  
(FORMERLY OMNICARE HEALTH PLAN IN REHABILITATION)**

**DEADLINE FOR FILING: MARCH 31, 2005**

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**PERSON OR ENTITY MAKING CLAIM AGAINST MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (formally OmniCare Health Plan in Rehabilitation):**

- 1. NAME: Huron Valley Sinai Hospital
- 2. MAILING ADDRESS: 1 Williams Care Drive Commerce MI 48382
- 4. TELEPHONE NUMBER (DAYTIME): 248 937-3253
- 5. CLAIM IS FROM: (Check "X" or specify below)

- A. ( ) Member Provide Social Security or OmniCare ID No: \_\_\_\_\_
- B. (X) Provider Federal tax I.D. No. of Payee: 382158995  
Social Security No. of Payee: \_\_\_\_\_

applicable) **Providers Note:** Each member claim must be submitted on UB 92 or CMS 1500 (HCFA 1500) claim forms. Also see "Instructions" (No. 1) about the "Proof of Claim" process for already adjudicated member claims.

- C. ( ) Trade Creditor for amounts owed on open account Social Security or Federal Tax I.D. No: \_\_\_\_\_
- D. ( ) All other claims - please explain and provide Social Security or Federal Tax I.D. No. : \_\_\_\_\_
- 6. In the space below give a CONCISE STATEMENT of the FACTS giving rise to your claim. Attach additional sheets if required.

- 7. NUMBER OF CLAIMS: 3 AND TOTAL AMOUNT OF YOUR CLAIM(S): \$ #4149.77. If amount of claim is unknown, insert words "Unstated Amount." Provider claims amount would be based on 'charges'. You may amend your timely filed claim up until the final date of adjudication. Please attach all documents, contracts and invoices. If they are voluminous, please attach a summary.
- 8. No part of the debt has been paid, except N/A
- 9. There are no setoffs or counterclaims to the debt, except N/A
- 10. There is no security for the debt, except N/A

The undersigned claimant affirms that the representations and information contained in this "Proof of Claim" are true and correct to the best of your knowledge. You also understand that any statements or representations contained herein which knowingly present a false claim is a criminal offense punishable under Michigan Law.

Dated: 3/17/05

NANCY A STANEK  
Claimant's Name (please print or type)

Signature Nancy A StaneK

Title (if applicable) Director, Patient Financial Services

The Detroit Medical Center Omnicare Liquidation IP/OP AR Settlement For Accounts 9/30/04 and Prior

| DMC Facility                       | Total Charges          | # Claims   |
|------------------------------------|------------------------|------------|
| Children's IP Approved Claims      | 245,025.91             | 30         |
| Children's IP Appealed Claims      | 128,496.76             | 9          |
| Children's Misc/Corrected Claims   | 586,442.96             | 18         |
| Children's 23/hr Resubmissions     | 31,853.23              | 7          |
| Payment Compliance/Underpayments   | 29,900.70              | 27         |
| <b>Total Inpatient</b>             | <b>\$ 1,021,719.56</b> | <b>91</b>  |
| Children's OP Approved Claims      | 486,091.78             | 559        |
| Children's OP Appealed Claims      | 8,973.10               | 3          |
| CHM Eligibility Resubmissions      | 12,742.97              | 16         |
| Children's Misc/Corrected Claims   | 95,318.23              | 143        |
| Children's OP Referral Claims      | 328.62                 | 5          |
| No Claim on File                   | 2,315.93               | 5          |
| <b>Total Outpatient</b>            | <b>\$ 605,770.63</b>   | <b>731</b> |
| <b>Grand Total CHM IP &amp; OP</b> | <b>1,627,490.19</b>    | <b>822</b> |
| DRH IP Approved Claims             | 1,071,729.96           | 35         |
| DRH IP Appealed Claims             | 137,849.71             | 2          |
| DRH IP Misc/Corrected Claims       | 645,116.31             | 20         |
| Payment Compliance/Underpayments   | 20,899.07              | 7          |
| DRH IP (Secondary Balances)        | 2,628.00               | 3          |
| DRH IP (Not on approved list)      | 284,452.24             | 12         |
| <b>Total Inpatient</b>             | <b>\$ 2,162,675.29</b> | <b>79</b>  |

