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UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF CALIFORNIA

In re BORREGO COMMUNITY HEALTH FOUNDATION, Debtor and Debtor in Possession.	Case No. 22-02384-11 Chapter 11 Case Judge: Honorable Laura S. Taylor **STIPULATION BY AND AMONG THE POST-EFFECTIVE DATE DEBTOR, THE LIQUIDATING TRUSTEE, THE CO-LIQUIDATING TRUSTEES, AND YONG HEE LEE DDS INC. REGARDING CLAIM NOS. 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, and 304**

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Borrego Community Health Foundation, the debtor and debtor in possession (prior to the effective date of the Plan (defined below), the "Debtor," and after the effective date, the "Post-Effective Date Debtor") in the above-captioned chapter 11 bankruptcy case, the Liquidating Trustee (the "Liquidating Trustee") of the Borrego Community Health Foundation Liquidating Trust (the "Liquidating Trust"), the Co-Liquidating Trustees of the Liquidating Trust (the "Co-Liquidating Trustees"), and Yong Hee Lee DDS Inc. (the "Claimant", and together with the Post-Effective Date Debtor, the Liquidating Trustee, and the Co-Liquidating Trustees, the "Parties") hereby enter into this *Stipulation By and Among the Post-Effective Date Debtor, the Liquidating Trustee, the Co-Liquidating Trustees, and Yong Hee Lee DDS Inc. Regarding Claim Nos. 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, and 304*.

RECITALS

WHEREAS, on September 12, 2022, the Debtor filed a voluntary petition for relief under chapter 11 of title 11 of the United States Code commencing Case No. 22-02384 (the "Chapter 11 Case") in the United States Bankruptcy Court for the Southern District of California;

WHEREAS, on September 13, 2022, the Bankruptcy Court established November 21, 2022 as the deadline by which parties holding prepetition claims against the Debtor must file proofs of claim (the "Claims Bar Date") [*See* Docket No. 16].

WHEREAS, after the Claims Bar Date, Claimant filed claim numbers 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, and 304 (collectively, the "Claims") as follows:

Claim No.	Date Filed	Filed Amount
248	4/1/2024	$ 5.00
249	4/1/2024	$ 150.00
250	4/3/2024	$ 1,600.00
251	4/2/2024	$ 1,500.00
252	4/2/2024	$ 1,505.00
253	4/2/2024	$ 1,750.00
254	4/2/2024	$ 305.00
255	4/2/2024	$ 480.00
256	4/2/2024	$ 305.00
257	4/2/2024	$ 1,500.00
258	4/2/2024	$ 255.00
259	4/2/2024	$ 10.00
260	4/2/2024	$ 1,270.00
261	4/2/2024	$ 5.00
262	4/2/2024	$ 505.00
263	4/2/2024	$ 1,500.00
264	4/2/2024	$ 560.00
265	4/3/2024	$ 100.00
266	4/3/2024	$ 300.00
267	4/3/2024	$ 255.00
268	4/3/2024	$ 3,205.00
269	4/3/2024	$ 305.00
270	4/3/2024	$ 100.00
271	4/3/2024	$ 505.00
272	4/3/2024	$ 585.00
273	4/3/2024	$ 5.00
274	4/3/2024	$ 100.00
275	4/3/2024	$ 800.00
276	4/3/2024	$ 600.00
277	4/4/2024	$ 10.00
278	4/4/2024	$ 150.00
279	4/4/2024	$ 255.00
280	4/4/2024	$ 305.00
281	4/5/2024	$ 255.00
282	4/5/2024	$ 1,955.00
283	4/5/2024	$ 3,000.00
284	4/5/2024	$ 305.00

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285	4/5/2024	$ 145.00
286	4/5/2024	$ 3,010.00
287	4/5/2024	$ 505.00
288	4/5/2024	$ 1,655.00
289	4/5/2024	$ 255.00
290	4/5/2024	$ 230.00
291	4/5/2024	$ 415.00
292	4/5/2024	$ 255.00
293	4/5/2024	$ 1,950.00
294	4/5/2024	$ 455.00
295	4/5/2024	$ 15.00
296	4/5/2024	$ 4,500.00
297	4/5/2024	$ 1,250.00
298	4/5/2024	$ 3,100.00
299	4/5/2024	$ 305.00
300	4/5/2024	$ 305.00
301	4/5/2024	$ 3,300.00
302	4/5/2024	$ 1,015.00
303	4/15/2024	$ 3,000.00
304	4/15/2024	$ 5.00
Total Amount of Filed Claims		**$ 51,970.00**

Copies of the Claims are attached hereto as **Exhibits 1-57**, respectively.

WHEREAS, the Liquidating Trust was established pursuant to the *First Amended Joint Combined Disclosure Statement and Chapter 11 Plan of Liquidation of Borrego Community Health Foundation* [Docket No. 1168] (the "Plan"), confirmed by the order [Docket No. 1273] entered January 25, 2024 (the "Confirmation Order"), and that certain *Liquidating Trust Agreement*, dated as of February 14, 2024 (the "Liquidating Trust Agreement");

WHEREAS, the Co-Liquidating Trustees have reviewed the Debtor's books and records and have reconciled the Claims to the aggregate amount of $36,290.00 (the "Reconciled Claim Amount").

WHEREAS, Claimant and the Co-Liquidating Trustees are in dispute over the Claims, both as to the validity of the Reconciled Claim Amount and whether Claimant has sufficient evidence of excusable neglect to avoid having the Claims disallowed as late filed.

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WHEREAS, the Parties have agreed to resolve their dispute regarding the Claims as set forth herein.

STIPULATION

NOW THEREFORE, subject to the approval of the Court, the Parties hereby agree and stipulate as follows:

1. Claim 248 shall be disallowed and expunged from the claims register maintained by the claims agent.

2. Claim 249 shall be disallowed and expunged from the claims register maintained by the claims agent.

3. Claim 250 shall be disallowed and expunged from the claims register maintained by the claims agent.

4. Claim 251 shall be disallowed and expunged from the claims register maintained by the claims agent.

5. Claim 252 shall be disallowed and expunged from the claims register maintained by the claims agent.

6. Claim 253 shall be disallowed and expunged from the claims register maintained by the claims agent.

7. Claim 254 shall be disallowed and expunged from the claims register maintained by the claims agent.

8. Claim 255 shall be disallowed and expunged from the claims register maintained by the claims agent.

9. Claim 256 shall be disallowed and expunged from the claims register maintained by the claims agent.

10. Claim 257 shall be disallowed and expunged from the claims register maintained by the claims agent.

11. Claim 258 shall be disallowed and expunged from the claims register maintained by the claims agent.

12. Claim 259 shall be disallowed and expunged from the claims register

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maintained by the claims agent.

13. Claim 260 shall be disallowed and expunged from the claims register maintained by the claims agent.

14. Claim 261 shall be disallowed and expunged from the claims register maintained by the claims agent.

15. Claim 262 shall be disallowed and expunged from the claims register maintained by the claims agent.

16. Claim 263 shall be disallowed and expunged from the claims register maintained by the claims agent.

17. Claim 264 shall be disallowed and expunged from the claims register maintained by the claims agent.

18. Claim 265 shall be disallowed and expunged from the claims register maintained by the claims agent.

19. Claim 266 shall be disallowed and expunged from the claims register maintained by the claims agent.

20. Claim 267 shall be disallowed and expunged from the claims register maintained by the claims agent.

21. Claim 268 shall be disallowed and expunged from the claims register maintained by the claims agent.

22. Claim 269 shall be disallowed and expunged from the claims register maintained by the claims agent.

23. Claim 270 shall be disallowed and expunged from the claims register maintained by the claims agent.

24. Claim 271 shall be disallowed and expunged from the claims register maintained by the claims agent.

25. Claim 272 shall be disallowed and expunged from the claims register maintained by the claims agent.

26. Claim 273 shall be disallowed and expunged from the claims register

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maintained by the claims agent.

27. Claim 274 shall be disallowed and expunged from the claims register maintained by the claims agent.

28. Claim 275 shall be disallowed and expunged from the claims register maintained by the claims agent.

29. Claim 276 shall be disallowed and expunged from the claims register maintained by the claims agent.

30. Claim 277 shall be disallowed and expunged from the claims register maintained by the claims agent.

31. Claim 278 shall be disallowed and expunged from the claims register maintained by the claims agent.

32. Claim 279 shall be disallowed and expunged from the claims register maintained by the claims agent.

33. Claim 280 shall be disallowed and expunged from the claims register maintained by the claims agent.

34. Claim 281 shall be disallowed and expunged from the claims register maintained by the claims agent.

35. Claim 282 shall be disallowed and expunged from the claims register maintained by the claims agent.

36. Claim 283 shall be disallowed and expunged from the claims register maintained by the claims agent.

37. Claim 284 shall be disallowed and expunged from the claims register maintained by the claims agent.

38. Claim 285 shall be disallowed and expunged from the claims register maintained by the claims agent.

39. Claim 286 shall be disallowed and expunged from the claims register maintained by the claims agent.

40. Claim 287 shall be disallowed and expunged from the claims register

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maintained by the claims agent.

41. Claim 288 shall be disallowed and expunged from the claims register maintained by the claims agent.

42. Claim 289 shall be disallowed and expunged from the claims register maintained by the claims agent.

43. Claim 290 shall be disallowed and expunged from the claims register maintained by the claims agent.

44. Claim 291 shall be disallowed and expunged from the claims register maintained by the claims agent.

45. Claim 292 shall be disallowed and expunged from the claims register maintained by the claims agent.

46. Claim 293 shall be disallowed and expunged from the claims register maintained by the claims agent.

47. Claim 294 shall be disallowed and expunged from the claims register maintained by the claims agent.

48. Claim 295 shall be disallowed and expunged from the claims register maintained by the claims agent.

49. Claim 296 shall be disallowed and expunged from the claims register maintained by the claims agent.

50. Claim 297 shall be disallowed and expunged from the claims register maintained by the claims agent.

51. Claim 298 shall be disallowed and expunged from the claims register maintained by the claims agent.

52. Claim 299 shall be disallowed and expunged from the claims register maintained by the claims agent.

53. Claim 300 shall be disallowed and expunged from the claims register maintained by the claims agent.

54. Claim 301 shall be disallowed and expunged from the claims register

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maintained by the claims agent.

55. Claim 302 shall be disallowed and expunged from the claims register maintained by the claims agent.

56. Claim 303 shall be disallowed and expunged from the claims register maintained by the claims agent.

57. Claim 304 shall be allowed as a general unsecured claim in the amount of $27,217.50. (the "Allowed Claim Amount").

58. The Claimant shall not file any additional proofs of claim, nor will the Claimant amend (or seek to amend) the Claims.

59. Within thirty (30) days of entry of the order approving this Stipulation, and after Claimant has provided a completed W-9 to the Co-Liquidating Trustees, the Liquidating Trust shall pay the Allowed Claim Amount to Claimant pursuant to the Plan.

60. In consideration of the agreements with and value provided herein and other good and valuable consideration, the Parties hereby waive, remise, release and forever discharge the other, including each of their respective former and current predecessors, successors, assigns, subsidiaries, parent companies, shareholders, partners, members, managers, investors directors, officers, accountants, attorneys, employees, agents, representatives and servants of, from and against any and all claims, actions, causes of action, suits, proceedings, defenses, counterclaims, contracts, judgments, damages, accounts, reckonings, executions, and liabilities whatsoever of every name and nature, whether known or unknown, whether or not well-founded in fact or in law, and whether in law, at equity or otherwise, which either Party ever had or now has for or by reason of any matter, cause or anything whatsoever to this date, relating to or arising out of the Chapter 11 Case.

61. Each of the Parties to the Stipulation acknowledge that they are familiar with California Civil Code Section 1542 and with respect to the matters

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released herein, each Party expressly waives any and all rights under California Civil Code Section 1542 and under any other federal or state statute or law of similar effect. California Civil Code Section 1542 provides:

> A general release does not extend to claims that the creditor or releasing party does not know or suspect to exist in his or her favor at the time of executing the release and that, if known by him or her, would have materially affected his or her settlement with the debtor or released party.

62. The Claimant hereby warrant that the Claimant (a) is authorized and empowered to execute this Stipulation on behalf of the Claimant, (b) has read this Stipulation in its entirety and fully understand and accept the terms set forth herein, (c) has had an opportunity to consult with legal counsel and any other advisors of the Claimant's choice with respect to the terms of this Stipulation, and (d) are signing this Stipulation on the Claimant's own free will.

63. The terms, covenants, conditions, and provisions of this Stipulation cannot be altered, changed, modified, or added to, or deleted from, except in a writing signed by all parties hereto.

64. This Stipulation may be executed in counterparts each of which shall be deemed an original, but all of which together shall constitute one and the same.

65. The Court shall retain jurisdiction over all matters relating to the interpretation and enforcement of this Stipulation.

Dated: May 7, 2025

DENTONS US LLP
SAMUEL R. MAIZEL
TANIA M. MOYRON

By */s/ Tania M. Moyron*
Tania M. Moyron
Attorneys for the Post-Effective Date Debtor and the Co-Liquidating Trustee

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Dated: May 7, 2025

PACHULSKI STANG ZIEHL & JONES LLP
Jeffrey N. Pomerantz
Steven W. Golden

By */s/ Steven W. Golden*
Steven W. Golden
Attorneys for the Co-Liquidating Trustee

Dated: April 28, 2025

YONG HEE LEE DDS INC.

By: _____
Its: owner

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(213) 623-9300

EXHIBIT 1

Claim #248 Date Filed: 4/1/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Uma Hee Lee DDS Inc.
   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)

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   APR 01 2024
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   Where should notices to the creditor be sent?
   Uma Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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?

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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: 9868 TID#

7. **How much is the claim?**
   $ 5.00 . **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.
   Dental

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 amount should match the amount in line 7.)

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   APR 01 2024
   KURTZMAN CARSON CONSULTANTS

   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.

- [x] No
- [ ] Yes. *Check all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
  - [ ] 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

- [x] No
- [ ] Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

  $_____

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:

- [x] 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 acknowledgement 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 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 03/28/2024 (MM / DD / YYYY)

Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4366 Email Lee office manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1 Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☒ EPSDT / Title XIX

2 Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3 Company/Plan Name, Address, City, State, Zip Code

Borrego Health claims Processing Center
C/O KCC
222 N. Pacific Coast Hwy Ste 300
El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5–11. If none, leave blank.)

