

Fill in this information to identify the case:

Debtor 1 Curae Health Inc.
 Debtor 2 _____
 (Spouse, if filing)
 United States Bankruptcy Court MIDDLE DISTRICT OF TENNESSEE
 Case number: 18-05665

FILED

U.S. Bankruptcy Court
 MIDDLE DISTRICT OF TENNESSEE

11/2/2018

MATTHEW T. LOUGHNEY, Clerk

Official 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?	<u>LABORATORY CORP OF AMERICA</u> Name of the current creditor (the person or entity to be paid for this claim) Other names the creditor used with the debtor <u>LabCorp</u>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> 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? <u>LABORATORY CORP OF AMERICA</u> Name PO BOX 12140 BURLINGTON, NC 27216-2140 Contact phone <u>8592520093</u> Contact email <u>kwhitmer@lexlaw.us</u> Uniform claim identifier for electronic payments in chapter 13 (if you use one): _____	Where should payments to the creditor be sent? (if different) _____ Name _____ Contact phone _____ Contact email _____
4. Does this claim amend one already filed?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes. Claim number on court claims registry (if known) <u>11</u> Filed on <u>09/24/2018</u> <div style="text-align: right;">MM / DD / YYYY</div>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim

page 1

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?	<div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor:</div><div style="border-bottom: 1px solid black; width: 150px; text-align: right;">2040</div></div>																		
7. How much is the claim?	<div style="display: flex; justify-content: space-between;"><div style="width: 40%;">\$ <u>134108.84</u></div><div>Does this amount include interest or other charges? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).</div></div>																		
8. What is the basis of the claim?	<p>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 healthcare information.</p> <p style="margin-left: 40px;"><u>lab services rendered</u></p>																		
9. Is all or part of the claim secured?	<div><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. The claim is secured by a lien on property.</div> <div>Nature of property: <input type="checkbox"/> Real estate. If the claim is secured by the debtor's principal residence, file a <i>Mortgage Proof of Claim Attachment</i> (Official Form 410-A) with this <i>Proof of Claim</i>. <input type="checkbox"/> Motor vehicle <input type="checkbox"/> Other. Describe: _____</div> <div style="margin-top: 10px;">Basis for perfection: _____</div> <div style="margin-top: 10px; font-size: small;">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.)</div> <div style="margin-top: 10px;"><table style="width: 100%;"><tr><td style="width: 40%;">Value of property:</td><td style="width: 10%;">\$</td><td style="width: 50%; border-bottom: 1px solid black;"></td></tr><tr><td>Amount of the claim that is secured:</td><td>\$</td><td style="border-bottom: 1px solid black;"></td></tr><tr><td>Amount of the claim that is unsecured:</td><td>\$</td><td style="border-bottom: 1px solid black;"></td></tr></table><div style="text-align: right; font-size: small;">(The sum of the secured and unsecured amounts should match the amount in line 7.)</div></div> <div style="margin-top: 10px;"><table style="width: 100%;"><tr><td style="width: 60%;">Amount necessary to cure any default as of the date of the petition:</td><td style="width: 10%;">\$</td><td style="width: 30%; border-bottom: 1px solid black;"></td></tr><tr><td>Annual Interest Rate (when case was filed)</td><td></td><td style="text-align: right;">_____%</td></tr><tr><td><input type="checkbox"/> Fixed <input type="checkbox"/> Variable</td><td></td><td></td></tr></table></div>	Value of property:	\$		Amount of the claim that is secured:	\$		Amount of the claim that is unsecured:	\$		Amount necessary to cure any default as of the date of the petition:	\$		Annual Interest Rate (when case was filed)		_____%	<input type="checkbox"/> Fixed <input type="checkbox"/> Variable		
Value of property:	\$																		
Amount of the claim that is secured:	\$																		
Amount of the claim that is unsecured:	\$																		
Amount necessary to cure any default as of the date of the petition:	\$																		
Annual Interest Rate (when case was filed)		_____%																	
<input type="checkbox"/> Fixed <input type="checkbox"/> Variable																			
10. Is this claim based on a lease?	<div><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Amount necessary to cure any default as of the date of the petition. \$ _____</div>																		
11. Is this claim subject to a right of setoff?	<div><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Identify the property: _____</div>																		

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. <i>Check all that apply.</i>	Amount entitled to priority
A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.	<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B). <input type="checkbox"/> 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). <input type="checkbox"/> 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). <input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8). <input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5). <input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)(<u> </u>) that applies	\$ _____ \$ _____ \$ _____ \$ _____ \$ _____ \$ _____
* 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.		

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 11/2/2018
MM / DD / YYYY

/s/ Karen L Whitmer

Signature

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

Name	Karen L Whitmer		
	First name	Middle name	Last name
Title	Attorney		
Company	Laboratory Corporation of America		
Address	Identify the corporate servicer as the company if the authorized agent is a servicer		
	535 Wellington Way, Suite 380		
	Number Street		
	Lexington, KY 40503		
	City	State	ZIP Code
Contact phone	8592520093	Email	kwhitmer@lexlaw.us

JCBB

LCBS

ID

Client Account: 23002040

Corp Account :

Client Bill Balances List

Report to Name1: DEPORRES HEALTH RYAN WHITE

Bill to Name1 : MERIT HEALTH MEDICAL GROUP

O ("O"pen or "A"ll)

10-24-18

08:25:23

More:

Client Balance

13,134.90

Client Payments

0.00

Client Adjustments

0.00

<u>Sel</u>	<u>Bill Number</u>	<u>Bill Switch</u>	<u>Bill Date</u>	<u>Billed Amount</u>	<u>Balance</u>
—	58755489	Y	04-28-18	1,358.90	1,343.30
—	58982894	Y	06-02-18	1,782.20	1,782.20
—	59315433	Y	06-30-18	2,304.50	2,304.50
—	59640479	Y	07-28-18	1,183.30	1,183.30
—	59872470	Y	09-01-18	2,226.00	2,142.40
—	60357215	Y	09-29-18	2,552.40	2,552.40
—	60583532	N		1,826.80	1,826.80

