B 10 (Official Form 10) (04/10)

UNITED STATES BANKRUPTCY COURT Northern District of Georgia

PROOF OF CLAIM

Name of Debtor: Hutcheson Medical Center, Inc.

Case Number: 3:14-bk-42863

NOTE: *This form should not be used to make a claim for an administrative expense arising after the commencement of the case. A request for payment of an administrative expense may be filed pursuant to 11 U.S.C. § 503.*

Name of Creditor (the person or other entity to whom the debtor owes money or property): Staff Care, Inc.

Name and address where notices should be sent:
Barakat Alao
AMN Healthcare, Inc.
12400 High Bluff Drive., Suite 100, San Diego CA 92130

Telephone number: (858) 509-3592

☐ Check this box to indicate that this claim amends a previously filed claim.

Court Claim Number: _____ (If known)

Filed on: _____

FILED IN CLERK'S OFFICE U.S. BANKRUPTCY COURT NDGA, ATLANTA DIVISION 2015 APR 21 P 4:44 M. REGINA THOMAS DEPUTY CLERK

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

Telephone number:

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

☐ Check this box if you are the debtor or trustee in this case.

1. Amount of Claim as of Date Case Filed: $ 55,382.38

If all or part of your claim is secured, complete item 4 below; however, if all of your claim is unsecured, do not complete item 4.

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

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

2. Basis for Claim: Services Provided
(See instruction #2 on reverse side.)

3. Last four digits of any number by which creditor identifies debtor: 5181

3a. Debtor may have scheduled account as: _____
(See instruction #3a on reverse side.)

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

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

Value of Property: $_____ **Annual Interest Rate** _____%

Amount of arrearage and other charges as of time case filed included in secured claim, if any: $_____ **Basis for perfection:** _____

Amount of Secured Claim: $_____ **Amount Unsecured:** $_____

6. Credits: The amount of all payments on this claim has been credited for the purpose of making this proof of claim.

7. 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. You may also attach a summary. Attach redacted copies of documents providing evidence of perfection of a security interest. You may also attach a summary. (*See instruction 7 and definition of "redacted" on reverse side.*)

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

If the documents are not available, please explain:

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

Specify the priority of the claim.

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

☐ Wages, salaries, or commissions (up to $11,725*) earned within 180 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier – 11 U.S.C. §507 (a)(4).

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

☐ Up to $2,600* 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)(__).

Amount entitled to priority:

$_____

**Amounts are subject to adjustment on 4/1/13 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.*

Date: 4/17/15

Signature: The person filing this claim must sign it. Sign and print name and title, if any, of the creditor or other person authorized to file this claim and state address and telephone number if different from the notice address above. Attach copy of power of attorney, if any.

Tamara Swenson, Tamara Swenson, Snr. Corporate Counsel

FOR COURT USE ONLY

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.

Hutcheson Med POC
00293

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, there may be exceptions to these general rules.

Items to be completed in Proof of Claim form

Court, Name of Debtor, and Case Number:
Fill in the federal judicial district where the bankruptcy case was filed (for example, Central District of California), the bankruptcy debtor's name, and the bankruptcy case number. If the creditor received a notice of the case from the bankruptcy court, all of this information is located 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 the delivery of 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 the trustee or another party in interest files an objection to your 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:
Use this space to 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.

4. **Secured Claim:**
Check the appropriate box and provide the requested information if the claim is fully or partially secured. Skip this section if the claim is entirely unsecured. (See DEFINITIONS, below.) State the type and the value of property that secures the claim, attach copies of lien documentation, and state annual interest rate and the amount past due on the claim as of the date of the bankruptcy filing.

5. **Amount of Claim Entitled to Priority Under 11 U.S.C. §507(a).**
If any portion of your claim falls in one or more of the listed categories, check the appropriate box(es) and state the amount entitled to priority. (See DEFINITIONS, below.) 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 to this proof of claim form redacted copies documenting the existence of the debt and of any lien securing the debt. You may also attach a summary. You must also attach copies of documents that evidence perfection of any security interest. You may also attach a summary. FRBP 3001(c) and (d). If the claim is based on the delivery of health care goods or services, see instruction 2. Do not send original documents, as attachments may be destroyed after scanning.

Date and Signature:
The person filing 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. 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. Attach a complete copy of any power of attorney. Criminal penalties apply for making a false statement on a proof of claim.

DEFINITIONS

Debtor
A debtor is the person, corporation, or other entity that has filed a bankruptcy case.