4 Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5 Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6 Date of Birth (MM/DD/CCYY)	7 Gender ☐ M ☐ F	8 Policyholder/Subscriber ID (SSN or ID#)
9 Plan/Group Number	10 Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11 Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24 Procedure Date (MM/DD/CCYY)	25 Area of Oral Cavity	26 Tooth System	27 Tooth Number(s) or Letter(s)	28 Tooth Surface	29 Procedure Code	29a Diag. Pointer	29b Qty.	30 Description	31 Fee
1	11/06/2020		JP			D1999		1	Personal Protective Equipment	5.00
2										
3										
4										
5										
6										
7										
8										
9										
10										

32 Missing Teeth Information (Place an "X" on each missing tooth.)

1 X 3 4 5 6 7 8 9 10 11 12 13 14 15 16X

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17X

33 Diagnosis Code List Qualifier ☐☐ (ICD-9 = B, ICD-10 = AB)

34a Diagnosis Code(s) (Primary diagnosis in "A") A ____ C ____ B ____ D ____

34a Other Fee(s)

32 Total Fee 5.00

35 Remarks

AUTHORIZATIONS

36 I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37 I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38 Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39 Enclosures (Y or N) ☐

40 Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41 Date Appliance Placed (MM/DD/CCYY)

42 Months of Treatment Remaining

43 Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44 Date of Prior Placement (MM/DD/CCYY)

45 Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46 Date of Accident (MM/DD/CCYY)

47 Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48 Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49 NPI	50 License Number	51 SSN or TIN
1760858153	64834	822169868

52 Phone Number (760) 243-4366 | 52a Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53 I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54 NPI	55 License Number
1760858153	64834

56 Address, City, State, Zip Code
12611 Hesperia Rd.
Victorville CA 923958307

56a Provider Specialty Code 1223G0001X

57 Phone Number (760) 243-4366 | 58 Additional Provider ID

EXHIBIT 2

Claim #249 Date Filed: 4/1/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:	
Debtor	Borrego Community Health Foundation
United States Bankruptcy Court for the Southern District of California	
Case number	22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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? _____

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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: 9868 TIDH

7. **How much is the claim?**
   $ 150.00 . **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.
   Dental

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 amount should match the amount in line 7.)

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   KURTZMAN CARSON CONSULTANTS

   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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024 (MM / DD / YYYY)

Signature

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

Name: Yung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4366 Email lee office manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☒ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
C/o KPC
222 N. Pacific Coast Hwy Ste 300
El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/06/2020		JP			D0150		1	comprehensive oral evaluation - new	150.00
2										
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
X	X														X
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ C ____ B ____ D ____

31a. Other Fee(s)

32. Total Fee 150.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — Patient/Guardian Signature — 03/29/2024 — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — Subscriber Signature — 03/29/2024 — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153

50. License Number 64834

51. SSN or TIN 822169868

52. Phone Number (760) 243 - 4366

52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee — Signed (Treating Dentist) — 03/29/2024 — Date

54. NPI 1760858153

55. License Number 64834

56. Address, City, State, Zip Code
12611 Hesperia Rd.
Victorville CA 923958307

56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243 - 4366

58. Additional Provider ID

EXHIBIT 3

Claim #250 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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? _____

22023842404030000000000042

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: 9868 TIDH

7. **How much is the claim?**
   $ 1600.00 **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.
   Dental

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.)

   RECEIVED
   APR 03 2024
   KURTZMAN CARSON CONSULTANTS

   Value of property: $_____
   Amount of the claim that is secured: $_____
   Amount of the claim that is unsecured: $_____ (The sum of the secured and unsecured amount 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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

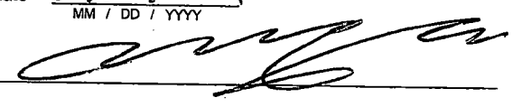
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2024
MM / DD / YYYY



Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee office manager@gmail.com

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APR 03 2024
KURTZMAN CARSON CONSULTANTS

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - ☐ Statement of Actual Services
   - ☐ Request for Predetermination/Preauthorization
   - ☐ EPSDT / Title XIX
2. Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Borrego Health Claims Processing Center c/o Kcc
222 N. Pacific Coast Hwy., Ste 300
El Segundo, CA 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	10/30/2020		JP	5		D2751		1	crown - porcelain fused to predomina	1500.00
2	11/16/2020		JP	5		2810.10		1	Seat Crown	100.00
3										[redacted]
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
												X			X
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
			X												

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A")
A _____ C _____
B _____ D _____

31a. Other Fee(s)
32. Total Fee 1600.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822169868
52. Phone Number (760) 243 - 4366
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54. NPI 1760858153
55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
56a. Provider Specialty Code 1223G0001X
57. Phone Number (760) 243 - 4366
58. Additional Provider ID

EXHIBIT 4

Claim #251 Date Filed: 4/2/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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? _____

2202384240402000000000007

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: 9868 TIDH

7. **How much is the claim?**
   $ 1500.00 . **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.
   Dental

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 amount should match the amount in line 7.)

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   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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03 / 28 / 2024 (MM / DD / YYYY)

Signature

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

Name: Yung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee.office.manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☒ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
c/o KAI
222 N. Pacific Coast Hwy Ste 300
El Segundo Ca 90245

[redacted]

OTHER COVERAGE (Mark applicable box and complete items 5-11 if none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/19/2020		JP	4		D2751		1	crown - porcelain fused to predomina	1500.00
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 X X 4 5 X 7 8 9 10 X 11 12 X 13 X 14 15 16 X

32 X X X X X 27 26 25 24 23 22 21 20 X 19 X 18 X 17 X

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = 9; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ C ____ B ____ D ____

31a. Other Fee(s)

32. Total Fee 1500.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153

50. License Number 64834

51. SSN or TIN 822189868

52. Phone Number (760) 243 - 4366

52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54. NPI 1760858153

55. License Number 64834

56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307

56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243 - 4366

58. Additional Provider ID

EXHIBIT 5

Claim #252 Date Filed: 4/2/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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?

2202384240402000000000010

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: 9868 TIDH

7. **How much is the claim?**
   $ 1505.00 **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.
   Dental

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 amount should match the amount in line 7.)

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   APR 0 2 2024
   KURTZMANCARSONCONSULTANTS

   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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03 / 28 / 2024 (MM / DD / YYYY)

Signature

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

Name: Ung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Ung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone: 760-243-4364 Email: lee.office.manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

[ ] Statement of Actual Services [ ] Request for Predetermination/Preauthorization

[X] EPSDT / Title XIX

2. Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
C/O KCC
222 N. Pacific Coast Hwy ste. 300
El Segundo, Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender [ ] M [ ] F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/19/2020		JP			D1999		1	Personal Protective Equipment	5.00
2	11/19/2020		JP	18		D2751		1	crown - porcelain fused to predomina	1500.00
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1 X X 4 X 6 7 X 8 9 10 X 11 12 X 13 X 14 X 15 16 X

32 X X 29 28 X 27 26 25 24 23 22 21 20 19 18 17 X

34. Diagnosis Code List Qualifier [ ] [ ] (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee 1505.00

35. Remarks #18 Existing fill with Lg decay on mesial cusp. Not enough Th structure to hold. Fill, CRN needed for permanent restoration

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/28/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/28/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) [ ]

40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153 | 50. License Number 64834 | 51. SSN or TIN 822169868

52. Phone Number (760) 243 - 4366 | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/28/2024
Signed (Treating Dentist) Date

54. NPI 1760858153 | 55. License Number 64834

56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307 | 56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243 - 4366 | 58. Additional Provider ID

EXHIBIT 6

Claim #253 Date Filed: 4/2/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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?

2202384240402000000000004

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: 9868 TID#

7. **How much is the claim?**
   $ 1750.00 **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.
   Dental

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 amount should match the amount in line 7.)

   RECEIVED
   APR 02 2024
   KURTZMAN CARSON CONSULTANTS

   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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

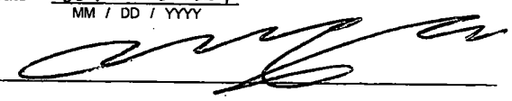
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2024
MM / DD / YYYY



Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee.office.manager@gmail.com

RECEIVED
APR 0 2 2024
KURTZMAN CARSON CONSULTANTS

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1 Type of Transaction (Mark all applicable boxes)

[ ] Statement of Actual Services [ ] Request for Predetermination/Preauthorization

[X] EPSDT / Title XIX

2 Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3 Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
C/O KCC
222 N. Pacific Coast HWY Ste 300
El Segundo, Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4 Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)

5 Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6 Date of Birth (MM/DD/CCYY)	7 Gender	8 Policyholder/Subscriber ID (SSN or ID#)
	[ ] M [ ] F	

9 Plan/Group Number	10 Patient's Relationship to Person named in #5
	[ ] Self [ ] Spouse [ ] Dependent [ ] Other

11 Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/10/2020		JP			D0150		1	comprehensive oral evaluation - new	150.00
2	11/10/2020		JP			D0274		1	bitewings - four radiographic images	150.00
3	11/10/2020		JP			D0230		1	intraoral - periapical each additional ra	50.00
4	11/10/2020		JP			D0230		1	intraoral - periapical each additional ra	50.00
5	11/10/2020	00	JP			D1208		1	topical application of fluoride – excludi	125.00
6	11/10/2020		JP	2	O	D1351		1	sealant - per tooth	175.00
7	11/10/2020		JP	3	O	D1351		1	sealant - per tooth	175.00
8	11/10/2020		JP	14	O	D1351		1	sealant - per tooth	175.00
9	11/10/2020		JP	15	O	D1351		1	sealant - per tooth	175.00
10	11/10/2020		JP	19	O	D1351		1	sealant - per tooth	175.00

33 Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34 Diagnosis Code List Qualifier [ ] [ ] (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee 1400.00

35 Remarks

AUTHORIZATIONS

36 I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37 I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) [ ]

40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI	50. License Number	51. SSN or TIN
1760858153	64834	822169868

52. Phone Number (760) 243 - 4366

52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53 I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54. NPI	55. License Number
1760858153	64834

56. Address, City, State, Zip Code
12611 Hesperia Rd.
Victorville CA 923958307

56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243 - 4366

58. Additional Provider ID

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
C/o KAC
222 N. Pacific Coast Hwy Ste c
El Segundo CA 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/10/2020		JP	30	O	D1351		1	sealant - per tooth	175.00
2	11/10/2020		JP	31	O	D1351		1	sealant - per tooth	175.00
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34. Diagnosis Code List Qualifier ☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ C ____ B ____ D ____

31a. Other Fee(s)

32. Total Fee 350.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — 03/29/2024
Patient/Guardian Signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — 03/29/2024
Subscriber Signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153 | 50. License Number 64834 | 51. SSN or TIN 822169868

52. Phone Number (760) 243-4366 | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee — 03/29/2024
Signed (Treating Dentist) — Date

54. NPI 1760858153 | 55. License Number 64834

56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307 | 56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243-4366 | 58. Additional Provider ID

To reorder call 800.947.4746

EXHIBIT 7

Claim #254 Date Filed: 4/2/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:	
Debtor	Borrego Community Health Foundation
United States Bankruptcy Court for the Southern District of California	
Case number	22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. Who is the current creditor?

Yong Hee Lee DDS Inc.
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)

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APR 02 2024
KURTZMAN CARSON CONSULTANTS

Where should notices to the creditor be sent?

Yong Hee Lee DDS Inc.
Name
12611 Hesperia Rd. Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code
USA
Country
Contact phone 760-243-4366
Contact email leeofficemanager@gmail.com

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

Name
Number Street
City State ZIP Code
Country
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? _____

2202384240402000000000003

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: 9868 TIDH

7. **How much is the claim?**
   $ 305.00 . **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.
   Dental

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 amount 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

RECEIVED
APR 0 2 2024
KURTZMAN CARSON CONSULTANTS

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.

- [x] No
- [ ] Yes. *Check all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
  - [ ] 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

- [x] No
- [ ] Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

  $_____

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:

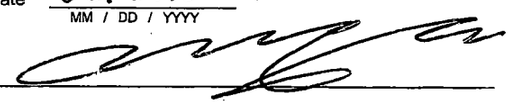
- [x] I am the creditor.
- [ ] I am the creditor's attorney or authorized agent.
- [ ] I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.
- [ ] I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2024
MM / DD / YYYY


Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee.officemanager@gmail.com

RECEIVED
APR 02 2024
KURTZMAN CARSON CONSULTANTS

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT, Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
C/o KCC
222 N. Pacific Coast Hwy Ste 300
El Segundo CA 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

[redacted]

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/09/2020		JP			D4910		1	periodontal maintenance	300.00
2	11/09/2020		JP			D1999		1	Personal Protective Equipment	5.00
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 X 3 4 X 6 X 7 8 X 9 X 10 X 11 X 12 13 X 14 X 15 16 X

32 X 30 X 29 X 28 27 26 25 24 23 22 21 20 X 19 X 18 17 X

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = 8; ICD-10 = AB)

34a. Diagnosis Code(s) A _____ C _____

(Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s)

32. Total Fee 305.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024

Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024

Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

42. Name, Address, City, State, Zip Code

Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

43. NPI 1760858153	50. License Number 64834	51. SSN or TIN 822169868
52. Phone Number (760) 243 - 4366	52a. Additional Provider ID	

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024

Signed (Treating Dentist) Date

54. NPI 1760858153	55. License Number 64834
	56a. Provider Specialty Code 1223G0001X

56. Address, City, State, Zip Code

12611 Hesperia Rd.
Victorville CA 923958307

57. Phone Number (760) 243 - 4366	58. Additional Provider ID

EXHIBIT 8

Claim #255 Date Filed: 4/2/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:	
Debtor	Borrego Community Health Foundation
United States Bankruptcy Court for the Southern District of California	
Case number	22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. Who is the current creditor?

Yong Hee Lee DDS Inc.
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)

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Where should notices to the creditor be sent?

Yong Hee Lee DDS Inc.
Name
12611 Hesperia Rd. Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code
USA
Country
Contact phone 760-243-4366
Contact email leeofficemanager@gmail.com

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

Name
Number Street
City State ZIP Code
Country
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? _____

2202384240402000000000008

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: 9868 TIDH

7. **How much is the claim?**
   $ 480.00 **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.
   Dental

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 amount should match the amount in line 7.)

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   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.

- [x] No
- [ ] Yes. *Check all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
  - [ ] 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

- [x] No
- [ ] Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

  $_____

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:

- [x] 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 acknowledgement 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 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 03/28/2024
MM / DD / YYYY

Signature

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

Name: Ung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Ung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4366 Email lee.officemanager@gmail.com

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ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☒ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/ Title XIX

2. Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Borrego Health Claims Processing Center
C/o KCC
222 N. Pacific Coast Hwy Ste 300
El Segundo Ca 90245

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☒ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number	10. Patient's Relationship to Person Named in #5
	☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	11/23/2020		JP	13		D2751	crown - porcelain fused to predominantly base meta	375.00
2	02/25/2021		JP	13		2810.10	Seat Crown	100.00
3	11/23/2020		JP			D1999	Personal Protective Equipment	5.00
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)
33. Total Fee 480.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — 03/29/2024
Patient/Guardian signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — 03/29/2024
Subscriber signature — Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI	50. License Number	51. SSN or TIN
1760858153	64834	822169868

52. Phone Number (760) 243 4366 — 52A. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment
☒ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99)
Radiograph(s) 0 — Oral Image(s) — Model(s)

40. Is Treatment for Orthodontics?
☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis?
☒ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from
☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee — 03/29/2024
Signed (Treating Dentist) — Date

54. NPI 1760858153 — 55. License Number 64834

56. Address, City, State, Zip Code
12611 Hesperia Rd.
Victorville CA 923958307

56A. Provider Specialty Code 1223G0001X

57. Phone Number 760) 243 -4366 — 58. Additional Provider ID

EXHIBIT 9

Claim #256 Date Filed: 4/2/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:	
Debtor	Borrego Community Health Foundation
United States Bankruptcy Court for the Southern District of California	
Case number	22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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? _____

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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: 9868 TIDH

7. **How much is the claim?**
   $ 305.00 . **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.
   Dental

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 amount should match the amount in line 7.)

