Docket #1613 Date Filed: 05/07/2025

CSD 1001A [07/01/18]**(Page 1)**

Name, Address, Telephone No. & I.D. No.

Samuel R. Maizel (Bar No. 189301)
Tania M. Moyron (Bar No. 235736)
DENTONS US LLP
601 South Figueroa Street, Suite 2500
Los Angeles, CA 90017-5704
Telephone: 213/623-9300

Attorneys for Post-Effective Date Debtor and the Co-Liquidating Trustee

Jeffrey N. Pomerantz (Bar No. 143717)
Steven W. Golden (Admitted Pro Hac Vice)
PACHULSKI STANG ZIEHL & JONES LLP
10100 Santa Monica Blvd., 13th Floor
Los Angeles, CA 90067
Telephone: 310/277-6910

Attorneys for the Co-Liquidating Trustee

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF CALIFORNIA
325 West F Street, San Diego, California 92101-6991

In Re	BANKRUPTCY NO.
BORREGO COMMUNITY HEALTH FOUNDATION, Debtor.	22-02384-LT11

ORDER ON 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

The court orders as set forth on the continuation pages attached and numbered 2 through 2 with exhibits, if any, for a total of 300 pages. Stipulation Docket Entry No. 1611 .

/

/

DATED: May 7, 2025

Judge, United States Bankruptcy Court

22023842505080000000000001

ORDER ON 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

DEBTOR: BORREGO COMMUNITY HEALTH FOUNDATION CASE NO: 22-02384-LT11

On May 7, 2025, Borrego Community Health Foundation (the Post-Effective Date Debtor), The Liquidating Trustee, the Co-Liquidating Trustees and Yong Hee Lee DDS Inc. filed a *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, 27.1, 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* [Docket No. 1611] (the "Stipulation").

IT IS HEREBY ORDERED:

1. That the Stipulation, attached hereto as **Exhibit A**, is approved in its entirety.

2. That the terms and conditions of the Stipulation shall be binding upon the parties and are hereby fully incorporated into this Order by this reference.

EXHIBIT A

SAMUEL R. MAIZEL (Bar No. 189301)
samuel.maizel@dentons.com
TANIA M. MOYRON (Bar No. 235736)
tania.moyron@dentons.com
DENTONS US LLP
601 South Figueroa Street, Suite 2500
Los Angeles, California 90017-5704
Telephone: 213 623-9300
Facsimile: 213 623-9924

Attorneys for the Post-Effective Date Debtor and the Co-Liquidating Trustee

Jeffrey N. Pomerantz (Bar No. 143717)
Steven W. Golden (Admitted Pro Hac Vice)
PACHULSKI STANG ZIEHL & JONES LLP
10100 Santa Monica Blvd., 13th Floor
Los Angeles, CA 90067
Telephone: 310-277-6910
Facsimile: 310-201-0760
Email: jpomerantz@pszjlaw.com
sgolden@pszjlaw.com

Attorneys for the Co-Liquidating Trustee

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

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].

DENTONS US LLP
601 South Figueroa Street, Suite 2500
Los Angeles, California 90017-5704
(213) 623-9300

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

DENTONS US LLP
601 SOUTH FIGUEROA STREET, SUITE 2500
LOS ANGELES, CALIFORNIA 90017-5704
(213) 623-9300

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.

DENTONS US LLP
601 South Figueroa Street, Suite 2500
Los Angeles, California 90017-5704
(213) 623-9300

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

DENTONS US LLP
601 SOUTH FIGUEROA STREET, SUITE 2500
LOS ANGELES, CALIFORNIA 90017-5704
(213) 623-9300

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

DENTONS US LLP
601 SOUTH FIGUEROA STREET, SUITE 2500
LOS ANGELES, CALIFORNIA 90017-5704
(213) 623-9300

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

DENTONS US LLP
601 SOUTH FIGUEROA STREET, SUITE 2500
LOS ANGELES, CALIFORNIA 90017-5704
(213) 623-9300

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

DENTONS US LLP
601 SOUTH FIGUEROA STREET, SUITE 2500
LOS ANGELES, CALIFORNIA 90017-5704
(213) 623-9300

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

DENTONS US LLP
601 SOUTH FIGUEROA STREET, SUITE 2500
LOS ANGELES, CALIFORNIA 90017-5704
(213) 623-9300

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

DENTONS US LLP
601 SOUTH FIGUEROA STREET, SUITE 2500
LOS ANGELES, CALIFORNIA 90017-5704
(213) 623-9300

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

DENTONS US LLP
601 South Figueroa Street, Suite 2500
Los Angeles, California 90017-5704
(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 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?** Myung 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?
   Name: Myung Hee Lee DDS Inc
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville State: CA ZIP Code: 92395
   Country: USA
   Contact phone: 760-243-4266
   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

   RECEIVED
   APR 01 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? _____

2202384240401000000000002

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 J10E

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.)
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 1 2024

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 acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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: 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

RECEIVED
APR 01 2024

Official Form 410 **Proof of Claim** page 3

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
332 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	11/06/2020		JR			D1999		1	Personal Protective Equipment	5.00
2										
3										
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 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) A ____ C ____ (Primary diagnosis in "A") B ____ D ____
35a. Other Fee(s)
32. Total Fee 5.00

36. Remarks

AUTHORIZATIONS

39. 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 2

Claim #249 Date Filed: 4/1/2024

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

Fill in this information to identify the case:

Debtor: Hermosa 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?** Name of the current creditor (the person or entity to be paid for this claim): Nong Her Lee DDS Inc
   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?
   Name: Nong Her Lee DDS Inc.
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville, CA. 92395
   State: ZIP Code:
   Country: USA
   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:

   RECEIVED
   APR 01 2024
   KURTZMAN CARSON CONSULTANTS LLC

   Uniform claim identifier for electronic payments in chapter 13 (if you have 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?

22023R424NAM1000000000001

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 TIDB
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.) **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:

RECEIVED
APR 01 2024

Official Form 410 **Proof of Claim** page 2

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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 03/28/2024
MM / DD / YYYY

Signature

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

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

Title: Dentist

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

RECEIVED
APR 01 2024

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

Official Form 410 **Proof of Claim** page 3

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 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

[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	11/06/2020		JP			D0150		1	comprehensive oral evaluation - new	150.00
2										
3										
4										
5										
6										
7										
8										
9										
10										

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

1 X X 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 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 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

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

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.

Yonghee Lee 03/29/2024

X 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

To reorder call 800.947.4746

EXHIBIT 3

Claim #250 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at https://epoq.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.

