

Fill in this information to identify the case:

Debtor 1  HUTCHESON MEDICAL CTR.

Debtor 2
(Spouse, if filing) _____

United States Bankruptcy Court for the: _____ District of _____

Case number  14-42863

Official Form 410
Proof of Claim

12/15

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? DIANA Lynn Pearson
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?	Where should payments to the creditor be sent? (if different)
Name <u>DIANA Lynn Pearson</u>	Name _____
Number Street <u>15 Old Longfellow Rd</u>	Number Street _____
City State ZIP Code <u>Chickamauga GA 30707</u>	City State ZIP Code _____
Contact phone <u>706-866-2801-Home</u> <u>423-260-3627-cell</u>	Contact phone _____
Contact email <u>DLPearson@aol.com</u>	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? \$ 5,593.85 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.
I would like my PTO and sick time that I did not use

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)? No Yes. Check all that apply:

A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<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 checked="" type="checkbox"/> Wages, salaries, or commissions (up to \$12,475* 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).	\$ <u>5,593.85</u>
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/01/16 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 12 28 2015
MM / DD / YYYY

Diana Lynn Peardon
Signature

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

Name DIANA Lynn Peardon
First name Middle name Last name

Title _____

Company _____

Identify the corporate servicer as the company if the authorized agent is a servicer.

Address 15 Old Longhollow Rd

Number Street

Chickamauga La. 30707
City State ZIP Code

Contact phone 706 866 2804 - Home DLPeardon@aol.com
423-200-3627 - cell Email

State of Georgia
Department of Labor
Separation Notice

1. Employee's

Name Diana L. Peardon

2. SSN ~~000~~ - ~~000~~ - 3 6 0 8

a. State any other name(s) under which employee worked: _____

3. Period of Last Employment: From 07/06/1992 To 12/04/2015

4. REASON FOR SEPARATION: a. LACK OF WORK
 b. If other than lack of work, state fully and clearly the circumstances of the separation. Type Below.

Lay off - reduction in force

5. Employee received payment for: (Severance Pay, Separation Pay, Wages-In-Lieu of Notice, bonus, profit sharing, etc.) DO NOT include vacation pay or earned wages.

type of payment _____ in the amount of \$ _____ for period from: _____ to _____

Date above payment(s) was/will be issued to employee: _____

IF EMPLOYEE RETIRED, furnish amount of retirement pay and what percentage of contributions were paid by the employer.

\$ _____ per month _____ % of contributions paid by employer.

6. Did this employee earn at least \$3,500.00 in your employ? YES NO If NO, how much? \$ _____

Average Weekly Wage: \$ 429.12

Employer's Name Hutcheson Medical Center

Address 100 Gross Crescent Circle

City Fort Oglethorpe State GA Zip Code 3 0 7 4 2

Employer's Telephone No. (7 0 6) 8 5 8 - 2 1 4 1 Ext. _____

Ga. DOL Account Number 1 0 2 1 8 9 - 0 8

(Number shown on Employer's Quarterly Tax and Wage Report, Form DOL-4.)

I CERTIFY that the above worker has been separated from work and the information furnished hereon is true and correct. This report has been handed to or mailed to the worker.

[Signature]
Signature of Official, Employee of the Employer or authorized agent for the employer

Manager Human Resources

Title of Person Signing

12/04/2015
Date Completed and Released to Employee

NOTICE TO EMPLOYER

At the time of separation, you are required by the Employment Security Law, OCGA Section 34-8-190(c), to provide the employee with this document, properly executed, giving the reasons for separation. If you subsequently receive a request for the same information on a DOL-1199FF, you may attach a copy of this form (DOL-800) as a part of your response.

NOTICE TO EMPLOYEE

OCGA SECTION 34-8-190(c) OF THE EMPLOYMENT SECURITY LAW REQUIRES THAT YOU TAKE THIS NOTICE TO THE GEORGIA DEPARTMENT OF LABOR FIELD SERVICE OFFICE IF YOU FILE A CLAIM FOR UNEMPLOYMENT INSURANCE BENEFITS.

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: Ronald L. Glass

Last Date to file (Govt):

Creditor: (19576762)
Diana Lynn Peardon
15 Old Longhollow Rd.
Chickamauga GA 30707

Claim No: 186
Original Filed
Date: 12/31/2015
Original Entered
Date: 12/31/2015

Status:
Filed by: CR
Entered by: rhg
Modified:

Amount claimed: \$5593.85

Priority claimed: \$5593.85

History:

[Details](#) [186-](#) 12/31/2015
[1](#)

Claim #186 filed by Diana Lynn Peardon, Amount claimed: \$5593.85 (rhg)

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*	\$5593.85
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	\$5593.85	
Administrative		