F1=HELP F3=EXIT F5=REFRESH F6=BILLSUM F7=UP F8=DOWN F9=ADJUST F10=CLNT NOTE
 F11=TRAN BAL F13=PMNTRCH F14=BULK ADJ F15=CLNTPYMT F16=CLNT INQ F17=REPRMNT

Tran: _____

pre-petition \$11,308.10

MIDDLE DISTRICT OF TENNESSEE

Claims Register

[3:18-bk-05665 Curae Health Inc.](#)

Judge: Charles M Walker

Chapter: 11

Office: Nashville

Last Date to file claims:

Trustee:

Last Date to file (Govt):

Creditor: (6718283)
LABORATORY CORP OF
AMERICA
PO BOX 12140
BURLINGTON, NC 27216-
2140

Claim No: 11
Original Filed
Date: 09/05/2018
Original Entered
Date: 09/05/2018
Last Amendment
Filed: 11/02/2018
Last Amendment
Entered: 11/02/2018

Status:
Filed by: CR
Entered by: admin
Modified: 11/02/2018

Amount claimed: \$134108.84

History:

[Details](#) [11-1](#) 09/05/2018 Claim #11 filed by LABORATORY CORP OF AMERICA, Amount claimed: \$95394.84 (admin)

[Details](#) [11-2](#) 09/24/2018 Amended Claim #11 filed by LABORATORY CORP OF AMERICA, Amount claimed: \$122800.74 (admin)

[Details](#) [11-3](#) 11/02/2018 Amended Claim #11 filed by LABORATORY CORP OF AMERICA, Amount claimed: \$134108.84 (admin)

Description:

Remarks: (11-1) Account Number (last 4 digits):1410

(11-2) Account Number (last 4 digits):2120

(11-3) Account Number (last 4 digits):2040

Claims Register Summary

Case Name: Curae Health Inc.

Case Number: 3:18-bk-05665

Chapter: 11

Date Filed: 08/24/2018

Total Number Of Claims: 1

Total Amount Claimed*	\$134108.84
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		

Fill in this information to identify the case:

Debtor 1 Curae Health Inc.
Debtor 2 _____
(Spouse, if filing)
United States Bankruptcy Court MIDDLE DISTRICT OF TENNESSEE
Case number: 18-05665

FILED
U.S. Bankruptcy Court
MIDDLE DISTRICT OF TENNESSEE
9/24/2018
MATTHEW T. LOUGHNEY, Clerk

**Official Form 410
Proof of Claim****04/16**

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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?	<u>LABORATORY CORP OF AMERICA</u> Name of the current creditor (the person or entity to be paid for this claim) Other names the creditor used with the debtor <u>LabCorp, Laboratory Corporation of America, Laboratory Corporation of America Holdings</u>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> 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? <u>LABORATORY CORP OF AMERICA</u> Name <u>PO BOX 12140</u> <u>BURLINGTON, NC 27216-2140</u> Contact phone <u>8592520093</u> Contact email <u>kwhitmer@lexlaw.us</u> Uniform claim identifier for electronic payments in chapter 13 (if you use one): _____	Where should payments to the creditor be sent? (if different) Name Contact phone _____ Contact email _____
4. Does this claim amend one already filed?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes. Claim number on court claims registry (if known) <u>11</u> Filed on <u>09/05/2018</u> MM / DD / YYYY	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim

page 1

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?	<div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor:</div><div style="border-bottom: 1px solid black; width: 150px; text-align: right;">2120</div></div>
7. How much is the claim?	<div style="display: flex; justify-content: space-between;"><div style="width: 40%;">\$ 122800.74</div><div style="width: 55%;">Does this amount include interest or other charges? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).</div></div>
8. What is the basis of the claim?	<p>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 healthcare information.</p> <p style="margin-left: 40px;">lab services rendered</p>
9. Is all or part of the claim secured?	<div style="display: flex; justify-content: space-between;"><div><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. The claim is secured by a lien on property.</div><div style="width: 80%;">Nature of property: <input type="checkbox"/> Real estate. If the claim is secured by the debtor's principal residence, file a <i>Mortgage Proof of Claim Attachment</i> (Official Form 410-A) with this <i>Proof of Claim</i>. <input type="checkbox"/> Motor vehicle <input type="checkbox"/> Other. Describe: </div></div> <p style="margin-left: 40px;">Basis for perfection: </p> <p>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.)</p> <div style="margin-left: 40px;">Value of property: \$</div> <div style="margin-left: 40px;">Amount of the claim that is secured: \$</div> <div style="margin-left: 40px;">Amount of the claim that is unsecured: \$ (The sum of the secured and unsecured amounts should match the amount in line 7.)</div> <div style="margin-left: 40px; margin-top: 20px;">Amount necessary to cure any default as of the date of the petition: \$</div> <div style="margin-left: 40px; margin-top: 10px;">Annual Interest Rate (when case was filed) % <input type="checkbox"/> Fixed <input type="checkbox"/> Variable</div>
10. Is this claim based on a lease?	<div style="display: flex; justify-content: space-between;"><div><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Amount necessary to cure any default as of the date of the petition.</div><div style="width: 80%;"></div></div>
11. Is this claim subject to a right of setoff?	<div style="display: flex; justify-content: space-between;"><div><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Identify the property:</div><div style="width: 80%;"></div></div>

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. <i>Check all that apply.</i>	Amount entitled to priority
A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.	<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
	<input type="checkbox"/> 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).	\$ _____
	<input type="checkbox"/> 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).	\$ _____
	<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
	<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
	<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies	\$ _____
* 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.		