FILE 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?** Ming 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?
   Name: Ming Hee Lee DDS Inc
   Number Street: 21611 Hesperia Rd. Ste C
   City: Victorville State: CA ZIP Code: 92395
   Country: USA
   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)

RECEIVED
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?

Official Form 410 **Proof of Claim** page 1

2202384240403000000000042

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 TIOH

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. This 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 a reasonable belief that the information is true and correct.

I declare under penalty of penalty 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

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

☐ 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	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 Tooth Information (Place an "X" on each missing tooth.)

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

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

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

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

Primary diagnosis in "A") B _____ D _____

35a. Other Fee(s)

32. Total Fee 1600.00

36. Remarks

AUTHORIZATIONS

10. 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

11. 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 [redacted] | 55. License Number 64834 | 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

To reorder call 800.947.4746

EXHIBIT 4

Claim #251 Date Filed: 4/2/2024

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

Fill in this information to identify the case:

Debtor: Romeo 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?** Uong 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?
   Uong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4266
   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

   RECEIVED
   APR 02 2024

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

5. 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 TIOH

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.)

RECEIVED
APR 02 2024

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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date: 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

RECEIVED
APR 02 2024

Official Form 410 **Proof of Claim** page 3

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☒ MEDI-CAL - 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 KPC
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 ☒ 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 = 9; ICD-10 = AB)

34a. Diagnosis Code(s) A C

(Primary diagnosis in "A") 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

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

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

44. NPI 1760858153 | 45. License Number 64834 | 51. SSN or TIN 822169868

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

ANCILLARY CLAIM/TREATMENT INFORMATION

39. Place of Treatment 11 (e.g. Pharmacy, 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.

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

To reorder call 800.947.4746

EXHIBIT 5

Claim #252 Date Filed: 4/2/2024

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

Fill in this information to identify the case:

Debtor: Romana 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?** Hong 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?
   Hong Hee Lee DDS Inc
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4266
   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

   RECEIVED
   APR 02 2024
   KINGSLEY KINGSLEY & 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?

2200238424040200000000010

Signed by Judge Laura Stuart Taylor May 7, 2025

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 TIOH

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.)

RECEIVED
APR 0 2 2024

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 acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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)

RECEIVED
APR 02 2024

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] 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 9 10 X 12 X 13 X 14 X 15 16 X
32 X X 29 28 X 26 25 24 23 22 21 20 19 18 17 X

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 1505.00

34. 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

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

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

39. NPI 1760858153	40. License Number 64834	41. SSN or TIN 822169868
42. Phone Number 760 243 4366	42a. Additional Provider ID	

ANCILLARY CLAIM/TREATMENT INFORMATION

30. 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

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/SomosHealth

Fill in this information to identify the case:

Debtor: Somos 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?** Ymq 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?
   Ymq 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

   RECEIVED
   APR 02 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?

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 TIOH

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

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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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 02 2024

Official Form 410 **Proof of Claim** page 3

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

☒ 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			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 ____ C ____ B ____ 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

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

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

41 NPI 1760858153	42 License Number 64834	43 SSN or TIN 822169868
44 Phone Number 760 243 4366	44a 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

To reorder call 800.947.4746

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 KAC
222 N. Pacific Coast Hwy Ste c
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	11/10/2020		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	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

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 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

   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?

RECEIVED
APR 02 2024
KURTZMAN CARSON CONSULTANTS

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 TIOH

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

   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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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

RECEIVED
APR 02 2024

Official Form 410 **Proof of Claim** page 3

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

[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 X5 X6 X7 8 X9 X10 X11 X12 13X 14X 15 16X
32 X 30 X29 X28 27 26 25 24 23 22 21 20X 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 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	50. License Number	51. SSN or TIN
1760858153	64834	822169868

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

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

56. Address, City, State, Zip Code	57. Phone Number	58. Additional Provider ID
12611 Hesperia Rd. Victorville CA 923958307	(760) 243 - 4366	

To reorder call 800.947.4746

EXHIBIT 8

Claim #255 Date Filed: 4/2/2024

You can file 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 this case.

Files 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 this creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Country
   Contact phone
   Contact email

   RECEIVED
   APR 02 2024

   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?

2209384240402000000000008

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 TIOH

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.)

RECEIVED
APR 02 2024
[illegible]

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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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: 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 0 7 2024

Official Form 410 **Proof of Claim** page 3

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

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

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

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

Permanent																Primary										32. Other Fee(s)	
X	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	33. Total Fee	480.00

34. 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) Radiographs(s) 0 | Oral Images(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

You can file electronically on KCC's website at https://epoc.kccllc.net/borrego/poc/claim

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?** Myung 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?
   Name: Myung Hee Lee DDS Inc
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville, CA. 92395
   State: ZIP Code:
   Country: USA
   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?

RECEIVED
APR 02 2024
KURTZMAN CARSON CONSULTANTS

2202384240402000000000001

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 TIOH

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
[illegible]

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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 03/28/2024 (MM / DD / YYYY)

Signature

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

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

Title: Dentist

Company: Uong 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
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
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	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	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	X	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

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

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

39. NPI 1760858153
40. License Number 64834
41. SSN or TIN 822169868
42. Phone Number (760) 243-4366
42a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

43. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
44. Enclosures (Y or N) [ ]
45. Is Treatment for Orthodontics? [X] No (Skip 45-47) [ ] Yes (Complete 45-47)
46. Date Appliance Placed (MM/DD/CCYY)
47. Months of Treatment Remaining
48. Replacement of Prosthesis [X] No [ ] Yes (Complete 48)
49. Date of Prior Placement (MM/DD/CCYY)
50. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
51. Date of Accident (MM/DD/CCYY)
52. 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

To reorder call 800.947.4746

EXHIBIT 10

Claim #257 Date Filed: 4/2/2024

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

Fill in this information to identify the case:

Debtor: Renown 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?** Uong Her 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?
   Name: Uong Her Lee DDS Inc.
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville, CA 92395
   State ZIP Code
   Country: U.S.A
   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

   RECEIVED
   APR 02 2026
   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?

22022384240407000000000008

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 T10th

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.)

RECEIVED
APR 02 2024
[illegible]

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 acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this Proof of Claim and have 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 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
   - [X] EPSDT (or) X12
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
220 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	03/12/2020		JP	19		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 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 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 the 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.)