   RECEIVED
   APR 02 2024
   KURTZMANCARSONCONSULTANTS

   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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

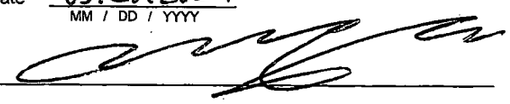
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2024
MM / DD / YYYY



Signature

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

Name: Yung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee.officemanager@gmail.com

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ FEDI / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health claims Processing Center
C/O KCC
2222 N. Pacific Coast Hwy Ste 300
El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

[redacted]

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/12/2020		JP			D4910		1	periodontal maintenance	300.00
2	11/12/2020		JP			D1999		1	Personal Protective Equipment	5.00
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 X 3 4 X 6 8 7 8 9 10 11 12 X 13 X 14 15 16 X

32 X X X X X 27 28 X 25 X 24 X 23 22 21 20 19 X 18 X 17 X

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ C ____ B ____ D ____

31a. Other Fee(s)

32. Total Fee 305.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI	50. License Number	51. SSN or TIN
1760858153	64834	822169868

52. Phone Number (760) 243 - 4366

52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54. NPI 1760858153

55. License Number 64834

56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307

56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243 - 4366

58. Additional Provider ID

EXHIBIT 10

Claim #257 Date Filed: 4/2/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   APR 02 2024
   KURTZMAN CARSON CONSULTANTS

   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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?

2202384240402000000000009

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: 9868 TID#

7. **How much is the claim?**
   $ 1500.00 . **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.
   Dental

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 amount should match the amount in line 7.)

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   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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

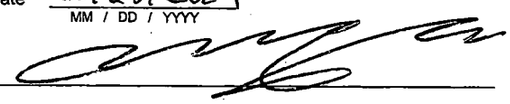
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2024
MM / DD / YYYY



Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee.office.manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
C/O Kaa
2229 N. Pacific Coast Hwy Ste 300
El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

[redacted]

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Policyholder/Subscriber ID (SSN or ID#)
[redacted]	X M ☐ F	[redacted]

16. Plan/Group Number	17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☒ Self ☐ Spouse ☐ Dependent Child ☐ Other	19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

[redacted]

21. Date of Birth (MM/DD/CCYY)	22. Gender X M ☐ F	23. Patient ID/Account # (Assigned by Dentist)
[redacted]		

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	03/12/2020		JP	19		D2751		1	crown - porcelain fused to predomina	1500.00
2										
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

33. Diagnosis Code List Qualifier ☐ (ICD-9 = B; ICD-10 = AB)

33a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ C ____ B ____ D ____

31a. Other Fee(s)

32. Total Fee 1500.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=OP Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

45. Name, Address, City, State, Zip Code

Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

48. NPI	50. License Number	51. SSN or TIN
1760858153	64834	822169868

52. Phone Number	52a. Additional Provider ID
760 243 4366	

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54. NPI	55. License Number
1760858153	64834

56. Address, City, State, Zip Code	56a. Provider Specialty Code
12611 Hesperia Rd. Victorville CA 923958307	1223G0001X

57. Phone Number	58. Additional Provider ID
760 243 4366	

EXHIBIT 11

Claim #258 Date Filed: 4/2/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Ung Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Ung Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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?

2202384240402000000000002

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: 9868 TIDH

7. **How much is the claim?**
$ 255.00 . **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.
Dental

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 amount should match the amount in line 7.)

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

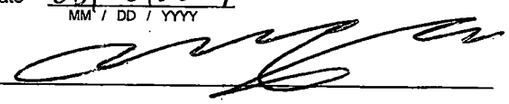
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2024
MM / DD / YYYY



Signature

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

Name: Yung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee office manager@gmail.com

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health claims Processing Center
c/o KCC
222 N. Pacific Coast Hwy Ste 300
El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/10/2020		JP	29		D7210		1	extraction, erupted tooth requiring rem	250.00
2	11/10/2020		JP	29		D1999		1	Personal Protective Equipment	5.00
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 X 3 4 5 X 7 8 9 10 11 12 X 13 14 15 16 X

32 X 30 29 28 27 26 25 24 23 22 21 20 19 18 17 X

34. Diagnosis Code List Qualifier ☐ (ICD-9 = B, ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ C ____ B ____ D ____

31a. Other Fee(s)

32. Total Fee 255.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153 | 50. License Number 64834 | 51. SSN or TIN 822169868

52. Phone Number 760 243 4366 | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54. NPI 1760858153 | 55. License Number 64834 | 55a. Provider Specialty Code 1223G0001X

56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307

57. Phone Number 760 243 4366 | 58. Additional Provider ID

EXHIBIT 12

Claim #259 Date Filed: 4/2/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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? _____

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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: 9868 TIDH

7. **How much is the claim?**
$ 10.00 **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.
Dental

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 amount should match the amount in line 7.)

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

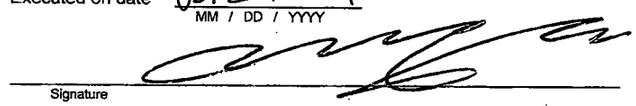
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2024
MM / DD / YYYY



Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone: 760-243-4364 Email: lee.officemanager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center C/o Kcc
222 N. Pacific Coast Hwy., Ste 300
Elseaundo, CA 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

[redacted]

13. Date of Birth (MM/DD/CCYY) [redacted] | 14. Gender ☐ M ☒ F | 15. Policyholder/Subscriber ID (SSN or ID#) [redacted]

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☒ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

[redacted]

21. Date of Birth (MM/DD/CCYY) [redacted] | 22. Gender ☐ M ☒ F | 23. Patient ID/Account # (Assigned by Dentist) [redacted]

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/16/2020		JP			D1999		1	Personal Protective Equipment	5.00
2	11/23/2020		JP			D1999		1	Personal Protective Equipment	5.00
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

33. Diagnosis Code List Qualifier ☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ C ____ B ____ D ____

34a. Other Fee(s)

32. Total Fee 10.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — 03/29/2024
Patient/Guardian Signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — 03/29/2024
Subscriber Signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153 | 50. License Number 64834 | 51. SSN or TIN 822169868

52. Phone Number (760) 243 - 4366 | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee — 03/29/2024
Signed (Treating Dentist) — Date

54. NPI 1760858153 | 55. License Number 64834

56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307 | 56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243 - 4366 | 58. Additional Provider ID

EXHIBIT 13

Claim #260 Date Filed: 4/2/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   Contact phone
   Contact email

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   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?

22023842404020000000000013

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: TIDH 9868

7. **How much is the claim?**
   $ 1270.00 . **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.
   Dental

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 amount 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

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

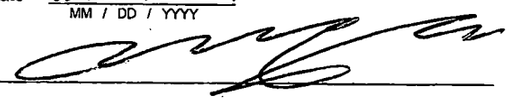
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2024
MM / DD / YYYY



Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4366 Email lee office manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

[ ] Statement of Actual Services [ ] Request for Predetermination/Preauthorization

[X] EPSDT/ Title XIX

2. Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
C/o KCC
2222 N. Pacific Coast Hwy Ste. 300
El Segundo CA 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender [ ] M [ ] F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	09/21/2020	01	JP			D5110		1	complete denture - maxillary	335.00
2	09/21/2020	02	JP			D5120		1	complete denture - mandibular	335.00
3	11/16/2020	01	JP			D3		1	Denture Delivery	300.00
4	11/16/2020	02	JP			D3		1	Denture Delivery	300.00
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1 X X X X X X X X X X X X X X X X

32 X X X X X X X X X X X X X X X X

33. Diagnosis Code List Qualifier [ ] [ ] (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) A _____ C _____

(Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s)

32. Total Fee 1270.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — 03/29/2024
Patient/Guardian Signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — 03/29/2024
Subscriber Signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) [ ]

40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from [ ] Occupational Illness/Injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI	50. License Number	51. SSN or TIN
1760858153	64834	822169868

52. Phone Number 760 243 4366

52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee — 03/29/2024
Signed (Treating Dentist) — Date

54. NPI	55. License Number
1760858153	64834

56. Address, City, State, Zip Code

12611 Hesperia Rd.
Victorville CA 923958307

56a. Provider Specialty Code 1223G0001X

57. Phone Number 760 243 4366

58. Additional Provider ID

EXHIBIT 14

Claim #261 Date Filed: 4/2/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com
   Uniform claim identifier for electronic payments in chapter 13 (if you use one):

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   Contact phone
   Contact email

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?

2202384240402000000000014

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: 9868 TIDH

7. **How much is the claim?**

$ 5.00. **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.

Dental

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 amount should match the amount in line 7.)

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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 all that apply:*

	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 $3,350* 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 $15,150*) 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).	$
☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024
MM / DD / YYYY

Signature

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

Name: Uyng (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Uyng Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12011 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee office manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [ ] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [X] EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center C/O Kcc
222 N. Pacific Coast Hwy., Ste 300
El Segundo, CA 90245

OTHER COVERAGE Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code [redacted]
13. Date of Birth (MM/DD/CCYY) [redacted]
14. Gender [ ] M [X] F
15. Policyholder/Subscriber ID (SSN or ID#) [redacted]
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [X] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code [redacted]
21. Date of Birth (MM/DD/CCYY) [redacted]
22. Gender [ ] M [X] F
23. Patient ID/Account # (Assigned by Dentist) [redacted]

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/23/2020		JP			D1999		1	Personal Protective Equipment	5.00
2										
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
		X												X	X
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
		X	X											X	

34. Diagnosis Code List Qualifier [ ] (ICD-9 = B, ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____
31a. Other Fee(s)
32. Total Fee 5.00
35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — Patient/Guardian Signature — 03/29/2024 — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — Subscriber Signature — 03/29/2024 — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational Illness/Injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307
49. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822189868
52. Phone Number 760 243 4366
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
Yonghee Lee
X ____ Signed (Treating Dentist) — 03/29/2024 — Date
54. NPI 1760858153
55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
56b. Provider Specialty Code 1223G0001X
57. Phone Number 760 243 4366
58. Additional Provider ID

EXHIBIT 15

Claim #262 Date Filed: 4/2/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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: 9868 TIDH

7. **How much is the claim?**
   $ 505.00 **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.
   Dental

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 amount should match the amount in line 7.)

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   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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024
MM / DD / YYYY

Signature

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

Name: Yung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee.officemanager@gmail.com

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KURTZMAN CARSON CONSULTANTS

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT/ Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
C/o KCC
222 N. Pacific Coast Hwy Ste 300
El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

[redacted]

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/16/2020	20	JP			D4341		1	UL periodontal scaling and root planin	250.00
2	11/16/2020	30	JP			D4341		1	LL periodontal scaling and root planin	250.00
3	11/16/2020		JP			D1999		1	Personal Protective Equipment	5.00
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1 X X 4 5 6 7 X8 X9 X10 11 12 13 14 15X 16X

32 X X X 28 27 26 25 24 23 22 21 20 19X 18 17X

33. Diagnosis Code List Qualifier ☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____

31a. Other Fee(s)

32. Total Fee 505.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 23=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153	50. License Number 64834	51. SSN or TIN 822169868
52. Phone Number (760) 243-4366	52a. Additional Provider ID	

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54. NPI 1760858153	55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307	56a. Provider Specialty Code 1223G0001X
57. Phone Number (760) 243-4366	58. Additional Provider ID

EXHIBIT 16

Claim #263 Date Filed: 4/2/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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? _____

2202384240402000000000012

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: 9868 TIDH

7. **How much is the claim?**

$ 1500.00 . **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.

Dental

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 amount should match the amount in line 7.)

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024
MM / DD / YYYY

Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4366 Email lee office manager@gmail.com

RECEIVED
APR 02 2024
KURTZMANCARSONCONSULTANTS

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [ ] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [X] EPSDT; Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
   Borrego Health Claims Processing Center
   C/o KCC
   2222 N. Pacific Coast Hwy Ste 300
   El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
    [redacted]
13. Date of Birth (MM/DD/CCYY) [redacted]
14. Gender [ ] M [X] F
15. Policyholder/Subscriber ID (SSN or ID#) [redacted]
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [X] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
    [redacted]
21. Date of Birth (MM/DD/CCYY) [redacted]
22. Gender [ ] M [X] F
23. Patient ID/Account # (Assigned by Dentist) [redacted]

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	09/29/2020		JP	2,3,12,13,15		D5213		1	maxillary partial denture - cast metal fr	1500.00
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
X	X	X	X								X	X		X	X

32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
X	X	X	X	X									X	X	X

34. Diagnosis Code List Qualifier [ ] (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____
31a. Other Fee(s)
32. Total Fee 1500.00
35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — Patient/Guardian Signature — 03/29/2024 — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — Subscriber Signature — 03/29/2024 — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational Illness/Injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
    Yonghee Lee
    12611 Hesperia Rd.
    Suite C
    Victorville CA 923958307
49. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822169868
52. Phone Number (760) 243 - 4366
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
    X Yonghee Lee — Signed (Treating Dentist) — 03/29/2024 — Date
54. NPI 1760858153
55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
56a. Provider Specialty Code 1223G0001X
57. Phone Number (760) 243 - 4366
58. Additional Provider ID

EXHIBIT 17

Claim #264 Date Filed: 4/2/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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: 9868 TID#

7. **How much is the claim?**

$ 560.00 . **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.

Dental

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 amount should match the amount in line 7.)

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

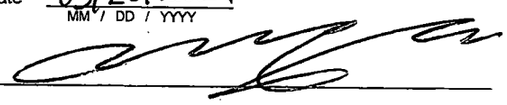
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2024
MM / DD / YYYY



Signature

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

Name: Yung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone: 760-243-4364 Email: lee.office.manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - ☐ Statement of Actual Services
   - ☐ Request for Predetermination/Preauthorization
   - ☐ EPSDT/ Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Borrego Health Claims Processing Center
C/o KCC
222 N Pacific Coast Hwy Ste 300
El Segundo Ca 90245

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
[redacted]	X M ☐ F	[redacted]

16. Plan/Group Number	17. Employer Name

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Subscriber ID (SSN or ID#)
	☐ M ☐ F	

9. Plan/Group Number	10. Patient's Relationship to Person named in #5
	☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above: X Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
[redacted]	X M ☐ F	

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/20/2020		JP			D4910		1	periodontal maintenance	300.00
2	11/20/2020		JP			D1999		1	Personal Protective Equipment	5.00
3	11/16/2020		JP	23	MF	D2331		1	resin-based composite - two surfaces,	250.00
4	11/16/2020		JP	23		D1999		1	Personal Protective Equipment	5.00
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 X X 4 5 X 7 X X X X 12 X 14 X X
32 X X X 28 27 26 25 24 23 22 21 20 X X X

34. Diagnosis Code List Qualifier ☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____

31a. Other Fee(s)
32. Total Fee 560.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — 03/29/2024
Patient/Guardian Signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — 03/29/2024
Subscriber Signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? X No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis X No ☐ Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI	50. License Number	51. SSN or TIN
1760858153	64834	822169868

52. Phone Number 760 243 4366
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X Yonghee Lee — 03/29/2024
Signed (Treating Dentist) — Date

54. NPI	55. License Number
1760858153	64834

56. Address, City, State, Zip Code
12611 Hesperia Rd.
Victorville CA 923958307
56a. Provider Specialty Code 1223G0001X

57. Phone Number 760 243 4366
58. Additional Provider ID

EXHIBIT 18

Claim #265 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:	
Debtor	Borrego Community Health Foundation
United States Bankruptcy Court for the Southern District of California	
Case number	22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. Who is the current creditor?

Yong Hee Lee DDS Inc.
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)

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Where should notices to the creditor be sent?

