

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

Docket #1613 Date Filed: 05/07/2025

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

BORREGO COMMUNITY HEALTH FOUNDATION,

Debtor.

BANKRUPTCY NO.
 22-02384-LT11

ORDER ON
STIPULATION BY AND AMONG THE POST-EFFECTIVE DATE DEBTOR,
THE LIQUIDATING TRUSTEE, THE CO-LIQUIDATING TRUSTEES AND

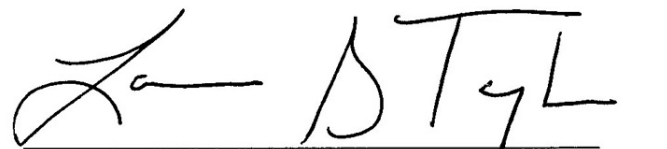
YONG HEE LEE DDS INC. REGARDING CLAIM NOS. 248, 249, 250, 251, 252, 253, 254, 255, 256,
257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278,
279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 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



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, 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* [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

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

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**

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

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

RECITALS

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

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

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

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

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

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

1	285	4/5/2024	\$ 145.00
2	286	4/5/2024	\$ 3,010.00
	287	4/5/2024	\$ 505.00
3	288	4/5/2024	\$ 1,655.00
	289	4/5/2024	\$ 255.00
4	290	4/5/2024	\$ 230.00
	291	4/5/2024	\$ 415.00
5	292	4/5/2024	\$ 255.00
	293	4/5/2024	\$ 1,950.00
6	294	4/5/2024	\$ 455.00
	295	4/5/2024	\$ 15.00
7	296	4/5/2024	\$ 4,500.00
	297	4/5/2024	\$ 1,250.00
8	298	4/5/2024	\$ 3,100.00
	299	4/5/2024	\$ 305.00
9	300	4/5/2024	\$ 305.00
10	301	4/5/2024	\$ 3,300.00
	302	4/5/2024	\$ 1,015.00
11	303	4/15/2024	\$ 3,000.00
	304	4/15/2024	\$ 5.00
12	Total Amount of Filed Claims		\$ 51,970.00

13
14 Copies of the Claims are attached hereto as **Exhibits 1-57**, respectively.

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

21 WHEREAS, the Co-Liquidating Trustees have reviewed the Debtor’s books
22 and records and have reconciled the Claims to the aggregate amount of \$36,290.00
23 (the “Reconciled Claim Amount”).

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

28

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

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

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

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

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

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

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

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

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

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

22
23 Dated: May 7, 2025

DENTONS US LLP
SAMUEL R. MAIZEL
TANIA M. MOYRON

24
25 By /s/ Tania M. Moyron
26 Tania M. Moyron
27 Attorneys for the Post-Effective Date
28 Debtor and the Co-Liquidating Trustee


1 Dated: May 7, 2025

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

2
3
4 By /s/ Steven W. Golden
Steven W. Golden
Attorneys for the Co-Liquidating Trustee

5
6 Dated: April 28, 2025

YONG HEE LEE DDS INC.

7
8 By: 
9 Its: owner

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

EXHIBIT 1

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

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. List 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TIO#

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

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

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12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$3,380* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(2).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 10/1/05 and every 3 years after that for dates 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 3011(b).

If you file this claim electronically, FRBP 5006(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 1591.

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.

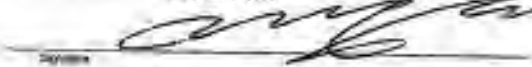
I understand that an authorized signature on this Proof of Claim serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

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

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

Executed on date 03/28/2024

DAY / MONTH / YEAR



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

Name: Ming Hee Lee

Title: Debtist

Company: Ming Hee Lee DDS Inc.

Address: 12611 Hesperia Rd Ste C

City: Victorville, CA ZIP Code: 92395

Contact phone: 760-243-4364

Email: lee.office.manager@gmail.com

EXHIBIT 2

Signed by Judge Laura Stuart Taylor May 7, 2025

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 19
of 297

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. List 4 digits of the debtor's account or any number you use to identify the debtor. 9868
TID#

7. How much is the claim? \$ 150.00 Does this amount include interest or other charges?
☒ No
☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. What is the basis of the claim? Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.
 Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).
 Limit disclosing information that is entitled to privacy, such as health care information.
Dental

9. Is all or part of the claim secured? ☒ No
☐ Yes. The claim is secured by a lien on property.
Nature of property:
☐ Real estate, if the claim is secured by the debtor's principal residence. file a Mortgage Proof of Claim Attachment (Official Form 410-A) with this Proof of Claim.
☐ Motor vehicle
☐ Other. Describe: _____
Basis for perfection:
 Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)
 Value of property: \$ _____
 Amount of the claim that is secured: \$ _____
 Amount of the claim that is unsecured: \$ _____ (The sum of the secured and unsecured amounts should match the amount in line 7.)
 Amount necessary to cure any default as of the date of the petition: \$ _____
 Annual interest rate (when case was filed) _____ %
☐ Fixed
☐ Variable

10. Is this claim based on a lease? ☒ No
☐ Yes. Amount necessary to cure any default as of the date of the petition: \$ _____

11. Is this claim subject to a right of setoff? ☒ No
☐ Yes. Identify the property: _____

Official Form 410

Proof of Claim
page 2

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12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$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)(2).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(6).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/01/25 and every 3 years after that for costs begun on or after the date of adjustment.

13. Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(2)?

☒ 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 5006(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

Signature [Signature]

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

Name Uong Hee Lee

First name Middle name Last name

Title Dentist

Company Uong Hee Lee DDS Inc.

(Identify the corporate title of the company if the authorized agent is a bankitor.)

Address 12411 Hesperia Rd Ste C

City Victorville, CA State 92395

Country

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

Official Form 410

Proof of Claim
page 3

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ADA American Dental Association Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services☐ Request for Predetermination/Preauthorization☒ EPOS Form 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
 Attn: HCC
 222 N. Pacific Coast Hwy Ste 300
 El Segundo Ca 90245

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

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

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

6. Date of Birth (MM/DD/CCYY)

7. Gender:

☐ M ☐ F

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person named in #5

☐ Self ☐ Spouse ☐ Dependent ☐ Other

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

RECORD OF SERVICES PROVIDED

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

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

34. Diagnosis Code List Qualifier ☐ (ICD-9 = 6; ICD-10 = AB)

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

34b. (Primary diagnosis in "A") 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 provider 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=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

☒ No ☐ Yes (Complete 44)

43. Replacement of Prosthesis

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 64834

54. NPI 1760858153

55. License Number

56. Address, City, State, Zip Code

1223G0001X

56a. Provider Specialty Code

12611 Hesperia Rd. Victorville CA 923958307

57. Phone Number 760-243-4366

58. Additional Provider ID

EXHIBIT 3

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 23 of 297

Claim #250 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at <https://www.kccdc.net/Forms/Health>.

Fill in this information to identify the case:

Debtor: Betsey Community Health Foundation

Kenneth C. Carson, Judge, Court for the Southern District of California

Case Number: 22-02384

Official Form 410 Proof of Claim

04/22

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

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed.

Part 1 Identify the Claim

1. Who is the current creditor? Monig Hee Lee DDS Inc
Name of the current creditor (the person or entity to be paid for the claim)
Other names the creditor uses 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(a)
Where should notices to the creditor be sent?
Monig Hee Lee DDS Inc
Name
2111 Hesperia Rd. Ste C
Number Street
Victorville, CA 92395
City State ZIP Code
USA
Country
Contact phone 760-293-4366
Contact email leeoffice@manager1@gmail.com
System 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 unpaid one already filed?
☒ No
☐ Yes. Claim number on court claims registry (if known) _____ Filed on MA 7 50 7 PM

5. Do you know if anyone else has filed a proof of claim for this claim?
☒ No
☐ Yes. Who made the earlier filing? _____

KURTZMAN CARSON CONSULTANTS

Official Form 410

Proof of Claim
page 1



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

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. List 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TID#

7. How much is the claim? \$ 1600.00 Does this amount include interest or other charges?
☒ No
☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. What is the basis of the claim? Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.
Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).
Limit disclosing information that is entitled to privacy, such as health care information.
Dental

9. Is all or part of the claim secured? ☒ No
☐ Yes. The claim is secured by a lien on property.
Nature of property:
☐ Real estate. If the claim is secured by the debtor's principal residence, file a Mortgage Proof of Claim Attachment (Official Form 410-A) with this Proof of Claim.
☐ Motor vehicle
☐ Other. Describe: _____
Basis for perfection:
Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)
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: _____

Official Form 410

Proof of Claim
page 2

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12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No.

☐ Yes. Check all that apply:

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

* Amounts are subject to adjustment on 4/1/25 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

Ying

Hee

Lee

Title

dentist

Company

Ying Hee Lee DDS Inc.

Address

12611 Hesperia Rd Ste C

Victorville, CA 92395

Contact phone

714-243-4364

Email

hee.office.manager@gmail.com

RECEIVED

APR 03 2024

KURTZMAN CHESON CONSULTANTS

Official Form 410

Proof of Claim
page 3

EXHIBIT 4

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 29 of 297

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

6. Do you have any number you use to identify the debtor? ☐ No ☒ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TIO#

7. How much is the claim? \$ 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.)
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

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 30 of 297

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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B)	\$ _____
<input type="checkbox"/> Up to \$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).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a) that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/25 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 6003(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 357.

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: Ming Hee Lee

Title: Dentist

Company: Ming Hee Lee DDS, Inc.

Indicate the corporate service on the company if the authorized agent is a service.

Address: 12411 Hesperia Rd Ste C

City: Victorville, CA State: 92395

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

RECEIVED

APR 02 2024

U.S. BANKRUPTCY COURT

Official Form 410

Proof of Claim
page 3

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ADA American Dental Association® Dental Claim Form 97

HEADER INFORMATION										
Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Prior Authorization <input checked="" type="checkbox"/> Request - Take XIX										
Predetermination/Prior Authorization Number										
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION										
Company/Plan Name, Address, City, State, Zip Code Borrego Health Claims Processing Center c/o KAC 232 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? <input type="checkbox"/> Medical? <input type="checkbox"/> (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 <input type="checkbox"/> M <input type="checkbox"/> F										
8. Policyholder/Subscriber ID (SSN or ID#)										
9. Plan/Group Number										
10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other										
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code										
RECORD OF SERVICES PROVIDED										
1. Procedure Date (MM/DD/CCYY)	2. Area of Oral Cavity	3. Teeth System	4. Tooth Number(s) or Letter(s)	5. Teeth Surface	6. Procedure Code	7. Diag. Pointer	8. Qty.	9. Description	10. Fee	
11/19/2020		JF	4		D2751		1	crown - porcelain fused to predomina	1500.00	
13. Missing Teeth Information (Place an "X" on each missing tooth.)										
14. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B, ICD-10 = AB)										
15. Diagnosis Code(s)										
16. Primary diagnosis in "A"										
17. Other Fee(s)										
18. Total Fee 1500.00										
19. Remarks										
AUTHORIZATIONS										
20. 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 provider 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.										
21. Signature on File 03/29/2024										
22. Patient/Guardian Signature Date										
23. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.										
24. Signature on File 03/29/2024										
25. 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.)										
26. Name, Address, City, State, Zip Code Yonghee Lee 12611 Hesperia Rd. Suite C Victorville CA 923958307										
27. NPI 1760858153										
28. License Number 64834										
29. SSN or ID# 822159868										
30. Phone Number 760 243 4366										
31. Additional Provider ID										
ANCILLARY CLAIM/TREATMENT INFORMATION										
32. Place of Treatment <input type="checkbox"/> (e.g. In-office, Out-of-office)										
33. Enclosures (Y or N)										
34. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Sko 41-42) <input type="checkbox"/> Yes (Complete 41-42)										
35. Date Appliance Placed (MM/DD/CCYY)										
36. Months of Treatment Remaining										
37. Replacement of Prosthesis <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 43)										
38. Date of Prior Placement (MM/DD/CCYY)										
39. Treatment Resulting from <input type="checkbox"/> Occupational Disease/Injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident										
40. Date of Accident (MM/DD/CCYY)										
41. Auto Accident State										
TREATING DENTIST AND TREATMENT LOCATION INFORMATION										
42. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.										
43. Name, Address, City, State, Zip Code Yonghee Lee 03/29/2024										
44. Signature (Treating Dentist) Date										
45. NPI 1760858153										
46. License Number 64834										
47. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307										
48. Phone Number 760 243 4366										
49. Additional Provider ID										

EXHIBIT 5

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 33 of 297

Claim #252 Date Filed: 4/2/2024

Your claim can be filed electronically on KOC's website at <https://kocscourt.com/filings/claims/>.

Fill in this information to identify the case:

Debit: Boston 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 357t.

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?	<u>Monia Hee Lee DDS Inc</u> 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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes From whom?	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? Name: <u>Monia Hee Lee DDS Inc</u> Address: <u>12111 Hesperia Rd. Ste C</u> City: <u>Victorville, CA</u> State: <u>92395</u> ZIP Code: <u>U.S.A.</u> Country: <u>U.S.A.</u> Contact phone: <u>760-243-4366</u> Contact email: <u>leeoffice@manager@gmail.com</u>	Where should payments to the creditor be sent? (if different) Name: _____ Address: _____ City: _____ State: _____ ZIP Code: _____ Country: _____ Contact phone: _____ Contact email: _____
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> 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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim
page 1

220238424140200000000000

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of 297

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
7304

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 incurred 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: _____

Official Form 410

Proof of Claim
page 2

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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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$3,300* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a) that applies: _____	\$ _____

* Amounts are subject to adjustment in 40125 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 357.

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 pays 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

Hee

Lee

Title

Dentist

Company

Yong Hee Lee DDS Inc.

Locate the corporate service in the company if the authorized agent is a service.

Address

12411 Hesperia Rd Ste C

Victorville, CA 92395

Contact phone

760-243-4364

and

Lee Office Manager@gmail.com

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 36
ADA American Dental Association® Dental Claim Form 97

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☒ E-SOT / 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

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. Teeth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/19/2020		JF			D1999		1	Personal Protective Equipment	5.00
2	11/19/2020		JF	18		D2751		1	crown - porcelain fused to predomina	1500.00
3										
4										
5										
6										
7										
8										
9										
10										

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

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

34. Diagnosis Code List Qualifier

(ICD-9 = B, ICD-10 = A6)

31a. Other Fee(s)

32. Total Fee 1505.00

34a. Diagnosis Code(s)

A C (Primary diagnosis in "A")

B D

35. Remarks #18 Existing All with lg decay on mesial cusp. Not enough All structure to hold Fill, can needed for permanent restoration

AUTHORIZATIONS

46. 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. 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.)

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 EIN 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-Other Hospital)

39. Enclosures (Y or N)

(Use "Place of Service Codes for Professional Claims")

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

X No Yes (Complete 44)

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

43. Replacement of Prosthesis

X No Yes (Complete 44)

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

Signature of Treating Dentist Date

54. NPI 1760858153

55. License Number 64834

56. Address, City, State, Zip Code

56a. Provider Specialty Code

12611 Hesperia Rd. Victorville CA 923958307

760 243 4366

57. Phone Number

58. Additional Provider ID

EXHIBIT 6

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 38 of 297

Claim #253 Date Filed: 4/2/2024

Your claim can be filed electronically on HCC's website at <https://easysys.hcc.net/submitclaim>.

Fill in this information to identify the case:

Debtor: Sanjour 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.

Debtors 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?	<u>Young Hee Lee DDS Inc</u> 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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom?	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? Name <u>Young Hee Lee DDS Inc</u> Address <u>12611 Hesperia Rd - Ste C</u> City <u>Victorville, CA</u> State <u>92395</u> ZIP Code <u>USA</u> Country Contact phone <u>760-243-4366</u> Contact email <u>leeoffice@manager@gmail.com</u>	Where should payments to the creditor be sent? (if different) Name Address City State ZIP Code Country Contact phone Contact email
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> 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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing?	

Official Form 410

Proof of Claim
page 1

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

6. Do you have any number you use to identify the debtor? ☐ No ☒ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor. 9868
TIOB

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 included 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: _____

Official Form 410

Proof of Claim
page 2

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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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$3,150* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/01/25 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 5011(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 \$505,000, 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 this information on this Proof of Claim and have made a true and correct statement 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

Signature [Signature]

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

Name: Young Hee Lee

First name Middle name Last name

Title Debtist

Company Young Hee Lee DDS Inc.

Address 12411 Hesperia Rd Ste C

City Victorville, CA State 92395

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

APR 02 2024

Official Form 410

Proof of Claim
page 3

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 41
ADA American Dental Association® Dental Claim Form 97

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

- ☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☒ Statement 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

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
11/10/2020		JP			D0150		1	comprehensive oral evaluation - new	150.00
11/10/2020		JP			D0274		1	bitewings - four radiographic images	150.00
11/10/2020		JP			D0230		1	intraoral - periapical each additional ra	50.00
11/10/2020		JP			D0230		1	intraoral - periapical each additional ra	50.00
11/10/2020	00	JP			D1208		1	topical application of fluoride - excludi	125.00
11/10/2020		JP	2	O	D1351		1	sealant - per tooth	175.00
11/10/2020		JP	3	O	D1351		1	sealant - per tooth	175.00
11/10/2020		JP	14	O	D1351		1	sealant - per tooth	175.00
11/10/2020		JP	15	O	D1351		1	sealant - per tooth	175.00
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
17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32

34. Diagnosis Code List Qualifier

(ICD-9 = B, ICD-10 = AB)

31a. Other Fee(s)

34a. Diagnosis Code(s)

A

B

C

D

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 provider 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

49. NPI 1760858153

50. License Number 64834

51. SSN 822-69868

52. 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?

☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

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

42. Months of Treatment Remaining

☒ 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 Signature (Treating Dentist)

Date

54. NPI 1760858153

55. License Number 64834

56. Address, City, State, Zip Code

56a. Provider Specialty Code 1223G0001X

12611 Hesperia Rd.

CA 923958307

Victorville

57. Phone Number 760-243-4366

58. Additional Provider ID

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 42
ADA American Dental Association® Dental Claim Form 97

HEADER INFORMATION

1. Type of Transaction (Mark off applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☒ E-SDT, Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

Bortego Health Claims Processing Center
C/O KAC
222 N. Pacific Coast Hwy Ste C
El Segundo CA 90245

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

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

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

6. Date of Birth (MM/DD/CCYY)

7. Gender

☐ M ☐ F

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person named in #5

☐ Self ☐ Spouse ☐ Dependent ☐ Other

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

RECORD OF SERVICES PROVIDED

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

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 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

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

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=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

☒ 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 (Printing Name)

Date

54. NPI 1760858153

55. License Number 64834

56. Address, City, State, Zip Code

56a. Provider Specialty Code 1223G0001X

12611 Hesperia Rd.

CA 923958307

Victorville

760-243-4366

57. Phone Number

58. Additional Provider ID

EXHIBIT 7

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 45 of 297

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 301(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 301(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: _____

Official Form 410

Proof of Claim
page 2

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 46 of 297

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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$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).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units, 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan, 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a) that applies: _____	\$ _____

* Amounts are subject to adjustment on 4/1/25 and every 5 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 \$990,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 357.

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 Hee Lee
First name Middle name Last name

Title Dentist

Company Yung Hee Lee DDS Inc.

Locate the corporate address as the company if the authorized agent is a servant.

Address 12411 Hesperia Rd Ste C

City Victorville, CA ZIP Code 92395

Country

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

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 47
ADA American Dental Association® Dental Claim Form 97

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☒ Request for Preauthorization

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

Domestic 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
11/09/2020		JP			D4910		1	periodontal maintenance	300.00
11/09/2020		JP			D1999		1	Personal Protective Equipment	5.00

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

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

34. Diagnosis Code List Qualifier

(ICD-9 = B; ICD-10 = A8)

34a. Diagnosis Code(s)

A

C

(Primary diagnosis in "A")

B

D

31a. Other Fee(s)

32. Total Fee

305.00

25. 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

50. License Number 64834

51. State ID 322169868

52. Phone Number 760 243 4366

52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☒ (e.g. H=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

☒ No ☐ Yes (Complete 44)

43. 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

56a. Provider Specialty Code 1223G0001X

12611 Hesperia Rd. Victorville CA 923958307

57. Phone Number 760 243 4366

58. Additional Provider ID

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To reorder call 800.947.4746

EXHIBIT 8

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 50 of 297

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
TIOSH

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.)
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

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 51 of 297

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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$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).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a) that applies: _____	\$ _____

* Amounts are subject to adjustment on 4/1/25 and every 2 years after that for costs 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

Signature: [Signature]

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

Name: Ung Hee Lee

First name Middle name Last name

Title: dentist

Company: Ung Hee Lee DDS Inc.

Specify the corporate service in this company if the authorized agent is a service.

Address: 12411 Hesperia Rd Ste C

Number Street

City: Victorville, CA ZIP Code: 92395 Country: _____

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

Official Form 410

Proof of Claim
page 3

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 52
of 297

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

- ☒ Statement of Actual Services ☐ Request for Predetermination/PrenAuthorization
☐ EPSDT Title XIX

2. Predetermination/PrenAuthorization 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

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	\$75.00
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

Permanent																																Primary												32. Other Fee(s)																													
																																A	B	C	D	E	F	G	H	I	J																																
34. (Place an 'X' on each missing tooth)																																																																									
																																T	S	R	Q	P	O	N	M	L	K																																
																																33. Total Fee																																									

35. Remarks

480.00

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
176085815350. License Number
6483451. SSN or TAN
82216986852. 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 (OO to 99)

☐ Resembling Original ☐ Photocopy ☐ Xerox

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

☒ No ☐ Yes (Complete 44)

43. Replacement of Prosthesis?

☐ No ☐ Yes (Complete 44)

44. Treatment Resulting from

☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

45. 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 data 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

56A. Provider Specialty Code 1223G0001X

12611 Hesperia Rd.
Victorville CA 923958307

57. Phone Number 760 243 4366

58. Additional Provider ID

EXHIBIT 9

Signed by Judge Laura Stuart Taylor May 7, 2025

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 55
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Part 2 Give Information About the Claim as of the Date the Case Was Filed	
6. Do you have any number you use to identify the debtor?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: <u>9868</u> <u>TIOB</u>
7. How much is the claim?	\$ <u>305.00</u> Does this amount include interest or other charges? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Attach statement itemizing interest, fees, expenses, or other charges received by Bankruptcy Rule 3001(c)(2)(A).
8. What is the basis of the claim?	Examples: Goods sold, money loaned, leased, 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. <u>Dental</u>
9. Is all or part of the claim secured?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. The claim is secured by a lien on property. Nature of property: <input type="checkbox"/> 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. <input type="checkbox"/> Motor vehicle <input type="checkbox"/> 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) _____ % <input type="checkbox"/> Fixed <input type="checkbox"/> Variable
10. Is this claim based on a lease?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Amount necessary to cure any default as of the date of the petition: \$ _____
11. Is this claim subject to a right of setoff?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Identify the property: _____

RECEIVED
APR 02 2024
KIMBERLY CRASIN CONSULTANTS

Official Form 410

Proof of Claim
page 2

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 56
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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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$3,300* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(2).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(9).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/25 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 co-debtor. 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 Wong Hee Lee
First name Middle name Last name

Title Dentist

Company Wong Hee Lee DDS Inc.
Indicate the corporate service as the company if the authorized agent is a service.

