B10 (Official Form 10) (04/13)	- 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 1			
UNITED STATES BANKRUPT	CY COURT Middle Distr	ict of Tennessee	P	ROOF OF CLAIM
Name of Debtor:		Case Number:		
Curae Health Inc.		3:18-bk-0566	35	Filed
				a
				OCT 0.2 2018
NOTE: Do not use this form to make a c	claim for an administrative expense that ar nent of an administrative expense accordin	ises after the bankrup g to 11 U.S.C. § 503.	tcy filing. You	DANKENETCY COLIET
	ity to whom the debtor owes money or pro		0.S. MI	BANKRUPTCY COURT
Crest Healthcare Supply				COURT USE ONLY
Name and address where notices should b	be sent:			this box if this claim amends a
Crest Healthcare Supply PO Box 727, 195 Third Street S				y filed claim.
Dassel, MN 55325			Court Cl (If kno	aim Number: wn)
Telephone number: (320) 275-3382	email: accounting@cresthealtho	care.com		
Name and address where payment should	the cent (if different from above):		Filed on:	this box if you are aware that
Name and address where payment should	be sent (it different from above).		anyone el	lse has filed a proof of claim
				o this claim. Attach copy of t giving particulars.
Telephone number:	email:			
		0.004.00		
1. Amount of Claim as of Date Case Fi	iled: \$	2,001.32		
If all or part of the claim is secured, comp	plete item 4.			
If all or part of the claim is entitled to prio	ority, complete item 5.			
Check this box if the claim includes in	terest or other charges in addition to the pri-	incipal amount of the	claim. Attach a statement t	hat itemizes interest or charges.
2. Basis for Claim: goods sold				
(See instruction #2)				
 Last four digits of any number by which creditor identifies debtor: 	3a. Debtor may have scheduled account	nt as: 3b. Uniform	a Claim Identifier (optiona	11):
2 2 1 6	(See instruction #3a)	(See instruc	tion #3b)	
	(See instruction #54)	Amount of	arrearage and other charg	ges, as of the time case was filed,
 Secured Claim (See instruction #4) Check the appropriate box if the claim is 	secured by a lien on property or a right of		secured claim, if any:	
setoff, attach required redacted documen	ts, and provide the requested information.		\$	
	Real Estate OMotor Vehicle OOthe	r Basis for po	erfection:	
Describe:				
Value of Property: \$	-	Amount of	Secured Claim: \$	
Annual Interest Rate% 🗇 Fixe	ed or 🗇 Variable	Amount Ur	secured: \$	
(when case was filed)				
5 Amount of Claim Entitled to Buiovi	ty under 11 U.S.C. § 507 (a). If any part	of the claim falls in	o one of the following cate	provide the solution of the so
the priority and state the amount.	ty under 11 0.5.0. 8 507 (a). It any part	or the claim rans in	o one of the following care	e,
Domestic support obligations under 1	1 🗇 Wages, salaries, or commissions	(up to \$12,475*)	Contributions to an	
U.S.C. § 507 (a)(1)(A) or (a)(1)(B).	earned within 180 days before the ca debtor's business ceased, whichever	se was filed or the	employee benefit plan – 11 U.S.C. § 507 (a)(5).	
	11 U.S.C. § 507 (a)(4).		11 0.0.0, 8 007 (a)(0).	Amount entitled to priority:
□ Up to \$2,775* of deposits toward	Taxes or penalties owed to gover	nmental units –	🗇 Other - Specify	\$
purchase, lease, or rental of property or	11 U.S.C. § 507 (a)(8).		applicable paragraph of 11 U.S.C. § 507 (a)().	
services for personal, family, or househouse – 11 U.S.C. § 507 (a)(7).	nu		(1 0.5.0. § 507 (a)	
				6 - 17
*Amounts are subject to adjustment on 4	1/01/16 and every 3 years thereafter with re	espect to cases comme	enced on or after the date of	aajusimeni.
6. Credits. The amount of all payment	s on this claim has been credited for the pu 065 Claim 63-1 Filed 10	rpose of making this	proof of claim. (See instruct	ion #6)
Case 3.18-0K-050	DUD CIAITI 03-1 FILEO 10		sc iviain Documer	nt Page 1 of 9