Yong Hee Lee DDS Inc.
Name
12611 Hesperia Rd. Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code
USA
Country
Contact phone 760-243-4366
Contact email leeofficemanager@gmail.com

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

Name
Number Street
City State ZIP Code
Country
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? _____

2202384240403000000000030

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: 9868 TIDH

7. **How much is the claim?** $ 100.00 **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.
   Dental

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 amount should match the amount in line 7.)

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   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.

		Amount entitled to priority
☑	No	
☐	Yes. *Check all that apply:*	
☐	Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	$_____
☐	Up to $3,350* 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 $15,150*) 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).	$_____
☐	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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

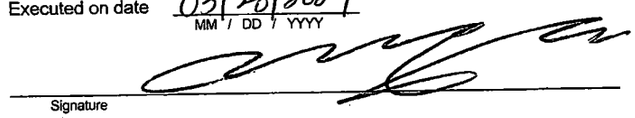
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2024
MM / DD / YYYY



Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee.officemanager@gmail.com

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APR 03 2024
KURTZMAN CARSON CONSULTANTS

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [ ] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [X] PSD / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Borrego Health claims Processing Center
c/o KCC
222 N. Pacific Coast Hwy Ste 300
El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
13. Date of Birth (MM/DD/CCYY) [redacted]
14. Gender [ ] M [X] F
15. Policyholder/Subscriber ID (SSN or ID#) [redacted]
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [X] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
21. Date of Birth (MM/DD/CCYY) [redacted]
22. Gender [ ] M [X] F
23. Patient ID/Account # (Assigned by Dentist) [redacted]

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/19/2020		JR			D9430		1	office visit for observation (during regu	100.00
2										
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)
1 X 3 X 5 X 7 8 9 10 11 12 X 13 14 X 15 16
32 X 30 29 28 27 26 25 24 23 22 21 20 19 X 18 X 17 X

34. Diagnosis Code List Qualifier [ ] (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A")
A _____ C _____
B _____ D _____

31a. Other Fee(s)
32. Total Fee 100.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307
49. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822169868
52. Phone Number 760 243 4366
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
Yonghee Lee 03/29/2024
X
Signed (Treating Dentist) Date
54. NPI 1760858153
55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
56a. Provider Specialty Code 1223G0001X
57. Phone Number 760 243 4366
58. Additional Provider ID

EXHIBIT 19

Claim #266 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   Contact phone
   Contact email

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

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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?

2202384240403000000000029

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: 9868 TIDH

7. **How much is the claim?** $ 300.00 **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.
   Dental

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 amount should match the amount in line 7.)

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   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 all that apply:*

	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 $3,350* 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 $15,150*) 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).	$_____
☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024 (MM / DD / YYYY)

Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc. (Identify the corporate servicer as the company if the authorized agent is a servicer.)

Address: 12611 Hesperia Rd Ste C (Number Street)
Victorville, CA. 92395 (City State ZIP Code Country)

Contact phone: 760-243-4364 Email: lee.office.manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [ ] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [X] EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Borrego Health claims Processing Center
c/o Kcc
222 N. Pacific Coast Hwy Ste 300
El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5–11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5–11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
13. Date of Birth (MM/DD/CCYY) [redacted]
14. Gender [X] M [ ] F
15. Policyholder/Subscriber ID (SSN or ID#) [redacted]
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [X] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
21. Date of Birth (MM/DD/CCYY) [redacted]
22. Gender [X] M [ ] F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	10/06/2020		JP			D31		1	Deliver Partial Upper Denture	300.00
2										
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)
1 X X X 5 6 7 8 9 10 11 12 13 14 15 X X
32 X 30 29 28 27 26 25 24 23 22 21 20 19 18 X

33. Diagnosis Code List Qualifier [ ] (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____
31a. Other Fee(s)
32. Total Fee 300.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational Illness/Injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307
49. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822169868
52. Phone Number 760 243 4366
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date
54. NPI 1760858153
55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
56a. Provider Specialty Code 1223G0001X
57. Phone Number 760 243 4366
58. Additional Provider ID

EXHIBIT 20

Claim #267 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   Contact phone
   Contact email

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

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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?

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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: 9868 TID#

7. **How much is the claim?**

$ 255.00 . **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.

Dental

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 amount should match the amount in line 7.)

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024
MM / DD / YYYY

Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone: 760-243-4364 Email: lee office manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1 Type of Transaction (Mark all applicable boxes)

[ ] Statement of Actual Services [ ] Request for Predetermination/Preauthorization

[X] EPSDT/Title XIX

2 Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3 Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center c/o Rcc
222 N. Pacific Coast Hwy., Ste 300
El Segundo. CA 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4 Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)

5 Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6 Date of Birth (MM/DD/CCYY)	7. Gender [ ] M [ ] F	8. Policyholder/Subscriber ID (SSN or ID#)
9 Plan/Group Number	10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other	

11 Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

[redacted]

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/16/2020		JP			D1999		1	Personal Protective Equipment	5.00
2	11/16/2020		JP	4		D7210		1	extraction, erupted tooth requiring rem	250.00
3										
4										
5										
6										
7										
8										
9										
10										

32 Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 X 5 6 7 8 X9 X10 X11 12X 13 14X 15 16X

32 31 X0 29 28 27 26 25 24 23 22 21 20 19X 18 17X

34 Diagnosis Code List Qualifier [ ] (ICD-9 = B; ICD-10 = AB)

34a Diagnosis Code(s) A _____ C _____

(Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s)

32. Total Fee 255.00

35 Remarks

AUTHORIZATIONS

36 I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024

Patient/Guardian Signature Date

37 I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024

Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) [ ]

40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153	50. License Number 64834	51. SSN or TIN 822169868
52. Phone Number (760) 243 - 4366	52a. Additional Provider ID	

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024

Signed (Treating Dentist) Date

54 NPI 1760858153	55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307	56a. Provider Specialty Code 1223G0001X
57. Phone Number (760) 243 - 4366	58. Additional Provider ID

EXHIBIT 21

Claim #268 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:	
Debtor	Borrego Community Health Foundation
United States Bankruptcy Court for the Southern District of California	
Case number	22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. Who is the current creditor?

Yong Hee Lee DDS Inc.
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?

Yong Hee Lee DDS Inc.
Name
12611 Hesperia Rd. Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code
USA
Country
Contact phone 760-243-4366
Contact email leeofficemanager@gmail.com

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

Name
Number Street
City State ZIP Code
Country
Contact phone
Contact email

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KURTZMAN CARSON CONSULTANTS

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? _____

2202384240403000000000039

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: 9868 TIO#

7. **How much is the claim?**
$ 3205.00 **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.
Dental

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 amount should match the amount in line 7.)

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APR 03 2024
KURTZMAN CARSON CONSULTANTS

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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024
MM / DD / YYYY

Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee office manager@gmail.com

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Processing Center
C/O KCC
222 N. Pacific Coast Hwy Ste 300
El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

[redacted]

13. Date of Birth (MM/DD/CCYY) [redacted] | 14. Gender ☐ M ☒ F | 15. Policyholder/Subscriber ID (SSN or ID#) [redacted]

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☒ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

[redacted]

21. Date of Birth (MM/DD/CCYY) [redacted] | 22. Gender ☒ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	10/20/2020		JP			D1999		1	Personal Protective Equipment	5.00
2	10/19/2020		JP	19		D2751		1	crown - porcelain fused to predomina	1500.00
3	11/10/2020		JP	19		2810.10		1	Seat Crown	100.00
4	10/20/2020		JP	20		D2751		1	crown - porcelain fused to predomina	1500.00
5	11/09/2020		JP	20		2810.10		1	Seat Crown	100.00
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1 X 3 4 5 6 7 8 9 10 11 12 13 14 15 16X

32 X X 29 28 27 26 25 24 23 22 21 20 19 18X 17X

34. Diagnosis Code List Qualifier ☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee 3205.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024

Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024

Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=OP Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153 | 50. License Number 64834 | 51. SSN or TIN 822169868

52. Phone Number (760) 243-4366 | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024

Signed (Treating Dentist) Date

54. NPI 1760858153 | 55. License Number 64834

56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307 | 56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243-4366 | 58. Additional Provider ID

EXHIBIT 22

Claim #269 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:	
Debtor	Borrego Community Health Foundation
United States Bankruptcy Court for the Southern District of California	
Case number	22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. Who is the current creditor?

Yong Hee Lee DDS Inc.
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)

RECEIVED
APR 03 2024
KURTZMAN CARSON CONSULTANTS

Where should notices to the creditor be sent?

Yong Hee Lee DDS Inc.
Name
12611 Hesperia Rd. Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code
USA
Country
Contact phone 760-243-4366
Contact email leeofficemanager@gmail.com

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

Name
Number Street
City State ZIP Code
Country
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? _____

2202384240403000000000037

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: 9868 TID#

7. **How much is the claim?** $ 305.00 **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.
   Dental

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 amount should match the amount in line 7.)

   RECEIVED
   APR 03 2024
   KURTZMAN CARSON CONSULTANTS

   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 all that apply:*

	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 $3,350* 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 $15,150*) 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).	$_____
☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

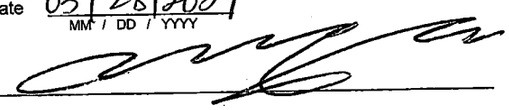
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03 / 28 / 2024
MM / DD / YYYY



Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone: 760-243-4364 Email: lee.officemanager@gmail.com

RECEIVED
APR 03 2024
KURTZMAN CARSON CONSULTANTS

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [ ] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [X] EPSDT / Title XIX
2. Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Barreso Health claims Processing Center
c/o KCC
2222 N. Pacific Coast Hwd Ste 300
El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/19/2020		JP			D4910		1	periodontal maintenance	300.00
2	11/19/2020		JP			D1999		1	Personal Protective Equipment	5.00
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 X 3 X 5 X 7 8 9 10 11 12 13 X 14 X 15 16 X
32 X 30 X 29 28 27 26 25 X 24 23 22 21 20 X 19 X 18 17 X

34. Diagnosis Code List Qualifier [ ] [ ] (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____

31a. Other Fee(s)
32. Total Fee 305.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822169868
52. Phone Number (760) 243 - 4366
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54. NPI 1760858153
55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
56a. Provider Specialty Code 1223G0001X
57. Phone Number (760) 243 - 4366
58. Additional Provider ID

EXHIBIT 23

Claim #270 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   Contact phone
   Contact email

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

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   APR 03 2024
   KURTZMAN CARSON CONSULTANTS

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?

22023842404030000000000040

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: 9868 TIN#

7. **How much is the claim?**
   $ 100.00 . **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.
   Dental

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 amount should match the amount in line 7.)

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   APR 03 2024
   KURTZMAN CARSON CONSULTANTS

   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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

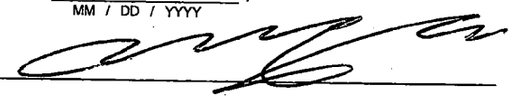
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2024
MM / DD / YYYY



Signature

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

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APR 03 2024
KURTZMAN CARSON CONSULTANTS

Name: Yung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4366 Email lee office manager@gmail.com

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [ ] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [X] ePSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Borrego Health Claims Processing Center
C/o KCC
322 N. Pacific Coast Hwy Ste 300
El Segundo CA 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
13. Date of Birth (MM/DD/CCYY) [redacted]
14. Gender [X] M [ ] F
15. Policyholder/Subscriber ID (SSN or ID#) [redacted]
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [X] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
21. Date of Birth (MM/DD/CCYY) [redacted]
22. Gender [X] M [ ] F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	12/15/2020		JP	19		2810.10		1	Seat Crown	100.00
2										
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34. Diagnosis Code List Qualifier [ ] (ICD-9 = 8; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____
31a. Other Fee(s)
32. Total Fee 100.00
33. Remarks

AUTHORIZATIONS

35. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X Signature on File 03/29/2024
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307
49. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822169868
52. Phone Number (760) 243-4366
52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational Illness/Injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date
54. NPI 1760858153
55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
56a. Provider Specialty Code 1223G0001X
57. Phone Number (760) 243-4366
58. Additional Provider ID

EXHIBIT 24

Claim #271 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   Contact phone
   Contact email

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   APR 03 2024
   KURTZMAN CARSON CONSULTANTS

   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: 9868 TID#

7. **How much is the claim?**
$ 505.00 . **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.
Dental

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 amount 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

RECEIVED
APR 03 2024
KURTZMAN CARSON CONSULTANTS

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 all that apply:*

	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 $3,350* 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 $15,150*) 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).	$_____
☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024 (MM / DD / YYYY)

Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee.officemanager@gmail.com

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APR 03 2024
KURTZMAN CARSON CONSULTANTS

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

[ ] Statement of Actual Services [ ] Request for Predetermination/Preauthorization

[X] EPSDT/ Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
C/O KCC
222 N. Pacific Coast Hwy Ste 300
El Segundo CA 90245

[redacted]

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender [ ] M [ ] F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/19/2020	20	JP			D4341		1	UL periodontal scaling and root planin	250.00
2	11/19/2020	30	JP			D4341		1	LL periodontal scaling and root planin	250.00
3	11/19/2020		JP			D1999		1	Personal Protective Equipment	5.00
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 X 3 X 5 X6 X7 X8 9 10 11 12X 13 14 15X 16X

32 X X X 28 27 26 25 24 23 22 21 20 19X 18 17X

34. Diagnosis Code List Qualifier [ ] (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee 505.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) [ ]

40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153

50. License Number 64834

51. SSN or TIN 822169868

52. Phone Number (760) 243 - 4366

52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54. NPI 1760858153

55. License Number 64834

56. Address, City, State, Zip Code
12611 Hesperia Rd.
Victorville CA 923958307

56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243 - 4366

58. Additional Provider ID

EXHIBIT 25

Claim #272 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   Contact phone
   Contact email

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

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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?

22023842404030000000000031

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: 9868 TIDH

7. **How much is the claim?**
$ 585.00 . **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.
Dental

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 amount should match the amount in line 7.)

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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.

- [x] No
- [ ] Yes. *Check all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
  - [ ] 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

- [x] No
- [ ] Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

  $_____

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:

- [x] 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 acknowledgement 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 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 03/28/2024
MM / DD / YYYY

Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone: 760-243-4366 Email: lee office manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [ ] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [X] EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Borrego Health Claims Processing Center
C/O KCC
222 N. Pacific Coast Hwy Ste 300
El Segundo, CA . 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
13. Date of Birth (MM/DD/CCYY) [redacted]
14. Gender [ ] M [X] F
15. Policyholder/Subscriber ID (SSN or ID#) [redacted]
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [X] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
21. Date of Birth (MM/DD/CCYY) [redacted]
22. Gender [ ] M [X] F
23. Patient ID/Account # (Assigned by Dentist) [redacted]

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/13/2020		JP			D0150		1	comprehensive oral evaluation - new	150.00
2	11/20/2020		JP			D1999		1	Personal Protective Equipment	5.00
3	11/23/2020	00	JP			D1110		1	prophylaxis - adult	200.00
4	11/23/2020		JP			D1999		1	Personal Protective Equipment	5.00
5	11/20/2020		JP	21	O	D2391		1	resin-based composite - one surface,	225.00
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)
1 X 3 4 5 6 7 8 9 10 11 12 13 14 15 16X
32 X 30 29 28X 27 26 25 24 23 22 21 20 19X 18 17X

33. Diagnosis Code List Qualifier [ ] [ ] (ICD-9 = 9; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A")
A _____ C _____
B _____ D _____

31a. Other Fee(s)
32. Total Fee 585.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307
49. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822169868
52. Phone Number (760) 243 - 4366
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date
54. NPI 1760858153
55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
56a. Provider Specialty Code 1223G0001X
57. Phone Number (760) 243 - 4366
58. Additional Provider ID

EXHIBIT 26

Claim #273 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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? _____

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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: 9868 TIDH

7. **How much is the claim?**
$ 5.00. **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.
Dental

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 amount should match the amount in line 7.)