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 9/24/2018
MM / DD / YYYY

/s/ Karen L Whitmer

Signature

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

Name	Karen L Whitmer		
	First name	Middle name	Last name
Title	Attorney		
Company	Laboratory Corporation of America		
Address	Identify the corporate servicer as the company if the authorized agent is a servicer		
	c/o Johnson Legal Network, PLLC, 535 Wel		
	Number Street		
	Lexington, KY 40503		
	City	State	ZIP Code
Contact phone	8592520093		Email kwhitmer@lexlaw.us

JBTI

LCBS

09-19-18

Client Bill Detail List

08:19:33

HL

More:

Client Number : 23002120 Report to Name1 : TRILAKES MEDICAL CENTER

Paying Account : 23002120 Bill to Name1 : TRILAKES MEDICAL CENTER

Bill : 60137158 Bill Date : 09-01-18 Billed Amount : 15.00

Percent : Disc Amount : 0.00 Balance : 15.00

Search On : F P=Product S=Specimen H=Paternity F=Special C=Cash A=Adjustment

Spec. / Case Number : 0 Specimen Invoice Date : 00-00-0000

Sel	Date	Transaction	Description	Tax Cd	Amount
-	09-01-18	Special Charge	INFECTION CONTROL RPTS		15.00
-					0.00
-					0.00
-					0.00
-					0.00
-					0.00
-					0.00
-					0.00
-					0.00
-					0.00

F3=EXIT F6=SPECINQ F7=UP F8=DOWN F9=ADJUST F10=CLNT NOTE F11=REFUND F13=FIXPMT
 F14=SPCLCHG F15=PRDCHG F16=SPECCASE F17=TESTS F18=ARCH F19=MULTADJ F20=REPRMNT

Tran: _____

W/o pre-petition \$15.00

JCBB

LCBS

HL

Client Bill Balances List

09-12-18

11:26:53

More:

Client Account: 23001410 Report to Name1: TRILAKES MEDICAL CENTER

Corp Account : Bill to Name1 : TRILAKES MEDICAL CENTER

O ("O"pen or "A"ll)

Client BalanceClient PaymentsClient Adjustments

192.96

0.00

0.00

<u>Sel</u>	<u>Bill Number</u>	<u>Bill Switch</u>	<u>Bill Date</u>	<u>Billed Amount</u>	<u>Balance</u>
-	59838763	Y	09-01-18	162.75	162.75
-	60238883	N		30.21	30.21

\$152.68

F1=HELP F3=EXIT F5=REFRESH F6=BILLSUM F7=UP F8=DOWN F9=ADJUST F10=CLNT NOTE
 F11=TRAN BAL F13=PMNTRCH F14=BULK ADJ F15=CLNTPYMT F16=CLNT INQ F17=REPRMNT

Tran: _____

pre-petition \$152.68

JCBB

LCBS

HL

Client Account: 23001420

Corp Account :

Client Bill Balances List

Report to Name1: TRILAKES MEDICAL CENTER

Bill to Name1 : TRILAKES MEDICAL CENTER

0 ("O"pen or "A"ll)

09-12-18

11:27:23

More:

Client Balance

670.00

Client Payments

0.00

Client Adjustments

0.00

<u>Sel</u>	<u>Bill Number</u>	<u>Bill Switch</u>	<u>Bill Date</u>	<u>Billed Amount</u>	<u>Balance</u>
-	59838764	Y	09-01-18	630.00	630.00
-	60297064	N		40.00	40.00

F1=HELP F3=EXIT F5=REFRESH F6=BILLSUM F7=UP F8=DOWN F9=ADJUST F10=CLNT NOTE
F11=TRAN BAL F13=PMNTRCH F14=BULK ADJ F15=CLNTPYMT F16=CLNT INQ F17=REPRMNT

Tran: _____

pre-petition \$630.00

JCBB

LCBS

HL

Client Account: 23004600

Corp Account :

Client Bill Balances List

Report to Name1: PANOLA MED CTR-EMPLOYEE HEALTH

Bill to Name1 : PANOLA MED CTR-EMPLOYEE HEALTH

O ("O"pen or "A"ll)

09-12-18

11:27:47

More:

Client Balance

318.97

Client Payments

0.00

Client Adjustments

0.00

<u>Sel</u>	<u>Bill Number</u>	<u>Bill Switch</u>	<u>Bill Date</u>	<u>Billed Amount</u>	<u>Balance</u>
-	59838792	Y	09-01-18	270.40	270.40
-	60238888	N		48.57	48.57

254.21

F1=HELP F3=EXIT F5=REFRESH F6=BILLSUM F7=UP F8=DOWN F9=ADJUST F10=CLNT NOTE
F11=TRAN BAL F13=PMNTRCH F14=BULK ADJ F15=CLNTPYMT F16=CLNT INQ F17=REPRMNT

Tran: _____

pre-petition \$254.21

JCBB

LCBS

HL

09-12-18

11:28:13

More:

Client Account: 23500700 Report to Name1: GILMORE MEMORIAL REG MED CTR

Corp Account : Bill to Name1 : GILMORE MEMORIAL REG MED CTR

O ("O"pen or "A"ll)

Client BalanceClient PaymentsClient Adjustments

595.44

0.00

0.00

<u>Sel</u>	<u>Bill Number</u>	<u>Bill Switch</u>	<u>Bill Date</u>	<u>Billed Amount</u>
-	59838967	Y	09-01-18	583.95
-	60285473	N		11.49

Balance

583.95

11.49

F1=HELP F3=EXIT F5=REFRESH F6=BILLSUM F7=UP F8=DOWN F9=ADJUST F10=CLNT NOTE
 F11=TRAN BAL F13=PMNTRCH F14=BULK ADJ F15=CLNTPYMT F16=CLNT INQ F17=REPRMNT

Tran: _____

pre-petition \$583.95

JCBB

LCBS

HL

Client Bill Balances List

09-12-18

11:27:39

More:

Client Account: 23003950

Report to Name1: TRILAKES-NON COC TOX

Corp Account :

Bill to Name1 : TRILAKES MEDICAL CENTER

O ("O"pen or "A"ll)