Ex. A

The Detroit Medical Center Omnicare Liquidation IP/OP AR Settlement For Accounts 9/30/04 and Prior

| DMC Facility                           | Total Charges       | # Claims   |
|--|---------------------|------------|
| DRH OP Approved Claims                 | 88,922.44           | 54         |
| DRH OP Appealed Claims & Rej Claims    | 455,040.73          | 255        |
| DRH OP Rejected claims                 | 36,403.28           | 22         |
| DRH OP (Not on apprvd/rejected report) | 59,646.11           | 47         |
| DRH OP (Secondary Balances)            | 16,858.32           | 15         |
| Total Outpatient                       | \$ 656,870.88       | 393        |
| Grand Total DRH IP & OP                | <b>2,819,546.17</b> | <b>472</b> |

The Detroit Medical Center Omnicare Liquidation IP/OP AR Settlement For Accounts 9/30/04 and Prior

| DMC Facility                        | Total Charges   | # Claims |
|-------------------------------------|-----------------|----------|
| Harper IP Approved Claims           | 2,187,585.89    | 153      |
| Harper IP Appealed Claims           | 674,702.62      | 41       |
| Harper IP Misc/Corrected Claims     | 195,981.54      | 7        |
| Harper IP Eligibility Resubmissions | 562,431.12      | 4        |
| Harper IP 15/day Readmission        | 131,041.52      | 11       |
| Total Inpatient                     | \$ 3,751,742.69 | 216      |

|   |                     |              |
|---|---------------------|--------------|
| Harper OP Approved Claims                 | 1,109,199.14        | 737          |
| Harper OP Appealed Claims                 | 28,230.24           | 12           |
| Harper OP Referral Resubmission           | 109,026.02          | 34           |
| Harper OP Misc/Corrected Claims           | 222,153.12          | 135          |
| Harper OP Eligibility Resubmissions (EVA) | 57,678.83           | 75           |
| Harper OP Omnicare Secondary Claims       | 4,691.84            | 22           |
| Total Outpatient                          | \$ 1,530,979.19     | 1015         |
| Grand Total HAR IP & OP                   | <b>5,282,721.88</b> | <b>1,231</b> |

| DMC Facility | Total Charges | # Claims |
|--------------|---------------|----------|
|--------------|---------------|----------|

The Detroit Medical Center Omnicare Liquidation IP/OP AR Settlement For Accounts 9/30/04 and Prior

| DMC Facility                     | Total Charges          | # Claims   |
|----------------------------------|------------------------|------------|
| Sinai IP Approved Claims         | 1,841,535.38           | 80         |
| Sinai IP Appealed Claims         | 51,210.27              | 2          |
| Sinai IP Misc/Corrected Claims   | 1,640,360.78           | 42         |
| Payment Compliance/Underpayments | 61,098.43              | 9          |
| Total Inpatient                  | <u>\$ 3,594,204.86</u> | <u>133</u> |

|                                    |            |     |
|------------------------------------|------------|-----|
| Sinai OP Approved Claims           | 632,620.96 | 375 |
| Sinai OP Appealed Claims           | 10,442.36  | 2   |
| Sinai OP Referral Claims           | 25,793.81  | 19  |
| Sinai OP Misc/Corrected Claims     | 147,029.82 | 171 |
| Sinai OP Eligibility Resubmissions | 18,332.28  | 17  |

|                  |                      |            |
|------------------|----------------------|------------|
| Total Outpatient | <u>\$ 834,219.23</u> | <u>584</u> |
|------------------|----------------------|------------|

|                         |                        |            |
|-------------------------|------------------------|------------|
| Grand Total SIN IP & OP | <u>\$ 4,428,424.09</u> | <u>717</u> |
|-------------------------|------------------------|------------|

|                                 |                      |          |
|---------------------------------|----------------------|----------|
| RIM IP Rejected/Appealed Claims | 76,504.59            | 1        |
| RIM IP Approved Claims          | 36,119.68            | 2        |
| Total Outpatient                | <u>\$ 112,624.27</u> | <u>3</u> |

|                                      |                      |           |
|--------------------------------------|----------------------|-----------|
| RIM OP Rejected/Appealed Claims/Auth | 15,061.00            | 9         |
| RIM OP Approved Claims               | 58,074.00            | 42        |
| RIM OP (No Record in Omnicare File)  | 402.00               | 1         |
| Total Outpatient                     | <u>\$ 73,537</u>     | <u>52</u> |
| Grand Total RIM IP & OP              | <u>\$ 186,161.27</u> | <u>55</u> |