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024
MM / DD / YYYY

Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone: 760-243-4366 Email: lee office manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health claims processing Center
c/o Rcc
222 N. Pacific Coast Hwy. Ste 300
El segundo, CA. 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/13/2020		JR			D1999		1	Personal Protective Equipment	5.00
2										
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ C ____ B ____ D ____

31a. Other Fee(s)

32. Total Fee 5.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI	50. License Number	51. SSN or TIN
1760858153	64834	822169868

52. Phone Number 760 243 4366

52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54. NPI	55. License Number
1760858153	64834

56. Address, City, State, Zip Code
12611 Hesperia Rd.
Victorville CA 923958307

56a. Provider Specialty Code 1223G0001X

57. Phone Number 760 243 4366

58. Additional Provider ID

EXHIBIT 27

Claim #274 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:	
Debtor	Borrego Community Health Foundation
United States Bankruptcy Court for the Southern District of California	
Case number	22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. Who is the current creditor?

Yong Hee Lee DDS Inc.
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)

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Where should notices to the creditor be sent?

Yong Hee Lee DDS Inc.
Name
12611 Hesperia Rd. Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code
USA
Country
Contact phone 760-243-4366
Contact email leeofficemanager@gmail.com

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

Name
Number Street
City State ZIP Code
Country
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? _____

2202384240403000000000035

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: 9868 TID#

7. **How much is the claim?** $ 100.00 **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.
   Dental

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 amount should match the amount in line 7.)

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   APR 03 2024
   KURTZMAN CARSON CONSULTANTS

   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.

Amount entitled to priority

- [x] No
- [ ] Yes. *Check all that apply:*
  - [ ] Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B). $_____
  - [ ] Up to $3,350* 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 $15,150*) 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). $_____
  - [ ] 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

- [x] No
- [ ] Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

  $_____

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:

- [x] 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 acknowledgement 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 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 03/28/2024 (MM / DD / YYYY)

Signature

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

Name: Yung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yung Hee Lee DDS Inc. (Identify the corporate servicer as the company if the authorized agent is a servicer.)

Address: 12611 Hesperia Rd Ste C (Number Street)
Victorville, CA. 92395 (City State ZIP Code Country)

Contact phone: 760-243-4364 Email: lee.officemanager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☒ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
C/o KCC
222 N. Pacific Coast Hwy ste 300
El Segundo CA 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/19/2020		JR			D9430		1	office visit for observation (during regu	100.00
2										
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1 ☒ 3 4 5 6 7 8 9 10 11 12 13 14 ☒ 15 ☒ 16

32 ☒ 30 29 28 27 26 25 24 23 22 21 20 19 ☒ 18 17 ☒

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ C ____ B ____ D ____

31a. Other Fee(s)

32. Total Fee 100.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153 | 50. License Number 64834 | 51. SSN or TIN 822169868

52. Phone Number (760) 243 - 4366 | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54. NPI 1760858153 | 55. License Number 64834

56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307 | 56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243 - 4366 | 58. Additional Provider ID

EXHIBIT 28

Claim #275 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   Contact phone
   Contact email

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

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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?

22023842404030000000000034

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: 9868 TIDH

7. **How much is the claim?**
$ 800.00. **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.
Dental

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 amount should match the amount in line 7.)

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024
MM / DD / YYYY

Signature

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

Name: Yung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4366 Email Lee office manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [ ] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [X] EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
   Barrego Health Claims Processing Center
   C/O KCC
   222 N. Pacific Coast Hwy Ste 300
   El Segundo CA 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY) | 7. Gender [ ] M [ ] F | 8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
    [redacted]
13. Date of Birth (MM/DD/CCYY) [redacted] | 14. Gender [ ] M [X] F | 15. Policyholder/Subscriber ID (SSN or ID#) [redacted]
16. Plan/Group Number [redacted] | 17. Employer Name [redacted]

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above: [X] Self [ ] Spouse [ ] Dependent Child [ ] Other | 19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
    [redacted]
21. Date of Birth (MM/DD/CCYY) [redacted] | 22. Gender [ ] M [X] F | 23. Patient ID/Account # (Assigned by Dentist) [redacted]

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26 Tooth System	27 Tooth Number(s) or Letter(s)	28 Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	07/02/2019		JP	24		D3310		1	endodontic therapy, anterior tooth (ex	800.00
2										
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)
1 X 3 4 5 6 7 8 9 10 11 12 13 14X 15 16X
32 X X X 28 27 26 25 24 X23 22 21 20 19 18 17X

33. Diagnosis Code List Qualifier [ ] [ ] (ICD-9 = B, ICD-10 = AB)
33a. Diagnosis Code(s) A ____ C ____
(Primary diagnosis in "A") B ____ D ____

31e. Other Fee(s)
32. Total Fee 800.00

34. Remarks

AUTHORIZATIONS

35. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contracted agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — 03/29/2024
Patient/Guardian Signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — 03/29/2024
Subscriber Signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational Illness/Injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
    Yonghee Lee
    12611 Hesperia Rd.
    Suite C
    Victorville CA 923958307
49. NPI 1760858153 | 50. License Number 64834 | 51. SSN or TIN 822169868
52. Phone Number (760) 243 - 4366 | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
    X Yonghee Lee — 03/29/2024
    Signed (Treating Dentist) — Date
54. NPI 1760858153 | 55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307 | 56a. Provider Specialty Code 1223G0001X
57. Phone Number (760) 243 - 4366 | 58. Additional Provider ID

EXHIBIT 29

Claim #276 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   Contact phone
   Contact email

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

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   APR 03 2024
   KURTZMAN CARSON CONSULTANTS

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? _____

2202384240403000000000033

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: 9868 TIDH

7. **How much is the claim?**
$ 600.00 . **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.
Dental

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 amount should match the amount in line 7.)

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APR 03 2024
KURTZMAN CARSON CONSULTANTS

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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024
MM / DD / YYYY

Signature

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

RECEIVED
APR 03 2024
WIPTZMAN CARSON CONSULTANTS

Name: Yung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone: 760-243-4364 Email: leeofficemanager@gmail.com

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - ☐ Statement of Actual Services
   - ☐ Request for Predetermination/Preauthorization
   - ☒ EPSDT/ Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Borrego Health Claims Processing Center
C/O KCC
222 N. Pacific Coast Hwy Ste 300
El Segundo, Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender ☐ M ☐ F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
13. Date of Birth (MM/DD/CCYY) [redacted]
14. Gender ☒ M ☐ F
15. Policyholder/Subscriber ID (SSN or ID#) [redacted]
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☒ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
21. Date of Birth (MM/DD/CCYY) [redacted]
22. Gender ☒ M ☐ F
23. Patient ID/Account # (Assigned by Dentist) [redacted]

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/19/2020	01	JR			D3		1	Denture Delivery	300.00
2	11/19/2020	02	JR			D3		1	Denture Delivery	300.00
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)
1 ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒
32 ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒ ☒

33. Diagnosis Code List Qualifier ☐☐ (ICD-9 = 8, ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A")
A ____ C ____
B ____ D ____
31a. Other Fee(s)
32. Total Fee 600.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307
49. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822169868
52. Phone Number (760) 243-4366
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date
54. NPI 1760858153
55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
56a. Provider Specialty Code 1223G0001X
57. Phone Number (760) 243-4366
58. Additional Provider ID

EXHIBIT 30

Claim #277 Date Filed: 4/4/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   APR 04 2024
   KURTZMAN CARSON CONSULTANTS

   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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?

2202384240404000000000003

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: 9868 TIDH

7. **How much is the claim?**
   $ 10.00 . **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.
   Dental

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 amount 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

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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.

- [x] No
- [ ] Yes. *Check all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
  - [ ] 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

- [x] No
- [ ] Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

  $_____

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:

- [x] 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 acknowledgement 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 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 03/28/2024
MM / DD / YYYY

Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee office manager@gmail.com

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APR 04 2024
KURTZMAN CARSON CONSULTANTS

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [ ] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [X] EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
   Borrego Health Claims Processing Center
   C/o KCC
   222 N. Pacific Coast Hwy Ste 300
   El Segundo Ca 90245

[redacted]

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/13/2020		JP			D1999		1	Personal Protective Equipment	5.00
2	11/12/2020		JP	5		D1999		1	Personal Protective Equipment	5.00
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
X		X	X										X	X	X

32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
X		X	X					X					X	X	X

33. Diagnosis Code List Qualifier [ ] (ICD-9 = B; ICD-10 = AB)
34. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____
34a. Other Fee(s)
35. Total Fee 10.00
36. Remarks

AUTHORIZATIONS

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — 03/29/2024
Patient/Guardian Signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — 03/29/2024
Subscriber Signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
    Yonghee Lee
    12611 Hesperia Rd.
    Suite C
    Victorville CA 923958307
49. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822169868
52. Phone Number (760) 243-4366
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
    X Yonghee Lee — 03/29/2024
    Signed (Treating Dentist) — Date
54. NPI 1760858153
55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
56a. Provider Specialty Code 1223G0001X
57. Phone Number (760) 243-4366
58. Additional Provider ID

EXHIBIT 31

Claim #278 Date Filed: 4/4/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   KURTZMAN CARSON CONSULTANTS

   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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?

2202384240404000000000002

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: 9868 TID#

7. **How much is the claim?**
   $ 150-00 . **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.
   Dental

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 amount should match the amount in line 7.)

   RECEIVED
   APR 04 2024
   KURTZMAN CARSON CONSULTANTS

   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 all that apply:*

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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024
MM / DD / YYYY

Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee.office.manager@gmail.com

RECEIVED
APR 04 2024
KURTZMAN CARSON CONSULTANTS

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☒ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
c/o ICOC
222 N. Pacific Coast Hwy Ste 300
El Segundo, Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/17/2020		JP			D0120		1	periodic oral evaluation - established	150.00
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 X 3 X 5 6 7 X8 X9 X10 X11 X12X 13X 14X 15X 16X

32 X X X X 27 26 25 24 X23 22 21 20X 19X 18X 17X

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ C ____ B ____ D ____

31a. Other Fee(s)

32. Total Fee 150.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use 'Place of Service Codes for Professional Claims')

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153 | 50. License Number 64834 | 51. SSN or TIN 822169868

52. Phone Number (760) 243-4366 | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54. NPI 1760858153 | 55. License Number 64834

56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307 | 56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243-4366 | 58. Additional Provider ID

EXHIBIT 32

Claim #279 Date Filed: 4/4/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Ung Hee Lee DDS Inc.
   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?
   Ung Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   Contact phone
   Contact email

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   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?

22023842404040000000000004

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: 9868 TID#

7. **How much is the claim?**
   $ 255.00 . **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.
   Dental

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 amount should match the amount in line 7.)

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   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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☑ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024
MM / DD / YYYY

Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4366 Email lee office manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT - Title XIX

2. Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center c/o Kcc
222 N. Pacific Coast Hwy., Ste 300
El Segundo, CA 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/12/2020		JP			D1999		1	Personal Protective Equipment	5.00
2	11/12/2020		JP	29	OD	D2392		1	resin-based composite - two surfaces,	250.00
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1 X 3 X 5 6 7 8 9 10 11 12 13 14 15 X 16 X
32 X 30 29 28 27 26 25 24 23 22 21 20 19 X 18 17 X

33. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ C ____ B ____ D ____

31a. Other Fee(s)

32. Total Fee 255.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153 50. License Number 64834 51. SSN or TIN 822169868

52. Phone Number (760) 243 - 4366 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54. NPI 1760858153 55. License Number 64834

56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307

56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243 - 4366 58. Additional Provider ID

EXHIBIT 33

Claim #280 Date Filed: 4/4/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Ung Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Ung Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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?

22023842404040000000000001

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: 9868 TID#

7. **How much is the claim?** $ 305.00 **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.
   Dental

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 amount should match the amount in line 7.)

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   APR 04 2024
   KURTZMAN CARSON CONSULTANTS

   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 all that apply:*

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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024
MM / DD / YYYY

Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone: 760-243-4364 Email: lee.office.manager@gmail.com

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APR 04 2024
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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☒ PPSCT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
C/o KCC
222 N Pacific Coast Hwy ste 300
El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

[redacted]

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/19/2020		JP			D4910		1	periodontal maintenance	300.00
2	11/19/2020		JP			D1999		1	Personal Protective Equipment	5.00
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1 X 3 4 5 X X 8 9 10 11 12X 13X 14X 15X 16X

32 X X X X 28 27 26 25 24 23 22 21 20 19X 18X 17X

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) A ____ C ____

(Primary diagnosis in "A") B ____ D ____

31a. Other Fee(s)

32. Total Fee 305.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153 | 50. License Number 64834 | 51. SSN or TIN 822159868

52. Phone Number (760) 243 - 4366 | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54. NPI 1760858153 | 55. License Number 64834

56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307 | 56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243 - 4366 | 58. Additional Provider ID

EXHIBIT 34

Claim #281 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   KURTZMAN CARSON CONSULTANTS

   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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?

2202384240405000000000014

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: 9868 TID#

7. **How much is the claim?**
$ 255.00 . **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.
Dental

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 amount should match the amount in line 7.)

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03 / 28 / 2024
MM / DD / YYYY

Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee office manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1 Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☒ EPSDT/Title XIX

2 Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3 Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
c/o KCC
222 N. Pacific Coast Hwy Ste 300
El Segundo, CA. 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4 Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5 Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6 Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9 Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11 Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/13/2020		JP			D1999		1	Personal Protective Equipment	5.00
2	11/13/2020		JP	12	MO	D2392		1	resin-based composite - two surfaces,	250.00
3										
4										
5										
6										
7										
8										
9										
10										

32 Total Fee: 255.00

33 Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 X 5 6 7 8 9 10 11 12 13 14 15 16X

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18X 17

34 Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) A ____ C ____ (Primary diagnosis in "A") B ____ D ____

31a. Other Fee(s)

35 Remarks

AUTHORIZATIONS

36 I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — 03/29/2024
Patient/Guardian Signature — Date

37 I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — 03/29/2024
Subscriber Signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38 Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39 Enclosures (Y or N) ☐

40 Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41 Date Appliance Placed (MM/DD/CCYY)

42 Months of Treatment Remaining

43 Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44 Date of Prior Placement (MM/DD/CCYY)

45 Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46 Date of Accident (MM/DD/CCYY)

47 Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48 Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49 NPI 1760858153 | 50 License Number 64834 | 51 SSN or TIN 822169868

52 Phone Number (760) 243-4366 | 52a Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53 I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee — 03/29/2024
Signed (Treating Dentist) — Date

54 NPI 1760858153 | 55 License Number 64834 1223G0001X

56 Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307 | 56a Provider Specialty Code

57 Phone Number (760) 243-4366 | 58 Additional Provider ID

EXHIBIT 35

Claim #282 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   Contact phone
   Contact email

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   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?

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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: 9868 TIDH

7. **How much is the claim?**
$ 1955.00 . **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.
Dental

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 amount should match the amount in line 7.)

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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.

- [x] No
- [ ] Yes. *Check all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
  - [ ] 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

- [x] No
- [ ] Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim..