Address 12411 Hesperia Rd Ste C

City Victorville, CA State CA ZIP Code 92395

Contact Phone 762-243-4366 Email hee.office.manager@gmail.com

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 57
ADA American Dental Association® Dental Claim Form 97

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☒ FSDI - 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

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		JF			D4910		1	periodontal maintenance	300.00
2	11/12/2020		JF			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 12X 13X 14 15 16X

34. Diagnosis Code List Qualifier

(ICD-9 = B; ICD-10 = AB)

31a. Other Fee(s)

32. X X X X X 27 28 X 29 X 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

(Primary diagnosis in "A")

A

C

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

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

38. Subscriber Signature Date

39. Endorsement (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

☒ No ☐ Yes (Complete 44)

43. Replacement of Prosthesis

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

48. 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 64884 52. SSN or ID# 822180868

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (1 = Office; 2 = Outpatient Hospital)

(Use "Place of Service Codes for Professional Claims")

39. Endorsement (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

☒ No ☐ Yes (Complete 44)

43. Replacement of Prosthesis

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

48. 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 64884 52. SSN or ID# 822180868

53. 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 Signature (Treating Dentist) Date

54. NPI 1760858153 55. License Number 64884

56. Address, City, State, Zip Code

12611 Hesperia Rd. Victorville CA 923958307

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

59. Additional Provider ID

EXHIBIT 10

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

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TIO#

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.)
 Amount necessary to cure any defaults as of the date of the petition: \$ _____
 Annual interest rate (after 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

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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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$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).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(9).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/25 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(c)(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 357.

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

Signature

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

Name: Yong Hee Lee

Title

Dentist

Company

Yong Hee Lee DDS, Inc.

Address: 12111 Hesperia Rd Ste C

City: Victorville, CA ZIP Code: 92395

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

Official Form 410

Proof of Claim
page 3

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ADA American Dental Association® Dental Claim Form 97

HEADER INFORMATION									
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Presubmitization <input checked="" type="checkbox"/> PREST (7/13/2012)									
2. Predetermination/Presubmitization 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									
4. Other Coverage (Mark applicable box and complete items 5-11. If none, leave blank.) 1. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (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 <input type="checkbox"/> M <input type="checkbox"/> F 8. Policyholder/Subscriber ID (SSN or ID#) 9. Plan/Group Number 10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other 11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code									
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insured 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 <input checked="" type="checkbox"/> M <input type="checkbox"/> 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 <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> 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 <input checked="" type="checkbox"/> M <input type="checkbox"/> F									
23. Patient ID/Account # (Assigned by Dentist) [Redacted]									
RECORD OF SERVICES PROVIDED									
34. Procedure Date (MM/DD/CCYY) 03/12/2020									
35. Area of Oral Care JP									
36. Tooth System 19									
37. Tooth Number(s) or Letter(s) 19									
38. Tooth Surface D2751									
39. Procedure Code D2751									
40a. Day 1									
40b. Day 1									
40. Description crown - porcelain fused to predomina									
41. Fee 1500.00									
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 <input type="checkbox"/> (ICD-9 = B; ICD-10 = A6)									
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 provider 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/Guarantor Signature Date									
37. I hereby authorize 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									
49. NPI 1760858153									
50. License Number 64834									
51. SSN 822-168868									
52. Phone Number 760-243-4366									
52a. Additional Provider ID									
ANCILLARY CLAIM/TREATMENT INFORMATION									
38. Place of Treatment <input checked="" type="checkbox"/> (e.g. 11 office; 22:OP Hospital) (Use "Place of Service Codes for Professional Claims")									
39. Enclosures (Y or N) <input type="checkbox"/>									
40. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)									
41. Date Appliance Placed (MM/DD/CCYY)									
42. Months of Treatment Remaining <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)									
43. Replacement of Prostheses									
44. Date of Prior Placement (MM/DD/CCYY)									
45. Treatment Resulting from <input type="checkbox"/> Occupational Illness/Injury <input type="checkbox"/> Auto accident <input type="checkbox"/> 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 1760858153 64834									
54. NPI 1760858153									
55. License Number 64834									
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307									
57. Phone Number 760-243-4366									
58. Additional Provider ID									

EXHIBIT

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Part 2 Give Information About the Claim as of the Date the Case Was Filed	
6. Do you have any number you use to identify the debtor?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: <u>9868</u> <u>TIOL</u>
7. How much is the claim?	\$ <u>255.00</u> Does this amount include interest or other charges? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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. <u>Dental</u>
9. Is all or part of the claim secured?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. The claim is secured by a lien on property. Nature of property: <input type="checkbox"/> 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. <input type="checkbox"/> Motor vehicle <input type="checkbox"/> 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) _____ % <input type="checkbox"/> Fixed <input type="checkbox"/> Variable
10. Is this claim based on a lease?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Amount necessary to cure any default as of the date of the petition: \$ _____
11. Is this claim subject to a right of setoff?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Identify the property: _____

Official Form 410

Proof of Claim
page 2

32. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply.

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$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).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(9).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/05 and every 3 years after that by dates begun on or after the date of adjustment.

33. Is all or part of the claim pursuant to 11 U.S.C. § 503(b)(3)?

☒ 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 5011(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 the 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

[Signature]

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

Name: Young Hee Lee

Title: dentist

Company: Young Hee Lee DDS Inc.

Address: 12411 Hesperia Rd Ste C

City: Victorville, CA ZIP Code: 92395

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

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EXHIBIT

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

6. Do you have any number you use to identify the debtor? ☐ No ☒ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 9868
7104

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

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

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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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$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).	\$ _____
<input type="checkbox"/> 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)(6).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other: Specify subsection of 11 U.S.C. § 507(a) that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/25 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. § 543(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(e).

If you file this claim electronically, FRBP 5015(c)(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

Signature [Signature]

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

Name Young Hee Lee
First name Middle name Last name

Title Debtist

Company Young Hee Lee DDS Inc.
(Specify the corporate division or the country if the authorized agent is a service.)

Address 12411 Hesperia Rd Ste C
Number Street
Victorville, CA 92395
City State ZIP Code County

Contact phone 760-243-4346 Email lee.office.manager@gmail.com

Official Form 410

Proof of Claim
page 3

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ADA American Dental Association® Dental Claim Form 97

HEADER INFORMATION		POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)																	
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input checked="" type="checkbox"/> X Pre-Settle This Claim 2. Preauthorization/Preauthorization Number		12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code <div style="background-color: black; width: 100px; height: 40px;"></div>																	
3. Insurance Company/Dental Benefit Plan Information 4. Company/Plan Name, Address, City, State, Zip Code Borrego Health Claims Processing Center C/O Acc 222 N. Pacific Coast Hwy., Ste 300 Eureka, CA 94045		13. Date of Birth (MM/DD/CCYY) 14. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F 15. Policyholder/Subscriber ID (SSN or ID#) <div style="background-color: black; width: 100px; height: 20px;"></div>																	
6. Other Coverage (Mark applicable box and complete items 5-11 if none, leave blank.) 4. Dental <input type="checkbox"/> Medical <input type="checkbox"/> (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 <input type="checkbox"/> M <input checked="" type="checkbox"/> F 8. Policyholder/Subscriber ID (SSN or ID#) 9. Plan/Group Number 10. Patient's Relationship to Person named in #6 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other 11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		16. Plan/Group Number 17. Employer Name 18. Relationship to Policyholder/Subscriber in #12 Above <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other 19. Reserved For Future Use 20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code <div style="background-color: black; width: 100px; height: 40px;"></div>																	
21. Date of Birth (MM/DD/CCYY) 22. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F 23. Patient ID/Account # (Assigned by Dentist) <div style="background-color: black; width: 100px; height: 20px;"></div>																			
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. Teeth Surface	29. Procedure Code	29a. Diag. Position	29b. Qty.	30. Description	31. Fee										
11/16/2020		JF			D1999		1	Personal Protective Equipment	5.00										
11/23/2020		JF			D1999		1	Personal Protective Equipment	5.00										
32. Moving 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	17	34. Diagnosis Code List Qualifier (ICD-9 = B, ICD-10 = A6)	31a. Other Fee(s)	32. Total Fee
																	A		10.00
																	B		
33. Remarks																			
AUTHORIZATIONS										ANCILLARY CLAIM/TREATMENT INFORMATION									
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. (Is 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										38. Place of Treatment <input checked="" type="checkbox"/> (e.g. 11-office, 22-OP Hospital) 39. Enclosures (Y or N) (Use "Place of Service Codes for Professional Claims") 40. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY) 42. Months of Treatment Remaining <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 43) 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY) 45. Treatment Resulting from <input type="checkbox"/> Occupational Illness/Injury <input type="checkbox"/> Auto accident <input type="checkbox"/> 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)										TREATING DENTIST AND TREATMENT LOCATION INFORMATION									
48. Name, Address, City, State, Zip Code Yonghee Lee 12611 Hesperia Rd. Suite C Victorville CA 923958307										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) 64832 54. NPI 1760858153 55. License Number 1223G0001X 56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307									
49. NPI 1760858153 50. License Number 64832 51. SSN or ID# 822169868										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. 74 of 297

Claim #260 Date Filed: 4/2/2024

Your claim can be filed electronically on KCC's website at <https://kcc.kccill.com/Forms/claim.html>

Fill in this information to identify the case:

Debtor Bonoso Community Health Foundation
 (United States Bankruptcy Court for the Southern District of California)
 Claim number 22-02384

Official Form 410

Proof of Claim

04/22

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

Filers must leave out or redact information that is entitled to privacy (on this form or on any attached documents). Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed.

Part 1. Identify the Claim

1. Who is the current creditor?	<u>Ming Hee Lee DDS Inc</u> <small>Name of the current creditor (the person or entity to be paid for the claim)</small>		
	<small>Other names the creditor used with the debtor</small>		
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____		
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different)	
Federal Rule of Bankruptcy Procedure (FRBP) 2002(c)	Name <u>Ming Hee Lee DDS Inc</u>	Name _____	
	Address <u>2211 Hesperia Rd. Ste C</u>	Address _____	
	City <u>Victorville, CA</u>	City _____ State _____ ZIP Code _____	
	State <u>USA</u>	Country _____	
	Country _____	Country _____	
	Contact phone <u>760-243-4366</u>	Contact phone _____	
	Contact email <u>leeoffice@manager@gmail.com</u>	Contact email _____	
<small>Uniform Claims Statement for administrative expenses in chapter 12 of the case and §</small>			
4. Does this claim assert one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on <u>MM / DD / YYYY</u>		
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____		

Official Form 410

Proof of Claim
page 1

220238424040200000000013

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 75
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Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes: Last 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TIOB

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 retained 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 retained 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: _____

Official Form 410

Proof of Claim
page 2

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 76
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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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$1,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/25 and every 3 years after that for dates 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 501(b)(2) authorizes courts to establish local rules specifying when 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 367.

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 co-obligor. 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 this 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: [Signature]

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

Name	<u>Young</u>	<u>Hee</u>	<u>Lee</u>
	First name	Middle name	Last name
Title	<u>dentist</u>		
Company	<u>Young Hee Lee DDS Inc.</u>		
	Identify the corporate position on the company if the authorized agent is a corporation.		
Address	<u>12411 Hesperia Rd Ste C</u>		
	Number	Street	
	<u>Victorville, CA</u>		<u>92395</u>
	City	State	ZIP Code
Contact phone	<u>760-243-4366</u>		
	Email <u>hee.office.manager@gmail.com</u>		

Official Form 416

Proof of Claim
page 3

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EXHIBIT 4

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 79 of 297

Claim #261 Date Filed: 4/2/2024

Your claim can be filed electronically on KDC's website at <https://kdcoc.kdc.net/DebtorsHealth>.

Use this information to identify the case:

Debtor: Deborah Grossmanly Health, Filing/Misc.

United States Bankruptcy Court for the Southern District of California

Case number: 22-02384

Official Form 410 Proof of Claim

04/22

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

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 207.

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?	<u>Nong Hee Lee DDS Inc.</u> 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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom?	
3. Where should notices and payments to the creditor be sent?	<p>Where should notices to the creditor be sent?</p> <p><u>Nong Hee Lee DDS Inc.</u> Name <u>2611 Hesperia Rd. Ste C</u> Number Street <u>Victorville, CA 92395</u> City State ZIP Code <u>USA</u> Country Contact phone <u>760-243-4366</u> Contact email <u>lee.office.manager@gmail.com</u></p> <p>Where should payments to the creditor be sent? (if different)</p> <p>Name Number Street City State ZIP Code Country Contact phone Contact email</p> <p>Uniform claim identifier for electronic payments in chapter 13 (if you use one)</p>	
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> 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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing?	

Official Form 410

Proof of Claim
page 1



220238424040200000000014

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 80
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Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. Did 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
7104

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(e).
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: _____

Official Form 410

Proof of Claim
page 2

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 81
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12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

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

* Amounts are subject to adjustment on 4/01/25 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. 11 U.S.C. §§ 152, 157, and 357.

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 reasonably believed 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

Signature [Signature]

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

Name	First name	Middle name	Last name
	Yong	Hee	Lee

Title dentist

Company Yong Hee Lee DDS Inc.

Address 12411 Hesperia Rd Ste C

City Victorville, CA ZIP Code 92391

County San Diego

Case Number 22-243-4364

Email lee.office.manager@gmail.com

Official Form 410

Proof of Claim
page 3

ADA American Dental Association Dental Claim Form 7

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Predetermination
☒ FFS/FFS File 20X
2. Predetermination/Predetermination 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
E! Segundo, CA 90245

OTHER COV. Mark applicable box and complete items 5-11, leave blank

4. Dentist? ☐ 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/YYYY)

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/YYYY)

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/YYYY)

22. Gender

☐ M ☒ F

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

1. Procedure Date (MM/DD/YYYY)	2. Area of Oral Care	3. Tooth System	4. Tooth Number(s) or Letter(s)	5. Tooth Surface	6. Procedure Code	7. Diag. Pointer	8. Qty	9. Description	10. Fee
11/23/2020		JP			D1999		1	Personal Protective Equipment	5.00

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

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

31. Diagnosis Code List Qualifier

(ICD-9 = B, ICD-10 = AB)

31a. Other Fee(s)

32. X X 73 78 77 26 25 24 23 22 21 20 19 X 17

32a. Diagnosis Code(s)

A B C D

32 Total Fee 5.00

33. Remarks

AUTHORIZATIONS

34. 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 issuing 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/Subscriber Signature Date

35. 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 822169868

44. Phone Number 760 243 4366 45. Additional Provider ID

46. Primary Number 760 243 4366 47. Additional Provider ID

48. Primary Number 760 243 4366 49. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

36. Place of Treatment (1 = Office; 2 = OP Hospital)

(Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N)

40. Is Treatment for Orthodontics?

☒ No (Complete 41-42) ☐ Yes (Complete 41-42)

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

42. Months of Treatment Remaining

☒ No ☐ Yes (Complete 44)

43. Date of Prior Placement (MM/DD/YYYY)

45. Treatment Resulting from

☐ Occupational disease/injury ☐ Auto accident ☐ Other accident

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

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 57. Provider Specialty Code

12611 Hesperia Rd. 923958307

Victorville CA 923958307

58. Primary Number 760 243 4366 59. Additional Provider ID

60. Primary Number 760 243 4366 61. Additional Provider ID

EXHIBIT

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 84
of 297

Claim #262 Date Filed: 4/2/2024

Your claim can be filed electronically on KCC's website at <https://www.kccs.net/ForCreditors>

Fill in this information to identify the case:

Debtor: Bortosa Community Health Foundation
United States Bankruptcy Court for the Southern District of California
Case number: 22-02384

Official Form 410

Proof of Claim

04/23

Read the instructions before filing 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. §§ 1562, 1591, 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?	<u>Nong Hee Lee DDS Inc</u> <small>Name of the current creditor (the person or entity to be paid for this claim)</small> <small>Does not name the creditor used with the debtor</small>	
2. Has this claim been assigned from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? <u>Nong Hee Lee DDS Inc</u> <u>2111 Hesperia Rd. Ste C</u> <u>Victorville, CA 92395</u> <u>USA</u> <small>City State ZIP Code</small> Country Contact phone: <u>760-243-4366</u> Contact email: <u>leeoffice@managerle@gmail.com</u> <small>Uniform claim identifier for electronic payments is assigned. 12 (if you use one)</small>	Where should payments to the creditor be sent? (if different) Name Address City State ZIP Code Country Contact phone Contact email
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on <u>MM / DD / YYYY</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim
page 1

22023842404121100000000005

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Part 2: Give Information About the Claim as of the Date the Case Was Filed	
6. Do you have any number you use to identify the debtor?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: <u>9868</u> <div style="text-align: right; margin-right: 50px;"><u>TECH</u></div>
7. How much is the claim?	<div style="display: flex; justify-content: space-between;"> \$ <u>505.00</u> <div> Does this amount include interest or other charges? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A). </div> </div>
8. What is the basis of the claim?	<p><small>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.</small></p> <p style="font-size: 1.2em; margin-top: 10px;"><u>Dental</u></p>
9. Is all or part of the claim secured?	<div> <input checked="" type="checkbox"/> No. <input type="checkbox"/> Yes. The claim is secured by a lien on property. </div> <div style="margin-top: 10px;"> <p>Nature of property:</p> <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> 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. </div> <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> Motor vehicle </div> <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> Other. Describe: _____ </div> </div> <div style="margin-top: 10px;"> <p>Basis for perfection:</p> <p><small>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.)</small></p> </div> <div style="margin-top: 10px;"> <p>Value of property: \$ _____</p> <p>Amount of the claim that is secured: \$ _____</p> <p>Amount of the claim that is unsecured: \$ _____ <small>(The sum of the secured and unsecured amount should match the amount in line 7.)</small></p> </div> <div style="margin-top: 10px;"> <p>Amount necessary to cure any default as of the date of the petition: \$ _____</p> </div> <div style="margin-top: 10px;"> <p>Annual Interest Rate (when claim was filed) _____ %</p> <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> Fixed </div> <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> Variable </div> </div>
10. Is this claim based on a lease?	<div> <input checked="" type="checkbox"/> No. <input type="checkbox"/> Yes. Amount necessary to cure any default as of the date of the petition: \$ _____ </div>
11. Is this claim subject to a right of setoff?	<div> <input checked="" type="checkbox"/> No. <input type="checkbox"/> Yes. Identify the property: _____ </div>

Official Form 410

Proof of Claim
page 2

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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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$8,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(2).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/22 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 5011(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 357.

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 basis that the information is true and correct.

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

Signed on date: 03/28/2024

Signature

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

Name: Yong Hee Lee
First name Middle name Last name

Title: owner

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

Address: 12111 Hesperia Rd Ste C
Number Street

City: Victorville, CA State: 92395 ZIP Code: Country:

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

Official Form 410

Proof of Claim
page 3

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EXHIBIT

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 89 of 297

Claim #263 Date Filed: 4/2/2024

Your claim can be filed electronically on KCC's website at <https://www.kccdc.net/Nonresidential/>.

Fill in this information to identify the case:

Debtor: Bethesda Community Health Foundation
United States Bankruptcy Court III 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)(7), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both, 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed.

Part 1 Identify the Claim

1. Who is the current creditor?	<u>Wong Hee Lee DDS Inc</u> <small>Name of the current creditor (the person or entity to be paid for this claim)</small>	
	<input type="checkbox"/> Other (insert the creditor listed with the debtor)	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different)
Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)	<u>Wong Hee Lee DDS Inc</u> <u>12111 Hesperia Rd. Ste C</u> <u>Victorville, CA 92395</u> <u>USA</u>	Name _____ Number _____ Street _____ City _____ State _____ ZIP Code _____
RECEIVED APR 02 2024	Contact phone: <u>760-243-4366</u> Contact email: <u>leeofficemanager@gmail.com</u>	Country _____ Contact phone _____ Contact email _____
Marked claim identified for electronic payments in chapter 13 (if you use one).		
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on <u>04</u> / <u>02</u> / <u>2024</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim
page 1



220238424040200000000012

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

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. List 4 digits of the debtor's account or any number you use to identify the debtor. 9868
7104

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 301(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 301(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: _____

Official Form 410

Proof of Claim
page 2

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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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$7,500* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(2).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/03 and every 3 years after that for claims 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 3011(b).

If you file this claim electronically, FRBP 3005(a)(2) authorizes courts to provisionally rule, 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 357.

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.

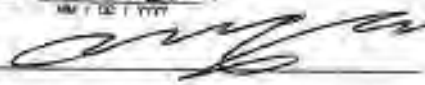
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

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: Wong Hee Lee
First name Middle name Last name

Title: Dentist

Company: Wong Hee Lee DDS Inc.
Specify the company number as the company if the authorized agent is a service.

Address: 12611 Hesperia Rd Ste C
Number Street

Victorville, CA 92395
City State ZIP Code

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

Official Form 410

Proof of Claim
page 3

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ADA American Dental Association Dental Claim Form 97

HEADER INFORMATION									
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Predetermination <input checked="" type="checkbox"/> Statement of Intent									
2. Predetermination/Predetermination Number									
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION									
3. Company/Plan Name, Address, City, State, Zip Code Barrago Health Claims Processing Center c/o KOC 222 N. Pacific Coast Hwy Ste 300 El Segundo Ca 90245									
4. Other Coverage (Mark applicable box and complete items 5-11, if none, leave blank) 4.1. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (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 <input type="checkbox"/> M <input type="checkbox"/> F 8. Policyholder/Subscriber ID (SSN or ID#) 9. Plan/Group Number 10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> 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 <input type="checkbox"/> M <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> 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 <input type="checkbox"/> M <input checked="" type="checkbox"/> 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. Plan	29b. Qty	30. Description	31. Fee
09/29/2020		JP	2,3,12,13,15		D5213		1	maxillary partial denture - cast metal fr	1500.00
32. Missing Teeth Information (Place an "X" on each missing tooth.) 1 X X X 2 3 4 5 6 7 8 9 10 11 12 X 13 X 14 15 X 16 X 17 X 18 X 19 X 20 21 22 23 24 25 26 27 28 29 30 33. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B; ICD-10 = A3) 34a. Diagnosis Code(s) A C 34b. (Primary diagnosis in "A") B D 35. Remarks									
31a. Other Fee(s) 32. Total Fee 1500.00									
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 produced health information to carry out payment services in connection with this claim. X Signature on File 03/29/2024 Patient/Subscriber 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 Dentist Signature Date									
ANCILLARY CLAIM/TREATMENT INFORMATION									
38. Place of Treatment <input checked="" type="checkbox"/> (e.g. in-office; 22=OP Hospital) 39. Enclosures (Y or N) (Use "Place of Service Codes for Professional Claims")									
40. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY)									
42. Months of Treatment Remaining <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) 43. Replacement of Prostheses 44. Date of Prior Placement (MM/DD/CCYY)									
45. Treatment Resulting from <input type="checkbox"/> Occupational Injury/Injury <input type="checkbox"/> Auto accident <input type="checkbox"/> 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 53. 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 54. NPI 1760858153 55. License Number 64834 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. 94 of 297

Claim #264 Date Filed: 4/2/2024

Your claim can be filed electronically on KCC's website at <https://kcc.kccdcourt.com/claims/submit>.