B10 (Official Form 10)	(04/13)		2	1
7. Documents: Attack running accounts, cont statement providing the evidence of perfection filed with this claim. (2)	hed are redacted copies of any documents the racts, judgments, mortgages, security agreem e information required by FRBP 3001(c)(3)(/ of a security interest are attached. If the clain See instruction #7, and the definition of "reda	A). If the claim is secured, box 4 has be n is secured by the debtor's principal res acted".)	notes, purchase orders, invoices, itemized statements of an open-end or revolving consumer credit agreement, a en completed, and redacted copies of documents providing idence, the Mortgage Proof of Claim Attachment is being	
DO NOT SEND ORIC	NAL DOCUMENTS. ATTACHED DOCU	JMENTS MAY BE DESTROYED AFT	ER SCANNING.	
If the documents are no	ot available, please explain:			
8. Signature: (See in	struction #8)			
Check the appropriate	box.			
I am the creditor.	□ I am the creditor's authorized agent.	 I am the trustee, or the debtor, or their authorized agent. (See Bankruptcy Rule 3004.) 	I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)	

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

Print Name:	Michelle Schnitzler
Title:	Finance Supervisor
Company:	Crest Healthcare Supply
Address and t	elephone number (if different from notice address above):

chille Schint le 09/21/2018 (Date)

 Telephone number: (320) 275-3382
 email: accounting@cresthealthcare.com

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

INSTRUCTIONS FOR PROOF OF CLAIM FORM

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

Items to be completed in Proof of Claim form

Court, Name of Debtor, and Case Number:

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

Creditor's Name and Address:

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

1. Amount of Claim as of Date Case Filed:

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

2. Basis for Claim:

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

3. Last Four Digits of Any Number by Which Creditor Identifies Debtor: State only the last four digits of the debtor's account or other number used by the creditor to identify the debtor.

3a. Debtor May Have Scheduled Account As:

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

3b. Uniform Claim Identifier:

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

4. Secure Celsie: 3:18-bk-05665 Claim 63-1 Filed 10/02/18 Check whether the claim is fully or partially secured. Skip this section if the

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

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

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

6. Credits:

An authorized signature on this proof of claim serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

7. Documents:

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

8. Date and Signature:

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

Desc Main Document

Page 2 of 9



195 Third Street South, PO Box 727 Dassel, MN 55325-0727 P: 800-328-8908 F: 800-369-9207 www.cresthealthcare.com STATEMENT

Statement Date: 8/9/2018 Account Number: CR22216

Page: 1

Gilmore Memorial Hospital 1105 Earl Frye Blvd PO Box 459 Amory, MS 38821 UNITED STATES

Document	Date	Terms	Туре	Debits	Credits	Balance
0077722 0082979 0083428 0083774 0085285 0085974	4/12/2018 5/31/2018 6/5/2018 6/7/2018 6/21/2018 6/28/2018	Net 30 Net 30 Net 30 Net 30 Net 30 Net 30	Invoice Invoice Invoice Invoice Invoice Invoice	55.90 421.95 421.95 424.95 254.62 421.95	ъ́	55.90 477.85 899.80 1,324.75 1,579.37 2,001.32
0085974	6/28/2018	Net 30	Invoice	421.95		2,001

	Statement Balance		2,001.32	0.00	2,001.32
Statement Aging: Days old:	Current	32 - 61 Days	62 - 92 Days	Over 92 Days	
Aged amounts Case 3.18-bk-056	65 Claim 63-1	Filed 10/02/18	1,268,85 Desc Main Documen	t Page 3 of 9	