Client BalanceClient PaymentsClient Adjustments

3,245.21

0.00

0.00

<u>Sel</u>	<u>Bill Number</u>	<u>Bill Switch</u>	<u>Bill Date</u>	<u>Billed Amount</u>	<u>Balance</u>
-	59838786	Y	09-01-18	2,776.20	2,776.20
-	60163848	N		469.01	469.01

2696.80

F1=HELP F3=EXIT F5=REFRESH F6=BILLSUM F7=UP F8=DOWN F9=ADJUST F10=CLNT NOTE
 F11=TRAN BAL F13=PMNTRCH F14=BULK ADJ F15=CLNTPYMT F16=CLNT INQ F17=REPRMNT

Tran: _____

pre-petition \$2696.80

JCBB

LCBS

HL

Client Account: 23005260

Corp Account :

Client Bill Balances List

Report to Name1: PANOLA MEDICAL CENTER

Bill to Name1 : LABORATORY

O ("O"pen or "A"ll)

09-12-18

11:27:55

More:

Client Balance

9,669.16

Client Payments

0.00

Client Adjustments

0.00

<u>Sel</u>	<u>Bill Number</u>	<u>Bill Switch</u>	<u>Bill Date</u>	<u>Billed Amount</u>	<u>Balance</u>
-	58843574	Y	04-28-18	14,043.25	4.89
-	59838799	Y	09-01-18	8,371.71	8,371.71
-	60163861	N		1,302.34	1,302.34

7,701.49

F1=HELP F3=EXIT F5=REFRESH F6=BILLSUM F7=UP F8=DOWN F9=ADJUST F10=CLNT NOTE
F11=TRAN BAL F13=PMNTRCH F14=BULK ADJ F15=CLNTPYMT F16=CLNT INQ F17=REPRMNT

Tran: _____

pre-petition \$ 7,701.49

JCBB

LCBS

HL

Client Bill Balances List

09-12-18

11:28:21

More:

Client Account: 23501685 Report to Name1: GILMORE MEMORIAL HOSPITAL

Corp Account : Bill to Name1 : GILMORE MEMORIAL HOSPITAL

O ("O"pen or "A"ll)

Client Balance

5,487.31

Client Payments

0.00

Client Adjustments

0.00

<u>Sel</u>	<u>Bill Number</u>	<u>Bill Switch</u>	<u>Bill Date</u>	<u>Billed Amount</u>	<u>Balance</u>
—	59838970	Y	09-01-18	4,143.24	4,143.24
—	60164016	N		1,344.07	1,344.07

F1=HELP F3=EXIT F5=REFRESH F6=BILLSUM F7=UP F8=DOWN F9=ADJUST F10=CLNT NOTE
 F11=TRAN BAL F13=PMNTRCH F14=BULK ADJ F15=CLNTPYMT F16=CLNT INQ F17=REPRMNT

Tran: _____

pre-petition \$3890.38

JCBB

LCBS

HL

Client Account: 23350007

Corp Account :

Client Bill Balances List

09-12-18

11:28:04

More:

Report to Name1: N.W. MISS. REGIONAL MED. CNT.

Bill to Name1 : N.W. MISS. REGIONAL MED. CNT.

O ("O"pen or "A"ll)

Client Balance

14,168.89

Client Payments

0.00

Client Adjustments

0.00

<u>Sel</u>	<u>Bill Number</u>	<u>Bill Switch</u>	<u>Bill Date</u>	<u>Billed Amount</u>	<u>Balance</u>
—	59838848	Y	09-01-18	12,043.24	12,043.24
—	60163904	N		2,125.65	2,125.65

F1=HELP F3=EXIT F5=REFRESH F6=BILLSUM F7=UP F8=DOWN F9=ADJUST F10=CLNT NOTE
 F11=TRAN BAL F13=PMNTRCH F14=BULK ADJ F15=CLNTPYMT F16=CLNT INQ F17=REPRMNT

Tran: _____

\$ 17042.73 — 23350005

\$ 651.90 — 23350015

\$ 3786.76 — 23350030

 \$11,481.39

pre-petition

MIDDLE DISTRICT OF TENNESSEE

Claims Register

[3:18-bk-05665 Curae Health Inc.](#)

Judge: Charles M Walker

Chapter: 11

Office: Nashville

Last Date to file claims:

Trustee:

Last Date to file (Govt):

Creditor: (6718283)
LABORATORY CORP OF
AMERICA
PO BOX 12140
BURLINGTON, NC 27216-
2140

Claim No: 11
Original Filed
Date: 09/05/2018
Original Entered
Date: 09/05/2018
Last Amendment
Filed: 09/24/2018
Last Amendment
Entered: 09/24/2018

Status:
Filed by: CR
Entered by: admin
Modified: 09/24/2018

Amount claimed: \$122800.74

History:

[Details](#) [11-1](#) 09/05/2018 Claim #11 filed by LABORATORY CORP OF AMERICA, Amount claimed: \$95394.84 (admin)

[Details](#) [11-2](#) 09/24/2018 Amended Claim #11 filed by LABORATORY CORP OF AMERICA, Amount claimed: \$122800.74 (admin)

Description:

Remarks: (11-1) Account Number (last 4 digits):1410
(11-2) Account Number (last 4 digits):2120

Claims Register Summary

Case Name: Curae Health Inc.

