UNITED STATES BANKRUPTCY COURT
Northern District of Georgia – Rome Division

PROOF OF CLAIM

Name of Debtor Against Which You Assert Your Claim. *(check one box - if you are asserting a claim against more than one Debtor, you must file a separate Proof of Claim against each Debtor)*

☒ **Hutcheson Medical Center, Inc., Case No. 14-42683**

☐ **Hutcheson Medical Division, Inc., Case No. 14-42684**

Deadline for filing Proofs of Claim
MAY 1, 2015
5:00 pm (Eastern)

NOTE: *Do not use this form to make a claim for an administrative expense. You may file a request for payment of an administrative expense according to 11 U.S.C. § 503.*

Name and Address of Creditor (the person or other entity to whom the debtor owes money or property):

TENNESSEE PHYSICIANS' QUALITY VERIFICATION ORGANIZATION, LLC
DBA "TPQVO, LLC"
1092 CHAMBERLAIN AVE, STE B
CHATTANOOGA, TN 37404

RECEIVED
MAR 09 2015
BMC GROUP

Telephone number: 423-495-1191 Fax number: 423-495-1189

Email: tpqvo@tpqvo.com

The address above will be used for service of notice of any objection to your claim, unless you provide a different notice address in the space provided by your signature on the reverse side. By submitting this Proof of Claim, you agree that the use of the above address, or the different address provided below, is sufficient for purposes of Bankruptcy Rule 7004.

☐ Check this box if the claim amends a previously filed claim.

Court Claim Number: _____
(If known)

Filed on: _____

Name and address where **payment** should be sent (if different from above):

☒ Check this box if you are aware that anyone else has filed a proof of claim relating to this claim. Attach copy of statement giving particulars.

Telephone number: _____ Fax number: _____

Email: _____

1. Amount of Claim as of Date Case Filed: $ 9,081.00

If all or part of your claim is **secured**, complete **item 4**. If all or part of your claim is entitled to **priority**, complete **item 5**.

☐ Check this box if the claim includes interest or other charges in addition to the principal amount of the claim. Attach a statement that itemizes interest or charges.

2. Basis for Claim: credentials verification services performed under contract.
(See instruction #2)

3. Last four digits of any number by which creditor identifies debtor:	**3a. Debtor may have scheduled account as:**	**3b. Uniform Claim Identifier (optional):**
_____	TN PHYSICIANS QUALITY (See instruction #3a)	_____ (See instructions #3b)

4. Secured Claim (See instruction #4)
Check the appropriate box if your claim is secured by a lien on property or a right of setoff, attach required redacted documents, and provide the requested information.

Nature of property or right of setoff: ☐ Real Estate ☐ Motor Vehicle ☐ Other
Describe: _____

Value of Property: $_____

Annual Interest Rate _____% ☐ Fixed or ☐ Variable
(when case was filed)

Amount of arrearage and other charges, as of the time case was filed, included in secured claim, if any:
$_____

Basis for perfection: _____

Amount of Secured Claim: $_____

Amount of Unsecured Claim: $_____

5. Amount of Claim Entitled to Priority under 11 U.S.C. § 507(a). If any part of the claim falls into one of the following categories, check the box specifying the priority and state the amount.

☐ Domestic support obligations under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).

☐ Up to $2,775 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 $12,475) earned within 180 days before the case was filed or the debtor's business ceased, 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 applicable paragraph of 11 U.S.C. § 507(a)(___).

Amount entitled to priority:
$_____

FOR COURT USE ONLY

Hutcheson Med POC
00142
[redacted]

TPQVO

COPY

TENNESSEE PHYSICIANS' QUALITY VERIFICATION ORGANIZATION, LLC

December 12, 2014

M. Regina Thomas
Clerk of the Bankruptcy Court
Room 339, Federal Building
600 East First Street
Rome, GA 30161-3187

RE: Case Number 14-42863-pwb

Dear Ms. Thomas:

Please find enclosed Tennessee Physicians' Quality Verification Organization, LLC's (TPQVO) Proof of Claim against Hutcheson Medical Center, Inc. I am submitting this proof of claim now although the Notice of Chapter 11 Bankruptcy Case Meeting of Creditors, & Deadlines for this case did not provide a deadline.

This claim concerns services rendered to Hutcheson Medical Center before November 20, 2014. Since TPQVO bills at the end of each month for work completed for the month, the last bill is dated November 30, 2014 but concerns work completed and delivered to Hutcheson Medical Center before November 20, 2014.