CREST					INVOICE
HEALTHCARE SUPPLY®					Page: 1
195 Third Street South, PO Box 727				Number: bice Date:	0077722 4/12/2018
Dassel, MN 55325-0727 2: 800-328-8908 F: 800-369-9207 vww.cresthealthcare.com			1	Due Date Terms	5/12/2018 Net 30
Bill To: Gilmore Memorial Hospital 1105 Earl Frye Blvd PO Box 459 Amory, MS 38821 UNITED STATES	Ship To	b: Gilmore Mer 1105 Earl Fr Amory, MS UNITED STA	38821		
Freight: Third Party Billing	Custor P.O. N Sales C	n seed that are			CR22216 00418 SO082578
Item/Description	UM	Order Qty	Shipped Qty	Unit Price	Total Price
XN0401W-08 CABLE ASSEMBLY,RAU,8 PIN DIN,XN AND XT Tracking #: 055479815722153	EA	2	2	27.95	55.90

DSSI.	Thank you for your recent order with Crest Healthcare Supply. Please let us know at (800) 328-8908 how we can better serve you, or if you have any questions regarding	Subtotal: Tax:	55.90 0.00
Ready	your invoice. Invoices are subject to Crest Healthcare Supply Polices and Warranties located at <u>www.cresthealthcare.com/policies.asp</u>	Total USD:	\$55.90

	DUE DATE: 5/12/2018			
		Payable in U.	S. funds only	
CR22216	Gilmore Memorial Hospital	INVOICE NO .:	0077722	
		INVOICE AMT:	\$55.90	
Please Remit to:	Crest Healthcare Supply PO Box 727 Dassel, MN 55325-0727		Amount Enclosed	100-00-00-00-00-00-00-00-00-00-00-00-00-
		aple check to remittance*		Contract Contractory

CREST	INVOICE Page: 1
195 Third Street South, PO Box 727	Invoice Number: 0082979 Invoice Date: 5/31/2018
Dassel, MN 55325-0727 P: 800-328-8908 F: 800-369-9207 www.cresthealthcare.com	Due Date 6/30/2018 Terms Net 30
Bill To: Gilmore Memorial Hospital	Ship To: Gilmore Memorial Hospital

1105 Earl Frye Blvd

Amory, MS 38821 UNITED STATES

PO Box 459

1105 Earl Frye Blvd

Amory, MS 38821

UNITED STATES

Freight:	Pre-Paid and Add	P.O. N	mer ID Jumber Order No.			CR22216 00910 SO087409
Item/Descri	intion	UM	Order Qty	Shipped Qty	Unit Price	Total Price
32LV570M	SLIM DIRECT LED HDTV, HOSPITAL GRADE	EA	1	1	389.95	389.95
S/H FedEx Tra	cking# 437693698762	EA	1	1	32.00	32.00

Deel	Thank you for your recent order with Crest Healthcare Supply. Please let us know at	Subtotal: Tax:	421.95 0.00
Doody	(800) 328-8908 how we can better serve you, or if you have any questions regarding your invoice. Invoices are subject to Crest Healthcare Supply Polices and Warranties located at <u>www.cresthealthcare.com/policies.asp</u>	Total USD:	\$421.95

		DUE DATE: 0	5/30/2018
		Payable in U.	S. funds only
CR22216	Gilmore Memorial Hospital	INVOICE NO .:	0082979
		INVOICE AMT:	\$421.95
Please Remit to:	Crest Healthcare Supply PO Box 727 Dassel, MN 55325-0727		Amount Enclosed
		aple check to remittance*	-

					1	NVOICE
C	REST					Page: 1
HEAL	THCARE SUPPLY®			Invoice		0083428 6/5/2018
5 Third SI	treet South, PO Box 727			Invoi	ce Date:	0/3/2010
800-328-	55325-0727 8908 F: 800-369-9207 ealthcare.com			D	oue Date Terms	7/5/2018 Net 30
	Gilmore Memorial Hospital 1105 Earl Frye Blvd PO Box 459 Amory, MS 38821 UNITED STATES	Ship To:	Gilmore Mem 1105 Earl Fry Amory, MS UNITED STAT	38821		
-reight:	Pre-Paid and Add	Custom P.O. Nu Sales C				CR22216 00971 SO088029
		UM	Order Qty	Shipped Qty	Unit Price	Total Price
tem/Des	4	EA	1	1	389.95	389.95
TV,LG 3	32" SLIM DIRECT LED HDTV, HOSPITAL GRADI	ΡE			00000	22.00