Creditor
A creditor is a person, corporation, or other entity owed a debt by the debtor that arose on or before the date of the bankruptcy filing. See 11 U.S.C. §101 (10)

Claim
A claim is the creditor's right to receive payment on a debt owed by the debtor that arose on the date of the bankruptcy filing. See 11 U.S.C. §101 (5). A claim may be secured or unsecured.

Proof of Claim
A proof of claim is a form used by the creditor to indicate the amount of the debt owed by the debtor on the date of the bankruptcy filing. The creditor must file the form with the clerk of the same bankruptcy court in which the bankruptcy case was filed.

Secured Claim Under 11 U.S.C. §506(a)
A secured claim is one backed by a lien on property of the debtor. The claim is secured so long as the creditor has the right to be paid from the property prior to other creditors. The amount of the secured claim cannot exceed the value of the property. Any amount owed to the creditor in excess of the value of the property is an unsecured claim. Examples of liens on property include a mortgage on real estate or a security interest in a car.

A lien may be voluntarily granted by a debtor or may be obtained through a court proceeding. In some states, a court judgment is a lien. A claim also may be secured if the creditor owes the debtor money (has a right to setoff).

Unsecured Claim
An unsecured claim is one that does not meet the requirements of a secured claim. A claim may be partly unsecured if the amount of the claim exceeds the value of the property on which the creditor has a lien.

Claim Entitled to Priority Under 11 U.S.C. §507(a)
Priority claims are certain categories of unsecured claims that are paid from the available money or property in a bankruptcy case before other unsecured claims.

Redacted
A document has been redacted when the person filing it has masked, edited out, or otherwise deleted, certain information. A creditor should redact and use only the last four digits of any social-security, individual's tax-identification, or financial-account number, all but the initials of a minor's name and only the year of any person's date of birth.

Evidence of Perfection
Evidence of perfection may include a mortgage, lien, certificate of title, financing statement, or other document showing that the lien has been filed or recorded.

INFORMATION

Acknowledgment of Filing of Claim
To receive acknowledgment of your filing, you may either enclose a stamped self-addressed envelope and a copy of this proof of claim or you may access the court's PACER system (www.pacer.psc.uscourts.gov) for a small fee to view your filed proof of claim.

Offers to Purchase a Claim
Certain entities are in the business of purchasing claims for an amount less than the face value of the claims. One or more of these entities may contact the creditor and offer to purchase the claim. Some of the written communications from these entities may easily be confused with official court documentation or communications from the debtor. These entities do not represent the bankruptcy court or the debtor. The creditor has no obligation to sell its claim. However, if the creditor decides to sell its claim, any transfer of such claim is subject to FRBP 3001(e), any applicable provisions of the Bankruptcy Code (11 U.S.C. § 101 *et seq.*), and any applicable orders of the bankruptcy court.

HUTCHESON MEDICAL CENTER			
Customer Name	Document Date	Document Number	Current Amount
HUTCHESON MEDICAL CENTER	9/11/2014	2045181	$1,280.20
HUTCHESON MEDICAL CENTER	9/18/2014	2048914	$7,860.00
HUTCHESON MEDICAL CENTER	9/28/2014	2053399	$171.14
HUTCHESON MEDICAL CENTER	10/2/2014	2056223	$8,134.40
HUTCHESON MEDICAL CENTER	10/2/2014	2056224	$7,860.00
HUTCHESON MEDICAL CENTER	10/16/2014	2064550	$18,991.44
HUTCHESON MEDICAL CENTER	10/19/2014	2066243	$240.75
HUTCHESON MEDICAL CENTER	10/26/2014	2069390	$298.83
HUTCHESON MEDICAL CENTER	10/26/2014	2069391	$607.39
HUTCHESON MEDICAL CENTER	11/2/2014	2073574	$787.92
HUTCHESON MEDICAL CENTER	11/9/2014	2077564	$8,134.40
HUTCHESON MEDICAL CENTER	12/2/2014	2090045	$707.70
HUTCHESON MEDICAL CENTER	12/2/2014	2090046	$308.21
		Total Due	$55,382.38

STAFF CARE
an AMN Healthcare company

INVOICE

Please Remit To:

Staff Care, Inc.
PO Box 281923
Atlanta GA 30384-1923

Bill To:

HUTCHESON MEDICAL CENTER
Attn: Stacey Kaufmann
100 GROSS CRESCENT CIRCLE
FT. OGLETHORPE GA 30742