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

44. NPI 1760858153
45. License Number 64834
46. SSN or TIN 822169868
47. Phone Number (760) 243-4366
52a. Additional Provider ID

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

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

To reorder call 800.947.4746

EXHIBIT

Claim #258 Date Filed: 4/2/2024

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

Fill in this information to identify the case:

Debtor: Royse 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?** Mong Her 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?
   Mong Her 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

   RECEIVED
   APR 02 2024
   KURTZMAN CARSON CONSULTANTS

   Unique 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?

2202384240405000000000002

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 T1042

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

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.

☑ 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: 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

Official Form 410 **Proof of Claim** page 3

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										

32. Missing Teeth Information (Place an "X" on each missing tooth.)
1 X 3 4 5 X 7 8 9 10 11 12 X 14 15 16 X
32 X 30 29 28 27 26 25 24 23 22 21 20 19 18 17 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: 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 dentist 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. (1=office 2=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
55. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307 | 56. Provider Specialty Code 1223G0001X
57. Phone Number 760 243 4366 | 58. Additional Provider ID

To reorder call 800.947.4746

EXHIBIT

Claim #259 Date Filed: 4/2/2024

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

Fill in this information to identify the case:

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

   RECEIVED
   APR 02 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?

22023R424M4090000000000008

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 T10H

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

RECEIVED
APR 02 2024
KUNTZEL & ASSOCIATES

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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 03/28/2024 (MM / DD / YYYY)

Signature

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

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

Title: dentist

Company: Uyng Her 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

RECEIVED
APR 02 2024

Official Form 410 **Proof of Claim** page 3

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
☐ Request for 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 Seaundo, 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

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 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. If 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 the 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

Claim #260 Date Filed: 4/2/2024

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

Fill in this information to identify the case:

Debtor: Romco 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?** Hong 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?
   Hong 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

   RECEIVED
   APR 02 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?

2202384240402000000000013

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 TEOH

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 amounts should match the amount in line 7.)

Amount necessary to cure any default as of the date of the petition: $_____

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

RECEIVED
APR 02 2025

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 acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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: 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
CLERK U.S. BANKRUPTCY COURT

Official Form 410 — Proof of Claim — page 3

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	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

2 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)

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

34a. Other Fee(s)

35. Total Fee 1270.00

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? ☒ 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

To reorder call 800.947.4746

EXHIBIT 4

Claim #261 Date Filed: 4/2/2024

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

Fill in this information to identify the case:

Debtor: National Community Renaissance

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?** Name of the current creditor (the person or entity to be paid for this claim): Hong Hee Lee DDS Inc.
   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?
   Name: Hong Hee Lee DDS Inc.
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville, CA. 92395
   State: ZIP Code:
   Country: USA
   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:

   RECEIVED APR 02 2024

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 TIOH

7. How much is the claim?
$ 0.00
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
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:

Official Form 410 **Proof of Claim** page 2

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 4/01/28 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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 03/28/2024
MM / DD / YYYY

Signature

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

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

Title: Dentist

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

RECEIVED
APR 02 2024

Address: 12011 Hesperia Rd Ste C
Number Street
Victorville, CA. 92395
City State ZIP Code Country

Contact phone: 760-243-4366 Email: leeofficemanager@gmail.com

Official Form 410 **Proof of Claim** page 3

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 4-11 (If no other coverage, leave blank.)

4. Dentaid? [ ] Medicaid? [ ] (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	

33. Remarks

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 5.00

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

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

To reorder call 800.947.4746

EXHIBIT

Claim #262 Date Filed: 4/2/2024

Your claim can be filed electronically on KCC's website at https://www.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

   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?

RECEIVED
APR 02 2024
KURTZMAN CARSON CONSULTANTS

72073R424n402n0000000005

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.)

RECEIVED
APR 02 2024

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 4/01/28 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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 03/28/2024 (MM / DD / YYYY)

Signature

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

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

Title: Dentist

Company: Uma 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: 760-243-4366 Email: Lee office manager@gmail.com

RECEIVED APR 11 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] ENDF This 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 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 _____ C _____ B _____ 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

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

46. 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; 23=ER 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.
Yonghee Lee 03/29/2024
X
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

To reorder call 800.947.4746

EXHIBIT

Claim #263 Date Filed: 4/2/2024

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

Fill in this information to identify the case:

Debtor: Bonnie 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?**	Ming 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?** Ming 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?	

RECEIVED
APR 02 2024
KCC ICA, LLC CLAIMS

Official Form 410 **Proof of Claim** page 1

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 TIOH

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.)

RECEIVED
APR 02 2024

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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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

APR 02 2024

Official Form 410 — Proof of Claim page 3

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
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										

32. Missing Teeth Information (Place an "X" on each missing tooth.)
1 X X X 5 6 7 8 9 10 11 12X 13X 14 15X 16X
32 X X 29 X 28 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) A. _____ C. _____
(Primary diagnosis in "A") 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

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

41. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307
42. NPI 1760858153 | 43. License Number 64834 | 44. SSN or TIN 822169868
45. Phone Number (760) 243-4366 | 45a. Additional Provider ID

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

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

Claim #264 Date Filed: 4/2/2024

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

Fill in the 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?** Myng 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?
   Name: Myng Hee Lee DDS Inc.
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville, CA. 92395
   State ZIP Code
   Country: USA
   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

   RECEIVED
   APR 02 2024

   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?

2202384240402000000000011

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 T1043

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.)

RECEIVED
APR 02 2024
[redacted]

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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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: 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 02 2024

Official Form 410 — Proof of Claim page 3

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
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 ☒ 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	11/20/2020		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										

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 ☒
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) A _____ C _____ B _____ D _____ (Primary diagnosis in "A")
31a. Other Fee(s)
32. Total Fee 560.00
35. 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

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 (Work)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

To reorder call 800.947.4746

EXHIBIT

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 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?** Myung 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?
   Myung 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):

RECEIVED
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?

22023842404030000000030

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 T1042

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.)

   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 acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this Proof of Claim and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 03/28/2024 (MM / DD / YYYY)

Signature

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

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

Title: Dentist

Company: Ming 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: leeOfficeManager@gmail.com

RECEIVED
APR 03 2024
KURTZMAN CARSON CONSULTANTS

Official Form 410 **Proof of Claim** page 3

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

Predetermination/Preauthorization Number:

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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.)

1. 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	24a. Diag Pointer	24b. Qty.	30. Description	31. Fee
1	11/19/2020		JF			D9430		1	office visit for observation (during requ	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 12X 13 14X 15 16

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

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 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 dental or dental practice has a contractual agreement with any 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.)