The Detroit Medical Center Omnicare Liquidation IP/OP AR Settlement For Accounts 9/30/04 and Prior

| <u>DMC Facility</u>                 | <u>Total Charges</u> | <u># Claims</u> |
|-------------------------------------|----------------------|-----------------|
| Huron Valley OP Approved Claims     | 4,149.77             | 3               |
| <b>Grand Total HVH OP</b>           | <b>\$ 4,149.77</b>   | <b>3</b>        |
| <b>Combined DMC Facility Totals</b> | <b>14,348,493.37</b> | <b>3,300</b>    |



Michigan Health Maintenance  
Organization Plans, Inc. (in Liquidation)

Formerly OmniCare Health Plan in Rehabilitation

Ingham County Circuit Court File No. 98-88265-CR

**For Office Use Only:**

Date Proof Received: \_\_\_\_\_

Proof of Claim #: \_\_\_\_\_

**"PROOF OF CLAIM"**

**MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (in LIQUIDATION)  
(FORMERLY OMNICARE HEALTH PLAN IN REHABILITATION)**

**DEADLINE FOR FILING: MARCH 31, 2005**

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**PERSON OR ENTITY MAKING CLAIM AGAINST MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (formerly OmniCare Health Plan in Rehabilitation):**

- 1. NAME: Detroit Medical Center
- 2. MAILING ADDRESS: Legal Affairs--3990 John R, 7 Brush West, Detroit, MI 48201
- 4. TELEPHONE NUMBER (DAYTIME): Charles Raimi (313) 887-5381

5. CLAIM IS FROM: (Check "X" or specify below)

- A. ( ) Member Provide Social Security or OmniCare ID No: \_\_\_\_\_
- B. (X) Provider Federal tax I.D. No. of Payee: 38-257-1767  
Social Security No. of Payee: \_\_\_\_\_

applicable) **Providers Note:** Each member claim must be submitted on UB 92 or CMS 1500 (HCFA 1500) claim forms. Also see "Instructions" (No. 1) about the "Proof of Claim" process for already adjudicated member claims.

- C. ( ) Trade Creditor for amounts owed on open account Social Security or Federal Tax I.D. No: \_\_\_\_\_
- D. ( ) All other claims - please explain and provide Social Security or Federal Tax I.D. No. : \_\_\_\_\_

6. In the space below give a CONCISE STATEMENT of the FACTS giving rise to your claim. Attach additional sheets if required. See Attached

7. NUMBER OF CLAIMS: AND TOTAL AMOUNT OF YOUR CLAIM(S): \$36,685,911.00. If amount of claim is unknown, insert words "Unstated Amount." Provider claims amount would be based on 'charges'. You may amend your timely filed claim up until the final date of adjudication. Please attach all documents, contracts and invoices. If they are voluminous, please attach a summary.

- 8. No part of the debt has been paid, except N/A
- 9. There are no setoffs or counterclaims to the debt, except N/A
- 10. There is no security for the debt, except N/A

The undersigned claimant affirms that the representations and information contained in this "Proof of Claim" are true and correct to the best of your knowledge. You also understand that any statements or representations contained herein which knowingly present a false claim is a criminal offense punishable under Michigan Law.

Detroit Medical Center

Dated: Feb. 15, 2005

By: Charles N. Raimi

This claim is in addition to DMC's claim for unpaid hospital/medical charges, which will be filed separately.

Claimant's Name \_\_\_\_\_ (please print or type)

Signature Charles N. Raimi

\* Title (if applicable) Associate General Counsel

*Ex. B*

STATE OF MICHIGAN  
CIRCUIT COURT FOR THE 30<sup>TH</sup> JUDICIAL CIRCUIT  
INGHAM COUNTY

E.L. COX, COMMISSIONER OF INSURANCE  
FOR THE STATE OF MICHIGAN,

Petitioner,

V

File No. 98-88265-CR

MICHIGAN HEALTH MAINTENANCE  
ORGANIZATION PLANS, INC., a  
Michigan health maintenance organization,  
doing business as OmniCare Health Plan,

Hon. James R. Giddings

Respondent.

---

**DETROIT MEDICAL CENTER'S CLAIM FOR BREACH OF CONTRACT,  
MISREPRESENTATION, OR, IN THE ALTERNATIVE,  
IMPAIRMENT OF CONTRACT**

The Detroit Medical Center respectfully submits this claim in the amount of \$36,685,911. This claim is in addition to the DMC's claims for outstanding and unpaid hospital/medical charges, which claims are being filed separately. The factual and legal basis for this claim is as follows.