Fill in the information to identify the case:

Debtor: Borness Community Health Foundation

(West) State Bankruptcy Court in the Southern District of California

Case number: 22-10284

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?	<u>Young Hee Lee DDS Inc.</u> 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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____		
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different)	
Federal Rule of Bankruptcy Procedure (FRBP) 2002(g) RECEIVED APR 02 2024	Name <u>Young Hee Lee DDS Inc.</u>	Name _____	
	Number <u>1201 Hesperia Rd. Ste C</u>	Number _____ Street _____	
	City <u>Victorville, CA</u>	City _____ State _____ ZIP Code _____	
	State <u>CA</u>	Country _____	
	Country <u>USA</u>	Contact online _____	
Contact phone <u>760-243-4366</u>	Contact email _____		
Contact email <u>leeofficemanager@gmail.com</u>	Contact email _____		
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on <u>04/02/2024</u>		
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____		

Official Form 410

Proof of Claim
page 1

220238424040200000000011

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

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TIOB

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 301(c)(2)(A).

8. What is the basis of the claim? Examples: Goods sold, money lent, loan, services performed, personal injury or wrongful death, or credit card.
 Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 301(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: \$ _____
 Actual 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)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B)	\$
<input type="checkbox"/> Up to \$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).	\$
<input type="checkbox"/> 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).	\$
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(6).	\$
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$

* Amounts are subject to adjustment on 4/01/25 and every 5 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 5002(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 357.

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

[Signature]

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

Name: Young Hee Lee

First name Middle name Last name

Title: Dentist

Company: Young Hee Lee DDS Inc.

(Specify the corporate service or the company if the authorized signer is a service.)

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

Signed by Judge Laura Stuart Taylor May 7, 2025

EXHIBIT

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 99
of 297

Claim #265 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at <https://kcc.uscourts.net/secureclaim>.

Fill in this information to identify the case:

Debtor: Bonanza 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 filing 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.

File must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of nursing 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. §§ 1592, 1597, 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? Monq 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: Monq Hee Lee DDS Inc.
Address: 12111 Hesperia Rd. Ste C
City: Victorville, CA State: 92395 ZIP Code: _____
Country: USA
Contact phone: 760-243-4366
Contact email: leeofficemanager@gmail.com
Uniform claim number for electronic payments in chapter 13 (if you use one): _____

Where should payments to the creditor be sent? (if different)
Name: _____
Address: _____
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: 04/03/2024

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



220238424040300000000000

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

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 9868
7104

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 included 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 included 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 item 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: _____

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:

<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$3,250* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/25 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)(2)?

☒ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 25 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 3001(b).

If you file this claim electronically, FRBP 3001(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 357.

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



Signature

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

Name: Ming Hee Lee
First name Middle name Last name

Title: Debitist

Company: Ming Hee Lee DDS Inc.
Specify the corporate service by the company if the authorized agent is a service

Address: 12411 Hesperia Rd Ste C
Number Street

City: Victorville, CA 92395
City State ZIP Code

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

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APR 03 2024

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EXHIBIT

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 104
of 297

Claim #266 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at <https://kcc.uscourts.gov/claims>.

Part 1: Information to identify the case

Debtor: Bonson 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)(7), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$200,000, 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?	<u>Nong Hee Lee DDS Inc</u> 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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom?	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? Name: <u>Nong Hee Lee DDS Inc</u> Address: <u>2611 Hesperia Rd. Ste C</u> City: <u>Vickerville, CA</u> State: <u>92395</u> Country: <u>USA</u> Contact phone: <u>760-243-4366</u> Contact email: <u>Lee.D@firemanageria@gmail.com</u> Unknown claim identifier for electronic payments in chapter 13 (if you use one)	Where should payments to the creditor be sent? (if different) Name: _____ Address: _____ City: _____ State: _____ ZIP Code: _____ Country: _____ Contact phone: _____ Contact email: _____
4. Does this claim amount already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on: _____	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

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APR 03 2024

Official Form 410

Proof of Claim
page 1



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of 297

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
7104

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

10. Is this claim based on a lease? ☒ No
☐ Yes. Amount necessary to cure any default as of the date of the petition: \$ _____

11. Is this claim subject to a right of setoff? ☒ No
☐ Yes. Identify the property: _____

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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$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).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applied.	\$ _____

* Amounts are subject to adjustment on 4/1/25 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 5011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying when 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 1571.

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 debtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this Proof of Claim serves as an acknowledgment that when calculating the amount of this 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 05/28/2024

Signature 

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

Name: Ming Hee Lee

Title: Dentist

Company: Ming Hee Lee DDS Inc.

Address: 12411 Hesperia Rd Ste C

City: Victorville, CA State: 92395 Country:

Caseid choice: 7100-243-4366 Email: lee.office.manager@gmail.com

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Official Form 110

Proof of Claim
page 3

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EXHIBIT

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 109 of 297

Claim #267 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at <https://eportal.kccdcourt.net/Borrower/Health>.

Fill in this information to identify the case:

Creditor: Borrower/Community Health Foundation
United States Bankruptcy Court for the Southern District of California
Case number: 22-02384

Official Form 410
Proof of Claim

04/22

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

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed.

Part I Identify the Claim

1. Who is the current creditor?	<u>Monica Hee Lee DDS Inc</u> <small>Name of the current creditor (the person or entity to be paid for this claim)</small> <small>Other names this creditor used with the debtor</small>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? <u>Monica Hee Lee DDS Inc</u> <u>2211 Hesperia Rd. Ste C</u> <u>Victorville, CA 92395</u> <u>USA</u> <small>City State ZIP Code</small> Country Contact phone: <u>Two-243-4366</u> Contact email: <u>LeeOfficeManager@gmail.com</u> <small>Uniform claim identifier for electronic payments in chapter 13 (if you use one):</small>	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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on _____	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim
Form 1



22023842404030000000041

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of 297

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?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: <u>9868</u> <u>TIOH</u>
7.	How much is the claim?	\$ <u>255.00</u> Does this amount include interest or other charges? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 this claim required by Bankruptcy Rule 3001(c). Limit disclosing information that is entitled to privacy, such as health care information. <u>Dental</u>
9.	Is all or part of the claim secured?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. The claim is secured by a lien on property. Name of property: <input type="checkbox"/> Real estate: If the claim is secured by the debtor's principal residence, file a <i>Mortgage Proof of Claim Attachment</i> (Official Form 410-A) with this <i>Proof of Claim</i> . <input type="checkbox"/> Motor vehicle <input type="checkbox"/> 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) _____ % <input type="checkbox"/> Fixed <input type="checkbox"/> Variable
10.	Is this claim based on a lease?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Amount necessary to cure any default as of the date of the petition: \$ _____
11.	Is this claim subject to a right of setoff?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Identify the property: _____

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Official Form 410

Proof of Claim
page 2

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12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$5,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(3).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/25 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 5011(b).

If you file this claim electronically, FRBP 5015(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 co-obligor. 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: 03/29/2024
MAY 1 2024


Signature

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

Name: Yung Hee Lee
First name Middle name Last name

Title: dentist

Company: Yung Hee Lee DDS Inc.
Specify the corporate position or the company if the authorized agent is a service.

Address: 12411 Hesperia Rd Ste C
Number Street

City: Victorville, CA ZIP Code: 92395

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

Official Form 410

Proof of Claim
page 3

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 112
ADA American Dental Association Dental Claim Form 97

HEADER INFORMATION

Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preadjustment

☒ EPOD Title XIX

Predetermination/Preadjustment Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

OTHER COV. 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. 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
11/16/2020		JP			D1999		1	Personal Protective Equipment	5.00
11/16/2020		JP	4		D7210		1	extraction, erupted tooth requiring rem	250.00

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

1	2	3	X	5	6	7	8	X	9	X	10	X	11	12	X	13	14	X	15	16	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 provider 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=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 ☒ No ☐ Yes (Complete 44)

43. Replacement of Prosthesis

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

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. 114
of 297

Claim #268 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at <https://www.kccs.net/Forms/claims.htm>.

Fill in this information to identify the case:

Debtor: Bornstein Construction 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 357.

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?	<u>Noma Hee Lee DDS Inc.</u> <small>Name of the current creditor (the person or entity to be paid for this claim)</small>	
	<small>Other names the creditor used with the debtor:</small>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? <u>Noma Hee Lee DDS Inc.</u> <u>12611 Hesperia Rd. Ste C</u> <u>Vickerville, CA 92395</u> <u>USA</u> Contact phone: <u>760-243-4366</u> Contact email: <u>Lee@ficmanager@gmail.com</u> <small>Uniform claim identifier (for electronic payments in Chapter 13 (if you use one))</small>	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 already exist or already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known): _____ Filed on: ____/____/____	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

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

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. List 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TIOB

7. How much is the claim? \$ 3205.00
Does this amount include interest or other charges?
☒ No
☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. What is the basis of the claim?
Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.
Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).
Limit disclosing information that is entitled to privacy, such as health care information.
Dental

9. Is all or part of the claim secured?
☒ No
☐ Yes. The claim is secured by a lien on property.
Nature of property:
☐ Real estate: If the claim is secured by the debtor's principal residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410-A) with this Proof of Claim.
☐ Motor vehicle
☐ Other. Describe: _____
Basis for perfection:
Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)
Value of property: \$ _____
Amount of the claim that is secured: \$ _____
Amount of the claim that is unsecured: \$ _____ (The sum of the secured and unsecured amount should match the amount in line 7.)
Amount necessary to cure any default as of the date of the petition: \$ _____
Actual 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: _____

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Proof of Claims
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12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$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)(2).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(6).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment in AD 1025 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 § 5011(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:

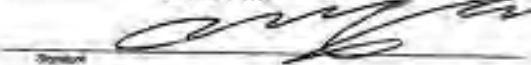
- ☒ I am the creditor.
- ☐ I am the creditor's attorney or authorized agent.
- ☐ I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.
- ☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

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



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

Name: Ming Hee Lee
First name Middle name Last name

Title: Dentist

Company: Ming Hee Lee DDS Inc.
Specify the corporate officer of the company if the authorized agent is a corporate officer.

Address: 12611 Hesperia Rd Ste C
Mailing Street

City: Victorville, CA 92395
City State ZIP Code Country

Contact phone: 714-243-4366 Email: lee.office.manager@gmail.com

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EXHIBIT

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Claim #269 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at <https://kccs.kccs-judicial.com/claims/>.

Fill in this information to identify the claim:

Debtor: Retired 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? Monq Hee Lee DDS Inc.
Name of the current creditor (the person or entity to be paid for this claim)
Does not list the creditor listed 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(a)

Where should notices to the creditor be sent?
Name: Monq Hee Lee DDS Inc.
Address: 2111 Hesperia Rd. Ste C
City: Victorville, CA State: 92395
Country: USA
Contact phone: 760-243-4366
Contact email: LeeOfficemanager@gmail.com

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

UNKNOWN claim identifier for electronic payments in Chapter 13 (if you use one): _____

4. Does this claim amount already filed?
☒ No
☐ Yes. Claims number on court claims registry (if known): _____ Filed on: MM / DD / YYYY

5. Do you know if anyone else has filed a proof of claim for this claim?
☒ No
☐ Yes. Who made the earlier filing? _____

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

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TIDH

7. How much is the claim? \$ 305.00 Does this amount include interest or other charges?
☒ No
☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. What is the basis of the claim? Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.
Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).
Limit disclosing information that is entitled to privacy, such as health care information.
Dental

9. Is all or part of the claim secured? ☒ No
☐ Yes. The claim is secured by a lien on property.
Nature of property:
☐ Real estate. If the claim is secured by the debtor's principal residence, file a Mortgage Proof of Claim Attachment (Official Form 410-A) with this Proof of Claim.
☐ Motor vehicle
☐ Other. Describe: _____
Basis for perfection: _____
Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)
Value of property: \$ _____
Amount of the claim that is secured: \$ _____
Amount of the claim that is unsecured: \$ _____ (The sum of the secured and unsecured amount should match the amount in line 7.)
Amount necessary to cure any default as of the date of the petition: \$ _____
Annual interest rate (when claim 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: _____

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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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$3,260* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> 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)(6).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/03 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 sale 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 9005(a)(2) authorizes courts to research 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 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
MAR 1 2024

Signature

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

Name

Wong Hee Lee
First name Middle name Last name

Title

Dentist

Company

Wong Hee Lee DDS Inc.
Specify the company name if the authorized agent is a service.

Address

12611 Hesperia Rd Ste C

City

Victorville, CA

State

92395

ZIP Code

Country

Contact phone

760-243-4364

Email

lee.office.manager@gmail.com

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Official Form 410

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ADA American Dental Association Dental Claim Form 97

HEADER INFORMATION

1. Case # (Transaction ID#; fill applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☒ FPD / Fee X3
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Borresco 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/YYYY) 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. Total Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

RECORD OF SERVICES PROVIDED

	24. Procedure Code (MM/DD/YYYY)	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 2 X 3 X 4 X 5 X 6 X 7 X 8 X 9 X 10 X 11 X 12 X 13 X 14 X 15 X 16 X 17 X 18 X 19 X 20 X 21 X 22 X 23 X 24 X 25 X 26 X 27 X 28 X 29 X 30 X 31 X 32 X 33 X 34 X 35 X 36 X 37 X 38 X 39 X 40 X 41 X 42 X 43 X 44 X 45 X 46 X 47 X 48 X 49 X 50 X 51 X 52 X 53 X 54 X 55 X 56 X 57 X 58 X 59 X 60 X 61 X 62 X 63 X 64 X 65 X 66 X 67 X 68 X 69 X 70 X 71 X 72 X 73 X 74 X 75 X 76 X 77 X 78 X 79 X 80 X 81 X 82 X 83 X 84 X 85 X 86 X 87 X 88 X 89 X 90 X 91 X 92 X 93 X 94 X 95 X 96 X 97 X 98 X 99 X 100 X
33. Diagnosis Code List Qualifier ☐ (ICD-9 = B, ICD-10 = AD)
34a. Diagnosis Code(s) A _____ C _____
(Primary diagnosis in "A") B _____ D _____
35. Business
36. Other Fee(s)
37. Total Fee 305.00

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 dental or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. In the event 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
41. I hereby authorize and direct payment of the dental benefits otherwise payable to me directly to the below named dental 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/YYYY)
42. Months of Treatment Remaining ☒ No ☐ Yes (Complete 44)
43. Replacement of Prosthesis ☒ No ☐ Yes (Complete 44)
44. Date of Prior Placement (MM/DD/YYYY)
45. Treatment Resulting from
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/YYYY)
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 provider(s)/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 53. 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
54. NPI 1760858153 55. License Number 64834
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. 124
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Claim #270 Date Filed: 4/3/2024

Your claim can be filed electronically on KDC's website at <https://epoc.kdcsciprilliam.com/health>.

Fill in this information to identify the case:

Debtor: Hesperia 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.

Debtors must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both, 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed.

Part 1 Identify the Claim

1. Who is the current creditor?	<u>Mona Hee Lee DDS Inc.</u> <small>Name of the current creditor (the person or entity to be paid for this claim)</small> <small>Other names the creditor uses with the debtor</small>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? <u>Mona Hee Lee DDS Inc.</u> <u>12111 Hesperia Rd. Ste C</u> <u>Victorville, CA 92395</u> <u>USA</u> <small>Name</small> <small>Number Street</small> <small>City State ZIP Code</small> <small>Country</small> <small>Contact phone</small> <u>760-243-4366</u> <small>Contact email</small> <u>leeoffice@manager@gmail.com</u> <small>Uniform claim identifier for electronic payments in chapter 13 (if you use one)</small>	Where should payments to the creditor be sent? (if different) <small>Name</small> <small>Number Street</small> <small>City State ZIP Code</small> <small>Country</small> <small>Contact phone</small> <small>Contact email</small>
4. Does this claim ascend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claim's registry (if known) _____ Filed on <u>4/3/2024</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

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

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
TIOB

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 3011(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 this 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: _____

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12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$5,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(9).	\$ _____
<input type="checkbox"/> 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(n)(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 301 (b).

If you file this claim electronically, FRBP 300(b)(1)(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 this 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

[Signature]

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

Name: Ying Hee Lee

Title: Debtist

Company: Ying Hee Lee DDS Inc.

Address: 12611 Hesperian Rd Ste C

City: Victorville, CA ZIP Code: 92395 County: San Diego

Contact phone: 714-243-4366 Email: lee.office.manager@gmail.com

Official Form 410

Proof of Claim
FD-309-3

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 127
ADA American Dental Association Dental Claim Form 97

HEADER INFORMATION									
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Prior Authorization <input checked="" type="checkbox"/> CASL Title XIX									
2. Predetermination/Prior Authorization Number									
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION									
3. Company/Plan Name, Address, City, State, Zip Code Borrego Health Claims Processing Center c/o KCC 322 N. Pacific Coast Hwy Ste 300 El Segundo CA 90245									
4. Is patient? <input type="checkbox"/> Medical? <input type="checkbox"/> (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 <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)					
9. Plan/Group Number		10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other							
11. (If not 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 <input checked="" type="checkbox"/> M <input type="checkbox"/> 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 <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> 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 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)					
RECORD OF SERVICES PROVIDED									
24. Procedure Code (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth Number(s) or Letter(s)	27. Tooth Surface	28. Procedure Code	29a. Diag. Provider	29b. Qty.	30. Description	31. Fee	
12/15/2020	JF	19		2810.10		1	Seat Crown	100.00	
32. Unusual Tooth Information (Place an "X" on each missing tooth)				34. Diagnosis Code, List Qualifier (ICD 9 = 8; ICD-10 = A6)			31a. Other Fee(s)		
1	2	3	4	5	6	7	8	9	10
11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30
35. Remarks				36a. Diagnostic Code(s) (Primary diagnosis in "A")			32. Total Fee 100.00		
36b. (Secondary diagnosis in "B")				37. Date of Accident (MM/DD/CCYY)			47. Auto Accident State		
AUTHORIZATIONS									
38. Place of Treatment (e.g. In-office, 22-GP Hospital) (Use "Place of Service Codes for Professional Claims")									
39. Enclosures (Y or N)									
40. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)									
41. Date Appliance Placed (MM/DD/CCYY)									
42. Months of Treatment Remaining <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 43)									
43. Replacement of Prosthesis <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)									
44. Date of Prior Placement (MM/DD/CCYY)									
45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident									
46. Date of Accident (MM/DD/CCYY)									
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 1750858153		50. License Number 64834		51. SSN or TIN 822169868					
52. Phone Number 760 243 4366		53. 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 <input checked="" type="checkbox"/> Signed (Treating Dentist) Date 64834									
54. NPI 1750858153		55. License Number 64834		56. Provider Specialty Code 1223G0001X					
57. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307		58. Phone Number 760 243 4366							
59. Additional Provider ID		60. Signature of Provider							

EXHIBIT 4

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 129
of 297

Claim #271 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at <https://www.kccclaw.com/Forms/Health>.

Fill in this information to identify the claim:

Debtor: Hesperia 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)(3), 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? Monq Hee Lee DDS Inc.
Name of the current creditor (the person or entity to be paid for this claim)
Other name (if a 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?
Where should notices to the creditor be sent?
Monq Hee Lee DDS Inc.
Name
12611 Hesperia Rd. Ste C
Address
Victorville, CA 92395
City State ZIP Code
USA
Country
Contact phone: 760-243-4366
Contact email: leed@icemanager@gmail.com
Where should payments to the creditor be sent? (if different)
Name
Address
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?

Official Form 410

Proof of Claim
page 1



Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 130
of 297

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. List 4 digits of the debtor's account or any number you use to identify the debtor: 9868
7104

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

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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$1,250* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/25 and every 3 years later 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 2011(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 357f.

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 excluder. 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

Signature 

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

Name Wong Hee Lee
First name Middle name Last name

Title dentist

Company Wong Hee Lee DDS Inc.
(Specify the corporate service as the company if the authorized agent is a service.)

Address 12611 Hespena 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
KUTZMAN CARSON CONSULTANTS

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 132
ADA American Dental Association Dental Claim Form 97

HEADER INFORMATION										
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input checked="" type="checkbox"/> Filing Fee 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? <input type="checkbox"/> Medical? <input type="checkbox"/> (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 <input type="checkbox"/> M <input type="checkbox"/> F										
8. Policyholder/Subscriber ID (SSN or ID#)										
9. Plan/Group Number										
10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other										
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code										
RECORD OF SERVICES PROVIDED										
1	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Teeth Surface	29. Procedure Code	29a. Diag. Panther	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.)						34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B, ICD-10 = AB)		31a. Other Fee(s)		
1	X	3	X	5	X	X	X	8	9	10
11	X	12	X	13	14	15	X	16		
17	X	18	X	19	20	21	22	23	24	25
26	X	27	28	29	30	31	32	33	34	35
35. Remarks						34a. Diagnostic Code(s) (Primary diagnosis in "A")		34b. Other Fee(s) (ICD-9 = B, ICD-10 = AB)		32. Total Fee 505.00
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) <input type="checkbox"/>										
40. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)										
41. Date Appliance Placed (MM/DD/CCYY)										
42. Months of Treatment Remaining										
43. Replacement of Prosthesis <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)										
44. Date of Prior Placement (MM/DD/CCYY)										
45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> 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										
57. Phone Number 760 243 4366										
58. Additional Provider ID										

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To reorder call 800.947.4746

EXHIBIT

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 134
of 297

Claim #272 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at <http://www.kcc.com/Forms/Claims>.

