Fill in this information to identify the case:	
Debtor 1	Curae Health Inc
Debtor 2 (Spouse, if filing)	
United States Bankruptcy Court for the:	Middle District of Tennessee
Case number	3:18:-bk-05665

FILED
SEP 05 2018
U.S. BANKRUPTCY COURT
MIDDLE DISTRICT OF TN

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?

Covidien LLC
Name of the current creditor (the person or entity to be paid for this claim)

Other names the creditor used with the debtor ______

2. Has this claim been acquired from someone else?

☑ No
☐ Yes. From whom? ______

3. Where should notices and payments to the creditor be sent?

Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)

Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different)
Name: Covidien LLC	Name:
Number Street: 15 Hampshire Street	Number Street:
City: Mansfield State: MA ZIP Code: 02048	City State ZIP Code
Contact phone: 508-452-4152	Contact phone:
Contact email: debra.m.ford@medtronic.com	Contact email:

Uniform claim identifier for electronic payments in chapter 13 (if you use one):
3 4 2 9 9 2

4. Does this claim amend one already filed?

☑ No
☐ Yes. Claim number on court claims registry (if known) ______ Filed on ______ MM / DD / YYYY

5. Do you know if anyone else has filed a proof of claim for this claim?

☑ No
☐ Yes. Who made the earlier filing? ______

Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. **Do you have any number you use to identify the debtor?**	☐ No ☑ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 2 9 9 2
7. **How much is the claim?**	$ 49,123.03 **Does this amount include interest or other charges?** ☑ No ☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).
8. **What is the basis of the claim?**	Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card. Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c). Limit disclosing information that is entitled to privacy, such as health care information. Goods sold
9. **Is all or part of the claim secured?**	☑ No ☐ Yes. The claim is secured by a lien on property. **Nature of property:** ☐ Real estate. If the claim is secured by the debtor's principal residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410-A) with this *Proof of Claim*. ☐ Motor vehicle ☐ Other. Describe: ______ **Basis for perfection:** ______ Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.) **Value of property**: $______ **Amount of the claim that is secured:** $______ **Amount of the claim that is unsecured:** $______ (The sum of the secured and unsecured amounts should match the amount in line 7.) **Amount necessary to cure any default as of the date of the petition:** $______ **Annual Interest Rate** (when case was filed)____% ☐ Fixed ☐ Variable
10. **Is this claim based on a lease?**	☑ No ☐ Yes. **Amount necessary to cure any default as of the date of the petition.** $______
11. **Is this claim subject to a right of setoff?**	☑ No ☐ Yes. Identify the property: ______

12. **Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?**

A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.

☑ No

☐ Yes. *Check one:*

	Amount entitled to priority
☐ Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	$
☐ 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).	$
☐ 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).	$
☐ Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	$
☐ Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	$
☐ 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 08/30/2018 (MM / DD / YYYY)

Debra Ford
Signature

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

Name	Debra (First name)	(Middle name)	Ford (Last name)
Title	Credit Supervisor		
Company	Covidien LLC Identify the corporate servicer as the company if the authorized agent is a servicer.		
Address	15 Hampshire Street (Number Street)		
	Mansfield (City)	MA (State)	02048 (ZIP Code)
Contact phone	508-452-4152	Email	debra.m.ford@medtronic.com

15 Hampshire Street
Mansfield, MA 02048

CORP ACCT #.	STATEMENT DATE	PAGE NO.
329785	08/30/18	1 of 1

Bill To # 329785
NORTHWEST MISSISSIPPI MEDICAL CENTER
PO BOX 1218
CLARKSDALE MS 38614

ATTENTION: ACCOUNTS PAYABLE

STATEMENT OF ACCOUNT

INVOICE DATE	DUE DATE	INVOICE	TRANS.	PO NO.	AMOUNT
04/12/18	04/12/18	3132998	TX DEDUCTION SALES TAX	749-6578243	452.56
04/17/18	05/17/18	26608510	INV INVOICE	749-6713323	3,956.65
04/23/18	05/23/18	26641733	INV INVOICE	7496696170	160.50
04/24/18	05/24/18	26645394	INV INVOICE	749-6718477	3,956.65
05/15/18	06/14/18	26740541	INV INVOICE	749-6732666	212.02
05/18/18	06/17/18	26763316	INV INVOICE	749-6720906	160.50
06/08/18	07/08/18	26848938	INV INVOICE	749-6748602	487.43
06/11/18	07/11/18	26856081	INV INVOICE	749-6698094	2,975.93
				TOTAL BALANCE	**$12,362.24**

Current	1 – 30	31 – 60	61 – 90	Over90
0.00	**0.00**	**3,463.36**	**372.52**	**8,526.36**

Remit To: COVIDIEN
DEPARTMENT 00 10318
PALATINE IL 60055-0318

Any questions regarding this notice should be referred to the Credit Department Immediately.