**FACTS<sup>1</sup>**

The DMC is a 501(c)(3) charitable organization. The DMC operates several hospitals within the City of Detroit and provides care to some 80,000 indigent patients each year, including a high percentage of Medicaid patients. The contract that governed DMC's relationship with Omnicare is attached as Exhibit A to Dr. Malone's affidavit, Ex. 1. That contract effectively ended when Omnicare's membership was transferred to Coventry as of October 1, 2004.

---

<sup>1</sup> This factual recitation is supported by the affidavit of Dr. Thomas Malone, Ex. 1.

The former DMC-Omni contract provides for Omnicare to pay DMC a monthly "capitation fee" for each Omnicare member assigned to the DMC. In exchange for that payment, DMC agreed to provide a variety of medical services for those Omnicare members. The total monthly payment to DMC was to be computed based on the per-member capitation fee, multiplied by the total membership assigned to DMC for the month in question. The per member capitation fee was initially computed based on medical utilization data provided by Omnicare which purported to show that the capitation fee would produce a total payment to DMC roughly equivalent to Medicaid fee-for-service rates.

Consistent with the parties' discussions, the Agreement provides that the DMC's compensation is to approximate Medicaid fee-for-service rates, as such rates might change over the term of the Agreement:

**"Capitation Payment.** As compensation for Covered Services for Medicaid and Commercial Members described below, Plan shall make monthly Capitation payments to the DMC based on the number of Members assigned to the Participating Centers who are eligible to receive Covered Services. Initially, the monthly Capitation rate shall be sixty (\$60.00) dollars per member per month. Effective April 1, 2002, the monthly capitation rate for Commercial Members shall be fifty-seven (\$57.00) dollars per Member per Month, and the monthly Capitation for (a) Aid to Families with Dependent Children ("AFDC") Members shall be forty (\$40.50) dollars and fifty cents per AFDC Member per month, and (b) Assistance to the Blind or Disabled ("ABAD") Members shall be two hundred (\$200.00) dollars per ABAD Member per month. The DMC shall accept such Capitation as payment in full for Covered Services rendered during that month to Members assigned to the Participating Centers less the Withhold stated below. The above Medicaid Capitation rates were derived applying projected utilization to the Medicaid DRG and per diem rates as set by the State of Michigan. Any changes in Medicaid DRG and per diem rates will be reflected as an adjustment to the Medicaid Capitation rates, effective concurrently with the date such changes are made by the State of Michigan. Ex. A, p. 29, section 1, emphasis added.

DMC later learned that the utilization data provided by Omnicare and used to compute the initial per member capitation fee was extremely inaccurate and misleading.

The population of Omnicare enrollees that was assigned to DMC was far sicker than suggested by the utilization data provided by Omnicare. The population assigned to DMC included many individuals suffering from long term chronic illnesses including diabetes, hepatitis, HIV/AIDS, etc., requiring DMC's expenditure of enormous resources in their care and treatment.

On May 16, 2003, the DMC notified Omnicare that the capitation fee produced compensation to DMC that was far below Medicaid fee-for-service rates. Omnicare conceded that DMC's calculations were essentially correct, but nevertheless rejected DMC's request for an increase to bring the capitation rates in line with Medicaid fee-for-service rates. See correspondence attached to Dr. Malone's affidavit (Ex. 1) as Ex. B.

The Omni - DMC contract gave DMC the right to terminate the agreement at any time, without cause, on 150 days notice. Contract, Art. 11, p. 18. However, it was DMC's understanding that the Court overseeing the Omnicare rehabilitation proceeding had entered an order prohibiting providers, including DMC, from exercising its right to terminate the contract.

As a result of Omnicare's refusal to adjust the capitation fee, DMC continued to provide care to Omnicare enrollees at grossly inadequate rates, and continued to sustain tens of millions of dollars of losses. DMC has calculated the losses on the DMC - Omni contract as follows:

| <u>Year</u>                                   | <u>Loss compared with Medicaid fee-for-service rate</u> |
|---|---|
| 2002  | \$13,466,436  |
| 2003  | 12,472,748  |
| 2004  | <u>10,746,727</u>                                       |
| Total loss compared with Medicaid f/f/s rates | \$36,685,911  |

(See exhibit C to Dr. Malone's affidavit for detail)

## **DISCUSSION**

### **I. BREACH OF CONTRACT**

As shown above in the factual recitation, the contract capitation rate was specifically intended to approximate Medicaid fee-for-service rates, and was to be adjusted accordingly. However, the capitation rate did not approximate Medicaid fee-for-service rates. That inadequate compensation represented a clear breach of the contract, and DMC is entitled to recover the sum of \$36,685,911.