42. 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
Signature (Treating Dentist) Date

54. NPI 1760858153 | 55. License Number 64834 | Site 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

Claim #266 Date Filed: 4/3/2024

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

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?**
   Name of the current creditor (the person or entity to be paid for this claim): Hong Hee Lee DDS Inc
   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?
   Name: Hong Hee Lee DDS Inc.
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville State: CA ZIP Code: 92395
   Country: USA
   Contact phone: 760-243-4266
   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:

   RECEIVED
   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?

Official Form 410 — Proof of Claim — page 1

2202384240403000000029

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 TIOH

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.)
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 $3,000* 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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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

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

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

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 300.00

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 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

To reorder call 800.947.4746

EXHIBIT

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 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?** Ming Her 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?
   Ming Her 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

   RECEIVED
   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?

2202384240403000000000041

Part 2: Give Information About the Claim as of the Date the Case Was Filed

5. **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 TIOH

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.)

   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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 03/27/2024 (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

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

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 Tooth 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 X 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) (Primary diagnosis in "A")
A _____ C _____
B _____ D _____

34a. 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

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
53. 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

To reorder call 800.947.4746

EXHIBIT

Claim #268 Date Filed: 4/3/2024

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

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?** Myung 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?
   Myung Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4266
   Contact email leeofficemanager@gmail.com
   Uniform claim identifier (if 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

   RECEIVED
   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?

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 T104

7. **How much is the claim?**
$ 3205.60
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 $16,150*) 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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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: 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

RECEIVED
APR 03 2024
KURTZMAN CARSON CONSULTANTS

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT ☐ Title XIX

7. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

1. 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)	14. Gender ☒ M ☐ F	15. Policyholder/Subscriber ID (SSN or ID#)
[redacted]		[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 ☒ 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	30a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	10/20/2020		JR			D1999		1	Personal Protective Equipment	5.00
2	10/19/2020		JR	19		D2751		1	crown - porcelain fused to predomina	1500.00
3	11/10/2020		JR	19		2810.10		1	Seat Crown	100.00
4	10/20/2020		JR	20		D2751		1	crown - porcelain fused to predomina	1500.00
5	11/09/2020		JR	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 16 17X

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 _____ C _____ B _____ 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

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

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

Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

40. NPI 1760858153	50. License Number 64834	51. SSN or TIN 822169868
41. Phone Number (760) 243 - 4366	55a. Additional Provider ID	

ANCILLARY CLAIM/TREATMENT INFORMATION

39. 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.

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

To reorder call 800 947 4746

EXHIBIT

Claim #269 Date Filed: 4/3/2024

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

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 760-243-4266
   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

   RECEIVED
   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?

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 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 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.

	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 gives the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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 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
Barresso Health claims Processing Center
c/o KCC
2222 N. Pacific Coast Hwd 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	30a. Diag. Pointer	30b. 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 X 5 X 7 8 9 10 11 12 13 X 14 X 15 16 X
32 X 30 X 28 27 26 25 X 24 23 22 21 20 X 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 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.
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

To reorder call 800.947.4746

EXHIBIT

Claim #270 Date Filed: 4/3/2024

You can file 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?** Hong 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?
   Hong 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

   Unique claim identifier for electronic payments in chapter 13 (if you use one):

RECEIVED
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?

2202384240403000000000040

Part 2: Give Information About the Claim as of the Date the Case Was Filed

5. 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 T10B

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).

6. 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.
Denton

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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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: 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 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

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

4. Eligible? [ ] 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)	24A. Area of Oral Cavity	24B. Tooth System	25. Tooth Number(s) or Letter(s)	26. Tooth Surface	27. Procedure Code	28A. Diag Pointer	29. 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 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
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 100.00

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. If 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

36. 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.)

40. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307
41. NPI 1760858153
42. License Number 64834
43. SSN or TIN 822159868
44. Phone Number 760 243 4366
44a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

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

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

47. 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
48. NPI 1760858153
49. License Number 64834
50. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
50a. Provider Specialty Code 1223G0001X
51. Phone Number 760 243 4366
51a. Additional Provider ID

To reorder call 800.947.4746

EXHIBIT 4

Claim #271 Date Filed: 4/3/2024

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

Fill in this information to identify the case:

Debtor: Revmax 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?** Uong 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?
   Name: Uong Hee Lee DDS Inc
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville State: CA ZIP Code: 92395
   Country: USA
   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

RECEIVED
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?

2202384240403000000000038

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 T10H

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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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: 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 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 X 6 X 7 X 8 9 10 11 12 X 13 14 15 X 16 X

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

To reorder call 800.947.4746

EXHIBIT

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 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?** 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

   Uniform claim identifier for electronic payments in chapter 13 (if you use one):

RECEIVED
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?

2202384240403000000000031

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 T108

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.)

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 $16,150*) 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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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 03 2024
KURTZMAN CARSON CONSULTANTS

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ [illegible]

Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

1. 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	11/13/2020		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 Tooth 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

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 585.00

35. 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

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

36. 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 | 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

To reorder call 800.947.4746

EXHIBIT

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 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
   U.S.A
   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):

RECEIVED
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?

2202384240405000000000036

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 TIOH

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. This 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 acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date: 03/28/2024 (MM / DD / YYYY)

Signature

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

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

Title: Dentist

Company: Myng 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 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

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

[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		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) A ____ C ____

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

31a. Other Fee(s)

32. Total Fee 5.00

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	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~~ 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

To reorder call 800.947.4746

EXHIBIT

Claim #274 Date Filed: 4/3/2024

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

Fill in this information to identify the case:

Debtor: Romego 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?**
   Name of the current creditor (the person or entity to be paid for this claim): Hong Her Lee DDS Inc
   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?
   Name: Hong Her Lee DDS Inc
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville State: CA ZIP Code: 92395
   Country: USA
   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):

RECEIVED
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?

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 TIOH

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.)
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 acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 03/28/2024 (MM / DD / YYYY)

Signature

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

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

Title: Dentist

Company: Ming 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

☒ 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			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

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 | 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

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 149 of 297

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 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?

Ming 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?

Name: Ming Hee Lee DDS Inc

Number Street: 12611 Hesperia Rd. Ste C

City State ZIP Code: Victorville, CA. 92395

Country: USA

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): ______

RECEIVED

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? ______

2202384240403000000000034

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 TIOH

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.)
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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date: 03/28/2024 (MM / DD / YYYY)

Signature

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

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

Title: dentist

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

Address: 12651 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 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

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 [redacted] | 17. Employer Name [redacted]

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	07/02/2019		JH	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 ☒ 3 4 5 6 7 8 9 10 11 12 13 14 ☒ 15 16 ☒
32 ☒ ☒ ☒ 26 27 28 29 30 ☒ 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 ____ B ____ C ____ D ____
33b. Other Fee(s)
32. Total Fee 800.00

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

Claim #276 Date Filed: 4/3/2024

Your claim can be filed electronically on KDC'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

   RECEIVED
   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?