Page:	1
Invoice No:	2045181
Invoice Date:	09/11/2014
Client Bill To ID:	707545
Payment Terms:	Net 30
Due Date:	10/11/2014
Worksite:	7682- HUTCHESON MEDICAL CENTER
AMOUNT DUE:	**1,280.20**

PLEASE FAX CHANGES TO 866.698.4941

Your Client Accounting Representative, Torin Blackford
can be reached at 866.748.3285

Billing Period: 08/17/2014 - 08/30/2014

NAME	TYPE	DESCRIPTION								RATE	EXTENSION
		8/24	8/25	8/26	8/27	8/28	8/29	8/30	Total		
Ayanbadejo M.D.,Clement	ADFSC						1.00		1.00	40.00	40.00
	RTH						5.00		5.00	215.00	1,075.00
	MIL						295.00		295.00	0.56	165.20

SCI_STNDRD
Client ID: 7682

Original

TOTAL AMOUNT DUE : 1,280.20

<ADFSC>-Administration Fee <MIL>-Mileage <RTH>-Regular Time Hourly

STAFF CARE
an AMN Healthcare company

INVOICE

Please Remit To:

Staff Care, Inc.
PO Box 281923
Atlanta GA 30384-1923

Bill To:

HUTCHESON MEDICAL CENTER
Attn: Stacey Kaufmann
100 GROSS CRESCENT CIRCLE
FT. OGLETHORPE GA 30742

Page:	1
Invoice No:	2048914
Invoice Date:	09/18/2014
Client Bill To ID:	707545
Payment Terms:	Net 30
Due Date:	10/18/2014
Worksite:	7682- HUTCHESON MEDICAL CENTER
AMOUNT DUE:	**7,860.00**

PLEASE FAX CHANGES TO 866.698.4941

Your Client Accounting Representative, Torin Blackford can be reached at 866.748.3285

Billing Period: 08/31/2014 - 09/13/2014

NAME	TYPE	DESCRIPTION								RATE	EXTENSION
		9/7	9/8	9/9	9/10	9/11	9/12	9/13	Total		
Ayanbadejo M.D.,Clement	ADFSC				1.00	1.00		1.00	3.00	40.00	120.00
	RTH				12.00	12.00		12.00	36.00	215.00	7,740.00

SCI_STNDRD
Client ID: 7682

Original

TOTAL AMOUNT DUE : 7,860.00

<ADFSC>-Administration Fee <RTH>-Regular Time Hourly

STAFF CARE
an AMN Healthcare company

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Page:	1
Invoice No:	2053399
Invoice Date:	09/28/2014
Client Bill To ID:	707545
Payment Terms:	Net 30
Due Date:	10/28/2014
Worksite:	7682- HUTCHESON MEDICAL CENTER
AMOUNT DUE:	**171.14**

PLEASE FAX CHANGES TO 866.698.4941

Your Client Accounting Representative, Torin Blackford can be reached at 866.748.3285

Hotel or Lodging Dates of Stay: 08/30/14
Rental Car timeframe: 08/28/14

Billing Period: 08/17/2014 - 08/30/2014

NAME	TYPE	DESCRIPTION	RATE	EXTENSION
		8/24 8/25 8/26 8/27 8/28 8/29 8/30 Total		
Ayanbadejo M.D.,Clement	HTL-B	HOTEL (Internal Ref: RCT01104754-1)	127.80	127.80
Ayanbadejo M.D.,Clement	RCR-B	RENTAL CAR (Internal Ref: RCT01105177-1)	43.34	43.34

SCI_STNDRD
Client ID: 7682

Original

TOTAL AMOUNT DUE : **171.14**

<HTL-B>-Hotel Expense <RCR-B>-Rental Car Expense

STAFF CARE
an AMN Healthcare company

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Staff Care, Inc.
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Atlanta GA 30384-1923

Bill To:
HUTCHESON MEDICAL CENTER
Attn: Stacey Kaufmann
100 GROSS CRESCENT CIRCLE
FT. OGLETHORPE GA 30742

Page:	1
Invoice No:	2056223
Invoice Date:	10/02/2014
Client Bill To ID:	707545
Payment Terms:	Net 30
Due Date:	11/01/2014
Worksite:	7682- HUTCHESON MEDICAL CENTER
AMOUNT DUE:	**8,134.40**

PLEASE FAX CHANGES TO 866.698.4941

Your Client Accounting Representative, Torin Blackford can be reached at 866.748.3285