Fill in this information to identify the case:

Debtor: Bonanza Community Health Foundation
United States Bankruptcy Court for the Southern District of California
Case Number: 22-02384

Official Form 410
Proof of Claim

04/22

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

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

File 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?	<u>Wong Hee Lee DDS Inc</u> <small>(Name of the current creditor (the person or entity to be paid for this claim). Other names for the creditor used with the debtor.</small>		
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes From whom? _____		
3. Where should notices and payments to this creditor be sent?	Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different)	
Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)	Name <u>Wong Hee Lee DDS Inc</u> Address <u>12411 Hesperia Rd. Ste C</u> City <u>Victorville, CA</u> State <u>CA</u> ZIP Code <u>92395</u> Country <u>USA</u> Contact phone <u>Two-243-4366</u> Contact email <u>leeoffice@manager@gmail.com</u>	Name _____ Address _____ 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 asserted one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on <u>MM / DD / YYYY</u>		
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____		

Official Form 410

Proof of Claim
page 1

220238424040300000000031

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of 297

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

6. Do you have any claimer you use to identify the debtor? ☐ No
☒ Yes. List 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TIO#

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).
List describing 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 this 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: _____

Official Form 410

Proof of Claim
page 2

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 136
of 297

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$5,250* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefits plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a) that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/25 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 3011(b).

If you file this claim electronically, FRBP 3005(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 3025.

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

Signature 

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

RECEIVED

APR 03 2024

KURTZMAN CARSON CONSULTANTS

Name Wong Hee Lee

Title Dentist

Company Wong Hee Lee DDS Inc.

Address 12411 Hespena Rd Ste C

Victorville, CA 92395

Contact phone 760-243-4364

Email hee@heeleemanager@gmail.com

Official Form 410

Proof of Claim
page 3

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 137

ADA American Dental Association Dental Claim Form

97

HEADER INFORMATION

Type of Transaction (Mark all applicable boxes):
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☒ EFS/OT Type XIX
Preauthorization Number: _____

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

1. Insurance Plan Name, Address, City, State, Zip Code
Borrego Health Claims Processing Center
c/o KCC
222 N. Pacific Coast Hwy Ste 300
Escondido, CA 92025

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/YYYY) 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. If not 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/YYYY) 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/YYYY) 22. Gender ☐ M ☒ F 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

24. Procedure Date (MM/DD/YYYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) (if Letter(s))	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. City	30. Description	31. Fee
11/13/2020		JP			D0150		1	comprehensive oral evaluation - new	150.00
11/20/2020		JP			D1999		1	Personal Protective Equipment	5.00
11/23/2020	OU	JP			D1110		1	prophylaxis - adult	200.00
11/23/2020		JP			D1999		1	Personal Protective Equipment	5.00
11/20/2020		JP	21	O	D2391		1	resin-based composite - one surface,	225.00

32. Missing Teeth Information (Place an "X" on each missing tooth.)
1 X 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 X 17 18 19 X 20 21 X 22 23 24 25 26 27 28 29 30 X 31 X 32
33. Diagnosis Code List Qualifier (ICD-9 = 0; ICD-10 = AB)
34a. Diagnosis Code(s) A C
34b. (Primary diagnosis in "A") B D
35. Other Fee(s)
36. Total Fee: 585.00

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 provider 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 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: ☒ Office (e.g. 11 office; 22+OP Hospital) 39. Enclosures (Y or N):
(Use "Place of Service Codes for Professional Claims")
40. Is Treatment for Orthodontics? ☒ No (Skip 41-42) ☐ Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/YYYY)
42. Months of Treatment Remaining ☒ No ☐ Yes (Complete 44) 43. Replacement of Prosthesis: ☒ No ☐ Yes (Complete 44) 44. Date of Prior Placement (MM/DD/YYYY)
45. Treatment Resulting from:
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/YYYY) 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. Phone Number: 760 243 4366 50. License Number: 64834 51. State ID: 822159868
52. Primary Number: 760 243 4366 53. 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
54. NPI: 1760858153 55. License Number: 64834
56. Address, City, State, Zip Code
12611 Hesperia Rd.
Victorville CA 923958307
57. Phone Number: 760 243 4366 58. Additional Provider ID

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EXHIBIT

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 139 of 297

Claim #273 Date Filed: 4/3/2024

Your claim can be filed electronically on KCD's website at <https://www.kcd.com/Forms/Health>.

Fill in this information to identify the case:

Debtor: Monro Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number: 22-02384

Official Form 410

Proof of Claim

04/22

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

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed.

Part 1: Identify the Claim

1. Who is the current creditor?	<u>Monro Hee Lee DDS Inc</u> <small>Name of the creditor (include the person or entity to be paid for this claim)</small> <small>Other name this creditor used with the debtor</small>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? <u>Monro Hee Lee DDS Inc</u> <u>2211 Hesperia Rd. Ste C</u> <u>Victorville, CA 92395</u> <u>USA</u> <u>760-243-4366</u> <u>leeoffice@monroheeleedental.com</u>	Where should payments to the creditor be sent? (if different) Name _____ Number _____ Street _____ City _____ State _____ ZIP Code _____ Country _____ Contact phone _____ Contact email _____
Federal Rule of Bankruptcy Procedure (FRBP) 2002(g) RECEIVED APR 03 2024 KURTZMAN CARSON CONSULTANTS		
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known): _____ Filed on: <u>MM / DD / YYYY</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim
page 1

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 140
of 297

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
7104

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 recorded 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 recorded 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 equal the amount in line 7.)
Amount necessary to cure any default as of the date of the petition: \$ _____
Annual interest rate (when last was fixed) _____ %
☐ 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

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 141
of 297

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

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

* Amounts are subject to adjustment on 4/1/25 and every 3 years after that for costs 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 co-debtor. 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:

RECEIVED

APR 03 2024

KURTZMAN CARSON CONSULTANTS

Name: Yong Hee Lee
First name Middle name Last name

Title: Dentist

Company: Yong Hee Lee DDS, Inc.
(Specify the corporate division or the company if the authorized agent is a service)

Address: 12411 Hesperia Rd Ste C
Number Street

City: Victorville, CA State: 92395 ZIP Code: _____ Country: _____

Unlisted phone: 714-243-4366 Email: lee.office.manager@gmail.com

Official Form 410

Proof of Claim
page 3

Case 22-02384-LTT-1 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 142

ADA American Dental Association Dental Claim Form

HEADER INFORMATION																																																															
1. Type of Transaction (Mark all applicable boxes)																																																															
<input type="checkbox"/> Statement of Actual Services						<input type="checkbox"/> Request for Predetermination/Preauthorization																																																									
<input checked="" type="checkbox"/> EFT-File 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 E1 Segundo, CA 90245																																																															
OTHER COVERAGE (Mark applicable box and complete items 5-11, if none, leave blank)																																																															
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (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/YYYY)				7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)																																																									
9. Plan Group Number				10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																																																											
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																																																															
RECORD OF SERVICES PROVIDED																																																															
24. Procedure Date (MM/DD/YYYY)		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																																													
11/13/2020				JP						D1999				1		Personal Protective Equipment		5.00																																													
32. Missing Teeth Information (Place an "X" on each missing tooth.)										34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)				31a. Other Fee(s)																																																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>17</td><td>18</td><td>19</td><td>20</td><td>21</td><td>22</td><td>23</td><td>24</td><td>25</td><td>26</td><td>27</td><td>28</td><td>29</td><td>30</td><td>31</td><td>32</td></tr> </table>										1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16																	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	34a. Diagnosis Code(s) A _____ C _____					
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16																																																
17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32																																																
										34b. (Primary diagnosis in "A") B _____ D _____				32. Total Fee 5.00																																																	
33. Remarks																																																															
AUTHORIZATIONS										ANCILLARY CLAIM/TREATMENT INFORMATION																																																					
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.										38. Place of Treatment <input checked="" type="checkbox"/> (e.g. 11=office; 22=OP Hospital) (Use "Place of Service Codes for Professional Claims")										39. Enclosures (Y or N) <input type="checkbox"/>																																											
X Signature on File 03/29/2024										40. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)										41. Date Appliance Placed (MM/DD/YYYY)																																											
Patient/Guardian Signature _____ Date _____										42. Months of Treatment Remaining <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)										44. Date of Prior Placement (MM/DD/YYYY)																																											
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.										45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident																																																					
X Signature on File 03/29/2024										46. Date of Accident (MM/DD/YYYY)										47. Auto Accident State																																											
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.)										TREATING DENTIST AND TREATMENT LOCATION INFORMATION																																																					
48. Name, Address, City, State, Zip Code										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 12611 Hesperia Rd. Suite C Victorville CA 923958307										Yonghee Lee 03/29/2024																																																					
49. NPI 1760858153										54. NPI 1760858153																																																					
50. License Number 64834										55. License Number 64834																																																					
51. SSN 822169868										56. Address, City, State, Zip Code																																																					
										12611 Hesperia Rd. Victorville CA 923958307																																																					
52. Phone Number 760 243 4366										57. Phone Number 760 243 4366																																																					
52a. Additional Provider ID										58. Additional Provider ID																																																					

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EXHIBIT

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 144
of 297

Claim #274 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at <https://kcc.kcc.com/claimform.html>.

Fill in this information to identify the case.

Debtor: Harris 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 I Identify the Claim

1. Who is the current creditor?	<u>Nong Hee Lee DDS Inc</u> <small>Name of the current creditor (the person or entity to be paid for the claim)</small>	
	<small>Other names the creditor used with the debtor</small>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom?	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different)
<small>Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)</small>	Name <u>Nong Hee Lee DDS Inc</u>	Name _____
	Number <u>12411 Hesperia Rd. Ste C</u>	Number _____ Street _____
	City <u>Victorville, CA</u>	City _____ State _____ ZIP Code _____
	State <u>CA</u>	State _____
	ZIP Code <u>92395</u>	ZIP Code _____
	Country <u>USA</u>	Country _____
	Contact phone <u>760-243-4366</u>	Contact phone _____
	Contact email <u>leedfiremanager@gmail.com</u>	Contact email _____
<small>Upload claim identifier for electronic payments in chapter 13 (if you use one)</small>		
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on _____	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim
page 1



220238424040300000000035

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 145
of 297

Part 1. 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. List 4 digits of the debtor's account or any number you use to identify the debtor: 9868
710#

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

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:

<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$3,550* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(9).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies:	\$ _____

* Amounts are subject to adjustment on 4/1/25 and every 3 years after that for years 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 case 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: Wong Hee Lee
First name Middle name Last name

Title: Dentist

Company: Wong Hee Lee DDS Inc.
Indicate the national service as the company if the authorized agent is a service.

Address: 12611 Hesperia Rd Ste C
Number Street

City: Victorville, CA ZIP Code: 92395 Country: _____

County (if any): San Diego Email: hee.office.manager@gmail.com

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APR 03 2024

KURTZMAN CARSON CONSULTANTS

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 147
ADA American Dental Association Dental Claim Form 97

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

Correco 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 (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		JF			D9430		1	office visit for observation (during regu	100.00
2									
3									
4									
5									
6									
7									
8									
9									
10									

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

1 X 2 3 4 5 6 7 8 9 10 11 12 13 14 X 15 16
17 X 18 19 20 21 22 23 24 25 26 27 28 29 30 31 X 32
33a. Diagnosis Code List Qualifier ☐ ICD-9 = B; ICD-10 = AB
31a. Other Fee(s)
32. Total Fee 100.00

33. Remarks

AUTHORIZATIONS

34. 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

35. 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.)

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

Yonghee Lee
12611 Hesperia Rd.
Suite C
Victorville CA 923958307

37. NPI 1760858153

38. License Number 64834

39. SSN or TIN 822159868

40. Phone Number 760 243 4366

41. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☒ (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

☒ 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

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

57. Provider Specialty Code 1223G0001X

12611 Hesperia Rd.

CA 923958307

Victorville

58. Phone Number 760 243 4366

59. 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 KGC's website at <https://www.kgc.com/submitclaim>

Fill in this information to identify the case:

Debit: 202202384

United States Bankruptcy Court for the Southern District of California

Claim number: 22-02384

Official Form 410 Proof of Claim

04/25

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

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both, 18 U.S.C. §§ 152, 157, and 357.

Fill in all the information about the claim as of the date the case was filed.

Part I: Identify the Claim

1. Who is the current creditor? Monq Hee Lee DDS Inc.
Name of the current creditor (the person or entity to be paid for this claim)
Obtain receipt from creditor used with the claim.

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)
Monq Hee Lee DDS Inc.
2211 Hesperia Rd. Ste C
Victorville, CA 92395
USA
City State ZIP Code Country
Contact phone: 760-243-4366
Contact email: leeoffice@monq.com
Uniform claim identifier for electronic payments is checked. If you use only.

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 warrant one already filed?
☒ No
☐ Yes. Claim number on court claims registry (if known) _____ Filed on 04/03/2024

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



220238424040300000000034

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 150
of 297

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
TDH

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 does your fixed) _____ %
☐ 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

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 151
of 297

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$1,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(2).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a) that applies: _____	\$ _____

* Amounts are subject to adjustment on 4/1/05 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 9006(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, this 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

Wing

Hee

Lee

Title

dentist

Company

Wing Hee Lee DDS Inc.

Specify the attorney service to the company if the authorized agent is a person.

Address

12451 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

Official Form 410

Proof of Claim
page 3

HEADER INFORMATION											
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Prior Authorization <input checked="" type="checkbox"/> EASD-1 / Title XIX											
2. Predetermination/Prior Authorization Number											
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)											
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code <div style="background-color: black; height: 40px; width: 100%;"></div>											
13. Date of Birth (MM/DD/YYYY)				14. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F		15. Policyholder/Subscriber ID (SSN or ID#) <div style="background-color: black; height: 20px; width: 100%;"></div>					
16. Plan/Group Number <div style="background-color: black; height: 20px; width: 100%;"></div>				17. Employer Name <div style="background-color: black; height: 20px; width: 100%;"></div>							
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION											
3. Company/Plan Name, Address, City, State, Zip Code Barrogo Health Claims Processing Center C/O KCC 222 N. Pacific Coast Hwy Ste 300 El Segundo CA 90245											
4. Other Coverage (Mark applicable box and complete items 5-11 if none, leave blank) Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (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/YYYY) 7. Gender <input type="checkbox"/> M <input type="checkbox"/> F 8. Policyholder/Subscriber ID (SSN or ID#) 9. Plan/Group Number 10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other 11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code											
PATIENT INFORMATION											
18. Relationship to Policyholder/Subscriber in #12 Above <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other										19. Reserved For Future Use	
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code <div style="background-color: black; height: 40px; width: 100%;"></div>											
21. Date of Birth (MM/DD/YYYY)				22. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist) <div style="background-color: black; height: 20px; width: 100%;"></div>					
RECORD OF SERVICES PROVIDED											
24. Procedure Date (MM/DD/YYYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag Power	29b. Qty.	30. Description	31. Fee		
07/02/2019		JH	24		D3310		1	endodontic therapy, anterior tooth (ex	800.00		
32. Missing Teeth Information (Place an "X" on each missing tooth.) 1 X 2 X 3 X 4 X 5 X 6 X 7 X 8 X 9 X 10 X 11 X 12 X 13 X 14 X 15 X 16 X 17 X 18 X 19 X 20 X 21 X 22 X 23 X 24 X 25 X 26 X 27 X 28 X 29 X 30 X				34. Diagnosis Code List Guidelines (ICD-9 = B, ICD-10 = A6) 34a. Diagnosis Code(s) A _____ C _____ (Primary diagnosis in "A") B _____ D _____				31a. Other Fees(s) 32. Total Fee 800.00			
33. Remarks											
AUTHORIZATIONS											
35. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contracted agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my proposed health information to carry out payment activities in connection with this claim. Signature on File 03/29/2024 Patient/Guardian Signature _____ Date _____											
36. I hereby authorize and direct payment of the dental benefits/insurance payable to me, directly to the below named dentist or dental entity. 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											
40. NPI 1760858153				45. License Number 64834				47. SSN 822169968			
Phone Number 760 243 4366				Additional Provider ID							
ANCILLARY CLAIM/TREATMENT INFORMATION											
38. Place of Treatment <input checked="" type="checkbox"/> Office (1-office, 22-QIP Hospital) (Use "Place of Service Codes for Professional Claims")										39. Enclosures (Y or N) <input type="checkbox"/>	
40. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)										41. Date Appliance Placed (MM/DD/YYYY)	
42. Months of Treatment Remaining				43. Replacement of Prosthesis <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)				44. Date of Prior Placement (MM/DD/YYYY)			
45. Treatment Resulting from: <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident											
46. Date of Accident (MM/DD/YYYY)										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 Signature (Treating Dentist) 1760858153 Date 64834											
54. NPI 1760858153				55. License Number 64834				56. Provider Specialty Code 1223G0004X			
Address, City, State, Zip Code 12611 Hesperia Rd, Victorville CA 923958307				Phone Number 760 243 4366				Additional Provider ID			

EXHIBIT

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 154
of 297

Claim #276 Date Filed: 4/3/2024

Your claim can be filed electronically on KCC's website at <https://epoc.kcc.com/RemedyHealth>.

Fill in this information to identify the case:

Debtor: Remedy Concepts 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 I Identify the Claim

1. Who is the current creditor?	<u>Monq Hee Lee DDS Inc</u> <small>Name of the current creditor (the person or entity to be paid for this claim)</small> <small>Other names the creditor used with the debtor</small>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different)
<small>Federal Rule of Bankruptcy Procedure (FRBP) 2003(a)</small> RECEIVED APR 03 2024 KORTZMAN CARSON CONSULTANTS	Name <u>Monq Hee Lee DDS Inc</u>	Name _____
	Number <u>12411 Hesperia Rd. Ste C</u>	Number _____
	Street <u>Vickerville, CA 92395</u>	Street _____
	City <u>USA</u>	City _____
	State <u>CA</u>	State _____
Country <u>USA</u>	Country _____	ZIP Code _____
Contact phone <u>760-243-4366</u>	Contact phone _____	Contact phone _____
Contact email <u>lee@remedymanager.com</u>	Contact email _____	Contact email _____
<small>William state identifier for electronic payments in chapter 13 (if you use one):</small>		
4. Does this claim unsecured claim already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> 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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim
page 1

220238424040300000000003

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 155
of 297

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? \$ 600.00
Does this amount include interest or other charges?
☒ No
☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. What is the basis of the claim? Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.
Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).
Limit disclosing information that is entitled to privacy, such as health care information.
Dental

9. Is all or part of the claim secured? ☒ No
☐ Yes. The claim is secured by a lien on property.
Nature of property:
☐ Real estate: If the claim is secured by the debtor's principal residence, file a Mortgage Proof of Claim Attachment (Official Form 410-A) with this Proof of Claim.
☐ Motor vehicle
☐ Other. Describe: _____
Basis for perfection:
Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)
Value of property: \$ _____
Amount of the claim that is secured: \$ _____
Amount of the claim that is unsecured: \$ _____ (The sum of the secured and unsecured amount should match the amount in line 7.)
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

RECEIVED
APR 03 2024
KURTZMAN CARSON CONSULTANTS

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 156
of 297

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$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)(2).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a) that applies: _____	\$ _____

* Amounts are subject to adjustment on 4/01/25 and every 5 years after that for rules 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 3034.
- ☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3035.

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.

Emitted on date 03/28/2024
and at San Jose, CA

Signature

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

Name Yong Hee Lee
First name Middle name Last name

Title Debtist

Company Yong Hee Lee DCS Inc.
Specify the corporate division or the company if the authorized agent is a division

Address 12611 Hesperia Rd Ste C
Municipality Parcel

City Victorville, CA State 92395 ZIP Code County

Local phone 714-243-4364 Email lee.office.manager@gmail.com

Official Form 410

Proof of Claim
page 3

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ADA American Dental Association Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☒ Prepaid - Title X/K

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. Received 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 ☐ F

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Care	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30a. Diag. Front	30b. City	30. Description	31. Fee
11/19/2020	01	JF			D3		1	Denture Delivery	300.00
11/19/2020	02	JF			D3		1	Denture Delivery	300.00

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

33. Remarks

34. Diagnosis Code List Qualifier ☐ (ICD-9 = 8, ICD-10 = A8)

35a. Diagnosis Code(s)

35b. Primary diagnosis in "A"

36. Other Fee(s)

37. Total Fee 600.00

AUTHORIZATIONS

38. 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 providing 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.

39. Signature on File 03/29/2024

40. Patient/Guardian Signature Date

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

42. Signature on File 03/29/2024

43. Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

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

45. Enclosures (Y or N) ☐

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

47. Date Appliances Placed (MM/DD/CCYY)

48. Months of Treatment Remaining ☒ No ☐ Yes (Complete 44)

49. Replacement of Prosthetics

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

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

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

55. NPI 1760858153

56. License Number 64834

57. SSN or ID# 822169868

58. Primary Number 760 243 4366

59. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

61. Signature (Treating Dentist) Yonghee Lee 03/29/2024

62. NPI 1760858153

63. License Number 64834

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

65. Primary Number 760 243 4366

66. Additional Provider ID

©2012 American Dental Association To reorder call 800.947.4746

EXHIBIT

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 159
of 297

Claim #277 Date Filed: 4/4/2024

Your claim can be filed electronically on KDC's website at <https://kdc.kdc.org/Form410Health>.

Fill in this information to identify the case:

Debtor: Himoda 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 nursing 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?	<u>Young Hee Lee DDS Inc</u> Name of the current creditor (the person to entity to be paid for the claim) Other names the creditor used with the debtor	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom?	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? Name <u>Young Hee Lee DDS Inc</u> Address <u>12611 Hesperia Rd. Ste C</u> City <u>Victorville, CA</u> State <u>92395</u> ZIP Code <u>U.S.A</u> Country Contact phone <u>760-243-4366</u> Contact email <u>leeoffice@manager@gmail.com</u> Uniform claims identifier for electronic payments in chapter 13 (if you use one):	Where should payments to the creditor be sent? (if different) Name Address City State ZIP Code Country Contact phone Contact email
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) Filed on: <u>4/4/2024</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing?	

Official Form 410

Proof of Claim
page 1

220238424040400000000003

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Part 2 Give information about the claim as of the date the case was filed.

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. List 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TID#

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 (which date 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

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12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$3,380* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(9).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/25 and every 3 years thereafter in cases begun on or after the date of adjustment.

13. Is all or part of the claim pursuant to 11 U.S.C. § 563(b)(3)?

☒ 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 9013(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 357.

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: Ming Hee Lee
First Name Middle Name Last Name

Title: dentist

Company: Ming Hee Lee DDS Inc.
Indicate the corporate service to the company if the authorized agent is a service.