Sincerely,

Sally L. Wencel

CEO

1092 Chamberlain Avenue, Suite B, Chattanooga, TN 37404
423-495-1191 FAX 423-495-1190

B10 (Official Form 10) (04/13)

UNITED STATES BANKRUPTCY COURT Northern District of Georgia		PROOF OF CLAIM
Name of Debtor: Hutcheson Medical Center, Inc 100 Gross Crescent Circle Fort Oglethorpe, GA 30742	Case Number: 14-42863-pwb	COPY
NOTE: *Do not use this form to make a claim for an administrative expense that arises after the bankruptcy filing. You may file a request for payment of an administrative expense according to 11 U.S.C. § 503.*		
Name of Creditor (the person or other entity to whom the debtor owes money or property): Tennessee Physicians' Quality Verification Organization, LLC		COURT USE ONLY
Name and address where notices should be sent: TPQVO, LLC 1092 Chamberlain Ave, Ste B Chattanooga, TN 37404 Telephone number: (423) 495-1191 email: tpqvo@tpqvo.com		☐ Check this box if this claim amends a previously filed claim. Court Claim Number:_____ (*If known*) Filed on:_____
Name and address where payment should be sent (if different from above): Telephone number: email:		☐ Check this box if you are aware that anyone else has filed a proof of claim relating to this claim. Attach copy of statement giving particulars.

1. Amount of Claim as of Date Case Filed: $ 9,081.00

If all or part of the claim is secured, complete item 4.

If all or part of the claim is entitled to priority, complete item 5.

☐ Check this box if the claim includes interest or other charges in addition to the principal amount of the claim. Attach a statement that itemizes interest or charges.

2. Basis for Claim: Credentials verification services performed under contract
(See instruction #2)

3. Last four digits of any number by which creditor identifies debtor:	3a. Debtor may have scheduled account as: TN PHYSICIANS QUALITY (See instruction #3a)	3b. Uniform Claim Identifier (optional): _____ (See instruction #3b)

4. Secured Claim (See instruction #4)
Check the appropriate box if the claim is secured by a lien on property or a right of setoff, attach required redacted documents, and provide the requested information.

Nature of property or right of setoff: ☐ Real Estate ☐ Motor Vehicle ☐ Other
Describe:

Value of Property: $_____

Annual Interest Rate _____% ☐ Fixed or ☐ Variable
(when case was filed)

Amount of arrearage and other charges, as of the time case was filed, included in secured claim, if any:
$_____

Basis for perfection: _____

Amount of Secured Claim: $_____

Amount Unsecured: $_____

5. Amount of Claim Entitled to Priority under 11 U.S.C. § 507 (a). If any part of the claim falls into one of the following categories, check the box specifying the priority and state the amount.

☐ Domestic support obligations under 11 U.S.C. § 507 (a)(1)(A) or (a)(1)(B).

☐ Wages, salaries, or commissions (up to $12,475*) earned within 180 days before the case was filed or the debtor's business ceased, whichever is earlier – 11 U.S.C. § 507 (a)(4).

☐ Contributions to an employee benefit plan – 11 U.S.C. § 507 (a)(5).

Amount entitled to priority:

☐ Up to $2,775* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use – 11 U.S.C. § 507 (a)(7).

☐ Taxes or penalties owed to governmental units – 11 U.S.C. § 507 (a)(8).

☐ Other – Specify applicable paragraph of 11 U.S.C. § 507 (a)(__).

$_____

**Amounts are subject to adjustment on 4/01/16 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.*

6. Credits. The amount of all payments on this claim has been credited for the purpose of making this proof of claim. (See instruction #6)

7. Documents: Attached are **redacted** copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, security agreements, or, in the case of a claim based on an open-end or revolving consumer credit agreement, a statement providing the information required by FRBP 3001(c)(3)(A). If the claim is secured, box 4 has been completed, and redacted copies of documents providing evidence of perfection of a security interest are attached. If the claim is secured by the debtor's principal residence, the Mortgage Proof of Claim Attachment is being filed with this claim. *(See instruction #7, and the definition of "redacted".)*

DO NOT SEND ORIGINAL DOCUMENTS. ATTACHED DOCUMENTS MAY BE DESTROYED AFTER SCANNING.

COPY

If the documents are not available, please explain:

8. Signature: (See instruction #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: SALLY L. WENCEL
Title: CEO
Company: Tennessee Physicians' Quality Verif Org, LLC
Address and telephone number (if different from notice address above):
1092 Chamberlain Avenue, Suite B
Chattanooga, TN 37404

Telephone number: (423) 495-1191 email: tpqvo@tpqvo.com

(Signature) 12/12/2014 (Date)

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. Secured Claim:
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 is filed by an authorized 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.

Invoice

TN Physicians Quality Verification Org, LLC
1092 Chamberlain Ave., Suite B
Chattanooga, TN 37404

COPY

Date	Invoice #
07/31/2014	5880

Bill To:

Hutcheson Medical Center, Inc
Medical Staff Office
102 Gross Crescent
Ft. Oglethorpe, GA 30742

PAST DUE

Balance Due	$2,243.00

Customer Contact	P.O. No.	Terms	Ship Via
Medical Staff Office			US Mail

Description	Quantity	Unit Price	Amount
Initial Application - Physician - Joint Commission	4	135.00	540.00
Reappointment - Physician - Joint Commission	11	90.00	990.00
AHP Initial Application - Joint Commission	1	135.00	135.00
AHP Reappointment - Joint Commission	1	90.00	90.00
Primary Source Query Fee (pass through)	1	258.00	258.00
File Fee - Physician	1	125.00	125.00
Abbreviated Initial Application	1	105.00	105.00

Total	$2,243.00
Payments/Credits	$0.00
Balance Due	$2,243.00

There will be a $30 charge for all returned checks. 12% simple annual interest may be assessed on all unpaid balances after 90 days. For billing inquiries please call Patty Davis at 423-495-1191.

