Fill in this information to identify the case:

Debtor 1: Amory Regional Medical Center, Inc.

Debtor 2 (Spouse, if filing):

United States Bankruptcy Court for the: Middle District of Tennessee

Case number: 3:18-bk-05675

FILED

JAN 08 2019

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?**

   Debra Kwykendall
   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?

   Debra Kwykendall
   Name

   63192 Hwy 25N
   Number Street

   Smithville MS 38870
   City State ZIP Code

   Contact phone 662-401-1697

   Contact email debrak.1959@hotmail.com

   Where should payments to the creditor be sent? (if different)

   Name

   Number Street

   City State ZIP Code

   Contact phone

   Contact email

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

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: ____ ____ ____ ____

7. **How much is the claim?** $ 2,151.38 . **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.
   Earned Wages / Paid Time Off

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).	$ 12,850.00
☐ 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 1/4/2019 (MM / DD / YYYY)

Debra Kuykendall
Signature

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

Name: Debra (First name) Kuykendall (Middle name / Last name)

Title: Medical Technologist

Company: (Identify the corporate servicer as the company if the authorized agent is a servicer.)

Address: 63192 Hwy 25N (Number Street)
Smithville (City) MS (State) 38870 (ZIP Code)

Contact phone: 662-401-1697 Email: debrak.1959@hotmail.com

Debra Kuykendall

Company 1964
Number 000578249
Social Security # [redacted]
Hire Date 6/8/1981
Period Begin 12/16/2018
Period End 12/29/2018
Check Number -99375784
Check Date 1/4/2019
Division 9454
Branch 1454
Department 6131
Team

Curae Health Inc.

1721 Midpark Road Suite B-200
Knoxville, TN 37921 865-269-4074

Sick 890.330000 Accr= 890.330000 Bal HOURS
Vacation 137.930000 Accr= 121.430000 Bal HO

Earnings

Description	Location / Job	Rate	Hours/Pieces	Current	Year To Date
01-Regular		26.42	65.75	1737.12	1737.12
07-PTO/Vacation		[redacted]			290.63
Holiday Worked Premium					128.80
Shift 2 Premium					41.25
Shift 3 Premium					37.50
Group Term Life					1.51
Memos					
ER Dental Ins Premium					8.68

Deductions

Description	Current	Year To Date
Fed (S/2) (1972.96)	[redacted]	
OASDI (1972.96)		
Medicare (1972.96)		
MS (S/1) (1972.96)		
Pre-Tax Medical		
Pre-Tax Dental		
Pre-Tax Vision		
Post-Tax Vol Accident		
Post-Tax Vol Critical Illness		
Post-Tax Vol Spousal Life/AD&D		
Post-Tax Vol EE Life/AD&D		
Post-Tax LTD		
Post-Tax Wellness Center		
DD Savings 2 35031XXXX		
Net Pay 35080XXXX		

Total Earnings [redacted] Total Deductions
NET PAY 1434.06 Total Direct Deposits [redacted] Check Amount

Regions Bank
Nashville, TN

87-1
640

Curae Health Inc.
1721 Midpark Road
Suite B-200
Knoxville, TN 37921

Check Date 1/4/2019

Check Number Memo

$**********

Pay *No Dollars and No Cents*

PAY ONLY [redacted] CTS

To the Order of:
9454 1454 6131
Debra Kuykendall
63192 Hwy 25 North
Smithville, MS 38870

000578249-99375784
NON NEGOTIABLE

Authorized Signature

Curae Health Inc.
1721 Midpark Road
Suite B-200
Knoxville, TN 37921

9454 1454 6131
000578249-99375784

Debra Kuykendall
63192 Hwy 25 North
Smithville, MS 38870

MIDDLE DISTRICT OF TENNESSEE
Claims Register

3:18-bk-05675 Amory Regional Medical Center, Inc.

Judge: Charles M Walker **Chapter:** 11
Office: Nashville **Last Date to file claims:**
Trustee: **Last Date to file (Govt):**

Creditor: (6817449)
DEBRA KUYKENDALL
63192 HWY 25N
SMITHVILLE MS 38870

Claim No: 17
Original Filed Date: 01/08/2019
Original Entered Date: 01/08/2019

Status:
Filed by: CR
Entered by: Intake3
Modified:

Amount claimed: $2151.38
Priority claimed: $12850.00

History:
Details 17-1 01/08/2019 Claim #17 filed by DEBRA KUYKENDALL, Amount claimed: $2151.38 (Intake3)
Description: (17-1) Earned Wages/Paid Time Off
Remarks:

Claims Register Summary

Case Name: Amory Regional Medical Center, Inc.
Case Number: 3:18-bk-05675
Chapter: 11
Date Filed: 08/24/2018
Total Number Of Claims: 1

Total Amount Claimed*	$2151.38
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	$12850.00	
Administrative		