Address: 12411 Hesperia Rd Ste C
Number Street

City: Victorville, CA State: 92395 ZIP Code: Country:

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

(Official Form 410)

Proof of Claim
page 3

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 162
ADA American Dental Association Dental Claim Form 97

HEADER INFORMATION										
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input checked="" type="checkbox"/> EASDT / 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? <input type="checkbox"/> Medical? <input type="checkbox"/> (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 <input type="checkbox"/> M <input type="checkbox"/> F										
8. Policyholder/Subscriber ID (SSN or ID#)										
9. Plan/Group Number										
10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other										
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code										
RECORD OF SERVICES PROVIDED										
12. Line	13. Procedure Date (MM/DD/CCYY)	14. Area of Oral Cavity	15. Tooth System	16. Tooth Number(s) or Letter(s)	17. Tooth Surface	18. Procedure Code	19a. Diag. Pointer	19b. City	20. Description	21. 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										
11										
12										
13										
14										
22. Missing Tooth Information (Place an "X" on each missing tooth.)										
1 X 2 X 3 X 4 X 5 X 6 X 7 X 8 X 9 X 10 X 11 X 12 X 13 X 14 X 15 X 16 X 17 X 18 X 19 X 20 X 21 X 22 X 23 X 24 X 25 X 26 X 27 X 28 X 29 X 30 X 31 X 32 X 33 X 34 X 35 X 36 X 37 X 38 X 39 X 40 X 41 X 42 X 43 X 44 X 45 X 46 X 47 X 48 X 49 X 50 X 51 X 52 X 53 X 54 X 55 X 56 X 57 X 58 X 59 X 60 X 61 X 62 X 63 X 64 X 65 X 66 X 67 X 68 X 69 X 70 X 71 X 72 X 73 X 74 X 75 X 76 X 77 X 78 X 79 X 80 X 81 X 82 X 83 X 84 X 85 X 86 X 87 X 88 X 89 X 90 X 91 X 92 X 93 X 94 X 95 X 96 X 97 X 98 X 99 X 100 X										
23. Diagnosis Code List Qualifier (ICD-9 = B, ICD-10 = AB)										
31a. Other Fee(s)										
32. Total Fee 10.00										
25. 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 (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? <input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)										
41. Date Appliance Placed (MM/DD/CCYY)										
42. Months of Treatment Remaining										
43. Replacement of Prosthesis <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)										
44. Date of Prior Placement (MM/DD/CCYY)										
45. Treatment Resulting from: <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> 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.)										
43. Name, Address, City, State, Zip Code Yonghee Lee 12611 Hesperia Rd. Suite C Victorville CA 923958307										
44. NPI 1760858153										
50. License Number 84834										
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 84834										
56a. Provider Specialty Code										
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. 164
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Claim #278 Date Filed: 4/4/2024

Your claim can be filed electronically on KCC's website at <https://spc.kccs.net/FormsHealth>.

Fill in this information to identify the case:

Debtor: Hispano 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. § 563(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed.

Part 1: Identify the Claim

1. Who is the current creditor?	<u>Nong Hee Lee DDS Inc.</u> 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?	<input checked="" type="checkbox"/> No. <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different)
Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)	<u>Nong Hee Lee DDS Inc.</u> Name <u>12111 Hesperia Rd. Ste C</u> Address <u>Victorville, CA 92395</u> City State ZIP Code <u>USA</u> Country Contact phone: <u>760-243-4366</u> Contact email: <u>lee@icemanager@gmail.com</u>	Name: _____ Number: _____ Street: _____ City: _____ State: _____ ZIP Code: _____ Country: _____ Contact phone: _____ Contact email: _____
APR 04 2024	Listed on claim register for electronic payments. If a dispute arises, file your claim soon.	
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No. <input type="checkbox"/> Yes. Claim number on court claims registry (if known): _____ Filed on: <u>4/4/2024</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No. <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim
page 1

220238424040400000000002

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

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TIO#

7. How much is the claim? \$ 150.00 Does this amount include interest or other charges?
☒ No
☐ Yes. Attach statement limiting 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: _____

Official Form 410

Proof of Claim
page 2

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12. Is all or part of this 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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$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).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on ADIGS 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 9005(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 557.

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 this information is true and correct.

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

Executed on date 03/28/2024
at San Diego, CA

Signature [Handwritten Signature]

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

Name: Wing Hee Lee
First name Middle name Last name

Title: Dentist

Company: Wing Hee Lee DDS Inc.
Indicate the corporate service as the company if the authorized agent is a service.

Address: 12611 Hespena Rd Ste C
Number Street

City: Victorville, CA State: 92395 ZIP Code Country

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

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ADA American Dental Association Dental Claim Form

HEADER INFORMATION

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

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Barreco Health Claims Processing Center
c/o 1500
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. Ponder	29b. City	30. Description	31. Fee
11/17/2020		JF			D0120		1	periodic oral evaluation - established	150.00

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 X 2 X 3 X 4 X 5 X 6 X 7 X 8 X 9 X 10 X 11 X 12 X 13 X 14 X 15 X 16 X 17 X 18 X 19 X 20 X 21 X 22 X 23 X 24 X 25 X 26 X 27 X 28 X 29 X 30 X 31 X 32 X 33 X 34 X 35 X 36 X 37 X 38 X 39 X 40 X 41 X 42 X 43 X 44 X 45 X 46 X 47 X 48 X 49 X 50 X 51 X 52 X 53 X 54 X 55 X 56 X 57 X 58 X 59 X 60 X 61 X 62 X 63 X 64 X 65 X 66 X 67 X 68 X 69 X 70 X 71 X 72 X 73 X 74 X 75 X 76 X 77 X 78 X 79 X 80 X 81 X 82 X 83 X 84 X 85 X 86 X 87 X 88 X 89 X 90 X 91 X 92 X 93 X 94 X 95 X 96 X 97 X 98 X 99 X 100 X
34. Diagnosis Code List Qualifier ☐ (ICD-9 = B, ICD-10 = AB)
34a. Diagnosis Code(s)
34b. (Primary diagnosis in "A")
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. 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 ☒ (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 ☒ No ☐ Yes (Complete 44)
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
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
54. NPI 1760858153 55. License Number 64834
56. Address, City, State, Zip Code
12611 Hesperia Rd.
Victorville CA 923958307
57. Phone Number 760 243 4366 58. Additional Provider ID

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EXHIBIT

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 169 of 297

Claim #279 Date Filed: 4/4/2024

Your claim can be filed electronically on KCC's website at <https://epic.kccourt.net/80mccp/claim>.

Fill in this information to identify the case:

Debt: Bankruptcy Court/Trustee

United States Bankruptcy Court for the Southern District of California

Case number: 22-02384

Official Form 410

Proof of Claim

04/22

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

filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of earnings, 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?	<u>Monq Hee Lee DDS Inc</u> Name of the current creditor (the person or entity to be paid for this claim) Other names the creditor uses (if the debtor)	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom?	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different)
Federal Rule of Bankruptcy Procedure (FRBP) 2002(a)	<u>Monq Hee Lee DDS Inc</u> <u>2211 Hesperia Rd. Ste C</u> <u>Victorville, CA 92395</u> <u>USA</u> Contact phone: <u>760-293-4360</u> Contact email: <u>lee@picmanager@gmail.com</u>	Name: _____ Number: _____ Street: _____ City: _____ State: _____ ZIP Code: _____ Country: _____ Contact phone: _____ Contact email: _____
RECEIVED APR 04 2024 UNITED STATES BANKRUPTCY COURT SOUTHERN DISTRICT OF CALIFORNIA	Uniform claims deadline for electronic payments is 30 days after 12:00 p.m. (EST) on the date of filing.	
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> 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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of c
page 1

220238424040400000000004

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 170
of 297**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?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes. List 4 digits of the debtor's account or any number you use to identify the debtor: <u>9868</u> <u>TIO#</u>
7. How much is the claim?	\$ <u>255.00</u> Does this amount include interest or other charges? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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). List disclosing information that is entitled to privacy, such as health care information. <u>Dental</u>
9. Is all or part of the claim secured?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. The claim is secured by a lien on property. Nature of property: <input type="checkbox"/> 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. <input type="checkbox"/> Motor vehicle <input type="checkbox"/> 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 cash was lent) _____ % <input type="checkbox"/> Fixed <input type="checkbox"/> Variable
10. Is this claim based on a lease?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Amount necessary to cure any default as of the date of the petition: \$ _____
11. Is this claim subject to a right of setoff?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Identify the property: _____

Official Form 410

Proof of Claim
page 2

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12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$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).	\$ _____
<input type="checkbox"/> Wages, salaries, or commissions (up to \$16,180*) 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a) that applies.	\$ _____

* Amounts are subject to adjustments on 4/1/25 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 2011(b).

If you file this claim electronically, FRBP 5006(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: 05/28/2024
MM / DD / YYYY

Signature: 

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

Name: Yung Hee Lee
First name Middle name Last name

Title: dentist

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

Address: 12411 Hesperia Rd Ste C
Number Street

City: Victorville, CA 92395
City State Zip

County: San Bern Co

Control phone: 760-243-4366 and lee.office.manager@gmail.com

Official Form 410

Proof of Claim
page 3

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 172

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
☒ PSUT - 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

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										
11										

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

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

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

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

35. Other Fee(s)

36. Total Fee: 255.00

37. Remarks

AUTHORIZATIONS

38. 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.

39. Signature on File: 03/29/2024

40. Patient/Guardian Signature: _____ Date: _____

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

42. Signature on File: 03/29/2024

43. Subscriber Signature: _____ Date: _____

ANCILLARY CLAIM/TREATMENT INFORMATION

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

45. Enclosures (Y or N)

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

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

48. Months of Treatment Remaining ☒ No ☐ Yes (Complete 44)

49. Replacement of Prosthesis

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

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

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

55. NPI: 1760858153

56. License Number: 64834

57. SSN or TIN: 822169868

58. Phone Number: 760-243-4366

59. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

61. Yonghee Lee 03/29/2024

62. Signature (Treating Dentist)

63. NPI: 1760858153

64. License Number: 64834

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

66. Phone Number: 760-243-4366

67. Additional Provider ID

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EXHIBIT

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 174
of 297

Claim #280 Date Filed: 4/4/2024

Your claim can be filed electronically on KCC's website at <https://kccs.kccourt.net/8/complaints>.

Fill in this information to identify the case:

Debtor: Revised 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 I Identify the Claim

1. Who is the current creditor?	<u>Nong Hee Lee DDS Inc</u> <small>Name of the current creditor (the person or entity to be paid for this claim)</small> <small>Other person the creditor dealt with the debtor</small>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes From whom?	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? <u>Nong Hee Lee DDS Inc</u> <u>12111 Hesperia Rd. Ste C</u> <u>Victorville, CA 92395</u> <u>USA</u> <small>City State ZIP Code Country</small> Contact phone: <u>760-243-4366</u> Contact email: <u>Lee.D@icmanager@gmail.com</u>	Where should payments to the creditor be sent? (if different) <small>Name</small> <small>Number Street</small> <small>City State ZIP Code</small> <small>Country</small> Contact phone Contact email
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) Filed on <u>MM / DD / YYYY</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing?	

Official Form 410

Proof of Claim
page 1

220238424040400000000001

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Part 3 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
7104

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 3031(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: _____

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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$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).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/25 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. § 509(b)(3)?

☒ 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 5011(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 1571.

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
MAY 11 2024

Signature

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

Name: Yong Hee Lee
First name Middle name Last name

Title: Dentist

Company: Yong Hee Lee DDS Inc.
(Specify the corporate division or the company if the individual agent is a service.)

Address: 12611 Hesperia Rd Ste C
Number Street

City: Victorville, CA ZIP Code: 92395 Country: _____

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

(Official Form 410)

Proof of Claim
page 3

HEADER INFORMATION											
1. Type of Transaction (Mark all applicable boxes)											
<input type="checkbox"/> Statement of Actual Services				<input type="checkbox"/> Request for Predetermination/Preadjustment							
<input checked="" type="checkbox"/> PRELIT - Title XIX											
2. Predetermination/Preadjustment Number											
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION											
3. Company/Plan Name, Address, City, State, Zip Code Borrego Health Claims Processing Center c/o KMC 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. Insurance Medical? <input type="checkbox"/> Dental? <input type="checkbox"/> (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/YYYY)				7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)					
9. Plan Group Number				10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other							
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code											
RECORD OF SERVICES PROVIDED											
24. Procedure Code (AMUD/CYY)	25. Area of Oral Cavity	26. Tooth System	27. Teeth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Portion	29b. City	30. Description	31. Fee		
11/19/2020		JF			D4910		1	periodontal maintenance	300.00		
11/19/2020		JF			D1999		1	Personal Protective Equipment	5.00		
32. Moving Teeth Information (Place an "X" on each missing tooth) 1 X 2 X 3 X 4 X 5 X 6 X 7 X 8 X 9 X 10 X 11 X 12 X 13 X 14 X 15 X 16 X					34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)			31e. Other Fees(s)			
33a. Diagnosis Code(s) A _____ C _____ (Primary diagnosis in "A") B _____ D _____								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 provider 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.											
Signature on File 03/29/2024											
Patient/Guarantor 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. Signature on File 03/29/2024											
Subscriber Signature Date											
ANCILLARY CLAIM/TREATMENT INFORMATION											
38. Place of Treatment 1 (e.g. 1=office; 2=D/F Hospital) (Use "Place of Service Codes for Professional Claims")								39. Enclosures (Y or N) <input type="checkbox"/>			
40. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Sup 41-42) <input type="checkbox"/> Yes (Complete 41-42)								41. Date Appliance Placed (MM/DD/CCYY)			
42. Months of Treatment Remaining <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 41)								44. Date of Prior Placement (MM/DD/CCYY)			
45. Treatment Resulting from: <input type="checkbox"/> Occupational/Work Injury <input type="checkbox"/> Auto accident <input type="checkbox"/> 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 822155868			
52. Phone Number 760 243 4366				53. Additional Provider ID				54. Phone Number 760 243 4366			
TREATING DENTIST AND TREATMENT LOCATION INFORMATION											
55. 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											
Signed Treating Dentist 1760858153								Date 64834			
56. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307								57. Provider Specialty Code			

EXHIBIT 4

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 179
of 297

Claim #281 Date Filed: 4/5/2024

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

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 or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 1571.

Fill in all the information about the claim as of the date the case was filed.

Part I Identify the Claim

1. Who is the current creditor?	<u>Mindy Hee Lee DDS Inc</u> <small>Name of the current creditor (the person or entity to be paid for this claim)</small> <small>Check internet for creditor claim with this debtor</small>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes From whom? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different?)
Federal Rule of Bankruptcy Procedure (FRBP) 2002(g) RECEIVED APR 05 2024	<u>Mindy Hee Lee DDS Inc</u> <u>2201 Hesperia Rd. Ste C</u> <u>Victorville, CA 92395</u> <u>USA</u> Contact phone: <u>760-243-4366</u> Contact email: <u>LeeDHeeManager@gmail.com</u>	Name: _____ Number: _____ Street: _____ City: _____ State: _____ ZIP Code: _____ Country: _____ Contact phone: _____ Contact email: _____
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known): _____ Filed on: <u>MM / DD / YYYY</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim
page 1

22023842404050000000014

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

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TLO#

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 303.1(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 303.1(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: _____

Official Form 410

Proof of Claim
page 2

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12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$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).	\$ _____
<input type="checkbox"/> 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)(6).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units, 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan, 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/25 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. § 509(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 7. Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 9005(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

Signature [Signature]

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

Name Ming Hee Lee

Title Dentist

Company Ming Hee Lee DDS Inc.

Address 12411 Hesperia Rd Ste C

City Victorville, CA ZIP Code 92395

Phone 714-243-4364 Email lee.office.manager@gmail.com

[illegible]

EXHIBIT

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Claim #282 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at <https://epoc.kccinc.net/interqual.html>

Fill in this information to identify the case:

Debtor: Wood Community Health Foundation

Court: 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.

Debtors must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$200,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 1512, 1571, 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?	<u>Monq Hee Lee DDS Inc</u> <small>Name of the current creditor (the person or entity to be paid for this claim)</small> <small>Other names the creditor uses with the debtor</small>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? <u>Monq Hee Lee DDS Inc</u> <u>12111 Hesperia Rd. Ste C</u> <u>Victorville, CA 92345</u> <u>USA</u> <small>City State ZIP Code Country</small> Contact phone: <u>760-243-4366</u> Contact email: <u>leeofficemanager@gmail.com</u> <small>Uniform claim identifier for electronic payments in chapter 13 (if you use one)</small>	Where should payments to the creditor be sent? (if different) <small>Name</small> <small>Number Street</small> <small>City State ZIP Code</small> <small>Country</small> Contact phone: _____ Contact email: _____
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on <u>MM / DD / YYYY</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim
page 1



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

6. Do you have any number you use to identify the debtor?	
<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes: Last 4 digits of the debtor's account or any number you use to identify the debtor: <u>9868</u> <u>TLOH</u>
7. How much is the claim?	
\$ <u>1955.00</u>	Does this amount include interest or other charges? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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. <u>Dental</u>	
9. Is all or part of the claim secured?	
<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes. The claim is secured by a lien on property. Nature of property: <input type="checkbox"/> 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. <input type="checkbox"/> Motor vehicle. <input type="checkbox"/> 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) _____ % <input type="checkbox"/> Fixed <input type="checkbox"/> Variable
10. Is this claim based on a lease?	
<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes. Amount necessary to cure any default as of the date of the petition: \$ _____
11. Is this claim subject to a right of setoff?	
<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes. Identify the property: _____

Official Form 410

Proof of Claim
page 2

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12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (A)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$3,360* of deposits (owed purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a) that applies: _____	\$ _____

* Amounts are subject to adjustment (a) 401(k)s and every 3 years after that for assets 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 301(b).

If you file this claim electronically, FRBP 301(b)(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 3 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 cosignor. 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

[Signature]

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

Name	<u>Wong</u>	<u>Hee</u>	<u>Lee</u>
	First name	Middle name	Last name
Title	<u>Debit</u>		
Company	<u>Wong Hee Lee DDS Inc.</u>		
	Verify the corporate name as the company if the authorized agent is a service.		
Address	<u>12411 Hesperia Rd Ste C</u>		
	Number	Street	
	<u>Victorville, CA 92395</u>		
	City	State	ZIP Code
Contact phone	<u>760-243-4364</u>		
	Email <u>lee.office.manager@gmail.com</u>		

Official Form 410

Proof of Claim
page 3

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EXHIBIT

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 189 of 297

Claim #283 Date Filed: 4/5/2024

Your claim can be filed electronically on KEC's website at <https://www.keccourt.com/submitclaim>

Fill in the information to identify the case:

Debtor: Alameda Community Health Foundation

United States Bankruptcy Court for the Southern District of California

Case number: 22-02384

Official Form 410

Proof of Claim

04/22

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

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3671.

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?	<u>Nong Hee Lee DDS Inc.</u> <small>Name of the current creditor (the person or entity to be paid for this claim)</small>	
	<small>Other names the creditor used with the debtor</small>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No. <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? <u>Nong Hee Lee DDS Inc.</u> <small>Name</small> <u>12111 Hesperia Rd. Ste C</u> <small>Address</small> <u>Victorville, CA 92395</u> <small>City State ZIP Code</small> <u>USA</u> <small>Country</small> Contact phone: <u>760-243-4366</u> Contact email: <u>LeeOfficeManager@gmail.com</u>	Where should payments to the creditor be sent? (if different) <small>Name</small> Number Street City State ZIP Code Country Contact phone Contact email
<small>Form claim identifier for electronic submission is required for all payments (see instructions).</small>		
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No. <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on <u>04/05/2024</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No. <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim
page 1

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

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 9868
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 381(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 381(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: _____

Official Form 410

Proof of Claim
page 2

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12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

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

* Amounts are subject to adjustment on 4/01/25 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 the 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

Signature

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

Name

Young

Hee

Lee

Title

Dentist

Company

Young Hee Lee DDS Inc.

Address

12411 Hesperia Rd Ste C

Victorville, CA 92391

Contact phone

760-243-4364

Email

lee.office.manager@gmail.com

Official Form 411

Proof of Claim
page 3

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EXHIBIT

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 194
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Claim #284 Date Filed: 4/5/2024

Your claim can be filed electronically on KGC's website at <https://www.kgc.com/claims/filing>

Fill in this information to identify the case:

Cases: Benson Community Health Foundation

Uniform Claims (Mandatory Court for the State) (State or District):

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 3671.

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?	<u>Nong Hee Lee DDS Inc</u> <small>(Name of the current creditor (the person or entity to be paid for this claim))</small>	
	<small>Other names this creditor used with the debtor</small>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? <u></u>	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? <u>Nong Hee Lee DDS Inc</u> <u>12011 Hesperia Rd. Ste C</u> <u>Victorville, CA 92395</u> <u>USA</u> Contact phone: <u>760-243-4366</u> Contact email: <u>leeoffice@nongheeleedds.com</u>	Where should payments to the creditor be sent? (if different) Name: <u></u> Number: <u></u> Street: <u></u> City: <u></u> State: <u></u> ZIP Code: <u></u> Country: <u></u> Contact phone: <u></u> Contact email: <u></u>
Federal Rule of Bankruptcy Procedure (FRBP) 2003(g) RECEIVED APR 05 2024 Uniform claim identifier for electronic payments in sheet 15 (if you use one)		
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) <u></u> Filed on <u>MM / DD / YYYY</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? <u></u>	

Official Form 410

Proof of Claim
page 1



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

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TIOH

7. How much is the claim? \$ 305.00 Does this amount include interest or other charges?
☒ No
☐ Yes. Attach statement limiting interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(a)(2)(A).

8. What is the basis of the claim? Examples: Goods sold, money loaned, leased, 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 this claim secured? ☒ No
☐ Yes. The claim is secured by a lien on property.
Name 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: _____

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Proof of Claim
page 2

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12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$9,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(2).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(6).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/01/25 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(c)(3)?

☒ 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 2: Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 9011(b)(2) authorizes courts to disregard 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 3671.

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 obligor. 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



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

Name: Ming Hee Lee
First name Middle name Last name

Title: Dentist

Company: Ming Hee Lee DDS Inc.
Verify the corporate status as the company if the authorized agent is a service.

Address: 12411 Hesperia Rd Ste C

City: Victorville, CA State: 92395

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

Official Form 410

Proof of Claim
page 3

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 197

ADA American Dental Association Dental Claim Form

HEADER INFORMATION

Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services
 ☐ Request for Predetermination/Preauthorization
 ☒ FFSOT - 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.)

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. City	30. Description	31. Fee
11/09/2020		JF			D1999		1	Personal Protective Equipment	5.00
11/09/2020		JF	10	MFL	D2332		1	resin-based composite - three surface	300.00

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	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 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 provider 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=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

☒ No ☐ Yes (Complete 44)

43. Replacement of Prosthesis

44. Date of Final 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. 923958307

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. 199
of 297

Claim #285 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at <http://kcc.ki.net/BorrogoHealth>.

Fill in this information to identify the case:

Date: 05/07/25
U.S. Bankruptcy Court for the Southern District of California
Case number: 22-02384

Official Form 410
Proof of Claim

04/23

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

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 11 U.S.C. §§ 152, 157, and 357i.

Fill in all the information about the claim as of the date this case was filed.