2202384240403000000000033

Part 2: Give Information About the Claim as of the Date the Case Was Filed

5. 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 T10H

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. This 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 410A) 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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 03/28/2024 (MM / DD / YYYY)

Signature

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

RECEIVED
APR 03 2024
WEITZMAN CARSON CONSULTANTS

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

Title: Dentist

Company: Hong 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
   - [ ] Predetermination/Preauthorization Number
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) [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	30a. Diag. Pointer	30b. 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. Total Fee: 600.00

33. 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

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

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 my 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.
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

Claim #277 Date Filed: 4/4/2024

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

Fill in this information to identify the case:

Debtor: Ramsey 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?
   Name: Yong Hee Lee DDS Inc
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville State: CA ZIP Code: 92395
   Country: U.S.A
   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:

   RECEIVED
   APR 04 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?

2202384240404000000000003

Signed by Judge Laura Stuart Taylor May 7, 2025

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 TIOH

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.)

RECEIVED
APR 04 2024

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

RECEIVED
APR 04 2024

Official Form 410 **Proof of Claim** page 3

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	11/13/2020		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										

23. Missing Tooth Information (Place an "X" on each missing tooth.)
1 X 3 X 5 6 7 8 9 10 11 12 13 14X 15X 16X
32 X 30 X 28 27 26 25 X24 23 22 21 20 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 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? [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

Claim #278 Date Filed: 4/4/2024

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

Fill in this information to identify the case:

Debtor: Roma 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?
   Name: Yong Hee Lee DDS Inc
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville, CA. 92395
   State ZIP Code
   Country: U.S.A.
   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

   RECEIVED
   APR 04 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?

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 TIOH

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 amounts 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
[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	11/17/2020		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 X12 X13 X14 X15 X16
32 X31 X30 X29 X28 27 26 25 24 X23 22 21 20 X19 X18 X17

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=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	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

To reorder call 800.947.4746

EXHIBIT

Claim #279 Date Filed: 4/4/2024

Your claim can be filed electronically on KCC's website at https://epos.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?** Myung 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?
   Name: Myung Hee Lee DDS Inc.
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville, CA. 92395
   State ZIP Code
   Country: USA
   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
   Uniform claim identifier for electronic payments in chapter 13 (if you use one):

   RECEIVED
   APR 04 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?

2202384240404000000000004

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 T10H

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.)

RECEIVED
APR 04 2024

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 $16,150*) 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 acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date: 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: 12011 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 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

[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 Tooth 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 _____ 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? [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 84834
51. SSN or TIN 822169868
57. 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

Claim #280 Date Filed: 4/4/2024

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

Fill in this information to identify the case:

Debtor: Stoneage 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.

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

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

   RECEIVED
   APR 04 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?

Official Form 410 Proof of Claim page 1

2202384240404000000000001

Signed by Judge Laura Stuart Taylor May 7, 2025

Part 2 **Give Information About the Claim as of the Date the Case Was Filed**

5. **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 TIOH

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 04 2024

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 acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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: 12011 Hesperia Rd Ste C (Number Street)
Victorville, CA. 92395 (City State ZIP Code Country)

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

RECEIVED
APR 11 2024

(Official Form 410) **Proof of Claim** page 3

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

☐ PASRR - 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			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 X6 X7 8 9 10 11 12X 13X 14X 15X 16X

32 X X6 X5 X4 27 26 25 24 23 22 21 20 19X 18X 17X

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

34. 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=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 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.

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 4

Claim #281 Date Filed: 4/5/2024

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

Fill in this information to identify the case:

Debtor: Romanic 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?** 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
   Dell 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

   RECEIVED
   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?

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 TIOH

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.)

RECEIVED
APR 05 2024

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 acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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: 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

RECEIVED
APR 05 2024
[illegible]

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	11/13/2020		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

32a. Other Fee(s):

33. Missing Tooth 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) (Primary diagnosis in "A") A ____ B ____ C ____ D ____

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.
Yonghee Lee — 03/29/2024
X 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

To reorder call 800.947.4746

EXHIBIT

Claim #282 Date Filed: 4/5/2024

You can file your claim 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?** Ming 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?
   Name: Ming Hee Lee DDS Inc
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville, CA. 92395
   State ZIP Code
   Country: USA
   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

   RECEIVED
   APR 05 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?

2202384240405000000000015

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 TIOH

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.)

RECEIVED
APR 05 2024
[illegible] 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 acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 03/28/2024 (MM / DD / YYYY)

Signature

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

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

Title: dentist

Company: Hung 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

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

31a Other Fee(s)

32 Total Fee 1955.00

35 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

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

36 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.

Yonghee Lee 03/29/2024
X 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

To reorder call 800.947.4746

EXHIBIT

Claim #283 Date Filed: 4/5/2024

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

Fill in this information to identify the case:

Debtor: BioSpecifics Technology Corp.

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?**
   Name of the current creditor (the person or entity to be paid for this claim): Hong Hee Lee DDS Inc
   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?
   Name: Hong Hee Lee DDS Inc
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville State: CA ZIP Code: 92395
   Country: USA
   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:

   RECEIVED
   APR 05 2024
   KCC/THERMOGENESIS CORP CLAIMS

   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 TIOH

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. This 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 05 2024

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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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 05 2024
KURTZMAN CARSON CONSULTANTS

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT/ Title XIX

3. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

2. 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	11/06/2020		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										

33. Missing Tooth 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 30 29 28 27 26 25 24 23 22 21 20 19 18 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 03/29/2024
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
Specialty Code 1223G0001X

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

56a. Provider

57. Phone Number (760) 243 - 4366

58. Additional Provider ID

To reorder call 800.947.4746

EXHIBIT

Claim #284 Date Filed: 4/5/2024

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

Fill in this information to identify the case:

Debtor: Bernard 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?** Myung 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?
   Name: Myung Hee Lee DDS Inc.
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville State: CA ZIP Code: 92395
   Country: USA
   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

   RECEIVED
   APR 05 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?

2202384240405000000000016

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 TIOH

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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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

RECEIVED
APR 05 2024

Official Form 410

Proof of Claim
page 3

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

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		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										

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

1 2 3 4 X 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 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? ☒ 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

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

To reorder call 800.947.4746

EXHIBIT

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.