DOREEN KIRBY
508-261-8279

15 Hampshire Street
Mansfield, MA 02048

CORP ACCT #.	STATEMENT DATE	PAGE NO.
9412369	08/30/18	1 of 1

Bill To # 9412369
AMORY REGIONAL MEDICAL CENTER INC
1105 EARL FRYE BLVD
DBA GILMORE MEMORIAL HOSPITAL
AMORY MS 38821

ATTENTION: ACCOUNTS PAYABLE

STATEMENT OF ACCOUNT

INVOICE DATE	DUE DATE	INVOICE	TRANS.	PO NO.	AMOUNT
05/31/18	06/30/18	26813964	INV INVOICE	00958	516.50
06/20/18	07/20/18	26899541	INV INVOICE	01119	337.20
06/20/18	07/20/18	26900949	INV INVOICE	01189	27.55
06/29/18	07/29/18	26946698	INV INVOICE	01189	20.67
06/29/18	07/29/18	26948098	INV INVOICE	01330	516.50
07/03/18	08/02/18	26959167	INV INVOICE	01350	516.50
07/05/18	08/04/18	26967958	INV INVOICE	01376	516.50
07/17/18	08/16/18	27015333	INV INVOICE	01498	516.50
07/25/18	08/24/18	27058803	INV INVOICE	01597	516.50
07/31/18	08/30/18	27080721	INV INVOICE	01672	516.50
08/16/18	09/15/18	27124968	INV INVOICE	01869	853.00
08/28/18	09/27/18	27156931	INV INVOICE	01980	516.50
				TOTAL BALANCE	$5,370.42

Current	1 – 30	31 – 60	61 – 90	Over90
1,886.00	2,066.00	901.92	516.50	0.00

Remit To: COVIDIEN
DEPARTMENT 00 10318
PALATINE IL 60055–0318

Any questions regarding this notice should be referred to the Credit Department Immediately.

DOREEN KIRBY
508–261–8279

15 Hampshire Street
Mansfield, MA 02048

CORP ACCT #.	STATEMENT DATE	PAGE NO.
342992	08/30/18	1 of 1

Bill To # 342992
RUSSELLVILLE HOSPITAL
PO BOX 1089
RUSSELLVILLE AL 35653-1089

ATTENTION: ACCOUNTS PAYABLE

STATEMENT OF ACCOUNT

INVOICE DATE	DUE DATE	INVOICE	TRANS.	PO NO.	AMOUNT
10/16/17	11/15/17	25774103	INV INVOICE	13247	1,907.50
10/19/17	11/18/17	25791693	INV INVOICE	13247	21,800.00
01/03/18	02/02/18	26125364	INV INVOICE	13617	603.32
01/29/18	02/28/18	26247430	INV INVOICE	13782	603.32
03/19/18	03/19/18	3123442	PA COA PARTIAL APPLIED CASH		-3,000.00
02/26/18	03/28/18	26375413	INV INVOICE	13912	603.32
03/27/18	04/26/18	26509224	INV INVOICE	14053	603.32
05/10/18	06/09/18	26719773	INV INVOICE	14249	603.32
05/31/18	06/30/18	26812354	INV INVOICE	14363	603.32
06/12/18	07/12/18	26862686	INV INVOICE	14418	603.32
07/16/18	08/15/18	27007227	INV INVOICE	14549	173.89
07/18/18	08/17/18	27020300	INV INVOICE	14573	603.32
08/10/18	09/09/18	27107890	INV INVOICE	14685	603.32
08/14/18	09/13/18	27117095	INV INVOICE	14622	2,682.49
08/16/18	09/15/18	27124723	INV INVOICE	14724	2,355.49
08/21/18	09/20/18	27135751	INV INVOICE	14753	41.12
				TOTAL BALANCE	**$31,390.37**

Current	1 - 30	31 - 60	61 - 90	Over90
5,682.42	**777.21**	**603.32**	**1,206.64**	**23,120.78**

Remit To: COVIDIEN
PO BOX 120823
DALLAS TX 75312-0823

Any questions regarding this notice should be referred to the Credit Department Immediately.

DOREEN KIRBY
508-261-8279

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: (6733474) COVIDIEN LLC 15 HAMPSHIRE STREET MANSFIELD MA 02048	**Claim No: 18** *Original Filed Date*: 09/05/2018 *Original Entered Date*: 09/05/2018	*Status:* *Filed by:* CR *Entered by:* Intake1 *Modified:*

Amount claimed: $49123.03

History:

Details 18-1 09/05/2018 Claim #18 filed by COVIDIEN LLC, Amount claimed: $49123.03 (Intake1)

Description: (18-1) Goods sold

Remarks:

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*	$49123.03
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		