Part 1: Identify the Claim

1. Who is the current creditor?	<u>Nong Hee Lee DDS Inc</u> <small>Name of the current creditor (the person or entity to be paid for this claim)</small> <small>Other (list all the creditor used with the debtor)</small>	
2. Has this claim been accounted for by someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. File when?	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? <u>Nong Hee Lee DDS Inc</u> <u>12111 Hesperia Rd. Ste C</u> <u>Victorville, CA 92395</u> <u>USA</u> <u>Two-243-4366</u> <u>leeoffice@nongheeleedds.com</u>	Where should payments to the creditor be sent? (if different) <u>Name</u> <u>Number</u> <u>Street</u> <u>City</u> <u>State</u> <u>ZIP Code</u> <u>Country</u> <u>Contact phone</u> <u>Contact email</u>
Federal Rule of Bankruptcy Procedure (FRBP) 2002(g) RECEIVED APR 05 2024 KURTZMAN CARSON CONSULTANTS <small>(claimant claim identifier for electronic payments in chapter 13 (if you use one))</small>		
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on <u>MM / DD / YYYY</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim
page 1

220238424040500000000017

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of 297

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

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TIO#

7. How much is the claim? \$ 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 reduced 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 reduced 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: _____

Official Form 410

Proof of Claim
page 2

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 201
of 297

1) Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (A)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$5,250* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/25 and every 3 years after that for cases begun on or after the date of adjustment.

2) 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 §011(b).

If you file this claim electronically, FRBP §005(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 reviewed 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


Signature

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

Name Yung Hee Lee
First name Middle name Last name

Title dentist

Company Yung Hee Lee DDS Inc.
Identify the corporate service(s) at the company if the submitter agent is a service

Address 12611 Hesperia Rd Ste C

City Victorville, CA State 92395

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

RECEIVED

APR 05 2024

MCQUINN CASEWORK CONSULTANTS

Official Form 410

Proof of Claim
page 3

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 202

ADA American Dental Association Dental Claim Form 97																																																																																																																																	
HEADER INFORMATION 1. Type of Transaction (Mark all applicable boxes): <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preadjustment <input checked="" type="checkbox"/> Final Title XIX 2. Predetermination/Preadjustment Number:																																																																																																																																	
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION 3. Company/Plan Name, Address, City, State, Zip Code: Bonterra 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? <input type="checkbox"/> Medical? <input type="checkbox"/> (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 <input type="checkbox"/> M <input type="checkbox"/> F 8. Policyholder/Subscriber ID (SSN or ID#) 9. Plan Group Number 10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other 11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																																																																																																																																	
PATIENT INFORMATION 12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code 13. Date of Birth (MM/DD/CCYY) 14. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F 15. Policyholder/Subscriber ID (SSN or ID#) 16. Plan/Group Number 17. Employer Name 18. Relationship to Policyholder/Subscriber in #12 Above <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> 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 <input checked="" type="checkbox"/> M <input type="checkbox"/> F 23. Patient ID/Account # (Assigned by Dentist)																																																																																																																																	
RECORD OF SERVICES PROVIDED <table border="1"> <thead> <tr> <th>24. Procedure Date (MM/DD/CCYY)</th> <th>25. Area of Oral Cavity</th> <th>26. Tooth System</th> <th>27. Tooth Number(s) or Letter(s)</th> <th>28. Tooth Surface</th> <th>29. Procedure Code</th> <th>29a. Diag. Pointer</th> <th>29b. Qty.</th> <th>30. Description</th> <th>31. Fee</th> </tr> </thead> <tbody> <tr> <td>11/10/2020</td> <td>20</td> <td>JP</td> <td></td> <td></td> <td>D4341</td> <td></td> <td>1</td> <td>UL periodontal scaling and root planin</td> <td>70.00</td> </tr> <tr> <td>11/10/2020</td> <td>30</td> <td>JP</td> <td></td> <td></td> <td>D4341</td> <td></td> <td>1</td> <td>LL periodontal scaling and root planin</td> <td>70.00</td> </tr> <tr> <td>11/10/2020</td> <td></td> <td>JP</td> <td></td> <td></td> <td>D1999</td> <td></td> <td>1</td> <td>Personal Protective Equipment</td> <td>5.00</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>										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	11/10/2020	20	JP			D4341		1	UL periodontal scaling and root planin	70.00	11/10/2020	30	JP			D4341		1	LL periodontal scaling and root planin	70.00	11/10/2020		JP			D1999		1	Personal Protective Equipment	5.00																																																																																
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32. Missing Teeth Information (Place an "X" on each missing tooth.) 1 X 2 3 4 5 6 7 8 9 10 11 12 X 13 14 X 15 16 X 17 18 X 19 20 21 22 23 24 25 26 27 28 29 30 31. Diagnosis Code List Qualifier (ICD-9 = B; ICD-10 = AB) 31a. Diagnosis Code(s) A C D (Primary diagnosis in "A") B D 31b. Other Fee(s) 32. Total Fee 145.00																																																																																																																																	
AUTHORIZATIONS 33. 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. In the treating dentist or dental provider 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. 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. Signature on File 03/29/2024 Subscriber Signature Date																																																																																																																																	
ANCILLARY CLAIM/TREATMENT INFORMATION 38. Place of Treatment 11 (e.g. 11-office, 22-GP Hospital) (Use "Place of Service Codes for Professional Claims") 39. Endlosures (Y or N) 40. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY) 42. Months of Treatment Remaining <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY) 45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> 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 Signature (Treating Dentist) Date 54. NPI 1760858153 55. License Number 64834 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. 204
of 297

Claim #286 Date Filed: 4/5/2024

Your claim can be filed electronically on RCC's website at <https://rcc.courtclerk.net/CaseWebEntry>.

Fill in this information to identify the case:

Debtor: Beverly 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 357f.

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?	<u>Nong Hee Lee DDS Inc</u> <small>Name of the current creditor (the person or entity to be paid for this claim)</small>		
	<small>Other names the creditor used with the debtor</small>		
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____		
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different)	
<small>Federal Rule of Bankruptcy Procedure (FRBP) 2002(a)</small>  <small>KURTZMAN CARSON CONSULTANTS</small>	<u>Nong Hee Lee DDS Inc</u> <small>Name</small> <u>2111 Hesperia Rd. Ste C</u> <small>Number Street</small> <u>Victorville, CA 92395</u> <small>City State ZIP Code</small> <u>USA</u> <small>Country</small> <u>760-243-4366</u> <small>Contact phone</small> <u>leeofficemanager@gmail.com</u> <small>Contact email</small>	<small>Name</small> <small>Number Street</small> <small>City State ZIP Code</small> <small>Country</small> <small>Contact phone</small> <small>Contact email</small>	
	<small>Use the current creditor for electronic payments to creditor 12 (if you use one)</small>		
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on <u>4/5/2024</u>		
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____		

Official Form 410

Proof of Claim
page 1



22023842404050000000000016

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 205
of 297

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
JLOH

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

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)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$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)(2).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment by 401(b) 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 5011(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 357.

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 codebitor. 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

[Signature]

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

Name: Yung Hee Lee

First name Middle name Last name

Title: Debtist

Company: Yung Hee Lee DDS Inc.

Indicate the official name of the company if the signatory agent is a corporation.

Address: 12411 Hesperia Rd Ste C

Number Street

City: Victorville, CA State: 92395 ZIP Code: _____ County: _____

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

Case 22-02384-L-1-1 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 207

ADAA American Dental Association Dental Claim Form											
HEADER INFORMATION											
1. Type of Transaction (Mark all applicable boxes)											
<input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input checked="" type="checkbox"/> E-SET - The ADA											
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. (Original) <input type="checkbox"/> (Retained) <input type="checkbox"/> (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/YYYY)											
7. Gender <input type="checkbox"/> M <input type="checkbox"/> F											
8. Policyholder/Subscriber ID (SSN or ID#)											
9. Plan Group Number											
10. Patient's Relationship to Person named in #5											
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other											
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code											
RECORD OF SERVICES PROVIDED											
24. Procedure Date (MM/DD/YYYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Location	28. Tooth Surface	29. Procedure Code	29a. Diag. Power	29b. Qty.	30. Description	31. Fee		
11/10/2020		JP			D1999		1	Personal Protective Equipment	5.00		
11/17/2020		JP			D1999		1	Personal Protective Equipment	5.00		
10/27/2020		JP	19		D3330		1	endodontic therapy, molar tooth (excl)	1200.00		
11/10/2020		JP	19		D3300		1	Finishing Root Canal	300.00		
11/17/2020		JP	19		D2751		1	crown - porcelain fused to predomina	1500.00		
32. Missing Teeth Indication (Place an "X" on each missing tooth.)										33. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B, ICD-10 = AB)	
34. Diagnosis Code(s)										35a. Other Fee(s)	
36. (Primary diagnosis in "A")										37. 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. If this 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.											
Signature on File 03/29/2024 Patient/Guardian Signature Date											
41. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.											
Signature on File 03/29/2024 Subscriber Signature Date											
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not billing claim on behalf of the patient or insured/subscriber.)											
42. Name, Address, City, State, Zip Code											
Yonghee Lee 12611 Hesperia Rd. Suite C Victorville CA 923958307											
43. NPI 1760858153 50. License Number 64834 51. SSN/ID# 822189868											
44. Phone Number 760 243 4366 52. Additional Provider ID											
ANCILLARY CLAIM/TREATMENT INFORMATION											
38. Place of Treatment (1) (e.g. 11-office, 22-QIP Hospital)											
39. Enclosures (Y or N)											
40. Is Treatment for Orthodontics?											
<input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)											
41. Date Appliance Placed (MM/DD/YYYY)											
42. Months of Treatment Remaining											
43. Replacement of Prosthesis											
<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)											
44. Date of Prior Placement (MM/DD/YYYY)											
45. Treatment Resulting from											
<input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident											
46. Date of Accident (MM/DD/YYYY)											
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 Signature (Treating Dentist) Date											
54. NPI 1760858153 55. License Number 64834											
56. Address, City, State, Zip Code											
12611 Hesperia Rd. Victorville CA 923958307											
57. Phone Number 760 243 4366 58. Additional Provider ID											

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EXHIBIT 4

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 210
of 297**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?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes. List 4 digits of the debtor's account or any number you use to identify the debtor: <u>9868</u> <u>TIOH</u>
7. How much is the claim?	\$ <u>505.00</u> Does this amount include interest or other charges? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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. <u>Dental</u>
9. Is all or part of the claim secured?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. The claim is secured by a lien on property. Nature of property: <input type="checkbox"/> 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. <input type="checkbox"/> Motor vehicle <input type="checkbox"/> 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) _____ % <input type="checkbox"/> Fixed <input type="checkbox"/> Variable
10. Is this claim based on a lease?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Amount necessary to cure any default as of the date of the petition: \$ _____
11. Is this claim subject to a right of setoff?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Identify the property: _____

Official Form 410

Proof of Claim
page 2

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of 297

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

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

* Amounts are subject to adjustment on 4/01/25 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 28 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 5011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying when 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

[Signature]

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

Name: Uming Hee Lee

Title: Debitist

Company: Uming Hee Lee DDS Inc.

Address: 12611 Hesperia Rd Ste C

City: Victorville, CA State: CA ZIP Code: 92395

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

Official Form 410

Proof of Claim
page 3

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 212

ADA American Dental Association Dental Claim Form

97

HEADER INFORMATION

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

2. Predetermination/Precertification 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 INFORMATION (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Lender? ☐ Medically? ☐ (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) 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 Left/Right	28. Tooth Surface	29. Procedure Code	30a. Diag. Modifier	29b. Qty.	30. Description	31. Fee
11/16/2020	20	JP			D4341		1	UL periodontal scaling and root planin	250.00
11/16/2020	30	JP			D4341		1	LL periodontal scaling and root planin	250.00
11/16/2020		JP			D1999		1	Personal Protective Equipment	5.00

32. Remarks

33. (Physician 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	17

34. Diagnosis Code List Qualifier ☐ (ICD-9 = B, ICD-10 = A3)

35a. Diagnosis Code(s) A: C: B: U:

35b. (Primary diagnosis in "A")

36. Other Fee(s)

37. Total Fee 505.00

AUTHORIZATIONS

38. 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 provider 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.

39. Signature on File 03/29/2024

40. Patient/Guardian Signature Date

41. Treating dentist and direct payment of the dental benefit is otherwise payable to me, directly to the below named dentist or dental entity.

42. Signature on File 03/29/2024

43. Treating dentist Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

44. Place of Treatment ☒ (e.g. 11-office, 22-Off Hospital) 45. Enclosures (Y or N) ☐

46. (Use "Place of Service Codes for Professional Claims")

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

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

49. Months of Treatment Remaining ☒ No ☐ Yes (Complete 44)

50. Replacement of Prosthesis

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

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

53. Date of Accident (MM/DD/CCYY) 54. 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)

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

56. NPI 1760858153 57. License Number 64834 58. SSN or ID# 822159863

59. Patient Number 760 243 4366 60. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

62. Yonghee Lee 03/29/2024

63. Signature (Treating Dentist) Date

64. NPI 1760858153 65. License Number 64834

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

67. Patient Number 760 243 4366 68. Additional Provider ID

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EXHIBIT 4

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 214
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Claim #288 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at <https://kcc.kccsolutions.com/submitclaim>.

Fill in this information to identify the case.

Debtor: Bonnie Commands 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.

Debtors 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 357f.

Fill in all the information about the claim as of the date the claim was filed.

Part 1: Identify the Claim

1. Who is the current creditor?	<u>Nong Hee Lee DDS Inc.</u> <small>Name of the current creditor (the person or entity to be paid on this claim)</small> <small>Other names the creditor used with the debtor</small>		
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____		
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different)	
Federal Rule of Bankruptcy Procedure (FRBP) 2003(g)	<u>Nong Hee Lee DDS Inc.</u> <u>12111 Hesperia Rd. Ste C</u> <u>Victorville, CA 92395</u> <u>USA</u> <u>760-293-4366</u> <u>leeofficemanager@gmail.com</u>	Name _____ Number _____ Street _____ City _____ State _____ ZIP Code _____ Country _____ Contact phone _____ Contact email _____	
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on <u>4/5/2024</u>		
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____		

Official Form 410

Proof of Claim
page 1



220238424040500000000019

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

6. Do you have any number you use to identify the debtor? ☐ No ☒ Yes. I am 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TIO#

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

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

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 216 of 297

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

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

* Amounts are subject to adjustment on 4/1/25 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 5012(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 1571.

Check the appropriate box:

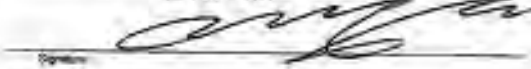
- ☒ I am the creditor.
- ☐ I am the creditor's attorney or authorized agent.
- ☐ I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.
- ☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

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



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

Name: Ming Hee Lee
First name Middle name Last name

Title: dentist

Company: Ming Hee Lee DDS, Inc.
Specify the corporate service in the company if the authorized agent is a service.

Address: 12411 Hesperia Rd Ste C
Number Street

City: Victorville, CA 92395
City State ZIP Code

Contact phone: 714-243-4364 Email: lee.office.manager@gmail.com

RECEIVED

APR 05 2024

MARTINE CHONG CONSULTANTS

Official Form 410

Proof of Claim
page 3

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EXHIBIT 4

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 220
of 297

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. List 4 digits of the debtor's account or any number you use to identify the debtor. 9868
TISH

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

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

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12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$3,380* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(2).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a) that applies: _____	\$ _____

* Amounts are subject to adjustment on 401025 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(c)(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 5011(b).

If you file this claim electronically, FRBP 5015(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

Signature

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

Name: Young Hee Lee

Title: dentist

Company: Young Hee Lee DDS Inc.

Indicate the corporate position of the company if the authorized agent is a service:

Address: 12411 Hesperia Rd Ste C

City: Victorville, CA ZIP Code: 92395

State: CA Country: USA

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

Official Form 410

Proof of Claim
page 3

To reorder call 800.947.4746

EXHIBIT 4

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 224
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Claim #290 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at <https://uscc.kcc.com/claims/submit>.

Fill in this information to identify the case:

Debtors: Southern 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)(1), 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?	<u>Ning Hee Lee DDS Inc.</u> <small>Name of the current creditor (the person or entity to be paid for this claim)</small> <small>Check names the creditor used with the debtor</small>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? <u>Ning Hee Lee DDS Inc.</u> <u>12111 Hesperia Rd. Ste C</u> <u>Victorville, CA 92395</u> <u>USA</u> <small>Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)</small> RECEIVED APR 05 2024 <small>Uniform claim identifier for e-filing payments in chapter 13 (if you use one):</small>	Where should payments to the creditor be sent? (if different) <small>Name</small> _____ <small>Number Street</small> _____ <small>City State ZIP Code</small> _____ <small>Country</small> _____ <small>Contact phone</small> _____ <small>Contact email</small> _____
4. Does this claim exceed one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on: <u>4-5-2024</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim
page 1



22023842404060000000021

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

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TID#

7. How much is the claim? \$ 230.00 Does this amount include interest or other charges?
☒ No
☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. What is the basis of the claim? Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.
Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).
Limit disclosing information that is entitled to privacy, such as health care information.
Dental

9. Is all or part of the claim secured? ☒ No
☐ Yes. The claim is secured by a lien on property.
Nature of property:
☐ Real estate. If the claim is secured by the debtor's principal residence, file a Mortgage Proof of Claim Attachment (Official Form 410-A) with this Proof of Claim.
☐ Motor vehicle
☐ Other. Describe: _____
Basis for perfection:
Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)
Value of property: \$ _____
Amount of the claim that is secured: \$ _____
Amount of the claim that is unsecured: \$ _____ (The sum of the secured and unsecured amount should match the amount in line 7.)
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

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12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$5,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use, 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units, 11 U.S.C. § 507(a)(6).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan, 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/25 and every 3 years after that for costs begun (a) or after the date of adjustment.

13. Is all or part of the claim pursuant to 11 U.S.C. § 503(h)(2)?

☒ 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 9006(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 357.

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 basis 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

[Signature]

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

Name: Ung Hee Lee

First name Middle name Last name

Title: Debit

Company: Ung Hee Lee DDS Inc.

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

Address: 12411 Hesperia Rd Ste C

City: Victorville, CA State: 92395 Country: _____

Contract phone: 714-243-4364 Email: lee.office.manager@gmail.com

Official Form 410

Proof of Claim
page 3

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EXHIBIT 44

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 230
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Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. List 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TECH

7. How much is the claim? \$ 415.00
Does this amount include interest or other charges?
☒ No
☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. What is the basis of the claim? Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.
Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).
Limit disclosing information that is entitled to privacy, such as health care information.
Dental

9. Is all or part of the claim secured? ☒ No
☐ Yes. The claim is secured by a lien on property.
Nature of property:
☐ Real estate. If the claim is secured by the debtor's principal residence, file a Mortgage Proof of Claim Attachment (Official Form 410-A) with this Proof of Claim.
☐ Motor vehicle
☐ Other. Describe: _____
Basis for perfection: _____
Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)
Value of property: \$ _____
Amount of the claim that is secured: \$ _____
Amount of the claim that is unsecured: \$ _____ (The sum of the secured and unsecured amount should match the amount in line 7.)
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

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 231 of 297

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

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

* Amounts are subject to adjustment in 2012 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. § 505(c)(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 5011(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

Signature

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

Name Yung Hee Lee

Title Dentist

Company Yung Hee Lee DDS Inc.

Address 12611 Hesperia Rd Ste G

City Victorville, CA State CA ZIP Code 92395

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

Official Form 410

Proof of Claim
page 3

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EXHIBIT 4

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 234
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Claim #292 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at <https://kcc.kccir.net/bankruptcy>

Fill in this information to identify the case:

Debtor: Stevens Community Health Foundation
United States Bankruptcy Court for the Southern District of California
Case number: 22-02384

Official Form 410 Proof of Claim

04/22

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

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of nursing 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?	<u>Nong Hee Lee DDS Inc</u> <small>(Name of the creditor (debtor, the person or entity to be paid for this claim))</small> <small>Or, if known, the creditor used with the debtor</small>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different)
Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)	Name: <u>Nong Hee Lee DDS Inc</u>	Name: _____
	Address: <u>12411 Hesperia Rd. Ste C</u>	Address: _____
	City: <u>Victorville, CA</u>	City: _____
	State: <u>CA</u>	State: _____
	ZIP Code: <u>92395</u>	ZIP Code: _____
Country: <u>USA</u>	Country: _____	Country: _____
Contact phone: <u>Two-243-4366</u>	Contact phone: _____	Contact phone: _____
Contact email: <u>Lee.H.E.lee@manager@gmail.com</u>	Contact email: _____	Contact email: _____
<small>Listed claim identifier for electronic payments as chapter 12 (if you use one)</small>		
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on <u>MM / DD / YYYY</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim
page 1



2202384240405000000000024

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of 297

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

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TIO#

7. How much is the claim? \$ 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).
List 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.
Name 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 claim 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

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of 297

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

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

* Amounts are subject to adjustment on 4/1/25 and every 3 years thereafter for costs 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 5011(b).

If you file this claim electronically, FRBP 5015(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 357.

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 this information is true and correct.

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

Executed on date 03/28/2024

[Signature]

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

Name: Ung Hee Lee

First name Middle name Last name

Title: partner

Company: Ung Hee Lee DDS Inc.

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

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

Official Form 410

Proof of Claim
page 3

Case 22-02884-L-11 Filed 05/07/25 Entered 05/07/25 08:02:03 Doc 1611 Pg. 237

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
☒ Prepaid Title XX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
 Borrego Health Claims Processing Center
 010 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. Initial? ☐ 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/YYYY) 7. Gender ☐ M ☐ F 8. Policyholder/Subscriber ID (SSN or ID#)

9. Non-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/YYYY)	25. Area of Oral Care	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Front	29b. Qty.	30. Description	31. Fee
1	11/13/2020		JF	9		D7210		1	extraction, erupted tooth requiring rem	250.00
2	11/13/2020		JF	9		D1999		1	Personal Protective Equipment	5.00
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
32. Missing Teeth Information (Place an "X" on each missing tooth.)						33. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B, ICD-10 = AB)			31a. Other Fee(s)	
1	X	X	X	X	X	33a. Diagnosis Code(s)	A	C		
10	X	X	X	X	X	(Primary diagnosis in "A")	B	D		
31b. Total Fee										265.00

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 benefit otherwise payable to me, directly to the below named dentist or dental entity.

X Signature on File 03/29/2024

Subscriber Signature Date

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

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

43. NPI 1760858153 44. License Number 64834 45. SSN or ID# 822159868

Phone Number 760-243-4366

46. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

36. Place of Treatment ☒ (e.g. office; 22=O.P. Hospital) 39. Enclosures (Y or N)

(Use "Place of Service Codes for Professional Claims")

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

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

42. Months of Treatment Remaining 43. Replacement of Prosthesis

☒ No ☐ Yes (Complete 44)

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

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

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

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

Signature (Treating Dentist)
 1760858153

54. NPI

55. License Number 64834

56. Address, City, State, Zip Code

57a. Provider Specialty Code 1223G0001X

12611 Hesperia Rd.
 Victorville CA 923958307

57b. Phone Number 760-243-4366

58. Additional Provider ID

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To reorder call 800.947.4700

EXHIBIT 4

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 239
of 297

Claim #293 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at <https://eccc.kcc.caustfirmsitehealth>.