Case Number: 3:18-bk-05665

Chapter: 11

Date Filed: 08/24/2018

Total Number Of Claims: 1

Total Amount Claimed*	\$122800.74
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		

Fill in this information to identify the case:

Debtor 1 Curae Health Inc.
 Debtor 2 _____
 (Spouse, if filing)
 United States Bankruptcy Court MIDDLE DISTRICT OF TENNESSEE
 Case number: 18-05665

FILED

U.S. Bankruptcy Court
 MIDDLE DISTRICT OF TENNESSEE

9/5/2018

MATTHEW T. LOUGHNEY, Clerk

Official 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?	<u>LABORATORY CORP OF AMERICA</u> Name of the current creditor (the person or entity to be paid for this claim) Other names the creditor used with the debtor <u>LabCorp, Laboratory Corporation of America, Laboratory Corporation of America Holdings</u>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? <u>LABORATORY CORP OF AMERICA</u> Name PO BOX 12140 BURLINGTON, NC 27216-2140 Contact phone <u>8592520093</u> Contact email <u>kwhitmer@lexlaw.us</u> Uniform claim identifier for electronic payments in chapter 13 (if you use one): _____	Where should payments to the creditor be sent? (if different) Name Contact phone _____ Contact email _____ Filed on _____ MM / DD / YYYY
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim

page 1

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?	<div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor:</div><div style="border-bottom: 1px solid black; width: 150px; text-align: right;">1410</div></div>															
7. How much is the claim?	<div style="display: flex; justify-content: space-between;"><div style="width: 40%;">\$ 95394.84</div><div>Does this amount include interest or other charges? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).</div></div>															
8. What is the basis of the claim?	<p>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 healthcare information.</p> <p style="margin-left: 40px;">lab services rendered</p>															
9. Is all or part of the claim secured?	<div><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. The claim is secured by a lien on property.</div> <div>Nature of property: <input type="checkbox"/> Real estate. If the claim is secured by the debtor's principal residence, file a <i>Mortgage Proof of Claim Attachment</i> (Official Form 410-A) with this <i>Proof of Claim</i>. <input type="checkbox"/> Motor vehicle <input type="checkbox"/> Other. Describe: _____</div> <div style="margin-top: 10px;">Basis for perfection: _____</div> <div style="margin-top: 10px; font-size: small;">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.)</div> <div style="margin-top: 10px;"><table style="width: 100%;"><tr><td style="width: 40%;">Value of property:</td><td style="width: 10%;">\$</td><td style="width: 50%; border-bottom: 1px solid black;"></td></tr><tr><td>Amount of the claim that is secured:</td><td>\$</td><td style="border-bottom: 1px solid black;"></td></tr><tr><td>Amount of the claim that is unsecured:</td><td>\$</td><td style="border-bottom: 1px solid black;"></td></tr></table><div style="text-align: right; font-size: small;">(The sum of the secured and unsecured amounts should match the amount in line 7.)</div></div> <div style="margin-top: 10px;"><table style="width: 100%;"><tr><td style="width: 60%;">Amount necessary to cure any default as of the date of the petition:</td><td style="width: 10%;">\$</td><td style="width: 30%; border-bottom: 1px solid black;"></td></tr><tr><td>Annual Interest Rate (when case was filed)</td><td></td><td style="border-bottom: 1px solid black; text-align: right;">%</td></tr></table><div style="margin-top: 5px;"><input type="checkbox"/> Fixed <input type="checkbox"/> Variable</div></div>	Value of property:	\$		Amount of the claim that is secured:	\$		Amount of the claim that is unsecured:	\$		Amount necessary to cure any default as of the date of the petition:	\$		Annual Interest Rate (when case was filed)		%
Value of property:	\$															
Amount of the claim that is secured:	\$															
Amount of the claim that is unsecured:	\$															
Amount necessary to cure any default as of the date of the petition:	\$															
Annual Interest Rate (when case was filed)		%														
10. Is this claim based on a lease?	<div><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Amount necessary to cure any default as of the date of the petition. \$ _____</div>															
11. Is this claim subject to a right of setoff?	<div><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Identify the property: _____</div>															

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. <i>Check all that apply.</i>	Amount entitled to priority
A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.	<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
	<input type="checkbox"/> 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).	\$ _____
	<input type="checkbox"/> 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).	\$ _____
	<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
	<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
	<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies	\$ _____
* 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.		

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 9/5/2018
MM / DD / YYYY

/s/ Karen L Whitmer

Signature

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

Name	Karen L Whitmer		
	First name	Middle name	Last name
Title	Attorney		
Company	Laboratory Corporation of America		
Address	Identify the corporate servicer as the company if the authorized agent is a servicer		
	535 Wellington Way, Suite 380		
	Number Street		
	Lexington, KY 40503		
	City	State	ZIP Code
Contact phone	8592520093	Email	kwhitmer@lexlaw.us

23001410

SUMMARY

07/28/18

1

R07-KSB

32,016

TRILAKES MEDICAL CENTER
ATTN:LABORATORY
303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606

TRILAKES MEDICAL CENTER
ATTN:LABORATORY
303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606-8608

* * * A T T E N T I O N * * *

** YOUR ACCOUNT IS NOW SERIOUSLY PAST DUE. **

To avoid collection activity, payment for the overdue
balance must be received immediately.

Please call us at 800-343-4407 to discuss any questions
you may have concerning this overdue balance and your
plans to bring this account within terms.

Please send your payment and the remittance stub in
the enclosed envelope. To pay your overdue balance
online, go to www.labcorp.com/client_billing, select
ePayBill and follow the instructions.

(800) 343 - 4407

PAYMENTS RECEIVED AFTER THE 23rd MAY BE REFLECTED ON NEXT MONTH'S STATEMENT

TAX ID: 13-3757370

12,140.67

927.87

64.47

391.91

13,524.92

58292402
58620530
59003521
59251533

6,214.47
5,926.20
927.87
64.47

59597373

391.91

13,524.92

(800) 343 - 4407

Account Number 23001410
TRILAKES MEDICAL CENTER
CONTACT: Hope Schiele

PO BOX 12140 BURLINGTON, NC 27216-2140

23001410

SUMMARY

07/28/18

2

R07-KSB

32,016

TRILAKES MEDICAL CENTER
ATTN:LABORATORY
303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606

TRILAKES MEDICAL CENTER
ATTN:LABORATORY
303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606-8608