$_____

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:

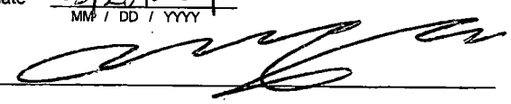
- [x] I am the creditor.
- [ ] I am the creditor's attorney or authorized agent.
- [ ] I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.
- [ ] I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2024
MM / DD / YYYY



Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee office manager@gmail.com

RECEIVED
APR 05 2024
KURTZMAN CARSON CONSULTANTS

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [ ] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [X] EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
   Borrego Health Claims Processing Center
   C/O KCC
   222 N. Pacific Coast Hwy Ste 300
   El Segundo, CA. 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code [redacted]
13. Date of Birth (MM/DD/CCYY) [redacted]
14. Gender [ ] M [X] F
15. Policyholder/Subscriber ID (SSN or ID#) [redacted]
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [X] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code [redacted]
21. Date of Birth (MM/DD/CCYY) [redacted]
22. Gender [ ] M [X] F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/16/2020		JP			D1999		1	Personal Protective Equipment	5.00
2	11/20/2020		JP	3		2810.10		1	Seat Crown	100.00
3	11/05/2020		JP	4		D2751		1	crown - porcelain fused to predomina	1500.00
4	11/23/2020		JP	4		2810.10		1	Seat Crown	100.00
5	11/16/2020		JP	8	DL	D2331		1	resin-based composite - two surfaces,	250.00
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	X	4	5	6	7	8	9	10	11	12	13	X	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

34. Diagnosis Code List Qualifier [ ] [ ] (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ C _____ B _____ D _____
31a. Other Fee(s)
32. Total Fee 1955.00
35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — 03/29/2024
Patient/Guardian Signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — 03/29/2024
Subscriber Signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational Illness/Injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822169868
52. Phone Number (760) 243 - 4366
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee — 03/29/2024
Signed (Treating Dentist) — Date

54. NPI 1760858153
55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
56a. Provider Specialty Code 1223G0001X
57. Phone Number (760) 243 - 4366
58. Additional Provider ID

To reorder call 800.947.4746

EXHIBIT 36

Claim #283 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Uma Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Uma Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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?

2202384240405000000000013

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: 9868 TIDH

7. **How much is the claim?**
   $ 3000.00 . **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.
   Dental

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 amount 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

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03 / 28 / 2024 (MM / DD / YYYY)

Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone: 760-243-4364 Email: lee office manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☒ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
C/O KCC
222 N. Pacific Coast Hwy Ste 300
El Segundo, Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/06/2020		JP	18		D2751		1	crown - porcelain fused to predomina	1500.00
2	11/09/2020		JP	19		D2751		1	crown - porcelain fused to predomina	1500.00
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1 ☒ 3 4 5 6 7 8 9 10 11 12 13 14 ☒ 15 16 ☒

32 ☒ 30 29 28 27 26 25 24 23 22 21 20 19 18 17 ☒

33. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) A _____ C _____

(Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s)

32. Total Fee 3000.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153 | 50. License Number 64834 | 51. SSN or TIN 822169868

52. Phone Number (760) 243 - 4366 | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54. NPI 1760858153 | 55. License Number 64834

56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307 | 56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243 - 4366 | 58. Additional Provider ID

EXHIBIT 37

Claim #284 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com
   Uniform claim identifier for electronic payments in chapter 13 (if you use one):

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   Contact phone
   Contact email

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?

22023842404050000000000016

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: 9868 TIDH

7. **How much is the claim?**
$ 305.00 . **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.
Dental

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 amount should match the amount in line 7.)

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024 (MM / DD / YYYY)

Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee.officemanager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

Type of Transaction (Mark all applicable boxes)

- [ ] Statement of Actual Services
- [ ] Request for Predetermination/Preauthorization
- [X] EPSDT / Title XIX

2. Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
C/o KCC
222 N. Pacific Coast Hwy Ste 300
El Segundo CA 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender [ ] M [ ] F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/09/2020		JR			D1999		1	Personal Protective Equipment	5.00
2	11/09/2020		JR	10	MFL	D2332		1	resin-based composite - three surface	300.00
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34. Diagnosis Code List Qualifier [ ] (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee 305.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — 03/29/2024
Patient/Guardian Signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — 03/29/2024
Subscriber Signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) [ ]

40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153 | 50. License Number 64834 | 51. SSN or TIN 822169868

52. Phone Number (760) 243 - 4366 | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee — 03/29/2024
Signed (Treating Dentist) — Date

54. NPI 1760858153 | 55. License Number 64834

56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307 | 56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243 - 4366 | 58. Additional Provider ID

EXHIBIT 38

Claim #285 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. Who is the current creditor?

Yong Hee Lee DDS Inc.
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)

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Where should notices to the creditor be sent?

Yong Hee Lee DDS Inc.
Name
12611 Hesperia Rd. Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code
USA
Country
Contact phone 760-243-4366
Contact email leeofficemanager@gmail.com

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

Name
Number Street
City State ZIP Code
Country
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? _____

22023842404050000000000017

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: 9868 TID#

7. **How much is the claim?**

$ 145.00 . **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.

Dental

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 amount should match the amount in line 7.)

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

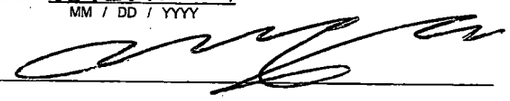
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2024
MM / DD / YYYY



Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4366 Email lee.officemanager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - ☐ Statement of Actual Services
   - ☐ Request for Predetermination/Preauthorization
   - ☒ EPSDT/Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
   Borrego HealthClaims Processing Center
   c/o KCC
   222 N. Pacific Coast Hwy Ste 300
   El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11 if none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender ☐ M ☐ F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
    [redacted]
13. Date of Birth (MM/DD/CCYY) [redacted]
14. Gender ☐ M ☒ F
15. Policyholder/Subscriber ID (SSN or ID#) [redacted]
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☒ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
    [redacted]
21. Date of Birth (MM/DD/CCYY) [redacted]
22. Gender ☐ M ☒ F
23. Patient ID/Account # (Assigned by Dentist) [redacted]

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/10/2020	20	JP			D4341		1	UL periodontal scaling and root planin	70.00
2	11/10/2020	30	JP			D4341		1	LL periodontal scaling and root planin	70.00
3	11/10/2020		JP			D1999		1	Personal Protective Equipment	5.00
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)
1 X 3 4 5 6 7 8 9 10 11 12X 13 14X 15 16X
32 X 30 29 28 27 26 25 24 23 22 21 20 19X 18X 17

33. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ C ____ B ____ D ____

31a. Other Fee(s)
32. Total Fee 145.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X Signature on File — 03/29/2024
Patient/Guardian Signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X Signature on File — 03/29/2024
Subscriber Signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=OP Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
    Yonghee Lee
    12611 Hesperia Rd.
    Suite C
    Victorville CA 923958307
49. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822169868
52. Phone Number 760 243 4366
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X Yonghee Lee — 03/29/2024
Signed (Treating Dentist) — Date
54. NPI 1760858153
55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
56a. Provider Specialty Code 1223G0001X
57. Phone Number 760 243 4366
58. Additional Provider ID

EXHIBIT 39

Claim #286 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   Contact phone
   Contact email

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   Last 4 digits of the 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: 9868 TIDH

7. **How much is the claim?**

$ 3010.00 . **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.

Dental

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 amount should match the amount in line 7.)

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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.

- [x] No
- [ ] Yes. *Check all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
  - [ ] 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

- [x] No
- [ ] Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

  $_____

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:

- [x] 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 acknowledgement 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 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 03/28/2024
MM / DD / YYYY

Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4366 Email lee.officemanager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1 Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☒ EPSDT / Title XIX

2 Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3 Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
C/o Kcc
222 N. Pacific Coast Hwy ste 300
El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4 Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5 Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6 Date of Birth (MM/DD/CCYY)	7 Gender ☐ M ☐ F	8 Policyholder/Subscriber ID (SSN or ID#)
9 Plan Group Number	10 Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11 Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24 Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28 Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/10/2020		JP			D1999		1	Personal Protective Equipment	5.00
2	11/17/2020		JP			D1999		1	Personal Protective Equipment	5.00
3	10/27/2020		JP	19		D3330		1	endodontic therapy, molar tooth (exclu	1200.00
4	11/10/2020		JP	19		D3300		1	Finishing Root Canal	300.00
5	11/17/2020		JP	19		D2751		1	crown - porcelain fused to predomina	1500.00
6										
7										
8										
9										
10										

32 Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34 Diagnosis Code List Qualifier ☐☐ (ICD-9 = 8, ICD-10 = AB)

34a. Diagnosis Code(s) A ____ C ____

(Primary diagnosis in "A") B ____ D ____

31a. Other Fee(s)

32. Total Fee 3010.00

33 Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49 NPI 1760858153 | 50. License Number 64834 | 51. SSN or TIN 822169868

52 Phone Number (760) 243 - 4366 | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54 NPI 1760858153 | 55. License Number 64834 | 55a. Provider Specialty Code 1223G0001X

56. Address, City, State, Zip Code
12611 Hesperia Rd.
Victorville CA 923958307

57. Phone Number (760) 243 - 4366 | 58. Additional Provider ID

EXHIBIT 40

Claim #287 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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? _____

2202384240405000000000023

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: 9868 TIDH

7. **How much is the claim?**
   $ 505.00 . **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.
   Dental

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 amount should match the amount in line 7.)

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   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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024
MM / DD / YYYY

Signature

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

Name: Yung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee office manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1 Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☒ EPSDT / Title XIX

2 Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3 Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center c/o Kcc
222 N. Pacific Coast Hwy., Ste 300
El Segundo, CA 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4 Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5 Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6 Date of Birth (MM/DD/CCYY)

7 Gender ☐ M ☐ F

8 Policyholder/Subscriber ID (SSN or ID#)

9 Plan/Group Number

10 Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11 Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12 Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

[redacted]

13 Date of Birth (MM/DD/CCYY) [redacted]

14 Gender ☐ M ☒ F

15 Policyholder/Subscriber ID (SSN or ID#) [redacted]

16 Plan/Group Number

17 Employer Name

PATIENT INFORMATION

18 Relationship to Policyholder/Subscriber in #12 Above ☒ Self ☐ Spouse ☐ Dependent Child ☐ Other

19 Reserved For Future Use

20 Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

[redacted]

21 Date of Birth (MM/DD/CCYY) [redacted]

22 Gender ☒ M ☐ F

23 Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/16/2020	20	JP			D4341		1	UL periodontal scaling and root planin	250.00
2	11/16/2020	30	JP			D4341		1	LL periodontal scaling and root planin	250.00
3	11/16/2020		JP			D1999		1	Personal Protective Equipment	5.00
4										
5										
6										
7										
8										
9										
10										

32 Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	X	29	28	27	26	25	24	23	22	21	20	19	18	17

33 Diagnosis Code List Qualifier ☐☐ (ICD-9 = B, ICD-10 = AB)

34 Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____

34a Other Fee(s)

35 Total Fee 505.00

36 Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — 03/29/2024
Patient/Guardian Signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — 03/29/2024
Subscriber Signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38 Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39 Enclosures (Y or N) ☐

40 Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41 Date Appliance Placed (MM/DD/CCYY)

42 Months of Treatment Remaining

43 Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44 Date of Prior Placement (MM/DD/CCYY)

45 Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46 Date of Accident (MM/DD/CCYY)

47 Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48 Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49 NPI 1760858153

50 License Number 64834

51 SSN or TIN 822189868

52 Phone Number 760 243 4366

52a Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53 I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee — 03/29/2024
Signed (Treating Dentist) — Date

54 NPI 1760858153

55 License Number 64834

56 Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307

56a Provider Specialty Code 1223G0001X

57 Phone Number 760 243 4366

58 Additional Provider ID

EXHIBIT 41

Claim #288 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Ung Hee Lee DDS Inc.
   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?
   Ung Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   Contact phone
   Contact email

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

   KURTZMANCARSONCONSULTANTS

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?

22023842404050000000000019

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: TID# 9868

7. **How much is the claim?**

$ 1655.00 . **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.

Dental

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 amount should match the amount in line 7.)

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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.

- [x] No
- [ ] Yes. *Check all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
  - [ ] 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

- [x] No
- [ ] Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

  $_____

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:

- [x] 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 acknowledgement 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 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 03/28/2024 (MM / DD / YYYY)

Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone: 760-243-4364 Email: lee office manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [ ] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [X] EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Borrego Health Claims Processing Center c/o Kcc
222 N. Pacific Coast Hwy., Ste 300
El Segundo, CA 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
13. Date of Birth (MM/DD/CCYY) [redacted]
14. Gender [ ] M [X] F
15. Policyholder/Subscriber ID (SSN or ID#) [redacted]
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [X] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
21. Date of Birth (MM/DD/CCYY) [redacted]
22. Gender [ ] M [X] F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/10/2020		JP			D0120		1	periodic oral evaluation - established	150.00
2	11/16/2020		JP			D4910		1	periodontal maintenance	300.00
3	11/16/2020		JP			D1999		1	Personal Protective Equipment	5.00
4	11/30/2020		JP	3,4		D5211		1	maxillary partial denture – resin base (	1200.00
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)
1 X 3 X X 6 7 8 9 10 11 12 13 14 15 16X
32 X 30 29 28 27 26 25 24 23 22 21 20 19 18 17X

33. Diagnosis Code List Qualifier [ ] [ ] (ICD-9 = B, ICD-10 = AB)
33a. Diagnosis Code(s) A ____ C ____
(Primary diagnosis in "A") B ____ D ____

31a. Other Fee(s)
32. Total Fee 1655.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=OP Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307
49. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822169868
52. Phone Number 760 243 4366
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date
54. NPI 1760858153
55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
56a. Provider Specialty Code 1223G0001X
57. Phone Number 760 243 4366
58. Additional Provider ID

EXHIBIT 42

Claim #289 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Uma Hee Lee DDS Inc.
   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?
   Uma Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   Contact phone
   Contact email

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   APR 05 2024
   KURTZMAN CARSON CONSULTANTS

   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?

2202384240405000000000020

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: 9868 TID#

7. **How much is the claim?**
   $ 255.00 . **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.
   Dental

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 amount 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

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APR 05 2024
KURTZMAN CARSON CONSULTANTS

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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

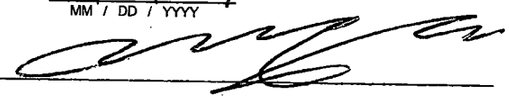
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2024
MM / DD / YYYY


Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4366 Email Lee office manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1 Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

2 ☒ EPSDT / Title XIX

3 Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

4 Company/Plan Name, Address, City, State, Zip Code

Barrego Health Claims Processing Center
C/O KCC
222 N. Pacific Coast Hwy Ste 300
El Segundo CA 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

6 Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5 Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6 Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9 Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11 Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

[redacted]

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/12/2020		JP	29	OD	D2392		1	resin-based composite - two surfaces,	250.00
2	11/12/2020		JP			D1999		1	Personal Protective Equipment	5.00
3										
4										
5										
6										
7										
8										
9										
10										

32 Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
X	X	X	X	28	27	26	25	24	23	22	21	20	19	18	17

33 Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____

31a Other Fee(s)

32 Total Fee 255.00

35 Remarks

AUTHORIZATIONS

36 I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37 I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38 Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39 Enclosures (Y or N) ☐

40 Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41 Date Appliance Placed (MM/DD/CCYY)

42 Months of Treatment Remaining

43 Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44 Date of Prior Placement (MM/DD/CCYY)

45 Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46 Date of Accident (MM/DD/CCYY)

47 Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48 Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49 NPI 1760858153 | 50 License Number 64834 | 51 SSN or TIN 822169868

52 Phone Number (760) 243-4366 | 52a Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53 I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54 NPI 1760858153 | 55 License Number 64834

56 Address, City, State, Zip Code
12611 Hesperia Rd.
Victorville CA 923958307

56a Provider Specialty Code 1223G0001X

57 Phone Number (760) 243-4366 | 58 Additional Provider ID

EXHIBIT 43

Claim #290 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:	
Debtor	Borrego Community Health Foundation
United States Bankruptcy Court for the Southern District of California	
Case number	22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Uma Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Uma Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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? _____

2202384240405000000000021

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: 9868 TIDH

7. **How much is the claim?**
$ 230.00. **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.
Dental

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 amount should match the amount in line 7.)