Fill in this information to identify the case:

Debtor: Belinda Cornwell-Harris 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)(2), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed.

Part 1: Identify the Claim

1. Who is the current creditor?	<u>Nong Hee Lee DDS Inc</u> <small>Name of the current creditor (the person or entity to be paid for the claim)</small>	
	<small>Other names the creditor uses with the debtor</small>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom?	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different)
<small>Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)</small> RECEIVED APR 05 2024 KURTZMAN & SONS CONSULTANTS	Name <u>Nong Hee Lee DDS Inc</u>	Name
	Number <u>12611 Hesperia Rd. Ste C</u>	Number Street
	City <u>Victorville, CA 92395</u>	City State ZIP Code
	State <u>USA</u>	State ZIP Code
	Country <u>USA</u>	Country
Contact phone <u>Two-243-4346</u>	Contact phone	Contact phone
Contact email <u>leeofficemanager@gmail.com</u>	Contact email	Contact email
<small>Uniform claim identifier for electronic payments in chapter 11 (if you use one)</small>		
4. Does this claim (asset or liability) already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) Filed on <u>MM / DD / YYYY</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing?	

Official Form 410

Proof of Claim
page 1

220238424040500000000011

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 240
of 297

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. List 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TIOB

7. How much is the claim? \$ 1450.00 Does this amount include interest or other charges?
☒ No
☐ Yes. Attach statement limiting interest, fees, expenses, or other charges required by Bankruptcy Rule 3031(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 3031(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.
Name 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. If the claim is 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

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 241
of 297

12. Is all or part of the claim settled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$5,350* of deposit toward purchase, lease, or rental of property or services for personal, family, or household use, 11 U.S.C. § 507(a)(2).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units, 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan, 11 U.S.C. § 507(a)(9).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a) that applies.	\$ _____

* Amounts are subject to adjustment on 10/25 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 3011(b).

If you file this claim electronically, FRBP 3003(b)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to \$550,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 159, 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

Signature

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

Name

Ming

Hee

Lee

Title

Debtist

Company

Ming Hee Lee DDS Inc.

Identify the corporate entity as the company if the authorized agent is a person.

Address

12411 Hesperia Rd Ste C

Victorville, CA 92395

Contact phone

760-243-4366

Email hee.office.manager@gmail.com

Official Form 410

Proof of Claim
page 2

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EXHIBIT 4

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 244
of 297

Claim #294 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at <https://kccs.kccs-judicial.com/claims/>

Fill in this information to identify the case:

Debtor Minnetonka Community Health Foundation
United States Bankruptcy Court for the Southern District of California
Case number 22-02384

Official Form 410
Proof of Claim

04/22

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

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed.

Part 1 Identify the Claim

1. Who is the current creditor?	<u>Monica Hee Lee DDS Inc</u> <small>Name of the current creditor (the person or entity to be paid for this claim)</small> <small>Other name: the creditor used with the debtor</small>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? <u>Monica Hee Lee DDS Inc</u> <u>2211 Hesperia Rd. Ste C</u> <u>Victorville, CA 92395</u> <u>USA</u> <u>Two-243-4366</u> <u>leeoffice@manager@gmail.com</u>	Where should payments to the creditor be sent? (if different) Name _____ Number _____ Street _____ City _____ State _____ ZIP Code _____ Country _____ Contact phone _____ Contact email _____
<p>RECEIVED APR 05 2024</p> <p>Uniform claim identifier by electronic payments in chapter 13 (if you use one): _____</p>		
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known): _____ Filed on: <u>MM / DD / YYYY</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of C
page



220238424040500000000012

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 245
of 297

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. List 4 digits of the debtor's account or any number you use to identify the debtor. 9868
TECH

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.)
Amount necessary to cure any default as of the date of the petition: \$ _____
Annual interest Rate (if not 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

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of 297

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No.

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$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).	\$ _____
<input type="checkbox"/> Wages, salaries, or commissions (up to \$15,157*) 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units, 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan, 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/01/25 and every 3 years after that for values 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 5011(b).

If you file this claim electronically, FRBP 5035(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 this information is true and correct.

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

Executed on date: 03/28/2024
MAY 1 20 1 11 PM

Signature: 

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

Name: Yong Hee Lee
First name Middle name Last name

Title: dentist

Company: Yong Hee Lee DDS Inc.
Specify the corporate position as the company if the individual agent is a partner.

Address: 12411 Hesperia Rd Ste C
Number Street

City: Victorville, CA ZIP Code: 92395

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

RECEIVED
APR 05 2024
CLERK OF COURT
U.S. BANKRUPTCY COURT
SOUTHERN DISTRICT OF CALIFORNIA

Official Form 410

Proof of Claim
page 3

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 247
ADA American Dental Association Dental Claim Form 97

HEADER INFORMATION																																																																																																			
Type of Transaction (Mark all applicable boxes)																																																																																																			
<input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization																																																																																																			
<input checked="" type="checkbox"/> Final Bill 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)																																																																																																			
4. Dental? <input checked="" type="checkbox"/> Medical? <input type="checkbox"/> (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 <input type="checkbox"/> M <input checked="" type="checkbox"/> F																																																																																																			
8. Policyholder/Subscriber ID (SSN or ID#)																																																																																																			
94208396A50044																																																																																																			
9. Plan/Group Number																																																																																																			
10. Patient's Relationship to Person named in #5																																																																																																			
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																																																																																																			
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																																																																																																			
Denti-Cai Po Box 15810 Sacramento CA 95852-0610																																																																																																			
RECORD OF SERVICES PROVIDED																																																																																																			
1	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		JF			D0150		1	comprehensive oral evaluation - new	150.00																																																																																									
2	11/19/2020		JF			D4910		1	periodontal maintenance	300.00																																																																																									
3	11/19/2020		JF			D1999		1	Personal Protective Equipment	5.00																																																																																									
4																																																																																																			
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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	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00
34. Diagnosis Code List Qualifier																																																																																																			
{ ICD-9 = B, ICD-10 = AB }																																																																																																			
34a. Diagnosis Code(s)																																																																																																			
A _____ C _____																																																																																																			
34b. (Primary diagnosis in "A")																																																																																																			
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.																																																																																																			
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.																																																																																																			
Signature on File 03/29/2024																																																																																																			
Subscriber Signature Date																																																																																																			
ANCILLARY CLAIM/TREATMENT INFORMATION																																																																																																			
38. Place of Treatment <input checked="" type="checkbox"/> (e.g. 11=office, 22=DIP Hospital)																																																																																																			
39. Enclosures (Y or N)																																																																																																			
40. Is Treatment for Orthodontics?																																																																																																			
<input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)																																																																																																			
41. Date Appliance Placed (MM/DD/CCYY)																																																																																																			
42. Months of Treatment Remaining																																																																																																			
43. Replacement of Prosthesis																																																																																																			
<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)																																																																																																			
44. Date of Prior Placement (MM/DD/CCYY)																																																																																																			
45. Treatment Resulting from																																																																																																			
<input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> 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																																																																																																			
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57. Phone Number																																																																																																			
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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																																																																																																			
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56. Address, City, State, Zip Code																																																																																																			
12611 Hesperia Rd. Victorville CA 923958307																																																																																																			
56a. Provider Specialty Code																																																																																																			
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58. Additional Provider ID																																																																																																			

EXHIBIT 4

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 249
of 297

Claim #295 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at <https://kccs.kcc.com/Forms/proofclaim>.

Fill in this information to identify this case.

Debtor: Bonanza Community Health Foundation
United States Bankruptcy Court for the Southern District of California
Case number: 22-02384

Official Form 410
Proof of Claim

04/22

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

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000; imprisoned for up to 5 years; or both. 18 U.S.C. §§ 152, 157, and 357.

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?	<u>Monica Hee Lee DDS Inc.</u> <small>Name of the current creditor (the person or entity to be paid for this claim)</small> <small>Other names the creditor used with the debtor</small>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No. <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? <u>Monica Hee Lee DDS Inc.</u> <u>2111 Hesperia Rd. Ste C</u> <u>Victorville, CA 92395</u> <u>USA</u> <small>City State ZIP Code</small> Country Contact phone: <u>760-243-4366</u> Contact email: <u>leeofficemanager@gmail.com</u>	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 amount one already filed?	<input checked="" type="checkbox"/> No. <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on <u>MM / DD / YYYY</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No. <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim
page 1

2202384240405000000000010

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 250
of 297

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
TECH

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

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)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$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).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other: Specify subsection of 11 U.S.C. § 507(a): _____ then specify: _____	\$ _____

* Amounts are subject to adjustment on 4/1/25 and every 5 years after that for dates 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 8: Sign Below

The person completing this proof of claim must sign and date it. FRBP 3011(c).

If you file this claim electronically, FRBP 3015(n)(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
MAY 1 2024

Signature 

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

Name Yung Hee Lee
First name Middle name Last name

Title dentist

Company Yung Hee Lee DDS Inc.
(Specify the applicable number as the company & the individual agent is a benefit.)

Address 12411 Hesperia Rd Ste C
Number Street

Victorville, CA 92395
City State ZIP Code

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

To reorder call 800.847.4746

EXHIBIT 4

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 254
of 297

Claim #296 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at <https://kcc.kcc.com/filing/claims/claims.html>.

Fill in this information to identify the case:

Debtor: Rosendo Commemorative Health Foundation
United States Bankruptcy Court for the Southern District of Georgia
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 this 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?	<u>Nong Hee Lee DDS Inc</u> <small>Name of the current creditor (the person or entity to be paid for this claim)</small> <small>Other names the creditor used with the debtor:</small>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent?	<p>Where should notices to the creditor be sent?</p> <p><u>Nong Hee Lee DDS Inc</u> <u>2211 Hesperia Rd. Ste C</u> <u>Vicksburg, GA 39345</u> <u>USA</u> <u>Two-243-4366</u> <u>leeoffice@nongheeleed.com</u></p> <p><small>Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)</small> <small>Country</small> <small>Contact phone</small> <small>Contact email</small></p>	<p>Where should payments to the creditor be sent? (if different)</p> <p><small>Name</small> <small>Number</small> <small>Street</small> <small>City</small> <small>State</small> <small>ZIP Code</small> <small>Country</small> <small>Contact phone</small> <small>Contact email</small></p>
4. Does this claim ascend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known): _____ Filed on: <u>MM</u> / <u>DD</u> / <u>YYYY</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim
page 1

22023842404050000000000009

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 255
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Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TID#

7. How much is the claim? \$ 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 3021(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 credit card 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: _____

Official Form 410

Proof of Claim
page 2

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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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$2,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(9).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/25 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 3011(b).

If you file this claim electronically, FRBP 3009(e)(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

and (in YYYY)

Signature [Signature]

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

Name Ung Hee Lee

First name Middle name Last name

Title Dentist

Company Ung Hee Lee DDS Inc.

Indicate the corporate person as the company if the authorized agent is a company.

Address 12611 Hesperia Rd Ste C

Number Street

City Victorville, CA ZIP Code 92381 Country US

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

RESERVED

APR 05 2024

KURTZMANCHASCONCONSULTANTS

To reorder call 800.947.4746

EXHIBIT

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 259
of 297

Claim #297 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at <https://www.kcc.uscourts.net/forms/claims.html>.

Fill in this information to identify the case:

Debtor Remond Community Health Foundation
(Filed Under Bankruptcy Court for the Southern District of California)
Case number 22-02384

Official Form 410
Proof of Claim

04/22

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

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both, 18 U.S.C. §§ 152, 157, and 357.

Fill in all the information about the claim as of the date this case was filed.

Part 1 Identify the Claim

1. Who is the current creditor?	<u>Noma Hee Lee DDS Inc</u> 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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom?	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? <u>Noma Hee Lee DDS Inc</u> <u>12411 Hesperia Rd. Ste C</u> <u>Victorville, CA 92395</u> <u>USA</u> City State ZIP Code Country Contact phone <u>760-243-4366</u> Contact email <u>lee@ccmanager@gmail.com</u>	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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> 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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing?	

Official Form 410

Proof of Claim
page 1

22023842404050000000000000

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

6.	Do you have any number you use to identify the debtor?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes. List 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? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. The claim is secured by a lien on property: Nature of property: <input type="checkbox"/> 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. <input type="checkbox"/> Motor vehicle <input type="checkbox"/> 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): _____ % <input type="checkbox"/> Fixed <input type="checkbox"/> Variable	
10.	Is this claim based on a lease?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Amount necessary to cure any default as of the date of the petition: \$ _____	
11.	Is this claim subject to a right of setoff?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Identify the property: _____	

RECEIVED

APR 05 2024

CHRISTIAN CARSON CONSULTANTS

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 261
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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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$5,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(2).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a) that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/22 and every 2 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 505(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.

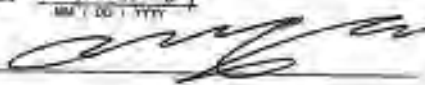
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

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 Ming Hee Lee
First name Middle name Last name

Title dentist

Company Ming Hee Lee DDS Inc.
Specify the corporate service as the company if the authorized agent is a service.

Address 12411 Hesperia Rd Ste C
City Victorville, CA State 92395
Country

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

APR 05 2026

RECEIVED

CLINTON COUNTY PROBATE COURT

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 262

ADA American Dental Association Dental Claim Form

HEADER INFORMATION

Type of Transaction (Mark all applicable boxes):
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☒ E-Submit / Fax XIX
 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 KBC
 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 #14 (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 #17 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) 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 Care	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
11/13/2020	10	JF			D4341		1	UR periodontal scaling and root planin	250.00
11/13/2020	40	JF			D4341		1	LR periodontal scaling and root planin	250.00
11/13/2020		JF			D1999		1	Personal Protective Equipment	5.00
11/17/2020	20	JF			D4341		1	UL periodontal scaling and root planin	250.00
11/17/2020	30	JF			D4341		1	LL periodontal scaling and root planin	250.00
11/17/2020		JF			D1999		1	Personal Protective Equipment	5.00
11/20/2020		JF			D1999		1	Personal Protective Equipment	5.00
11/23/2020		JF			D1999		1	Personal Protective Equipment	5.00
11/24/2020		JF			D1999		1	Personal Protective Equipment	5.00
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 2 3 4 5 6 7 8 9 10 11 12 13 14 15 X
 16 X 17 18 19 20 21 22 23 24 25 26 27 28 29 30 X
 31. Other Fee(s)
 32. Total Fee 1250.00

33. Remarks

AUTHORIZATIONS
 34. 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. In the event a 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 in 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
 35. 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-Other Hospital)
 (Use "Place of Service Codes for Professional Claims")
 37. Enticement (Y or N)
 38. Is Treatment for Orthodontics?
☒ No (Skip 41-42) ☐ Yes (Complete 41-42)
 39. Date Appliance Placed (MM/DD/CCYY)
 40. Months of Treatment Remaining 41. Replacement of Prosthesis
☒ No ☐ Yes (Complete 44)
 42. Date of Prior Placement (MM/DD/CCYY)
 43. Treatment Resulting from
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
 44. Date of Accident (MM/DD/CCYY) 45. 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.)
 46. Name, Address, City, State, Zip Code
 Yonghee Lee
 12611 Hesperia Rd.
 Suite C
 Victorville CA 923958307
 47. NPI 1760858153 48. License Number 64834 49. SSN or TIN 822169868
 50. Phone Number 760 243 4366 51. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION
 52. 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
 53. NPI 1760858153 54. License Number 64834 55. 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

2202384240405000000000007

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of 297

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?	<input type="checkbox"/> No. <input checked="" type="checkbox"/> Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: <u>9868</u> <u>TIOH</u>
7. How much is the claim?	\$ <u>3100.00</u> Does this amount include interest or other charges? <input checked="" type="checkbox"/> No. <input type="checkbox"/> 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. <u>Dental</u>
9. Is all or part of the claim secured?	<input checked="" type="checkbox"/> No. <input type="checkbox"/> Yes. The claim is secured by a lien on property. Nature of property: <input type="checkbox"/> Real estate: If the claim is secured by the debtor's principal residence, file a <i>Mortgage Proof of Claim Attachment</i> (Official Form 410-A) with this <i>Proof of Claim</i> . <input type="checkbox"/> Motor vehicle <input type="checkbox"/> 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) _____ % <input type="checkbox"/> Fixed <input type="checkbox"/> Variable
10. Is this claim based on a lease?	<input checked="" type="checkbox"/> No. <input type="checkbox"/> Yes. Amount necessary to cure any default as of the date of the petition: \$ _____
11. Is this claim subject to a right of setoff?	<input checked="" type="checkbox"/> No. <input type="checkbox"/> 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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$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).	\$ _____
<input type="checkbox"/> Wages, salaries, or commissions (up to \$15,750*) 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(9).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies.	\$ _____

* Amounts are subject to adjustment on 4/1/25 and every 5 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 357.

Check all that apply:

☒ 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

[Signature]

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

Name: Yung Hee Lee

Title: Dentist

Company: Yung Hee Lee DDS Inc.

Address: 12611 Hesperia Rd Ste C

City: Victorville, CA State: 92395 ZIP Code: _____ Country: _____

Direct phone: 760-243-4364 Email: hee.office.manager@gmail.com

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ADA American Dental Association Dental Claim Form

HEADER INFORMATION																														
1. Type of Transaction (Mark all applicable boxes)																														
<input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input checked="" type="checkbox"/> FSDT/THEX/IX																														
2. Predetermination/Preauthorization Number																														
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																														
3. Company/Plan Name, Address, City, State, Zip Code																														
Correcto Health Claims Processing Center c/o KMC 2822 N. Pacific Coast Hwy Ste 300 El Segundo, Ca 90245																														
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)																														
12. Policyholder/Subsriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																														
[Redacted]																														
13. Date of Birth (MM/DD/CCYY)																														
14. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F																														
15. Policyholder/Subsriber ID (SSN or ID#)																														
16. Plan/Group Number																														
17. Employer Name																														
PATIENT INFORMATION																														
18. Relationship to Policyholder/Subsriber in #12 Above																														
<input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> 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 <input checked="" type="checkbox"/> M <input type="checkbox"/> F																														
23. Patient ID/Account # (Assigned by Dental)																														
[Redacted]																														
RECORD OF SERVICES PROVIDED																														
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth Surface	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30a. Diag. Points	30b. Qty	30. Description	31. Fee																					
10/27/2020		JR	2,5,7-10		D5213		1	maxillary partial denture - cast metal fr	500.00																					
11/09/2020		JR	18		D2751		1	crown - porcelain fused to predomina	500.00																					
11/24/2020		JP	18		2810.10		1	Seat Crown	100.00																					
32. Moving Teeth Information (Place an 'X' on each missing tooth)																														
1	2	X	4	5	X	7	X	8	X	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
33. Remarks																														
34. Diagnosis Code List Qualifier																														
(ICD-9 = B, ICD-10 = A6)																														
35a. Diagnosis Code(s)																														
A _____ C _____																														
35b. Primary diagnosis in "A"																														
B _____ D _____																														
36. Other Fee(s)																														
37. Total Fee 3100.00																														
AUTHORIZATIONS																														
38. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contracted agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.																														
39. Signature on File 03/29/2024																														
40. Patient/Guardian Signature Date																														
41. I hereby authorize and direct payment of the dental benefits addressed payable to me, directly to the below named dentist or dental entity.																														
42. Signature on File 03/29/2024																														
43. Subscriber Signature Date																														
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not providing 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																														
50. License Number 64834																														
51. SSN or TIN 822-69868																														
52. Phone Number 760-243-4366																														
53a. Additional Provider ID																														
ANCILLARY CLAIM/TREATMENT INFORMATION																														
38. Place of Treatment <input checked="" type="checkbox"/> (e.g. 11-office; 22-OP Hospital)																														
39. Enclosures (Y or N)																														
(Use "Place of Service Codes for Professional Claims")																														
40. Is Treatment for Orthodontics?																														
<input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)																														
41. Date Appliance Placed (MM/DD/CCYY)																														
42. Months of Treatment Remaining																														
<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)																														
43. Replacement of Prosthesis																														
44. Date of Prior Placement (MM/DD/CCYY)																														
45. Treatment Resulting from																														
<input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> 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																														
Signature (Printed Name)																														
54. NPI 1760858153																														
55. License Number 64834																														
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. 269 of 297

Claim #299 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at <https://eproc.kccdc.net/SecureHealth>.

Fill in this information to identify the case:

Debit: Boston 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. § 553(b)(9), this form should not be used to make a claim for an administrative expense arising after the commencement of the case.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 357.

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?	<u>Mona Hee Lee DDS Inc</u> Name of the current creditor (the person or entity to be paid for this claim) Check names the creditor used with the debtor	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? <u>Mona Hee Lee DDS Inc</u> Name <u>2611 Hesperia Rd. Ste C</u> Address <u>Victorville, CA 92395</u> City State ZIP Code <u>USA</u> Country Contact phone <u>760-243-4366</u> Contact email <u>leeofficemanager@gmail.com</u>	Where should payments to the creditor be sent? (if different) Name _____ Number _____ Street _____ City _____ State _____ ZIP Code _____ Country _____ Contact phone _____ Contact email _____
<p>RECEIVED APR 05 2024</p> <p>U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF CALIFORNIA</p> <p>U.S. Bankruptcy Court for the Southern District of California</p>		
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claims number on court claims registry (if known) _____ Filed on <u>4/5/2024</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim
page 1

220238424040500000000000

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of 297

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
7104

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 3071(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).
Until 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: _____

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)?

☒ No.

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$2,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(9).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies:	\$ _____

* Amounts are subject to adjustment on 4/1/25 and every 3 years after that for costs begun on or after the date of adjustment.

13. Is all or part of the claim pursuant to 11 U.S.C. § 503(c)(3)?

☒ 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(k)(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 cosigner. 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

[Signature]

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

Name: Young Hee Lee

First name Middle name Last name

Title: dentist

Company: Young Hee Lee DDS Inc.

Verify the corporate person as the company if the authorized agent is a senior.