* * * PRIOR PERIODS SUMMARY * * *

02/24/18	INVOICE	57985689		6,907.32
07/24/18	PAYMENT	13735	Check	3,527.62CR
06/29/18	PAYMENT	13584	Check	3,379.70CR
			INVOICE BALANCE	0.00
03/31/18	INVOICE	58292402		7,549.66
06/05/18	PAYMENT	13318	Check	1,335.19CR
			INVOICE BALANCE	6,214.47
04/28/18	INVOICE	58620530		5,926.20
			INVOICE BALANCE	5,926.20
06/02/18	INVOICE	59003521		927.87
			INVOICE BALANCE	927.87
06/30/18	INVOICE	59251533		64.47
			INVOICE BALANCE	64.47
			PRIOR PERIOD BALANCE	13,133.01

23002120

SUMMARY

07/28/18

1

R07-MSB

32,035

TRILAKES MEDICAL CENTER
MICROBIOLOGY
303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606

TRILAKES MEDICAL CENTER
MICROBIOLOGY
303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606-8608

* * * A T T E N T I O N * * *

** YOUR ACCOUNT IS NOW SERIOUSLY PAST DUE. **

To avoid collection activity, payment for the overdue
balance must be received immediately.

Please call us at 800-343-4407 to discuss any questions
you may have concerning this overdue balance and your
plans to bring this account within terms.

Please send your payment and the remittance stub in
the enclosed envelope. To pay your overdue balance
online, go to www.labcorp.com/client_billing, select
ePayBill and follow the instructions.

(800) 343 - 4407

PAYMENTS RECEIVED AFTER THE 23rd MAY BE REFLECTED ON NEXT MONTH'S STATEMENT

TAX ID: 13-3757370

578.93	15.00	46.39	15.00	655.32
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57714249	51.58	_____	59220077	15.00	_____	655.32
58176377	198.45	_____	59434286	46.39	_____	
58342622	165.29	_____	59800125	15.00	_____	
58671932	163.61	_____				

(800) 343 - 4407

Account Number 23002120
TRILAKES MEDICAL CENTER
CONTACT: Jamie Harper

PO BOX 12140 BURLINGTON, NC 27216-2140

23002120

SUMMARY

07/28/18

2

R07-MSB

32,035

TRILAKES MEDICAL CENTER
MICROBIOLOGY
303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606

TRILAKES MEDICAL CENTER
MICROBIOLOGY
303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606-8608

* * * PRIOR PERIODS SUMMARY * * *

01/27/18	INVOICE	57714249	51.58
		INVOICE BALANCE	51.58
02/24/18	INVOICE	58176377	198.45
		INVOICE BALANCE	198.45
03/31/18	INVOICE	58342622	165.29
		INVOICE BALANCE	165.29
04/28/18	INVOICE	58671932	163.61
		INVOICE BALANCE	163.61
06/02/18	INVOICE	59220077	15.00
		INVOICE BALANCE	15.00
06/30/18	INVOICE	59434286	46.39
		INVOICE BALANCE	46.39
		PRIOR PERIOD BALANCE	640.32

23001420

SUMMARY

07/28/18

1

R07-MSB

32,017

TRILAKES MEDICAL CENTER
WOMEN'S DEPARTMENT
255 MEDICAL CENTER DR STE B
BATESVILLE, MS 38606

TRILAKES MEDICAL CENTER
ATTN A/P
255 MEDICAL CENTER DR STE B
BATESVILLE, MS 38606-

* * * A T T E N T I O N * * *

** YOUR ACCOUNT IS NOW SERIOUSLY PAST DUE. **

To avoid collection activity, payment for the overdue
balance must be received immediately.

Please call us at 800-343-4407 to discuss any questions
you may have concerning this overdue balance and your
plans to bring this account within terms.

Please send your payment and the remittance stub in
the enclosed envelope. To pay your overdue balance
online, go to www.labcorp.com/client_billing, select
ePayBill and follow the instructions.

(800) 343 - 4407

PAYMENTS RECEIVED AFTER THE 23rd MAY BE REFLECTED ON NEXT MONTH'S STATEMENT

TAX ID: 13-3757370

665.78	644.74	.00	230.00	1,540.52
--------	--------	-----	--------	----------

57985690	210.00	_____	59760696	230.00	_____	1,540.52
58582279	217.37	_____				
58620531	238.41	_____				
59055197	644.74	_____				

(800) 343 - 4407

Account Number 23001420
TRILAKES MEDICAL CENTER
CONTACT: MALLORY HAIRE

PO BOX 12140 BURLINGTON, NC 27216-2140

23001420

SUMMARY

07/28/18

2

R07-MSB

32,017

TRILAKES MEDICAL CENTER
WOMEN'S DEPARTMENT
255 MEDICAL CENTER DR STE B
BATESVILLE, MS 38606

TRILAKES MEDICAL CENTER
ATTN A/P
255 MEDICAL CENTER DR STE B
BATESVILLE, MS 38606-

* * * PRIOR PERIODS SUMMARY * * *

02/24/18	INVOICE	57985690	210.00
		INVOICE BALANCE	210.00
03/31/18	INVOICE	58582279	217.37
		INVOICE BALANCE	217.37
04/28/18	INVOICE	58620531	238.41
		INVOICE BALANCE	238.41
06/02/18	INVOICE	59055197	644.74
		INVOICE BALANCE	644.74
		PRIOR PERIOD BALANCE	1,310.52
			=====

23003950

SUMMARY

07/28/18

1

R07-MSB

32,093

TRILAKES-NON COC TOX

TRILAKES MEDICAL CENTER

303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606-8608

**** N O T I C E ****

** YOUR ACCOUNT IS NOW 60 DAYS PAST DUE. **

Prompt attention must be given to this matter. Please return payment for the overdue balance in the enclosed envelope immediately. To pay your overdue balance online, go to www.labcorp.com/clientbilling, select ePayBill and follow the instructions.

If there is a problem delaying payment, please call us at 800-343-4407, fax us at 877-867-8266, or visit us online at www.labcorp.com/clientbilling. Written correspondence can be mailed to LabCorp Client Billing, PO Box 2250, Burlington, NC 27216-2250.

