


B10 (Official Form 10) (04/13)

UNITED STATES BANKRUPTCY COURT		Northern District of Georgia	PROOF OF CLAIM
Name of Debtor: Hutcheson Medical Center		Case Number: 14-42863	COURT USE ONLY <input type="checkbox"/> Check this box if this claim amends a previously filed claim. Court Claim Number: _____ (If known) Filed on: _____
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): Memorial Hospital			
Name and address where notices should be sent: c/o NRS P.O. Box 8005 Cleveland, TN 37320-8005		<input type="checkbox"/> 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: (423) 559-4174 email: helen.ledford@nrsagency.com			
Name and address where payment should be sent (if different from above):		<input type="checkbox"/> 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.	
Telephone number: _____ email: _____			
1. Amount of Claim as of Date Case Filed: \$ <u> 1,701.70</u> 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. <input type="checkbox"/> 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: _____ (See instruction #2)			
3. Last four digits of any number by which creditor identifies debtor: 3 4 2 3	3a. Debtor may have scheduled account as: _____ (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.		Amount of arrearage and other charges, as of the time case was filed, included in secured claim, if any: \$ _____	
Nature of property or right of setoff: <input type="checkbox"/> Real Estate <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Other Describe: _____		Basis for perfection: _____	
Value of Property: \$ _____		Amount of Secured Claim: \$ _____	
Annual Interest Rate _____ % <input type="checkbox"/> Fixed or <input type="checkbox"/> Variable (when case was filed)		Amount Unsecured: \$ <u> 1,701.70</u>	
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.			
<input type="checkbox"/> Domestic support obligations under 11 U.S.C. § 507 (a)(1)(A) or (a)(1)(B).	<input type="checkbox"/> 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).	<input type="checkbox"/> Contributions to an employee benefit plan – 11 U.S.C. § 507 (a)(5).	
<input type="checkbox"/> 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).	<input type="checkbox"/> Taxes or penalties owed to governmental units – 11 U.S.C. § 507 (a)(8).	<input type="checkbox"/> Other – Specify applicable paragraph of 11 U.S.C. § 507 (a)(____).	
		Amount entitled to priority: \$ _____	
*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)			

Hutcheson Med POC

00189

MEMORIAL HOSPITAL
C/O NATIONWIDE RECOVERY SERVICE
P.O. BOX 8005
CLEVELAND, TN 37320-8005

March 16, 2015

Hutcheson Medical Center, Inc
100 Gross Crescent Cir.
Ft. Oglethorpe, GA 30742

FOR SERVICES RENDERED: B.J.G. \$1,701.70

Account reference or patient #: 3423

Date of last charge: 10-13-14

Date of last payment:

Account placed with NATIONWIDE RECOVERY SERVICE on: 03-13-15

(This collection agency is licensed by the Collection Service Board, State Department of
Commerce and Insurance, 500 James Robertson Parkway, 37243.)

BALANCE DUE: \$1,701.70

NATIONWIDE RECOVERY SVC. REF. #
3423
F5/L5 LSG

Northern District of Georgia Claims Register

[14-42863-pwb Hutcheson Medical Center, Inc.](#)

Judge: Paul W. Bonapfel **Chapter:** 11
Office: Rome **Last Date to file claims:** 05/01/2015
Trustee: **Last Date to file (Govt):**

Creditor: (18892325) Memorial Hospital c/o NRS P.O. Box 8005 Cleveland, TN 37320-8005	Claim No: 127 <i>Original Filed</i> Date: 03/16/2015 <i>Original Entered</i> Date: 03/16/2015	Status: Filed by: CR Entered by: Nationwide Recovery Service Modified:
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Amount claimed: \$1701.70				
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History:

Details	127-1	03/16/2015	Claim #127 filed by Memorial Hospital, Amount claimed: \$1701.70 (Nationwide Recovery Service)
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Description:

<i>Remarks:</i>		
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Claims Register Summary

Case Name: Hutcheson Medical Center, Inc.
Case Number: 14-42863-pwb
Chapter: 11
Date Filed: 11/20/2014
Total Number Of Claims: 1

Total Amount Claimed*	\$1701.70
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		