Files 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?** Hong Hee Lee DDS Inc
   Name of the current creditor (the person or entity to be paid for this claim)
   Other name 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?
   Hong 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

   ENDORSED
   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?

2202384240405000000000017

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 TIOB

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 amounts should match the amount in line 7.)
Amount necessary to cure any default as of the date of the petition: $_____
Annual Interest Rate (when case was filed) _____%
☐ Fixed
☐ Variable

RECEIVED
APR 05 2024
[redacted]

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: _____

11. **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.

12. **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: 12011 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 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 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 [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	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 12[X] 13 14[X] 15 16[X]
2 [X] 30 29 28 27 26 25 24 23 22 21 20 19[X] 18[X] 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 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. If 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.
    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

To reorder call 800.947.4746

EXHIBIT

Claim #286 Date Filed: 4/5/2024

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

Fill in this information to identify the case:

Debtor: Sorrento 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?** Ming 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?
   Name: Ming Hee Lee DDS Inc.
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville, CA 92395
   State ZIP Code
   Country: USA
   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

   RECEIVED
   APR 05 2024
   KCC/SORRENTO CARDIOVASCULAR

   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?

2202384240405000000000016

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 TIOH

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.)

   Amount necessary to cure any default as of the date of the petition: $_____

   Annual interest rate (when case was filed) _____%
   - ☐ Fixed
   - ☐ Variable

RECEIVED
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 acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have 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

RECEIVED
APR 05 2024
[illegible] CONSULTANTS

Official Form 410 **Proof of Claim** page 3

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	11/10/2020		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

33. Diagnosis Code List Qualifier [ ] [ ] (ICD-9 = B, ICD-10 = AB)
34. Diagnosis Code(s) (Primary diagnosis in "A") A _____ C _____ B _____ D _____
35. Remarks
35a. Other Fee(s)
36. Total Fee 3010.00

AUTHORIZATIONS

40. 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

42. 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.)

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

45. NPI 1760858153
46. License Number 64834
47. SS# or TIN 822169868
48. Phone Number (760) 243 - 4366
48a. 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
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

To reorder call 800.947.4746

EXHIBIT 4

Claim #287 Date Filed: 4/5/2024

Your claim can be filed electronically on KDC'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?** Hong 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?
   Hong Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   760-243-4366
   Contact phone
   leeofficemanager@gmail.com
   Contact email

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

   RECEIVED
   APR 05 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?

2201238424044860000000000123

Signed by Judge Laura Stuart Taylor May 7, 2025

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 T10H

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.)

RECEIVED
APR 05 2024

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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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: 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 15 2024

Official Form 410 **Proof of Claim** page 3

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	11/16/2020	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 16X
32 31 X 29 28 27 26 25 24 23 22 21 20 19 18 17

33. Diagnosis Code List Qualifier [ ] [ ] (ICD-9 = 9, ICD-10 = AB)
34. Diagnosis Code(s) (Primary diagnosis in "A") A _____ C _____ B _____ D _____
34a. Other Fee(s)
35. Total Fee 505.00
36. Remarks

AUTHORIZATIONS

37. 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

37a. 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 822159863
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

To reorder call 800.947.4746

EXHIBIT 4

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 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?**	Mong 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?** Mong 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? ______

RECEIVED
APR 05 2024
KURTZMAN CARSON CONSULTANTS

2202384240405000000000019

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 TIOH

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.)
Amount necessary to cure any default as of the date of the petition: $
Annual Interest Rate (when case was filed) %
☐ Fixed
☐ Variable

RECEIVED
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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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.officemanager@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	11/10/2020		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 16[X]
32 [X] 30 29 28 27 26 25 24 23 22 21 20 19 18 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 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

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

To reorder call 800.947.4746

EXHIBIT 4

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 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?** Uong Hee Lee DDS Inc
   Name of 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?
   Uong 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

   RECEIVED
   APR 05 2024

   [redacted] Short 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

5. **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.)

     Amount necessary to cure any default as of the date of the petition: $_____

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

RECEIVED
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 $3,360* 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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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: 17611 Hesperia Rd Ste C (Number Street)

Victorville, CA 92395 (City State ZIP Code Country)

Contact phone: 760-243-4366 Email: leeofficemanager@gmail.com

RECEIVED
APR 05 2024

Official Form 410 — Proof of Claim — page 3

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] ESDT - 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

[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										

31. 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) 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

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
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

To reorder call 800.947.4746

EXHIBIT 4

Claim #290 Date Filed: 4/5/2024

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

Fill in this information to identify the case:

Debtor: Sorrento 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?**
   Uma Her 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 Her Lee DDS Inc
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4266
   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

   RECEIVED
   APR 05 2024
   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?

Official Form 410 Proof of C[illegible] page 1

2202384240405000000000021

Part 2: Give Information About the Claim as of the Date the Case Was Filed

5. **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 TIOH

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 amounts should match the amount in line 7.)

   Amount necessary to cure any default as of the date of the petition: $_____

   Annual interest rate (when case was filed) _____ %
   - ☐ Fixed
   - ☐ Variable

RECEIVED
APR 05 2024
[illegible]

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 acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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: 12011 Hesperia Rd Ste C (Number, Street) Victorville, CA 92395 (City, State, ZIP Code, Country)

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

RECEIVED
APR 05 2026
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

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

33. Diagnosis Code List Qualifier [ ] (ICD-9 = B; ICD-10 = AB)
34. Diagnosis Code(s) A ____ C ____ B ____ D ____ (Primary diagnosis in "A")
34a. Other Fee(s)
35. Total Fee 230.00
36. Remarks

AUTHORIZATIONS

37. 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

38. 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

39. Place of Treatment 11 (e.g. 11=office; 22=OP Hospital) (Use "Place of Service Codes for Professional Claims")
40. Enclosures (Y or N) [ ]
41. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
42. Date Appliance Placed (MM/DD/CCYY)
43. Months of Treatment Remaining
44. Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
45. Date of Prior Placement (MM/DD/CCYY)
46. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
47. Date of Accident (MM/DD/CCYY)
48. 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.)

49. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307
50. NPI 1760858153
51. License Number 84832
52. SSN or TIN 822169868
53. Phone Number 760 243 4366
53a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

54. 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
55. NPI 1760858153
56. License Number 84834
57. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307
56a. Provider Specialty Code 1223G0001X
58. Phone Number 760 243 4366
58a. Additional Provider ID

EXHIBIT 44

Claim #291 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://www.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?** Myung 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?
   Name: Myung Hee Lee DDS Inc.
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville State: CA ZIP Code: 92395
   Country: USA
   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

   RECEIVED
   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?