### **II. MISREPRESENTATION**

The initial contract capitation rate was based on medical utilization data provided by Omnicare, and which Omnicare represented would be consistent with utilization under the contract. However, that utilization data was grossly inaccurate and misleading and resulted in a capitation rate which produced compensation to DMC far below Medicaid fee-for-service rates.

As a direct result of Omnicare's misrepresentations, DMC has sustained damages of \$36,685,911.

### **III. MEDICAID LAW**

Under applicable law and regulations, the Medicaid fee-for-service rate is intended to give providers such as DMC a minimally adequate payment so as to allow such providers to pay their costs of operations—including doctors, nurses, other medical staff, administrative staff, facilities' expense, etc., etc. Even in the absence of a contract, providers are entitled to recover Medicaid fee-for-service rates for services provided to Medicaid patients.

In this case, the Omni-DMC contract, contrary to the purpose and intent of Medicaid law, paid DMC an amount dramatically less than Medicaid fee-for-service

rates. That rate resulted from misrepresentation and/or a contract breach, and also was contrary to Medicaid law and regulations. For all of those reasons, this claim should be allowed in full.

#### **IV. IMPAIRMENT OF CONTRACT.**

DMC submits that it is entitled to recover its losses under the legal theories discussed above. However, in the alternative, DMC asserts a claim for impairment of contract. (DMC exercises its right under law to assert alternative theories of recovery. MCR 2.111(A)(2)).

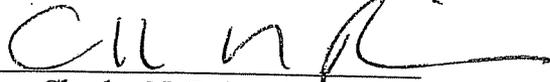
DMC had the contract right to terminate the Omni Agreement without cause. DMC was prohibited from exercising that right by the Court's injunction. DMC is entitled to recover its damages resulting from that impairment of contract. Michigan Constitution, Art. I, § 10.

#### **CONCLUSION AND RELIEF**

Regardless of the legal theory asserted, the bottom line is this: Omnicare's desperately ill enrollees needed medical care, they received that care at the DMC, and the DMC is entitled to at least recover compensation approximating Medicaid fee-for-service rates for providing that treatment. DMC has already sustained serious financial hardship as a result of Omnicare's rehabilitation, including the write off of tens of millions of dollars under the rehabilitation plan. Similarly, DMC now stands to receive only pennies on the dollar for its present claims.

For the reasons stated, DMC asks that the Court allow this claim in the amount stated, namely, \$36,685,911, and that the Court allow the other claims submitted by the DMC in connection with this matter.

DETROIT MEDICAL CENTER



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January \_\_\_\_, 2005

STATE OF MICHIGAN  
CIRCUIT COURT FOR THE 30<sup>TH</sup> JUDICIAL CIRCUIT  
INGHAM COUNTY

COMMISSIONER OF INSURANCE  
FOR THE STATE OF MICHIGAN

Petitioner,

File No. 98-88265-CR

Hon. James R. Giddings

A.G. No. 199805333A

vs.

MICHIGAN HEALTH MAINTENANCE  
ORGANIZATION PLANS, INC., a  
Michigan health maintenance organization,  
Doing business as OmniCare Health Plan

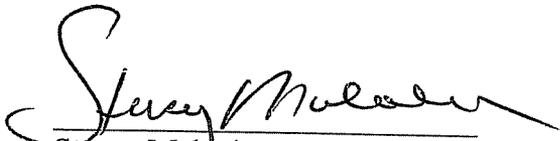
Respondent.

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**PROOF OF SERVICE**

I, Stacey Malcolm certify that on June 13, 2005, I served a copy Detroit Medical Center's brief on priority, and this Proof of Service upon Amy M. Sitner, Esq. by placing said copies in an envelope with first class postage prepaid to her address of record at Zausmer, Kaufman, August & Caldwell, PC, 31700 Middlebelt Road Suite 150, Farmington Hills, MI 48334.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge, information and belief.

  
Stacey Malcolm

Dated: June 13, 2005