Phone Number	Fax Number	E-mail	Web Site
423-495-1191	423-495-1190	patty@tpqvo.com	www.tpqvo.com

Invoice

TN Physicians Quality Verification Org, LLC
1092 Chamberlain Ave., Suite B
Chattanooga, TN 37404

COPY

Date	Invoice #
08/31/2014	5921

Bill To:

Hutcheson Medical Center, Inc
Medical Staff Office
102 Gross Crescent
Ft. Oglethorpe, GA 30742

PAST DUE

Balance Due	$2,834.00

Customer Contact	P.O. No.	Terms	Ship Via
Medical Staff Office			US Mail

Description	Quantity	Unit Price	Amount
Initial Application - Physician - Joint Commission	5	135.00	675.00
Abbreviated Initial Application	4	105.00	420.00
Reappointment - Physician - Joint Commission	10	90.00	900.00
AHP Initial Application - Joint Commission	1	135.00	135.00
AHP Reappointment - Joint Commission	1	90.00	90.00
File Maintenance Fee - Physician	4	125.00	500.00
Primary Source Query Fee (pass through)	1	114.00	114.00

Total	$2,834.00
Payments/Credits	$0.00
Balance Due	$2,834.00

There will be a $30 charge for all returned checks. 12% simple annual interest may be assessed on all unpaid balances after 90 days. For billing inquiries please call Patty Davis at 423-495-1191.

Phone Number	Fax Number	E-mail	Web Site
423-495-1191	423-495-1190	patty@tpqvo.com	www.tpqvo.com

Invoice

TN Physicians Quality Verification Org, LLC
1092 Chamberlain Ave., Suite B
Chattanooga, TN 37404

Date	Invoice #
09/30/2014	5955

Bill To:

Hutcheson Medical Center, Inc
Medical Staff Office
102 Gross Crescent
Ft. Oglethorpe, GA 30742

COPY

Balance Due	$1,905.00

Customer Contact	P.O. No.	Terms	Ship Via
Medical Staff Office			US Mail

Description	Quantity	Unit Price	Amount
Initial Application - Physician - Joint Commission	5	135.00	675.00
Reappointment - Physician - Joint Commission	8	90.00	720.00
AHP Initial Application - Joint Commission	2	135.00	270.00
File Maintenance Fee - Physician	1	125.00	125.00
Abbreviated Initial Application	1	115.00	115.00

Total	$1,905.00
Payments/Credits	$0.00
Balance Due	$1,905.00

There will be a $30 charge for all returned checks. 12% simple annual interest may be assessed on all unpaid balances after 90 days. For billing inquiries please call Patty Davis at 423-495-1191.

Phone Number	Fax Number	E-mail	Web Site
423-495-1191	423-495-1190	patty@tpqvo.com	www.tpqvo.com

Invoice

TN Physicians Quality Verification Org, LLC
1092 Chamberlain Ave., Suite B
Chattanooga, TN 37404

Date	Invoice #
10/31/2014	5995

COPY

Bill To:

Hutcheson Medical Center, Inc
Medical Staff Office
102 Gross Crescent
Ft. Oglethorpe, GA 30742

Balance Due	$1,845.00

Customer Contact	P.O. No.	Terms	Ship Via
Medical Staff Office			US Mail

Description	Quantity	Unit Price	Amount
Initial Application - Physician - Joint Commission	2	135.00	270.00
Reappointment - Physician - Joint Commission	13	90.00	1,170.00
AHP Initial Application - Joint Commission	3	135.00	405.00

Total	$1,845.00
Payments/Credits	$0.00
Balance Due	$1,845.00

There will be a $30 charge for all returned checks. 12% simple annual interest may be assessed on all unpaid balances after 90 days. For billing inquiries please call Patty Davis at 423-495-1191.

Phone Number	Fax Number	E-mail	Web Site
423-495-1191	423-495-1190	patty@tpqvo.com	www.tpqvo.com

Invoice

TN Physicians Quality Verification Org, LLC
1092 Chamberlain Ave., Suite B
Chattanooga, TN 37404

Date	Invoice #
11/30/2014	6032

Bill To:

Hutcheson Medical Center, Inc
Medical Staff Office
102 Gross Crescent
Ft. Oglethorpe, GA 30742

COPY

Balance Due	$254.00

Customer Contact	P.O. No.	Terms	Ship Via
Medical Staff Office			US Mail

Description	Quantity	Unit Price	Amount
Reappointment - Physician - Joint Commission	2	90.00	180.00
Primary Source Query Fee (pass through)	1	74.00	74.00

Total	$254.00
Payments/Credits	$0.00
Balance Due	$254.00

There will be a $30 charge for all returned checks. 12% simple annual interest may be assessed on all unpaid balances after 90 days. For billing inquiries please call Patty Davis at 423-495-1191.

Phone Number	Fax Number	E-mail	Web Site
423-495-1191	423-495-1190	patty@tpqvo.com	www.tpqvo.com