(800) 343 - 4407

PAYMENTS RECEIVED AFTER THE 23rd MAY BE REFLECTED ON NEXT MONTH'S STATEMENT

TAX ID: 13-3757370

815.57CR	1,832.37	2,208.04	2,733.06	5,957.90
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57694667	1,388.94CR	58922484	1,832.37	5,957.90
57985709	1,472.38CR	59251550	2,208.04	
58292423	239.97	59550246	2,733.06	
58620550	1,805.78			

(800) 343 - 4407

Account Number 23003950
TRILAKES-NON COC TOX
CONTACT: . Schiele

PO BOX 12140 BURLINGTON, NC 27216-2140

23003950

SUMMARY

07/28/18

2

R07-MSB

32,093

TRILAKES-NON COC TOX

TRILAKES MEDICAL CENTER

303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606-8608

* * * PRIOR PERIODS SUMMARY * * *

01/27/18	INVOICE	57694667		1,388.94
06/08/18	PAYMENT	13426	Check	1,388.94CR
06/29/18	PAYMENT	13584	Check	1,388.94CR
			INVOICE BALANCE	1,388.94CR
02/24/18	INVOICE	57985709		1,847.57
07/24/18	PAYMENT	13735	Check	1,472.38CR
06/08/18	PAYMENT	13426	Check	1,847.57CR
			INVOICE BALANCE	1,472.38CR
03/31/18	INVOICE	58292423		2,354.93
06/08/18	PAYMENT	13426	Check	2,114.96CR
			INVOICE BALANCE	239.97
04/28/18	INVOICE	58620550		1,805.78
			INVOICE BALANCE	1,805.78
06/02/18	INVOICE	58922484		1,832.37
			INVOICE BALANCE	1,832.37
06/30/18	INVOICE	59251550		2,208.04
			INVOICE BALANCE	2,208.04
			PRIOR PERIOD BALANCE	3,224.84

23500700

SUMMARY

07/28/18

1

R04-MSB

32,564

GILMORE MEMORIAL REG MED CTR
CO
1105 EARL FRYE BLVD
AMORY, MS 38821

GILMORE MEMORIAL REG MED CTR
1105 EARL FRYE BLVD
AMORY, MS 38821-5500

* * * A T T E N T I O N * * *

** YOUR ACCOUNT IS NOW SERIOUSLY PAST DUE. **

To avoid collection activity, payment for the overdue
balance must be received immediately.

Please call us at 800-343-4407 to discuss any questions
you may have concerning this overdue balance and your
plans to bring this account within terms.

Please send your payment and the remittance stub in
the enclosed envelope. To pay your overdue balance
online, go to www.labcorp.com/client_billing, select
ePayBill and follow the instructions.

(800) 343 - 4407

PAYMENTS RECEIVED AFTER THE 23rd MAY BE REFLECTED ON NEXT MONTH'S STATEMENT

TAX ID: 13-3757370

1,865.69	276.78	510.12	308.85	2,961.44
----------	--------	--------	--------	----------

58620694	1,865.69	_____		
58922637	276.78	_____		2,961.44
59251699	510.12	_____		
59580077	308.85	_____		

(800) 343 - 4407

Account Number 23500700
GILMORE MEMORIAL REG MED CTR
CONTACT: TOMMY GANN

PO BOX 12140 BURLINGTON, NC 27216-2140

23500700

SUMMARY

07/28/18

2

R04-MSB

32,564

GILMORE MEMORIAL REG MED CTR
CO
1105 EARL FRYE BLVD
AMORY, MS 38821

GILMORE MEMORIAL REG MED CTR
1105 EARL FRYE BLVD
AMORY, MS 38821-5500

* * * PRIOR PERIODS SUMMARY * * *

04/28/18	INVOICE	58620694	1,865.69
		INVOICE BALANCE	1,865.69
06/02/18	INVOICE	58922637	276.78
		INVOICE BALANCE	276.78
06/30/18	INVOICE	59251699	510.12
		INVOICE BALANCE	510.12
		PRIOR PERIOD BALANCE	2,652.59
			=====

23501685

SUMMARY

07/28/18

1

R04-MSB

32,572

GILMORE MEMORIAL HOSPITAL
INTERFACE ACCOUNT
1105 EARL FRYE BLVD
AMORY, MS 38821

GILMORE MEMORIAL HOSPITAL
INTERFACE ACCOUNT
1105 EARL FRYE BLVD
AMORY, MS 38821-5500

* * * A T T E N T I O N * * *

** YOUR ACCOUNT IS NOW SERIOUSLY PAST DUE. **

To avoid collection activity, payment for the overdue
balance must be received immediately.

Please call us at 800-343-4407 to discuss any questions
you may have concerning this overdue balance and your
plans to bring this account within terms.

Please send your payment and the remittance stub in
the enclosed envelope. To pay your overdue balance
online, go to www.labcorp.com/client_billing, select
ePayBill and follow the instructions.

(800) 343 - 4407

PAYMENTS RECEIVED AFTER THE 23rd MAY BE REFLECTED ON NEXT MONTH'S STATEMENT

TAX ID: 13-3757370

2,823.79	4,091.12	4,117.45	2,806.27	13,838.63
----------	----------	----------	----------	-----------

58620697	2,823.79	_____		
58922640	4,091.12	_____		13,838.63
59251702	4,117.45	_____		
59550415	2,806.27	_____		

(800) 343 - 4407

Account Number 23501685
GILMORE MEMORIAL HOSPITAL
CONTACT: JERRY WALDEN

PO BOX 12140 BURLINGTON, NC 27216-2140

23501685

SUMMARY

07/28/18

2

R04-MSB

32,572

GILMORE MEMORIAL HOSPITAL
 INTERFACE ACCOUNT
 1105 EARL FRYE BLVD
 AMORY, MS 38821

GILMORE MEMORIAL HOSPITAL
 INTERFACE ACCOUNT
 1105 EARL FRYE BLVD
 AMORY, MS 38821-5500

* * * PRIOR PERIODS SUMMARY * * *

04/28/18	INVOICE	58620697	2,823.79
		INVOICE BALANCE	2,823.79
06/02/18	INVOICE	58922640	4,091.12
		INVOICE BALANCE	4,091.12
06/30/18	INVOICE	59251702	4,117.45
		INVOICE BALANCE	4,117.45
		PRIOR PERIOD BALANCE	11,032.36
			=====

23004600

SUMMARY

07/28/18

1

R07-MSB

32,110

PANOLA MED CTR-EMPLOYEE HEALTH

PANOLA MED CTR-EMPLOYEE HEALTH

303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606-8608

* * * A T T E N T I O N * * *

** YOUR ACCOUNT IS NOW SERIOUSLY PAST DUE. **

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you may have concerning this overdue balance and your
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online, go to www.labcorp.com/client_billing, select
ePayBill and follow the instructions.