2202384240405000000000002

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. This 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 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 4/01/28 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 acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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: leeofficemanager@gmail.com

RECEIVED
APR 05 2024
KLESTADT WINTERS JURELLER SOUTHARD & STEVENS

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 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 [X] 7 8 9 10 11 12 [X] 13 14 15 16 [X]
32 [X] 30 29 28 [X] 26 25 24 23 22 21 [X] 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 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

To reorder call 800.947.4746

EXHIBIT 4

Claim #292 Date Filed: 4/5/2024

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

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?** Uong 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?
   Uong 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

   RECEIVED
   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?

2202384240405000000000024

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 TIOH

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

RECEIVED
APR 05 2024

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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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

RECEIVED
APR 05 2024
[illegible]

Official Form 410 **Proof of Claim** page 3

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

☒ Send to 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.)

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)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan Group Number	10. Patient's Relationship to Person named in #6 ☐ 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	11/13/2020		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 Tooth Information (Place an "X" on each missing tooth.)

1 X X 4 X5 6 7 8 9 10 11 12 13 14X 15X 16X

32 X X0 X9 X8 X7 X6 X5 X4 X3 X2 X1 X 20 X 19X 18X 17X

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

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

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

34b. Other Fee(s)

35. Total Fee 255.00

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 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.

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

To reorder call 800.947.4746

EXHIBIT 4

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 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?
   Name: Yong Hee Lee DDS Inc
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville, CA. 92395
   State ZIP Code
   Country: U.S.A
   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

   RECEIVED
   APR 05 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?

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 TIOH

7. How much is the claim?
$ 1450.00
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

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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 03/28/2024 (MM / DD / YYYY)

Signature

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

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

Title: Dentist

Company: Uma 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

Official Form 410 **Proof of Claim** page 3

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/ Kids Xtra
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
2232 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 Tooth 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)
33a. Diagnosis Code(s) (Primary Diagnosis in "A") A _____ C _____ B _____ D _____
33b. Other Fee(s)
34. 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

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

40. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307
41. NPI 1760858153 | 42. License Number 64834 | 43. SSN or TIN 822169868
44. Phone Number 760 243 4366 | 44a. Additional Provider ID

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

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
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

To reorder call 800.947.4746

EXHIBIT 4

Claim #294 Date Filed: 4/5/2024

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

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?** Ming 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?
   Ming 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

   RECEIVED
   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?

220238424040500000000012

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 T104-

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.)

RECEIVED
APR 05 2024
[illegible] 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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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

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
   - [ ] 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. Dentaid? [ ] 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) 03/17/1981
7. Gender [ ] M [X] F
8. Policyholder/Subscriber ID (SSN or ID#) 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

[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			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 _____ C _____
B _____ 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 — Date 03/29/2024

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 — Date 03/29/2024

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) — Date 03/29/2024
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 4

Claim #295 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://epos.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
   760-243-4366
   Contact phone
   leeofficemanager@gmail.com
   Contact email

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

   RECEIVED
   APR 05 2024

   Last 4 digits of the account number [illegible] 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 TOH

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. This 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 05 2024

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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 03/28/2024
MM / DD / YYYY

Signature

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

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

Title: Dentist

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

RECEIVED
APR 05 2024
KURTZMAN CARSON CONSULTANTS

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

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

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

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

33a. 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

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

46. 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.

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

To reorder call 800.947.4746

EXHIBIT 4

Claim #296 Date Filed: 4/5/2024

You can file 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?** Hong 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?
   Name: Hong Hee Lee DDS Inc.
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville, State: CA. ZIP Code: 92395
   Country: USA
   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

   RECEIVED
   APR 05 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?

2202384240405000000000009

Part 2: Give Information About the Claim as of the Date the Case Was Filed

9. 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 TIOH

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. This 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 410A) 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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 03/28/2024 (MM / DD / YYYY)

Signature

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

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

Title: Dentist

Company: Ming 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
KURTZMANCHESSONCONSULTANTS

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] 4. PSHIT - 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)
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)
22. Gender [ ] M [X] F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	26. 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)
33a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____
33b. Other Fee(s)
34. 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. I authorize 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.)

38. Name, Address, City, State, Zip Code
Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307
39. NPI 1760858153
40. License Number 64834
41. State License ID 822169868
42. Phone Number (760) 243 - 4366
43. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

44. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
45. Enclosures (Y or N) [ ]
46. Is Treatment for Orthodontics? [X] No (Skip 47-52) [ ] Yes (Complete 47-52)
47. Date Appliance Placed (MM/DD/CCYY)
48. Months of Treatment Remaining
49. Replacement of Prosthesis [X] No [ ] Yes (Complete 50)
50. Date of Prior Placement (MM/DD/CCYY)
51. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
52. Date of Accident (MM/DD/CCYY)
53. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

To reorder call 800.947.4746

EXHIBIT

Claim #297 Date Filed: 4/5/2024

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

Fill in this information to identify the case:

Debtor: Roman Catholic Bishop of San Diego

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

   RECEIVED
   APR 05 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?

2202364240405000000000008

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 TIOH

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
CITIZENS CHOICE 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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 03/28/2024 (MM / DD / YYYY)

Signature

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

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

Title: Dentist

Company: Ming 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 officemanager@gmail.com

RECEIVED
APR 05 2024
KURTZMAN CARSON CONSULTANTS

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

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	JF			D4341		1	UR periodontal scaling and root planin	250.00
2	11/13/2020	40	JF			D4341		1	LR periodontal scaling and root planin	250.00
3	11/13/2020		JF			D1999		1	Personal Protective Equipment	5.00
4	11/17/2020	20	JF			D4341		1	UL periodontal scaling and root planin	250.00
5	11/17/2020	30	JF			D4341		1	LL periodontal scaling and root planin	250.00
6	11/17/2020		JF			D1999		1	Personal Protective Equipment	5.00
7	11/20/2020		JF			D1999		1	Personal Protective Equipment	5.00
8	11/23/2020		JF			D1999		1	Personal Protective Equipment	5.00
9	11/24/2020		JF			D1999		1	Personal Protective Equipment	5.00
10	11/16/2020		JF	28	B	D2391		1	resin-based composite - one surface,	225.00

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 16

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

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

34a Diagnosis Code(s) A _____ C _____ (Primary diagnosis is "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=Outpatient 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

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 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?** Ming 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?
   Name: Ming Hee Lee DDS Inc
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville State: CA ZIP Code: 92395
   Country: USA
   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

   RECEIVED
   APR 05 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?