ΕA

32.00

32.00

1 1

FedEx Tracking# 445991252215

S/H

Usal.	Thank you for your recent order with Crest Healthcare Supply. Please let us know at	Subtotal: Tax:	421.95 0.00
	Thank you for your recent order with Crest Healthout o capty in questions regarding (800) 328-8908 how we can better serve you, or if you have any questions regarding your invoice. Invoices are subject to Crest Healthcare Supply Polices and Warranties located at <u>www.cresthealthcare.com/policies.asp</u>	Total USD:	\$421.95
	er contras. E		

		DUE DATE: 7/5/2018				
		Payable in U.S. funds only				
0000016	Gilmore Memorial Hospital	INVOICE NO .:	0083428			
CR22216	Gimble Memorial Hospital	INVOICE AMT:	\$421.95			
Please Remit to:	Crest Healthcare Supply		Amount Enclosed			
	PO Box 727					
	Dassel, MN 55325-0727		L	Designment of the local data and the		
	int de catet	aple check to remittance*		Distance of the owner of the local		

Please do not staple check to remittance

C	REST			INVOICE Page: 1
HEA 195 Third Dassel, N P: 800-32	ALTHCARE SUPPLY® Street South, PO Box 727 IN 55325-0727 88-8908 F: 800-369-9207 Sthealthcare.com		Invoice Number: Invoice Date: Due Date Terms	0083774 6/7/2018 7/7/2018 Net 30
Bill To:	Gilmore Memorial Hospital 1105 Earl Frye Blvd PO Box 459 Amory, MS 38821 UNITED STATES	Ship To:	Gilmore Memorial Hospital 1105 Earl Frye Blvd Amory, MS 38821 UNITED STATES	
	Pur Drid and Add	Custome P.O. Nur Salas Or	nber	CR22216 01021 SO088500

Freight:	Pre-Paid and Add	Sales Order No.			20088200	
		UM	Order Qty	Shipped Qty	Unit Price	Total Price
Item/Descri	SLIM DIRECT LED HDTV, HOSPITAL GRADE	EA	1	1	389.95	389.95
S/H	SLIM DIRECT LED TIDTY, HOSTING CONTROL	EA	1	1	35.00	35.00

FedEx Tracking# 445991256129

		Subtotal:	424.95
U331.	Thank you for your recent order with Crest Healthcare Supply. Please let us know at	Tax:	0.00
	Thank you for your recent order with Crest Healthcare Supply Polices and Warranties (800) 328-8908 how we can better serve you, or if you have any questions regarding your invoice. Invoices are subject to Crest Healthcare Supply Polices and Warranties located at www.cresthealthcare.com/policies.asp		\$424.95

		DUE DATE: 7, Payable in U.S	
	au Auraria Hacrital	INVOICE NO.:	0083774
CR22216	Gilmore Memorial Hospital	INVOICE AMT:	\$424.95
Please Remit to:	Crest Healthcare Supply		Amount Enclosed
	PO Box 727		
	Dassel, MN 55325-0727		
	+Disease do not st	able check to remittance*	

*Please do not staple che

100	REST			Page: 1
	LTHCARE SUPPLY®		Invoice Number: Invoice Date:	0085285 6/21/2018
195 Third Street South, PO Box 727 Dassel, MN 55325-0727 P: 800-328-8908 F: 800-369-9207 www.cresthealthcare.com			7/21/2018 Net 30	
Bill To:	Gilmore Memorial Hospital 1105 Earl Frye Blvd	Ship To:	Gilmore Memorial Hospital 1105 Earl Frye Blvd Amory, MS 38821	