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

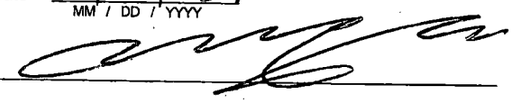
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2024
MM / DD / YYYY



Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4366 Email lee office manager@gmail.com

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APR 05 2024
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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [ ] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [X] EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Borrego Health Claims Processing Center
C/o KCC
222 N. Pacific Coast Hwy Ste 300
El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

[redacted]

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/16/2020		JP	28		D1999		1	Personal Protective Equipment	5.00
2	11/16/2020		JP	31	B	D2391		1	resin-based composite - one surface,	225.00
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Tooth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	X														X

32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
	X												X		X

33. Diagnosis Code List Qualifier [ ] (ICD-9 = B; ICD-10 = AB)
34. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____
31a. Other Fee(s)
32. Total Fee 230.00
35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — 03/29/2024
Patient/Guardian Signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — 03/29/2024
Subscriber Signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822169868
52. Phone Number (760) 243-4366
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee — 03/29/2024
Signed (Treating Dentist) — Date

54. NPI 1760858153
55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
56a. Provider Specialty Code 1223G0001X
57. Phone Number (760) 243-4366
58. Additional Provider ID

To reorder call 800.947.4746

EXHIBIT 44

Claim #291 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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: 9868 TIDH

7. **How much is the claim?**
$ 415.00. **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.
Dental

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 amount should match the amount in line 7.)

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03 / 28 / 2024 (MM / DD / YYYY)

Signature

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

Name: Ung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Ung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4366 Email lee office manager@gmail.com

RECEIVED
APR 05 2024
KURTZMAN CARSON CONSULTANTS

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [ ] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [X] EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Borrego Health claims processing Center
c/o Rcc
222N. Pacific Coast Hwy ste 300
El Segundo, CA. 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
13. Date of Birth (MM/DD/CCYY) [redacted]
14. Gender [ ] M [X] F
15. Policyholder/Subscriber ID (SSN or ID#) [redacted]
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [X] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
21. Date of Birth (MM/DD/CCYY) [redacted]
22. Gender [ ] M [X] F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	10/20/2020		JP			D9430		1	office visit for observation (during regu	100.00
2	11/13/2020		JP			D4910		1	periodontal maintenance	300.00
3	11/13/2020		JP			D1999		1	Personal Protective Equipment	5.00
4	11/20/2020		JP			D1999		1	Personal Protective Equipment	5.00
5	11/24/2020		JP			D1999		1	Personal Protective Equipment	5.00
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 X 3 4 5 X6 7 8 9 10 11 12X 13 14 15 16X
32 X 30 29 28 X27 26 25 24 23 22 21X 20 19 18 17X

34. Diagnosis Code List Qualifier [ ] (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)
32. Total Fee 415.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational Illness/Injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307
49. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822169868
52. Phone Number (760) 243 - 4366
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date
54. NPI 1760858153
55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
56a. Provider Specialty Code 1223G0001X
57. Phone Number (760) 243 - 4366
58. Additional Provider ID

EXHIBIT 45

Claim #292 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Uma Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Uma Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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: 9868 TID#

7. **How much is the claim?**
$ 255.00 . **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.
Dental

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 amount 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

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024 (MM / DD / YYYY)

Signature

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

Name: Yung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email Lee office manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

[ ] Statement of Actual Services [ ] Request for Predetermination/Preauthorization
[X] MEDI-CAL Title XIX

2. Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health claims Processing Center
c/o KCC
222 N. Pacific Coast Hwy Ste 300
El Segundo, CA. 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

5. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)

6. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

7. Date of Birth (MM/DD/CCYY)	8. Gender [ ] M [ ] F	9. Policyholder/Subscriber ID (SSN or ID#)

10. Plan/Group Number	11. Patient's Relationship to Person named in #6
	[ ] Self [ ] Spouse [ ] Dependent [ ] Other

12. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/13/2020		JP	9		D7210		1	extraction, erupted tooth requiring rem	250.00
2	11/13/2020		JP	9		D1999		1	Personal Protective Equipment	5.00
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1 X 3 X 4 X 5 6 7 8 9 10 11 12 13 14 X 15 X 16 X
32 X 31 X 30 X 29 X 28 X 27 X 26 X 25 X 24 X 23 X 22 X 21 X 20 X 19 X 18 X 17 X

33. Diagnosis Code List Qualifier [ ] (ICD-9 = B, ICD-10 = AB)

33a. Other Fee(s)

34a. Diagnosis Code(s) (Primary diagnosis in "A")
A _____ C _____
B _____ D _____

34. Total Fee 255.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) [ ]

40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from [ ] Occupational Illness/Injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI	50. License Number	51. SSN or TIN
1760858153	64834	822169868

52. Phone Number 760 243 4366

52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54. NPI	55. License Number
1760858153	64834

56. Address, City, State, Zip Code
12611 Hesperia Rd.
Victorville CA 923958307

56a. Provider Specialty Code 1223G0001X

57. Phone Number 760 243 4366

58. Additional Provider ID

EXHIBIT 46

Claim #293 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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?

2202384240405000000000011

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: 9868 TIDH

7. **How much is the claim?**
$ 1950.00 . **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.
Dental

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 amount should match the amount in line 7.)

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024 (MM / DD / YYYY)

Signature

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

Name: Yung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4366 Email lee office manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
- [ ] Statement of Actual Services
- [ ] Request for Predetermination/Preauthorization
- [X] EPSDT/ Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Borrego Health Claims Processing Center
C/O KCC
2302 N. Pacific Coast Hwy Ste 300
El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)

7. Gender [ ] M [ ] F

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]

13. Date of Birth (MM/DD/CCYY) [redacted]

14. Gender [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#) [redacted]

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [X] Self [ ] Spouse [ ] Dependent Child [ ] Other

19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]

21. Date of Birth (MM/DD/CCYY) [redacted]

22. Gender [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/17/2020		JP			D6999		1	unspecified fixed prosthodontic proce	250.00
2	10/19/2020		JP			D9430		1	office visit for observation (during regu	100.00
3	11/02/2020		JP	3		D2751		1	crown - porcelain fused to predomina	1500.00
4	11/17/2020		JP	3		2810.10		1	Seat Crown	100.00
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
		X													
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

33. Diagnosis Code List Qualifier [ ] (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ C _____ B _____ D _____

31a. Other Fee(s)

32. Total Fee 1950.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) [ ]

40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from [ ] Occupational Illness/Injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153

50. License Number 64834

51. SSN or TIN 822169868

52. Phone Number (760) 243 - 4366

52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54. NPI 1760858153

55. License Number 64834

56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307

56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243 - 4366

58. Additional Provider ID

EXHIBIT 47

Claim #294 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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?

2202384240405000000000012

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: 9868 TID#

7. **How much is the claim?**
   $ 455.00 . **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.
   Dental

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 amount should match the amount in line 7.)

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   KURTZMAN CARSON CONSULTANTS

   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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024 (MM / DD / YYYY)

Signature

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

Name: Ujong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Ujong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4366 Email lee.office.manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

[ ] Statement of Actual Services [ ] Request for Predetermination/Preauthorization

[X] EPSDT/ Title XIX

2. Predetermination/Preauthorization Number

[redacted]

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
C/o KAC
222 N. Pacific Coast Hwy Ste 300
El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [X] (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

Leduc, Rosa

6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Subscriber ID (SSN or ID#)
03/17/1981	[ ] M [X] F	94208396A50044

9. Plan/Group Number	10. Patient's Relationship to Person named in #5
	[X] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

Denti-Cal
Po Box 15610
Sacramento CA 95852-0610

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/16/2020		JP			D0150		1	comprehensive oral evaluation - new	150.00
2	11/19/2020		JP			D4910		1	periodontal maintenance	300.00
3	11/19/2020		JP			D1999		1	Personal Protective Equipment	5.00
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 [X] 3 4 5 6 7 8 9 10 11 12 13 14 15 16[X]

32 [X] 30 29 28 27 26 25 24 23 22 21 20 19 18 17[X]

34. Diagnosis Code List Qualifier [ ] (ICD-9 = B, ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee 455.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — Patient/Guardian Signature — 03/29/2024 Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — Subscriber Signature — 03/29/2024 Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) [ ]

40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI	50. License Number	51. SSN or TIN
1760858153	64834	822169868

52. Phone Number 760 243 4366

52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee — Signed (Treating Dentist) — 03/29/2024 Date

54. NPI 1760858153

55. License Number 64834

56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307

56a. Provider Specialty Code 1223G0001X

57. Phone Number 760 243 4366

58. Additional Provider ID

EXHIBIT 48

Claim #295 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   KURTZMANCARSONCONSULTANTS

   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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?

2202384240405000000000010

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: 9868 TIO#

7. **How much is the claim?**
   $ 15.00 . **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.
   Dental

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 amount 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

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024
MM / DD / YYYY

Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee.office.manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☒ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
C/O KCC
222 N. Pacific Coast Hwy Ste 300
El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

[redacted]

13. Date of Birth (MM/DD/CCYY) [redacted] | 14. Gender ☐ M ☒ F | 15. Policyholder/Subscriber ID (SSN or ID#) [redacted]

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☒ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

[redacted]

21. Date of Birth (MM/DD/CCYY) [redacted] | 22. Gender ☐ M ☒ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/05/2020		JP			D1999		1	Personal Protective Equipment	5.00
2	11/17/2020		JP			D1999		1	Personal Protective Equipment	5.00
3	11/19/2020		JP			D1999		1	Personal Protective Equipment	5.00
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1 X X 4 5 6 7 8 9 10 11 12 13 X 14 15 X 16 X

32 X 30 X 29 X 28 X 27 26 25 24 23 22 21 20 19 X 18 X 17 X

33. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____

31a. Other Fee(s)

32. Total Fee 15.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — 03/29/2024
Patient/Guardian Signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — 03/29/2024
Subscriber Signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153 | 50. License Number 64834 | 51. SSN or TIN 822169868

52. Phone Number (760) 243 - 4366 | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee — 03/29/2024
Signed (Treating Dentist) — Date

54. NPI 1760858153 | 55. License Number 64834 | 56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307 | 56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243 - 4366 | 58. Additional Provider ID

EXHIBIT 49

Claim #296 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   APR 05 2024
   KURTZMAN CARSON CONSULTANTS

   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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: 9868 TID#

7. **How much is the claim?**
   $ 4500.00 . **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.
   Dental

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 amount should match the amount in line 7.)

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   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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024 (MM / DD / YYYY)

Signature

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

Name: Yung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee.officemanager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ Medicaid / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
C/O KGC
222 N. Pacific Coast Hwy Ste 300
El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

[redacted]

13. Date of Birth (MM/DD/CCYY) [redacted] | 14. Gender ☐ M ☒ F | 15. Policyholder/Subscriber ID (SSN or ID#) [redacted]

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☒ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

[redacted]

21. Date of Birth (MM/DD/CCYY) [redacted] | 22. Gender ☐ M ☒ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/17/2020		JP	7		D2740		1	crown - porcelain/ceramic	1500.00
2	11/17/2020		JP	8		D2740		1	crown - porcelain/ceramic	1500.00
3	11/17/2020		JP	9		D2740		1	crown - porcelain/ceramic	1500.00
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 X 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

33. Diagnosis Code List Qualifier ☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ C _____ B _____ D _____

31a. Other Fee(s)

32. Total Fee 4500.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153 | 50. License Number 64834 | 51. SSN or TIN 822169868

52. Phone Number 760 243 4366 | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54. NPI 1760858153 | 55. License Number 64834

56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307 | 56a. Provider Specialty Code 1223G0001X

57. Phone Number 760 243 4366 | 58. Additional Provider ID

EXHIBIT 50

Claim #297 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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: 9868 TID#

7. **How much is the claim?**
   $ 1250.00 . **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.
   Dental

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 amount should match the amount in line 7.)

   RECEIVED
   APR 05 2024
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   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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2024
MM / DD / YYYY

Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee office manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1 Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☒ EPSDT/ Title XIX

2 Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3 Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
c/o KCC
222 N. Pacific Coast Hwy. Ste 300
El Segundo Ca 90245

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

[redacted]

13. Date of Birth (MM/DD/CCYY) [redacted] | 14. Gender ☐ M ☒ F | 15. Policyholder/Subscriber ID (SSN or ID#) [redacted]

16. Plan/Group Number | 17. Employer Name

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4 Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5 Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6 Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☒ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

[redacted]

21. Date of Birth (MM/DD/CCYY) [redacted] | 22. Gender ☐ M ☒ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/13/2020	10	JP			D4341		1	UR periodontal scaling and root planin	250.00
2	11/13/2020	40	JP			D4341		1	LR periodontal scaling and root planin	250.00
3	11/13/2020		JP			D1999		1	Personal Protective Equipment	5.00
4	11/17/2020	20	JP			D4341		1	UL periodontal scaling and root planin	250.00
5	11/17/2020	30	JP			D4341		1	LL periodontal scaling and root planin	250.00
6	11/17/2020		JP			D1999		1	Personal Protective Equipment	5.00
7	11/20/2020		JP			D1999		1	Personal Protective Equipment	5.00
8	11/23/2020		JP			D1999		1	Personal Protective Equipment	5.00
9	11/24/2020		JP			D1999		1	Personal Protective Equipment	5.00
10	11/16/2020		JP	28	B	D2391		1	resin-based composite - one surface,	225.00

33 Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	X														X
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
	X												X		X

34 Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) A _____ C _____

(Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s)

32. Total Fee 1250.00

35 Remarks

AUTHORIZATIONS

36 I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024

Patient/Guardian Signature Date

37 I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024

Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=OP Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153 | 50. License Number 64834 | 51. SSN or TIN 822169868

52. Phone Number (760) 243 - 4366 | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53 I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

Yonghee Lee 03/29/2024

X

Signed (Treating Dentist) Date

54. NPI 1760858153 | 55. License Number 64834

56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307 | 56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243 - 4366 | 58. Additional Provider ID

EXHIBIT 51

Claim #298 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   KURTZMAN CARSON CONSULTANTS

   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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? ____

22023842404050000000007

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: 9868 TIDH

7. **How much is the claim?**
$ 3100.00 . **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.
Dental

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 amount should match the amount in line 7.)