2202384240405000000000007

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 TIOH

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.)

   RECEIVED
   APR 05 2024
   [illegible]

   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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 03/28/2024 (MM / DD / YYYY)

Signature

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

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

Title: Dentist

Company: Ming Hee Lee DDS Inc

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

RECEIVED

APR 05 2024

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

Official Form 410 **Proof of Claim** page 3

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 KMS
2812 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	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 11 12 13 14 15 16
32 X 30 29 28 27 26 25 24 23 22 21 20 X 18 17

33. Diagnosis Code List Qualifier ☐ (ICD-9 = B, ICD-10 = AB)
33a. Diagnosis Code(s) A ____ C ____ B ____ D ____ (Primary diagnosis in "A")
33a. 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 if 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
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 | 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

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 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?** Name of the current creditor (the person or entity to be paid for this claim): Hong Hee Lee DDS Inc
   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?
   Name: Hong Hee Lee DDS Inc
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville State: CA ZIP Code: 92395
   Country: USA
   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:

   RECEIVED
   APR 05 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?

22023842404050000000000006

Part 2: Give Information About the Claim as of the Date this 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 TIOH

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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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
KCC BANKRUPTCY 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 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? ☒ (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 ☐ F
8. Policyholder/Subscriber ID (SSN or ID#) 97933745F
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
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 ☐ 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 ☒ 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	30a. Diag. Pointer	30b. 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. Total Fee: 305.00

33. 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 ____ B ____ C ____ 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=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 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

To reorder call 800.947.4746

EXHIBIT

Claim #300 Date Filed: 4/5/2024

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

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?** Myong 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?
   Myong 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

   RECEIVED
   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?

2202384240405000000000005

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 this 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 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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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: 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 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
☒ 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 MCC
2102 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. Medicaid? ☒ Medical? ☐ (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 ☒ F
8. Policyholder/Subscriber ID (SSN or ID#) 96933745F
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
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 ☒ 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 ☒ 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		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 14X 15X 16X
32 31 30X 29 28 27 26 25 24 23 22 21 20 19 18 17X

34. Diagnosis Code List Qualifier ☐ ☐ (ICD-9 = 0; 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

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

46. NPI 1760858153
50. License Number 64834
51. SSN or TIN 822169868
52. Phone Number (760) 242 - 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.
Yonghee Lee 03/29/2024
X
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

To reorder call 800.947.4746

EXHIBIT 4

Claim #301 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at https://www.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?** Myong 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?
   Name: Myong Hee Lee DDS Inc.
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville State: CA ZIP Code: 92395
   Country: USA
   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

   RECEIVED
   APR 05 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?

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 TIOH

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.)

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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 03/28/2024 (MM / DD / YYYY)

Signature

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

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

Title: Dentist

Company: Uma 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.officemanager@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) [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										

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 18X 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: 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.
Yonghee Lee — 03/29/2024
X Signed (Treating Dentist) — Date

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

To reorder call 800.947.4746

EXHIBIT

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?** Ming 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?
   Ming Hee Lee DDS Inc.
   Name
   12611 Hesperia Rd. Ste C
   Number Street
   Victorville, CA. 92395
   City State ZIP Code
   USA
   Country
   Contact phone 760-243-4266
   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

   RECEIVED
   APR 05 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?

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 T102

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.)

   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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 03 / 28 / 2024 (MM / DD / YYYY)

Signature

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

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

Title: dentist

Company: Ming 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, County)

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

RECEIVED
APR 05 2024
[illegible]

Official Form 410 **Proof of Claim** page 3

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
☒ DENTI-CAL Title 22

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 (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	11/13/2020	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										

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 31X 30X 29 28 27 26 25 X24 23 22 21 20 19X 18X 17X

33. Diagnosis Code List Qualifier ☐ (ICD-9 = B, ICD-10 = AB)
34. Diagnosis Code(s) A C (Primary diagnosis in "A") B D
34a. Other Fee(s)
35. Total Fee 1015.00

36. Remarks

AUTHORIZATIONS

37. 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, to the rendering 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

38. 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

39. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 40. Enclosures (Y or N) ☐

41. 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 | 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

Claim #303 Date Filed: 4/15/2024

Your claim can be filed electronically on KCC's website at https://cases.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?** Ming 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?
   Name: Ming Hee Lee DDS Inc.
   Number Street: 12611 Hesperia Rd. Ste C
   City: Victorville, State: CA, ZIP Code: 92395
   Country: USA
   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

   RECEIVED
   APR 15 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?

2002384240415000000000002

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 TIOH

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.)

RECEIVED
APR 15 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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 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

RECEIVED
APR 15 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] PSNOT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

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) | 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 X X 8 9 10 11 12X 13X 14 15 16X
32 X X X X 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 _____ B _____ C _____ 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 | 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

Claim #304 Date Filed: 4/15/2024

Your claim can be filed electronically on KCC's website at https://www.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
   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

RECEIVED
APR 15 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?

2203384240415000000000001

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 TIOH

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.)

   RECEIVED
   APR 15 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 a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 03/28/2020 (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: 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 15 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

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 ☒ 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 ☒ 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 ☒ 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)
33a. Diagnosis Code(s) A ____ C ____ (Primary diagnosis in "A") B ____ D ____
31a. Other Fee(s)
32. Total Fee 5.00

34. 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? ☒ 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
57. 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 — 12/21/2020
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

To reorder call 800.947.4746

Notice Recipients

District/Off: 0974−3	User: Admin.	Date Created: 5/8/2025
Case: 22−02384−LT11	Form ID: pdfO1	Total: 6

Recipients of Notice of Electronic Filing:

aty	Jeffrey N. Pomerantz	jpomerantz@pszjlaw.com
aty	Jeffrey N. Pomerantz	jpomerantz@pszjlaw.com;tkapur@pszjlaw.com;sgolden@pszjlaw.com
aty	Steven W Golden	sgolden@pszjlaw.com
aty	Tania M. Moyron	tania.moyron@dentons.com

TOTAL: 4

Recipients submitted to the BNC (Bankruptcy Noticing Center):

db	BORREGO COMMUNITY HEALTH FOUNDATION,	587 Palm Canyon Dr.	Suite 208	Borrego Springs, CA 92004	
aty	Samuel Ruven Maizel	Dentons US LLP	601 South Figueroa Street	Suite 2500	Los Angeles, CA 90017

TOTAL: 2