Billing Period: 09/14/2014 - 09/27/2014

NAME	TYPE	DESCRIPTION								RATE	EXTENSION
		9/21	9/22	9/23	9/24	9/25	9/26	9/27	Total		
Patel M.D.,Niki	ADFSC			1.00	1.00	1.00			3.00	40.00	120.00
	RTH			12.00	12.00	12.00			36.00	215.00	7,740.00
	MIL			235.00	20.00	235.00			490.00	0.56	274.40

SCI_STNDRD
Client ID: 7682

Original

TOTAL AMOUNT DUE : **8,134.40**

<ADFSC>-Administration Fee <MIL>-Mileage <RTH>-Regular Time Hourly

STAFF CARE
an AMN Healthcare company

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Page:	1
Invoice No:	2056224
Invoice Date:	10/02/2014
Client Bill To ID:	707545
Payment Terms:	Net 30
Due Date:	11/01/2014
Worksite:	7682- HUTCHESON MEDICAL CENTER
AMOUNT DUE:	**7,860.00**

PLEASE FAX CHANGES TO 866.698.4941

Your Client Accounting Representative, Torin Blackford can be reached at 866.748.3285

Billing Period: 09/14/2014 - 09/27/2014

NAME	TYPE	DESCRIPTION								RATE	EXTENSION
		9/14	9/15	9/16	9/17	9/18	9/19	9/20	Total		
Ayanbadejo M.D.,Clement	ADFSC	1.00	1.00	1.00					3.00	40.00	120.00
	RTH	12.00	12.00	12.00					36.00	215.00	7,740.00

SCI_STNDRD
Client ID: 7682

Original

TOTAL AMOUNT DUE : 7,860.00

<ADFSC>-Administration Fee <RTH>-Regular Time Hourly

STAFF CARE
an AMN Healthcare company

INVOICE

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Staff Care, Inc.
PO Box 281923
Atlanta GA 30384-1923

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HUTCHESON MEDICAL CENTER
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FT. OGLETHORPE GA 30742

Page:	1
Invoice No:	2064550
Invoice Date:	10/16/2014
Client Bill To ID:	707545
Payment Terms:	Net 30
Due Date:	11/15/2014
Worksite:	7682- HUTCHESON MEDICAL CENTER
AMOUNT DUE:	**18,991.44**

PLEASE FAX CHANGES TO 866.365.8927

Your Client Accounting Representative, Jason Ancheta
can be reached at 866.960.5359

Billing Period: 09/28/2014 - 10/11/2014

NAME	TYPE	9/28	9/29	9/30	10/1	10/2	10/3	10/4	Total	RATE	EXTENSION
Banegura M.D.,Glenn	ADFSC			1.00	1.00	1.00	1.00	1.00	5.00	40.00	200.00
	RTH			2.00	12.00	12.00	12.00	12.00	50.00	215.00	10,750.00
	MIL			126.00	12.00	12.00	12.00	12.00	174.00	0.56	97.44

NAME	TYPE	10/5	10/6	10/7	10/8	10/9	10/10	10/11	Total	RATE	EXTENSION
Banegura M.D.,Glenn	ADFSC	1.00	1.00	1.00					3.00	40.00	120.00
	RTH	12.00	12.00	12.00					36.00	215.00	7,740.00
	MIL	12.00	12.00	126.00					150.00	0.56	84.00

SCI_STNDRD
Client ID: 7682

Original

TOTAL AMOUNT DUE : **18,991.44**

<ADFSC>-Administration Fee <MIL>-Mileage <RTH>-Regular Time Hourly

STAFF CARE
an AMN Healthcare company

INVOICE

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Staff Care, Inc.
PO Box 281923
Atlanta GA 30384-1923

Bill To:
HUTCHESON MEDICAL CENTER
Attn: Stacey Kaufmann
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FT. OGLETHORPE GA 30742

Page:	1
Invoice No:	2066243
Invoice Date:	10/19/2014
Client Bill To ID:	707545
Payment Terms:	Net 30
Due Date:	11/18/2014
Worksite:	7682- HUTCHESON MEDICAL CENTER
AMOUNT DUE:	**240.75**

PLEASE FAX CHANGES TO 866.365.8927

Your Client Accounting Representative, Jason Ancheta
can be reached at 866.960.5359