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

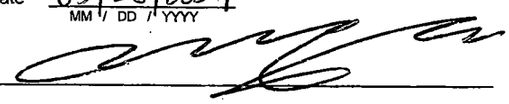
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2024
MM / DD / YYYY



Signature

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

Name: Ung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Ung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4366 Email lee.office.manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [ ] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [X] EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Borrego Health Claims Processing Center
c/o KCC
2242 N. Pacific Coast Hwy Ste 300
El Segundo, Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
13. Date of Birth (MM/DD/CCYY) [redacted]
14. Gender [X] M [ ] F
15. Policyholder/Subscriber ID (SSN or ID#) [redacted]
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [X] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
21. Date of Birth (MM/DD/CCYY) [redacted]
22. Gender [X] M [ ] F
23. Patient ID/Account # (Assigned by Dentist) [redacted]

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	10/27/2020		JP	2,5,7-10		D5213		1	maxillary partial denture - cast metal fr	1500.00
2	11/09/2020		JP	18		D2751		1	crown - porcelain fused to predomina	1500.00
3	11/24/2020		JP	18		2810.10		1	Seat Crown	100.00
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 X 4 5 X 7 X X X X 12 13 14 15 16
32 X 30 29 28 27 26 25 24 23 22 21 20 X 18 17

34. Diagnosis Code List Qualifier [ ] (ICD-9 = B, ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)
32. Total Fee 3100.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X Signature on File — Patient/Guardian Signature — 03/29/2024 — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X Signature on File — Subscriber Signature — 03/29/2024 — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307
49. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822169868
52. Phone Number (760) 243 - 4366
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X Yonghee Lee — Signed (Treating Dentist) — 03/29/2024 — Date
54. NPI 1760858153
55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
56a. Provider Specialty Code 1223G0001X
57. Phone Number (760) 243 - 4366
58. Additional Provider ID

EXHIBIT 52

Claim #299 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:	
Debtor	Borrego Community Health Foundation
United States Bankruptcy Court for the Southern District of California	
Case number	22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. Who is the current creditor?

Yong Hee Lee DDS Inc.
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)

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Where should notices to the creditor be sent?

Yong Hee Lee DDS Inc.
Name
12611 Hesperia Rd. Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code
USA
Country
Contact phone 760-243-4366
Contact email leeofficemanager@gmail.com

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

Name
Number Street
City State ZIP Code
Country
Contact phone
Contact email

Last 4 digits of the account number used by the creditor to identify the debtor's account or 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? _____

2202384240405000000000006

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: 9868 TIDH

7. **How much is the claim?**
   $ 305.00 . **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.
   Dental

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 amount should match the amount in line 7.)

   RECEIVED
   APR 05 2024
   KURTZMAN CARSON CONSULTANTS

   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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

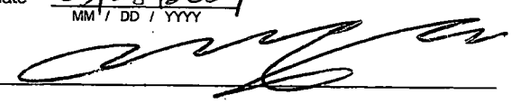
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2024 (MM / DD / YYYY)



Signature

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

Name: Ung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Ung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee.office.manager@gmail.com

RECEIVED
APR 05 2024
KURTZMAN CARSON CONSULTANTS

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [ ] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [X] EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Borrego Health Claims Processing Center
c/o IHCC
222 N. Pacific Coast Hwy Ste 300
El Segundo Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [X] (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
Lee, Jang
6. Date of Birth (MM/DD/CCYY) 03/07/1954
7. Gender [ ] M [X] F
8. Policyholder/Subscriber ID (SSN or ID#) 97933745F
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 [X] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code
Denti-Cal
Po Box 15610
Sacramento CA 95852-0610

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
13. Date of Birth (MM/DD/CCYY) [redacted]
14. Gender [X] M [ ] F
15. Policyholder/Subscriber ID (SSN or ID#) [redacted]
16. Plan/Group Number [redacted]
17. Employer Name [redacted]

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [X] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
21. Date of Birth (MM/DD/CCYY) [redacted]
22. Gender [X] M [ ] F
23. Patient ID/Account # (Assigned by Dentist) [redacted]

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/10/2020		JP			D4910		1	periodontal maintenance	300.00
2	11/10/2020		JP			D1999		1	Personal Protective Equipment	5.00
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)
1 X X 4 5 6 7 8 9 10 11 12 13 14 15 16
32 X 30 29 28 27 26 25 24 23 22 21 20 19 X 18 17

34. Diagnosis Code List Qualifier [ ] (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ C ____ B ____ D ____

31a. Other Fee(s)
32. Total Fee 305.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X Signature on File — 03/29/2024
Patient/Guardian Signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X Signature on File — 03/29/2024
Subscriber Signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307
49. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822169868
52. Phone Number 760 243 4366
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X Yonghee Lee — 03/29/2024
Signed (Treating Dentist) — Date
54. NPI 1760858153
55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
56a. Provider Specialty Code 1223G0001X
57. Phone Number 760 243 4366
58. Additional Provider ID

EXHIBIT 53

Claim #300 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   Contact phone
   Contact email

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   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? ____

22023842404050000000000005

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: 9868 TID#

7. **How much is the claim?**
   $ 305.00 . **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.
   Dental

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 amount should match the amount in line 7.)

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   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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

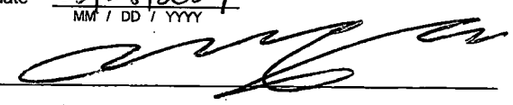
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2024 (MM / DD / YYYY)



Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone: 760-243-4364 Email: leeofficemanager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [ ] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [X] EPSDT/ Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Borrego Health Claims Processing Center
C/O MCC
222 N. Pacific Coast Hwy Ste 300
El Segundo CA 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [X] (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
Yoon, Myeongja
6. Date of Birth (MM/DD/CCYY) 04/07/1955
7. Gender [ ] M [X] F
8. Policyholder/Subscriber ID (SSN or ID#) 96933745F
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 [X] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code
Denti-Cal
Po Box 15610
Sacramento CA 95852-0610

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
13. Date of Birth (MM/DD/CCYY) [redacted]
14. Gender [ ] M [X] F
15. Policyholder/Subscriber ID (SSN or ID#) [redacted]
16. Plan/Group Number [redacted]
17. Employer Name [redacted]

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [X] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
21. Date of Birth (MM/DD/CCYY) [redacted]
22. Gender [ ] M [X] F
23. Patient ID/Account # (Assigned by Dentist) [redacted]

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/10/2020		JP			D4910		1	periodontal maintenance	300.00
2	11/10/2020		JP			D1999		1	Personal Protective Equipment	5.00
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)
1 [X] 3 4 5 6 7 8 9 10 11 12 13 14[X] 15[X] 16[X]
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17[X]

33. Diagnosis Code List Qualifier [ ] [ ] (ICD-9 = 0; ICD-10 = AB)
33a. Diagnosis Code(s) A _____ C _____
(Primary diagnosis in "A") B _____ D _____
31a. Other Fee(s)
32. Total Fee 305.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational Illness/Injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307
49. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822169868
52. Phone Number (760) 243 - 4366
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date
54. NPI 1760858153
55. License Number 64834
55a. Provider Specialty Code 1223G0001X
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
57. Phone Number (760) 243 - 4366
58. Additional Provider ID

EXHIBIT 54

Claim #301 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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? _____

2202384240405000000000004

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: 9868 TID#

7. **How much is the claim?** $ 3300.00 . **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.

Dental

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 amount should match the amount in line 7.)

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

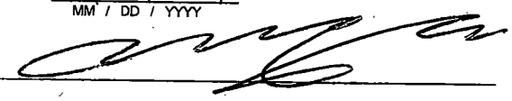
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2024
MM / DD / YYYY



Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4366 Email Lee Office manager@gmail.com

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APR 05 2024
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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [ ] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [X] PPO/DHMO/Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Borrego Health claims Processing Center
C/O KCC
222 N. Pacific coast. Hwy Ste 302
El Segundo, CA. 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
13. Date of Birth (MM/DD/CCYY) [redacted]
14. Gender [ ] M [X] F
15. Policyholder/Subscriber ID (SSN or ID#) [redacted]
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [X] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
21. Date of Birth (MM/DD/CCYY) [redacted]
22. Gender [ ] M [X] F
23. Patient ID/Account # (Assigned by Dentist) [redacted]

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/10/2020		JP			D9430		1	office visit for observation (during regu	100.00
2	11/03/2020		JP	19		D2751		1	crown - porcelain fused to predomina	1500.00
3	11/23/2020		JP	19		2810.10		1	Seat Crown	100.00
4	11/02/2020		JP	20		D2751		1	crown - porcelain fused to predomina	1500.00
5	11/20/2020		JP	20		2810.10		1	Seat Crown	100.00
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18X 17X

34. Diagnosis Code List Qualifier [ ] (ICD-9 = 0; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____
31a. Other Fee(s)
32. Total Fee 3300.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307
49. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822169868
52. Phone Number (760) 243 - 4366
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date
54. NPI 1760858153
55. License Number 64834
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
56a. Provider Specialty Code 1223G0001X
57. Phone Number (760) 243 - 4366
58. Additional Provider ID

EXHIBIT 55

Claim #302 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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)

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   KURTZMAN CARSON CONSULTANTS

   Where should notices to the creditor be sent?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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? _____

2202384240405000000000003

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: 9868 TIDH

7. **How much is the claim?**

$ 1015.00 . **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.

Dental

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 amount should match the amount in line 7.)

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

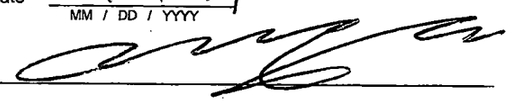
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03 / 28 / 2024
MM / DD / YYYY



Signature

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

Name: Yong (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yong Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee.office.manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
- [ ] Statement of Actual Services
- [ ] Request for Predetermination/Preauthorization
- [X] EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Borrego Health claims Processing Center
c/o Kcc
222 N. Pacific Coast Hwy Ste 300
El Segundo, CA. 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)

7. Gender [ ] M [ ] F

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person named in #5
[ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]

13. Date of Birth (MM/DD/CCYY) [redacted]

14. Gender [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#) [redacted]

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above
[X] Self [ ] Spouse [ ] Dependent Child [ ] Other

19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]

21. Date of Birth (MM/DD/CCYY) [redacted]

22. Gender [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/13/2020	10	JP			D4341		1	UR periodontal scaling and root planin	250.00
2	11/13/2020	40	JP			D4341		1	LR periodontal scaling and root planin	250.00
3	11/13/2020		JP			D1999		1	Personal Protective Equipment	5.00
4	11/23/2020	20	JP			D4341		1	UL periodontal scaling and root planin	250.00
5	11/23/2020	30	JP			D4341		1	LL periodontal scaling and root planin	250.00
6	11/23/2020		JP			D1999		1	Personal Protective Equipment	5.00
7	11/24/2020		JP			D1999		1	Personal Protective Equipment	5.00
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
		X													X
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
		X	X	X				X					X	X	X

34. Diagnosis Code List Qualifier [ ] (ICD-9 = B, ICD-10 = AB)

34a. Diagnosis Code(s) A _____ C _____

(Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s)

32. Total Fee 1015.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File 03/29/2024
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153

50. License Number 64834

51. SSN or TIN 822169868

52. Phone Number (760) 243 - 4366

52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=Off Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) [ ]

40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from
[ ] Occupational illness/injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee 03/29/2024
Signed (Treating Dentist) Date

54. NPI 1760858153

55. License Number 64834

56. Address, City, State, Zip Code
12611 Hesperia Rd.
Victorville CA 923958307

56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243 - 4366

58. Additional Provider ID

EXHIBIT 56

Claim #303 Date Filed: 4/15/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   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? ____

2202384240415000000000002

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: 9868 TIDH

7. **How much is the claim?**
   $ 3000.00 . **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.
   Dental

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 amount 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

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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.

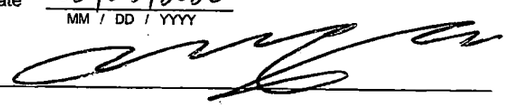
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement 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 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 03/28/2020
MM / DD / YYYY



Signature

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

Name: Ung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Ung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone: 760-243-4364 Email: lee.office.manager@gmail.com

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

[ ] Statement of Actual Services [ ] Request for Predetermination/Preauthorization

[X] PPO/DT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health processing Center
c/o KCC
2222 N. Pacific Coast Hwy. Ste 300
El Segundo, Ca 90245

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender [ ] M [X] F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender [ ] M [ ] F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [X] Self [ ] Spouse [ ] Dependent Child [ ] Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender [ ] M [X] F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	10/29/2020		JP	14		D2751		1	crown - porcelain fused to predomina	1500.00
2	11/06/2020		JP	15		D2751		1	crown - porcelain fused to predomina	1500.00
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 X X 4 5 X6 X7 8 9 10 11 12X 13X 14 15 16X

32 X X9 X20 X28 27 26 25 24 23 22 21X 20X 19 18X 17X

34. Diagnosis Code List Qualifier [ ] (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ C _____ B _____ D _____

31a. Other Fee(s)

32. Total Fee 3000.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — 03/28/2024
Patient/Guardian Signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — 03/28/2024
Subscriber Signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) [ ]

40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153 | 50. License Number 64834 | 51. SSN or TIN 822169868

52. Phone Number (760) 243 4366 | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee — 03/28/2024
Signed (Treating Dentist) — Date

54. NPI 1760858153 | 55. License Number 64834

56. Address, City, State, Zip Code
12611 Hesperia Rd.
Victorville CA 923958307

56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243 4366 | 58. Additional Provider ID

EXHIBIT 57

Claim #304 Date Filed: 4/15/2024

Your claim can be filed electronically on KCC's website at https://epoc.kccllc.net/BorregoHealth.

Fill in this information to identify the case:

Debtor Borrego Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number 22-02384

Official Form 410
Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Other than a claim under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or 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.

Part 1: Identify the Claim

1. **Who is the current creditor?**
   Yong Hee Lee DDS Inc.
   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?
   Yong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4366
   Contact email leeofficemanager@gmail.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   Contact phone
   Contact email

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   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?

2202384240415000000000001

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: 9868 TIDH

7. **How much is the claim?**
$ 5.00 . **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.
Dental

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 amount should match the amount in line 7.)

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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 all that apply:* **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 $3,350* 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 $15,150*) 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). $_____
- ☐ 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 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(9)?**

☑ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

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 acknowledgement 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 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 03/28/2020 (MM / DD / YYYY)

Signature

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

Name: Yung (First name) Hee (Middle name) Lee (Last name)

Title: Dentist

Company: Yung Hee Lee DDS Inc.
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 12611 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone 760-243-4364 Email lee.office.manager@gmail.com

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Borrego Health Claims Processing Center
C/O KCC
222 N. Pacific Coast Hwy. Ste 300
El Segundo, Ca 90245

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M X F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above: X Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) 08/11/1974 | 22. Gender ☐ M X F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/05/2020		JP			D1999		1	Personal Protective Equipment	5.00
2										
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 X 5 6 7 8 9 10 11 12 13 14X 15X 16

32 X 30 29 28 27 26 25 24 23 22 21 20 19 18 17X

33. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ C ____ B ____ D ____

31a. Other Fee(s)

32. Total Fee 5.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Signature on File — 12/21/2020
Patient/Guardian Signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File — 12/21/2020
Subscriber Signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=OP Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? X No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis X No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

49. NPI 1760858153 | 50. License Number 64834 | 51. SSN or TIN 822189868

52. Phone Number (760) 243 - 4366 | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Yonghee Lee — 12/21/2020
Signed (Treating Dentist) — Date

54. NPI 1760858153 | 55. License Number 64834

56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307 | 56a. Provider Specialty Code 1223G0001X

57. Phone Number (760) 243 - 4366 | 58. Additional Provider ID