Amory, MS 38821

UNITED STATES

Freight:	Pre-Paid and Add	P.O. N	mer ID lumber Order No.			CR22216 01226 SO090349	
		UM	Order Qty	Shipped Qty	Unit Price	Total Price	
Item/Descri	ព្រះលោ	EA	1	1	28.95	28.95	
106412 RECEPTAG	CLE,RAU,12P, PIGTAIL&HEADER	EA	1	1	125.95	125.95	
BS300C STATION,	,CRE/RAU,1/4-2C,SGL	EA	1	1	74.95	74.95	
HVB-100BC STATION	,CR/EKT,SGL,8P,1G	LA					
Tracking #:	055479815780801	EA	1	1	24.77	24.77	

S/H

Freight

DSSI.

Ready

PO Box 459

Amory, MS 38821 UNITED STATES

> Thank you for your recent order with Crest Healthcare Supply. Please let us know at (800) 328-8908 how we can better serve you, or if you have any questions regarding your invoice. Invoices are subject to Crest Healthcare Supply Polices and Warranties located at www.cresthealthcare.com/policies.asp

254.62 Subtotal: 0.00 Tax: \$254.62 Total USD:

INIVOICE

DUE DATE: 7/21/2018 Payable in U.S. funds only 0085285 INVOICE NO .: Gilmore Memorial Hospital CR22216 \$254.62 INVOICE AMT: Amount Enclosed Crest Healthcare Supply Please Remit to: PO Box 727 Dassel, MN 55325-0727

Please do not staple check to remittance



1105 Earl Frye Blvd

Amory, MS 38821 UNITED STATES

PO Box 459

INVOICE

Page: 1

195 Third Street South, PO Box 727	Invoice Number:			
Dassel, MN 55325-0727	Invoice Date:			
P: 800-328-8908 F: 800-369-9207	Due Date	7/28/2018		
www.cresthealthcare.com	Terms	Net 30		
Bill To: Gilmore Memorial Hospital	Ship To: Gilmore Memorial Hospital			

1105 Earl Frye Blvd

Amory, MS 38821

UNITED STATES

Freight:	Pre-Paid and Add	Customer ID P.O. Number Sales Order No.			CR22216 01137 SO090000	
Item/Description		ИМ	Order Qty	Shipped Qty	Unit Price	Total Price
32LV570M TV,LG 32"	SLIM DIRECT LED HDTV, HOSPITAL GRADE	EA	1	1	389.95	389.95
S/H FedEx Trac	cking# 445991291381	EA	1	1	32.00	32.00

DSSI. Ready

Thank you for your recent order with Crest Healthcare Supply. Please let us know at (800) 328-8908 how we can better serve you, or if you have any questions regarding your invoice. Invoices are subject to Crest Healthcare Supply Polices and Warranties located at www.cresthealthcare.com/policies.asp

421.95 Subtotal: 0.00 Tax: Total USD: \$421.95

		DUE DATE: 7/	28/2018			
		Payable in U.S. funds only				
CR22216	Gilmore Memorial Hospital	INVOICE NO .:	0085974			
		INVOICE AMT:	\$421.95			
Please Remit to:	Crest Healthcare Supply PO Box 727		Amount Enclosed			
	Dassel, MN 55325-0727			Provide Contract on the Party of		
	Please do not st	anle check to remittance				

MIDDLE DISTRICT OF TENNESSEE Claims Register

3:18-bk-05665 Curae Health Inc.

Judge: Charles M WalkerChapter: 11Office: NashvilleLast Date to file claims:Trustee:Last Date to file (Govt):Creditor:(6754173)Claim No: 63Status:

CREST HEALTHCARE SUPPLY PO BOX 727 195 THIRD STREET S DASSEL MN 55325 Claim No: 63 Original Filed Date: 10/02/2018 Original Entered Date: 10/02/2018 Status: Filed by: CR Entered by: Intake1 Modified:

Amount claimed: \$2001.32

History:

Details 63-1 10/02/2018 Claim #63 filed by CREST HEALTHCARE SUPPLY, Amount claimed: \$2001.32 (Intake1)

Description: (63-1) 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* \$2001.32

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		