Rental Car timeframe: 09/10/14 - 09/17/14

Billing Period: 08/31/2014 - 09/13/2014

NAME	TYPE	DESCRIPTION	RATE	EXTENSION
		9/7 9/8 9/9 9/10 9/11 9/12 9/13 Total		
Ayanbadejo M.D.,Clement	RCR-B	RENTAL CAR (Internal Ref: RCT01120762-1)	240.75	240.75

SCI_STNDRD
Client ID: 7682

Original

TOTAL AMOUNT DUE : 240.75

<RCR-B>-Rental Car Expense

STAFF CARE
an AMN Healthcare company

INVOICE

Please Remit To:
Staff Care, Inc.
PO Box 281923
Atlanta GA 30384-1923

Bill To:
HUTCHESON MEDICAL CENTER
Attn: Stacey Kaufmann
100 GROSS CRESCENT CIRCLE
FT. OGLETHORPE GA 30742

Page:	1
Invoice No:	2069390
Invoice Date:	10/26/2014
Client Bill To ID:	707545
Payment Terms:	Net 30
Due Date:	11/25/2014
Worksite:	7682- HUTCHESON MEDICAL CENTER
AMOUNT DUE:	**298.83**

PLEASE FAX CHANGES TO 866.365.8927

Your Client Accounting Representative, Jason Ancheta can be reached at 866.960.5359

Hotel or Lodging Dates of Stay: 09/23/14 - 09/25/14

Billing Period: 09/14/2014 - 09/27/2014

NAME	TYPE	DESCRIPTION	RATE	EXTENSION
		9/21 9/22 9/23 9/24 9/25 9/26 9/27 Total		
Patel M.D.,Niki	HTL-B	HOTEL (Internal Ref: RCT01126298-1)	298.83	298.83

SCI_STNDRD
Client ID: 7682

Original

TOTAL AMOUNT DUE : 298.83

<HTL-B>-Hotel Expense

STAFF CARE
an AMN Healthcare company

INVOICE

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Staff Care, Inc.
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Atlanta GA 30384-1923

Bill To:

HUTCHESON MEDICAL CENTER
Attn: Stacey Kaufmann
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FT. OGLETHORPE GA 30742

Page:	1
Invoice No:	2069391
Invoice Date:	10/26/2014
Client Bill To ID:	707545
Payment Terms:	Net 30
Due Date:	11/25/2014
Worksite:	7682- HUTCHESON MEDICAL CENTER
AMOUNT DUE:	**607.39**

PLEASE FAX CHANGES TO 866.365.8927

Your Client Accounting Representative, Jason Ancheta can be reached at 866.960.5359

Hotel or Lodging Dates of Stay: 09/10/14 - 09/16/14

Billing Period: 08/31/2014 - 09/13/2014

NAME	TYPE	DESCRIPTION	RATE	EXTENSION
		9/7 9/8 9/9 9/10 9/11 9/12 9/13 Total		
Ayanbadejo M.D.,Clement	HTL-B	HOTEL (Internal Ref: RCT01124247-1)	607.39	607.39

SCI_STNDRD Original
Client ID: 7682

TOTAL AMOUNT DUE : 607.39

<HTL-B>-Hotel Expense

STAFF CARE
an AMN Healthcare company

INVOICE

Please Remit To:
Staff Care, Inc.
PO Box 281923
Atlanta GA 30384-1923

Bill To:
HUTCHESON MEDICAL CENTER
Attn: Stacey Kaufmann
100 GROSS CRESCENT CIRCLE
FT. OGLETHORPE GA 30742

Page:	1
Invoice No:	2073574
Invoice Date:	11/02/2014
Client Bill To ID:	707545
Payment Terms:	Net 30
Due Date:	12/02/2014
Worksite:	7682- HUTCHESON MEDICAL CENTER
AMOUNT DUE:	**787.92**

PLEASE FAX CHANGES TO 866.365.8927

Your Client Accounting Representative, Jason Ancheta can be reached at 866.960.5359

Hotel or Lodging Dates of Stay: 09/30/14 - 10/07/14

Billing Period: 09/28/2014 - 10/11/2014

NAME	TYPE	DESCRIPTION	RATE	EXTENSION
		9/28 9/29 9/30 10/1 10/2 10/3 10/4 Total		
Banegura M.D.,Glenn	HTL-B	HOTEL (Internal Ref: RCT01130390-1)	787.92	787.92

SCI_STNDRD
Client ID: 7682

Original

TOTAL AMOUNT DUE : 787.92

<HTL-B>-Hotel Expense

STAFF CARE
an AMN Healthcare company

INVOICE

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Staff Care, Inc.
PO Box 281923
Atlanta GA 30384-1923