(800) 343 - 4407

PAYMENTS RECEIVED AFTER THE 23rd MAY BE REFLECTED ON NEXT MONTH'S STATEMENT

TAX ID: 13-3757370

803.31

255.29

231.66

259.04

1,549.30

58016622
58365099
58690658
58953827226.66
317.61
259.04
255.29_____

_____59283673
59623208231.66
259.04_____

1,549.30

(800) 343 - 4407

Account Number 23004600
PANOLA MED CTR-EMPLOYEE HEALTH
CONTACT: Laura Allgood

PO BOX 12140 BURLINGTON, NC 27216-2140

23004600

SUMMARY

07/28/18

2

R07-MSB

32,110

PANOLA MED CTR-EMPLOYEE HEALTH

PANOLA MED CTR-EMPLOYEE HEALTH

303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606303 MEDICAL CENTER DRIVE
BATESVILLE, MS 38606-8608

* * * PRIOR PERIODS SUMMARY * * *

02/24/18	INVOICE	58016622	226.66
		INVOICE BALANCE	226.66
03/31/18	INVOICE	58365099	317.61
		INVOICE BALANCE	317.61
04/28/18	INVOICE	58690658	259.04
		INVOICE BALANCE	259.04
06/02/18	INVOICE	58953827	255.29
		INVOICE BALANCE	255.29
06/30/18	INVOICE	59283673	231.66
		INVOICE BALANCE	231.66
		PRIOR PERIOD BALANCE	1,290.26

JCBB
LCBS
HL

Client Bill Balances List

08-29-18
08:59:42
More:

Client Account: 23005260 Report to Name1: PANOLA MEDICAL CENTER
Corp Account : Bill to Name1 : LABORATORY
0 ("O"pen or "A"ll)

<u>Client Balance</u>		<u>Client Payments</u>		<u>Client Adjustments</u>	
23,329.41		0.00		0.00	
<u>Sel</u>	<u>Bill Number</u>	<u>Bill Switch</u>	<u>Bill Date</u>	<u>Billed Amount</u>	<u>Balance</u>
-	58843574	Y	04-28-18	14,043.25	1,392.07
-	58922500	Y	06-02-18	56,238.50	5,223.23
-	59251564	Y	06-30-18	28,416.39	5,146.52
-	59550260	Y	07-28-18	4,648.78	4,648.78
-	59838799	N		6,918.81	6,918.81

F1=HELP F3=EXIT F5=REFRESH F6=BILLSUM F7=UP F8=DOWN F9=ADJUST F10=CLNT NOTE
F11=TRAN BAL F13=PMNTRCH F14=BULK ADJ F15=CLNTPYMT F16=CLNT INQ F17=REPRMNT
Tran: _____

pre-petition \$16,510.60

JCBB
LCBS
HL

Client Bill Balances List

08-28-18

14:27:54

More:

Client Account: 23350007 Report to Name1: N.W. MISS. REGIONAL MED. CNT.

Corp Account : Bill to Name1 : N.W. MISS. REGIONAL MED. CNT.

O ("O"pen or "A"ll)

Client Balance

49,803.14

Client Payments

0.00

Client Adjustments

0.00

<u>Sel</u>	<u>Bill Number</u>	<u>Bill Switch</u>	<u>Bill Date</u>	<u>Billed Amount</u>	<u>Balance</u>
-	58620599	Y	04-28-18	11,678.33	11,678.33
-	58922539	Y	06-02-18	12,166.93	12,166.93
-	59224324	Y	06-30-18	7,992.40	7,992.40
-	59550297	Y	07-28-18	7,018.55	7,018.55
-	59838848	N		10,946.93	10,946.93

F1=HELP F3=EXIT F5=REFRESH F6=BILLSUM F7=UP F8=DOWN F9=ADJUST F10=CLNT NOTE
F11=TRAN BAL F13=PMNTRCH F14=BULK ADJ F15=CLNTPYMT F16=CLNT INQ F17=REPRMNT

Tran: _____

pre-petition \$38,856.21

MIDDLE DISTRICT OF TENNESSEE

Claims Register

[3:18-bk-05665 Curae Health Inc.](#)

Judge: Charles M Walker

Chapter: 11

Office: Nashville

Last Date to file claims:

Trustee:

Last Date to file (Govt):

Creditor: (6718283)
LABORATORY CORP OF
AMERICA
PO BOX 12140
BURLINGTON, NC 27216-
2140

Claim No: 11
Original Filed
Date: 09/05/2018
Original Entered
Date: 09/05/2018

Status:
Filed by: CR
Entered by: admin
Modified:

Amount claimed: \$95394.84

History:

[Details](#) [11-1](#) 09/05/2018 Claim #11 filed by LABORATORY CORP OF AMERICA, Amount claimed: \$95394.84 (admin)

Description:

Remarks: (11-1) Account Number (last 4 digits):1410

Claims Register Summary

Case Name: Curae Health Inc.

Case Number: 3:18-bk-05665

Chapter: 11

Date Filed: 08/24/2018

Total Number Of Claims: 1

Total Amount Claimed*	\$95394.84
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		