Bill To:

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Page:	1
Invoice No:	2077564
Invoice Date:	11/09/2014
Client Bill To ID:	707545
Payment Terms:	Net 30
Due Date:	12/09/2014
Worksite:	7682- HUTCHESON MEDICAL CENTER
AMOUNT DUE:	**8,134.40**

PLEASE FAX CHANGES TO 866.365.8927

Your Client Accounting Representative, Jason Ancheta
can be reached at 866.960.5359

Billing Period: 10/12/2014 - 10/25/2014

NAME	TYPE	DESCRIPTION								RATE	EXTENSION
		10/19	10/20	10/21	10/22	10/23	10/24	10/25	Total		
Patel M.D.,Niki	ADFSC				1.00	1.00	1.00		3.00	40.00	120.00
	RTH				12.00	12.00	12.00		36.00	215.00	7,740.00
	MIL				225.00	20.00	20.00	225.00	490.00	0.56	274.40

SCI_STNDRD Original

Client ID: 7682 TOTAL AMOUNT DUE : 8,134.40

<ADFSC>-Administration Fee <MIL>-Mileage <RTH>-Regular Time Hourly

STAFF CARE
an AMN Healthcare company

INVOICE

Please Remit To:

Staff Care, Inc.
PO Box 281923
Atlanta GA 30384-1923

Bill To:

HUTCHESON MEDICAL CENTER
Attn: Stacey Kaufmann
100 GROSS CRESCENT CIRCLE
FT. OGLETHORPE GA 30742

Page:	1
Invoice No:	2090045
Invoice Date:	12/02/2014
Client Bill To ID:	707545
Payment Terms:	Net 30
Due Date:	01/01/2015
Worksite:	7682- HUTCHESON MEDICAL CENTER
AMOUNT DUE:	**707.70**

PLEASE FAX CHANGES TO 866.365.8927

Your Client Accounting Representative, Jason Ancheta
can be reached at 866.960.5359

Billing Period: 11/09/2014 - 11/22/2014

NAME	TYPE	DESCRIPTION	RATE	EXTENSION
		11/9 11/10 11/11 11/12 11/13 11/14 11/15 Total		
Habib M.D.,Adnan	FLT-B	FLIGHT (INTERNAL REF: RCT01144991-1)	707.70	707.70

SCI_STNDRD
Client ID: 7682

Original

TOTAL AMOUNT DUE : **707.70**

<FLT-B>-Flight Expense

STAFF CARE
an AMN Healthcare company

INVOICE

Please Remit To:
Staff Care, Inc.
PO Box 281923
Atlanta GA 30384-1923

Bill To:
HUTCHESON MEDICAL CENTER
Attn: Stacey Kaufmann
100 GROSS CRESCENT CIRCLE
FT. OGLETHORPE GA 30742

Page:	1
Invoice No:	2090046
Invoice Date:	12/02/2014
Client Bill To ID:	707545
Payment Terms:	Net 30
Due Date:	01/01/2015
Worksite:	7682- HUTCHESON MEDICAL CENTER
AMOUNT DUE:	**308.21**

PLEASE FAX CHANGES TO 866.365.8927

Your Client Accounting Representative, Jason Ancheta can be reached at 866.960.5359

Hotel or Lodging Dates of Stay: 10/22/14 - 10/24/14

Billing Period: 10/12/2014 - 10/25/2014

NAME	TYPE	DESCRIPTION	RATE	EXTENSION
		10/19 10/20 10/21 10/22 10/23 10/24 10/25 Total		
Patel M.D.,Niki	HTL-B	HOTEL (Internal Ref: RCT01146305-1)	308.21	308.21

SCI_STNDRD
Client ID: 7682

Original

TOTAL AMOUNT DUE : 308.21

<HTL-B>-Hotel Expense

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: (18980057) Staff Care Inc Barakat Alao AMN Healthcare Inc 12400 High Bluff Dr., Ste 100 San Diego CA 92130	**Claim No: 157** *Original Filed Date*: 04/21/2015 *Original Entered Date*: 04/21/2015	*Status:* *Filed by:* CR *Entered by:* mrr *Modified:*

Amount claimed: $55382.38

History:

Details	157-1	04/21/2015	Claim #157 filed by Staff Care Inc, Amount claimed: $55382.38 (mrr)

Description:
Remarks:

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*	$55382.38
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		
Administrative		