Address: 12411 Hesperia Rd Ste C

City: Victorville, CA State: 92395

Country

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

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ADA American Dental Association Dental Claim Form 97

HEADER INFORMATION		POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)													
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Presubmital <input checked="" type="checkbox"/> E-OSIT - TADA XIX		12. Policyholder/Subsriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code [Redacted]													
2. Questionnaire/Presubmital Number		13. Date of Birth (MM/DD/CCYY) 14. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F 15. Policyholder/Subsriber ID (SSN or ID#) [Redacted]													
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		16. Plan/Group Number 17. Employer Name [Redacted]													
3. Company/Plan Name, Address, City, State, Zip Code Dorrego Health Claims Processing Center c/o VACO 222 N. Pacific Coast Hwy Ste 300 El Segundo Ca 90245		PATIENT INFORMATION													
4. Dental? <input checked="" type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)		18. Relationship to Policyholder/Subsriber in #12 Above <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other													
5. Name of Policyholder/Subsriber in #4 (Last, First, Middle Initial, Suffix) Lee, Jang		19. Reserved For Future Use													
6. Date of Birth (MM/DD/CCYY) 7. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F 8. Policyholder/Subsriber ID (SSN or ID#) 03/07/1954 97933745F		20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code [Redacted]													
9. Plan/Group Number 10. Patient's Relationship to Person named in #5 <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other		21. Date of Birth (MM/DD/CCYY) 22. Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F 23. Patient ID/Account # (Assigned by Dentist) [Redacted]													
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code Denti-Cal Po Box 15610 Sacramento CA 95852-0610															
RECORD OF SERVICES PROVIDED															
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Care	26. Tooth System	27. Tooth Number(s) or Teeth(s)	28. Teeth Surface	29. Procedure Code	30a. Diag. Pointer	30b. Qty.	30. Description	31. Fee						
11/10/2020		JP			D4910		1	periodontal maintenance	300.00						
11/10/2020		JP			D1999		1	Personal Protective Equipment	5.00						
32. Moving 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
17	X	20	21	22	23	24	25	26	27	28	29	30	31	32	33
34. Diagnosis Code List Qualifier (ICD-9 = B; ICD-10 = A8)										31a. Other Fee(s)					
34a. Diagnosis Code(s) A C										32. Total Fee 305.00					
34b. Primary diagnosis in "A"															
35. Remarks															
AUTHORIZATIONS					ANCILLARY CLAIM/TREATMENT INFORMATION										
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 have been treated by a dentist or dental practice that has a written 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.					38. Place of Treatment (1 = Office; 2 = Outpatient Hospital) 39. Enclosures (Y or N) (Use "Place of Service Codes for Professional Claims")										
X Signature on File 03/29/2024 Patient/Guarantor Signature Date					40. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)										
41. Monthly copayment and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.					42. Months of Treatment Remaining 43. Replacement of Prosthesis <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)										
X Signature on File 03/29/2024 Subscriber Signature Date					44. Date of Prior Placement (MM/DD/CCYY)										
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. Treatment Resulting from <input type="checkbox"/> Occupational Illness/Injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other incident										
48. Name, Address, City, State, Zip Code Yonghee Lee 12611 Hesperia Rd. Suite C Victorville CA 923958307					46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State										
49. NPI 1760858153 50. License Number 64834 51. SSN 822169868					TREATING DENTIST AND TREATMENT LOCATION INFORMATION										
52. Name 760 243 4366 53. Additional Provider ID					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 54. NPI 1760858153 55. License Number 64834 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. 274
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Claim #300 Date Filed: 4/5/2024

Your claim can be filed electronically on KGC's website at <https://eclerk.kgc.net/8ccomplaint>.

Fill in this information to identify the case:

Clerk: Hesperia Community Health Foundation
United States Bankruptcy Court 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. § 502(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 or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 357i.

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?	<u>Yong Hee Lee DDS Inc.</u> 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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From Whose? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? Name: <u>Yong Hee Lee DDS Inc.</u> Address: <u>2111 Hesperia Rd. Ste C</u> City: <u>Victorville, CA</u> State: <u>92395</u> ZIP Code: <u>USA</u> Country: _____ Contact phone: <u>760-243-4366</u> Contact email: <u>leeofficemanager@gmail.com</u>	Where should payments to the creditor be sent? (if different) Name: _____ Address: _____ City: _____ State: _____ ZIP Code: _____ Country: _____ Contact phone: _____ Contact email: _____
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on: <u>MM / DD / YYYY</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim
page 1

22023842404050000000000005

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

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. List 4 digits of the debtor's account or any number you use to identify the debtor: 9868
TECH

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 (written down with date) _____ %
☐ 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)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$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)(2).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a) that applies: _____	\$ _____

* Amounts are subject to adjustment in 401025 and every 3 years after that for costs 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 2) Sign Below

The person completing this proof of claim must sign and date it. FRBP 5011(c).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to permit 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 of 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

Signature [Signature]

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

First name Young Middle name Hee Last name Lee

Title dentist

Company Young Hee Lee DDS Inc.
(Indicate the corporate service as the company if the authorized agent is a servant.)

Address 12411 Hesperia Rd Ste C
City Victorville State CA ZIP Code 92395

Or 714-243-4364 Email lee.office.manager@gmail.com

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 277
ADA American Dental Association Dental Claim Form 97

HEADER INFORMATION		POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)							
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Precertification <input checked="" type="checkbox"/> FSDT: JDA XIX		12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code [Redacted]							
2. Predetermination/Precertification Number		13. Date of Birth (MM/DD/CCYY) 14. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F 15. Policyholder/Subscriber ID (SSN or ID#) [Redacted]							
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		16. Plan/Group Number 17. Employer Name [Redacted]							
3. Company/Plan Name, Address, City, State, Zip Code Borrego Health Claims Processing Center C/O MCC 222 N Pacific Coast Hwy Ste 300 El Segundo CA 90245		PATIENT INFORMATION							
4. Other Coverage (Mark applicable box and complete items 5-11. If none, leave blank.) <input type="checkbox"/> Dental <input checked="" type="checkbox"/> Medical <input type="checkbox"/> (If both, complete 5-11 for dental only.)		18. Relationship to Policyholder/Subscriber in #12 Above <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other							
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) Yoon, Myeongja		19. Reserved For Future Use							
6. Date of Birth (MM/DD/CCYY) 04/07/1955		20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code [Redacted]							
7. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F 8. Policyholder/Subscriber ID (SSN or ID#) 95833745F		21. Date of Birth (MM/DD/CCYY) 22. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F 23. Patient ID/Account # Assigned by Dentist [Redacted]							
9. Plan Group Number		10. Patient's Relationship to Person named in #5 <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other							
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code Denti-Cal Po Box 15610 Sacramento CA 95852-0610									
RECORD OF SERVICES PROVIDED									
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Dog Pointer	29b. Qty.	30. Description	31. Fee
11/10/2020		JP			D4910		1	periodontal maintenance	300.00
11/10/2020		JP			D1999		1	Personal Protective Equipment	5.00
32. Missing Teeth Information (Place an "X" on each missing tooth.)									
1	X	2		3		4		5	
6		7		8		9		10	
11		12		13		14		15	
16		17		18		19		20	
21		22		23		24		25	
26		27		28		29		30	
31		32		33		34		35	
34. Diagnosis Code List Qualifier (ICD-9 = D; ICD-10 = AB)									
34a. Diagnosis Code(s) A C D									
34b. (Primary diagnosis in "A") S D									
31a. Other Fee(s)									
32. Total Fee 305.00									
35. Remarks									
AUTHORIZATIONS					ANCILLARY CLAIM/TREATMENT INFORMATION				
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. In the treating dentist or dental provider 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. Place of Treatment 11 (e.g. 11-office; 22-O/F Hospital) 39. Enclosures (Y or N) (Use "Place of Service Codes for Professional Claims")				
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					40. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42) 41. Date Appliances Placed (MM/DD/CCYY)				
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. Months of Treatment Remaining 43. Replacement of Prosthesis <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) 44. Date of Prior Placement (MM/DD/CCYY)				
45. Name, Address, City, State, Zip Code Yonghee Lee 12611 Hesperia Rd. Suite C Victorville CA 923958307					45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident				
46. NPI 1760858153 50. License Number 64834 51. SSO Number 822169868					46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State				
52. Phone Number 760 242 4366 53a. 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 56. Provider Specialty Code 1223G0001X				
58. Address, City, State, Zip Code 12611 Hesperia Rd. Victorville CA 923958307					59. Phone Number 760 242 4366 60. Additional Provider ID				

EXHIBIT 4

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Claim #301 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at <https://www.kcc.com/ThomasHealth>.

Fill in this information to identify the case:

Debtor: Thomas Community Health Foundation
United States Bankruptcy Court for the Southern District of Georgia
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?	<u>Nong Hee Lee DDS Inc</u> <small>(Name of the current creditor (the person or entity to be paid for this claim))</small> <small>Other names the creditor used with the debtor:</small>		
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom?		
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different)	
<small>Federal Rule of Bankruptcy Procedure (FRBP) 2003(g)</small> RECEIVED APR 05 2024 KURTSON & ASSOCIATES	Name <u>Nong Hee Lee DDS Inc</u>	Name	
	Number <u>12611 Hesperia Rd. Ste C</u>	Number Street	
	City <u>Vickerville, GA</u>	City State ZIP Code	
	State <u>GA</u>	State	
	ZIP Code <u>30395</u>	ZIP Code	
Country <u>USA</u>	Country		
Contact phone <u>Two-243-4366</u>	Contact phone		
Contact email <u>leeoffice@manager@gmail.com</u>	Contact email		
4. Does this claim extend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) Filed on <u>Mar 1 2024</u>		
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing?		

Official Form 410



220238424040500000000004

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Part 2: Give Information About the Claim as of the Date the Case Was Filed	
6. Do you have any number you use to identify the debtor?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes. List 4 digits of the debtor's account or any number you can to identify the debtor: <u>9868</u> <div style="text-align: right; margin-right: 50px;"><u>TIO#</u></div>
7. How much is the claim?	<div style="display: flex; justify-content: space-between;"> \$ <u>3300.00</u> <div> Does this amount include interest or other charges? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A). </div> </div>
8. What is the basis of the claim?	<p><small>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.</small></p> <p style="font-size: 1.2em; margin-top: 10px;"><u>Dental</u></p>
9. Is all or part of the claim secured?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. The claim is secured by a lien on property: <div style="margin-top: 5px;"> Nature of property: <input type="checkbox"/> Real estate. If the claim is secured by the debtor's principal residence, file a <i>Mortgage Proof of Claim Attachment</i> (Official Form 410-A) with this Proof of Claim. <input type="checkbox"/> Motor vehicle <input type="checkbox"/> Other. Describe: _____ </div> <div style="margin-top: 10px;"> Basis for perfection: _____ <small>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.)</small> </div> <div style="margin-top: 10px;"> Value of property: \$ _____ Amount of the claim that is secured: \$ _____ Amount of the claim that is unsecured: \$ _____ <small>(The sum of the secured and unsecured amount should match the amount in line 7.)</small> </div> <div style="margin-top: 10px;"> Amount necessary to cure any default as of the date of the petition: \$ _____ </div> <div style="margin-top: 10px;"> Annual interest rate (when case was filed) _____ % <input type="checkbox"/> Fixed <input type="checkbox"/> Variable </div>
10. Is this claim based on a lease?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Amount necessary to cure any default as of the date of the petition: \$ _____
11. Is this claim subject to a right of setoff?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Identify the property: _____

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$3,300* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(9).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a) that applies: _____	\$ _____

* Amounts are subject to adjustment on 4/1/25 and every 3 years after that for costs 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 503(b)(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

[Signature]

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

Name: Ung Hee Lee

First name Middle name Last name

Title: dentist

Company: Ung Hee Lee DDS Inc.

Specify the corporate service as the company if the authorized agent is a service.

Address: 12411 Hesperia Rd Ste C

Number Street

Victorville, CA 92395

City State ZIP Code County

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

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ADA American Dental Association Dental Claim Form 97

HEADER INFORMATION									
1. Type of Transaction (Mark all applicable boxes): <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Predetermination <input checked="" type="checkbox"/> FFS/OT/THE XIX									
2. Predetermination/Predetermination Number:									
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION									
3. Company/Plan Name, Address, City, State, Zip Code Porrego Health Claims Processing Center c/o KCC 222 N. Pacific Coast Hwy Ste 300 El Segundo, CA 90245									
4. Other Coverage (Mark applicable box and complete items 5-11. If none, leave blank.) a. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.) b. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) c. Date of Birth (MM/DD/CCYY) 7. Gender <input type="checkbox"/> M <input type="checkbox"/> F 8. Policyholder/Subscriber ID (SSN or ID#) d. Plan/Group Number 10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other e. 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 <input type="checkbox"/> M <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> 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 <input type="checkbox"/> M <input checked="" type="checkbox"/> F 23. Patient ID/Account # (Assigned by Dentist) [Redacted]									
RECORD OF SERVICES PROVIDED									
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Care	26. Tooth System	27. Tooth Number(s) or Location	28. Tooth Surface	29. Procedure Code	30a. Diag. Pointer	30b. Qty.	30. Description	31. Fee
11/10/2020		JF			D9430		1	office visit for observation (during regu	100.00
11/03/2020		JF	19		D2751		1	crown - porcelain fused to predomina	1500.00
11/23/2020		JF	19		2810.10		1	Seat Crown	100.00
11/02/2020		JF	20		D2751		1	crown - porcelain fused to predomina	1500.00
11/20/2020		JF	20		2810.10		1	Seat Crown	100.00
32. Missing Teeth Information (Place an "X" on each missing tooth.) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 [X] [X] [X] [X] [X] [X] [X] [X] [X] [X] [X] [X] [X] [X] [X] [X]									
33. Diagnosis Code List Qualifier (ICD-9 = B, ICD-10 = AB)									
34a. Diagnosis Code(s) A C 34b. Diagnosis Code(s) B D 35. Remarks:									
32. Total Fee 3300.00									
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 predicted 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 822189868									
44. Phone Number 760 243 4366 45. 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) [Redacted]									
40. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Step 41-42) <input type="checkbox"/> Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY)									
42. Months of Treatment Remaining <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY)									
45. Treatment Requesting from <input type="checkbox"/> Occupational Illness/Injury <input type="checkbox"/> Auto accident <input type="checkbox"/> 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 Signature (Treating Dentist) 54. NPI 1760858153 55. License Number 64834 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. 284
of 297

Claim #302 Date Filed: 4/5/2024

Your claim can be filed electronically on KCC's website at <http://www.kcc.org/FormsandHealth>.

Fill in this information to identify this case:

Debtor: Biscaya Community Health Foundation
United States Bankruptcy Court in the Southern District of California
Case Number: 22-02384

Official Form 410

Proof of Claim

04/22

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

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed.

Part 1: Identify the Claim

1. Who is the current creditor?	<u>Nong Hee Lee DDS Inc</u> <small>Name of the current creditor (the person or entity to be paid for the claim)</small> <small>Other names the creditor used with the debtor</small>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? <u>Nong Hee Lee DDS Inc</u> <u>2111 Hesperia Rd. Ste C</u> <u>Victorville, CA 92395</u> <u>USA</u> <u>Two-243-4266</u> <u>lee@ice-manager.com</u>	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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on <u>MM / DD / YYYY</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Official Form 410

Proof of Claim
page 1

220238424040500000000003

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 285
of 297

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
7102

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.)
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

RECEIVED
APR 05 2024
KURTZMAN GARDNER CONSULTANTS

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

☒ No.

☐ Yes. Check all that apply:

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

* Amounts are subject to adjustment on 4/1/25 and every 3 years after that (or dates begin on or after the date of adjustment).

13. Is all or part of the claim secured 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.

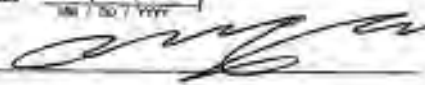
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on the 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.

Excluded on date 03/28/2024
180 / 360 / 720

Signature: 

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

Name: Ming Hee Lee
First name Middle name Last name

Title: dentist

Company: Ming Hee Lee DDS Inc.
Identify the corporate division or the company if the authorized agent is a service.

Address: 12411 Hesperia Rd Ste C
Number Street

City: Victorville, CA State: 92395 ZIP Code County

Contact phone: 760-243-4346 Email: lee.office.manager@gmail.com

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 287
ADA American Dental Association Dental Claim Form 97

HEADER INFORMATION									
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input checked="" type="checkbox"/> Preauthorization/Preauthorization Number									
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION									
2. Insurance Plan Name, Address, City, State, Zip Code Borrego Health Claims Processing Center c/o KCC 222 N. Pacific Coast Hwy Ste 302 Escondido, CA 92045									
3. Other Coverage (Mark applicable box and complete items 5-11 if none, leave blank) 4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (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 <input type="checkbox"/> M <input type="checkbox"/> F 8. Policyholder/Subscriber ID (SSN or ID#) 9. Plan/Group Number 10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> 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 <input checked="" type="checkbox"/> M <input type="checkbox"/> 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 <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> 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 <input checked="" type="checkbox"/> M <input type="checkbox"/> F 23. Patient ID/Account # (Assigned by Dentist) [Redacted]									
RECORD OF SERVICES PROVIDED									
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Care	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Point	29b. City	30. Description	31. Fee
11/13/2020	10	JF			D4341			JR periodontal scaling and root planin	250.00
11/13/2020	40	JF			D4341			LR periodontal scaling and root planin	250.00
11/13/2020		JF			D1999			Personal Protective Equipment	5.00
11/23/2020	20	JF			D4341			JL periodontal scaling and root planin	250.00
11/23/2020	30	JF			D4341			LL periodontal scaling and root planin	250.00
11/23/2020		JF			D1999			Personal Protective Equipment	5.00
11/24/2020		JF			D1999			Personal Protective Equipment	5.00
32. Missing Teeth Information (Place an "X" on each missing tooth.) 1 X 2 X 3 X 4 X 5 X 6 X 7 X 8 X 9 X 10 X 11 X 12 X 13 X 14 X 15 X 16 X 17 X 18 X 19 X 20 X 21 X 22 X 23 X 24 X 25 X 26 X 27 X 28 X 29 X 30 X 31 X 32 X 33 X 34 X 35 X 36 X 37 X 38 X 39 X 40 X 41 X 42 X 43 X 44 X 45 X 46 X 47 X 48 X 49 X 50 X 51 X 52 X 53 X 54 X 55 X 56 X 57 X 58 X 59 X 60 X 61 X 62 X 63 X 64 X 65 X 66 X 67 X 68 X 69 X 70 X 71 X 72 X 73 X 74 X 75 X 76 X 77 X 78 X 79 X 80 X 81 X 82 X 83 X 84 X 85 X 86 X 87 X 88 X 89 X 90 X 91 X 92 X 93 X 94 X 95 X 96 X 97 X 98 X 99 X 100 X									
33. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B, ICD-10 = AB) 31a. Other Fee(s) 34a. Diagnosis Code(s) A. C. 32. Total Fee 1015.00 (Primary diagnosis in "A") B. C.									
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, in the existing written 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. Signature on File 03/29/2024 Date									
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. Signature on File 03/29/2024 Date									
ANCILLARY CLAIM/TREATMENT INFORMATION									
38. Place of Treatment <input checked="" type="checkbox"/> (e.g. Home, 22-DIP Hospital) 39. Enclosures (Y or N) (Use "Place of Service Codes for Professional Claims")									
40. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY)									
42. Months of Treatment Remaining <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) 43. Replacement of Prosthesis <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) 44. Date of Prior Placement (MM/DD/CCYY)									
45. Treatment Resulting from <input type="checkbox"/> Occupational Illness/Injury <input type="checkbox"/> Auto accident <input type="checkbox"/> 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 822165868									
52. Phone Number 760-243-4366 53. 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 Signed (Treating Dentist) 54. NPI 1760858153 55. License Number 64834 56. Address, City, State, Zip Code 12611 Hesperia Rd. 4223G0001X Victorville CA 923958307 57. Phone Number 760-243-4366 58. Additional Provider ID									

EXHIBIT



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of 297

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 (enter case web 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)?

☒ No

☐ Yes. Check all that apply:

	Amount entitled to priority
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$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).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(6).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a) that applies: _____	\$ _____

* Amounts are subject to adjustment on 4/1/85 and every 3 years after that for costs 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 3011(b).

If you file this claim electronically, FRBP 3003(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 co-debtor. Bankruptcy Rule 3005.

I understand that an authorized signature on the Proof of Claim serves as an acknowledgement that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

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

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

Executed on date 03/28/2020
MAR 1 2020



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

Name: Yung Hee Lee
First name Middle name Last name

Title: Debitist

Company: Yung Hee Lee DDS Inc.
(Specify the office or location as the company if the authorized agent is a partner.)

Address: 12411 Hesperia Rd Ste C
Number Street

City: Victorville, CA State: 92395 ZIP Code: _____ County: _____

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

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APR 15 2024

KRITZMAN CARSON CONSULTANTS

Case 22-02384-LT11 Filed 05/07/25 Entered 05/07/25 08:04:02 Doc 1611 Pg. 292
ADA American Dental Association Dental Claim Form 97

HEADER INFORMATION		POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)																		
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input checked="" type="checkbox"/> NOT File XIX		12. Policyholder/Subsriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																		
2. Predetermination/Preauthorization Number		13. Date of Birth (MM/DD/CCYY) 14. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F 15. Policyholder/Subsriber ID (SSN or ID#)																		
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		16. Plan/Group Number 17. Employer Name																		
3. Company/Plan Name, Address, City, State, Zip Code Borrego Health Processing Center c/o KCC 222 N. Pacific Coast Hwy. Ste 300 El Segundo, Ca 90245		18. Relationship to Policyholder/Subsriber in #12 Above <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other 19. Reserved For Future Use																		
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)		PATIENT INFORMATION																		
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)		20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																		
5. Name of Policyholder/Subsriber in #4 (Last, First, Middle Initial, Suffix)		21. Date of Birth (MM/DD/CCYY) 22. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F 23. Patient ID/Account # (Assigned by Dentist)																		
6. Date of Birth (MM/DD/CCYY) 7. Gender <input type="checkbox"/> M <input type="checkbox"/> F 8. Policyholder/Subsriber ID (SSN or ID#)																				
9. Plan/Group Number 10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> 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											
10/29/2020		JP	14		D2751		1	crown - porcelain fused to predomina	1500.00											
11/06/2020		JP	15		D2751		1	crown - porcelain fused to predomina	1500.00											
33. Missing Teeth Information (Place an "X" on each missing tooth.)																				
1	X	X	4	X	5	X	6	X	7	8	9	10	11	12	X	13	X	14	15	X
16	X	X	17	X	18	X	19	X	20	X	21	X	22	X	23	X	24	X	25	X
34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B, ICD-10 = AB)										31a. Other Fee(s)										
34a. Diagnosis Code(s) A C										32. Total Fee 3000.00										
(Primary diagnosis in "A") B D																				
35. Remarks																				
AUTHORIZATIONS					ANCILLARY CLAIM/TREATMENT INFORMATION															
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 disclosing 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					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) <input type="checkbox"/>															
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					40. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY)															
					42. Months of Treatment Remaining <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY)															
					45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> 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.)					TREATING DENTIST AND TREATMENT LOCATION INFORMATION															
48. Name, Address, City, State, Zip Code Yonghee Lee 12611 Hesperia Rd. Suite C Victorville CA 923958307					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 03/28/2024 X Signed (Treating Dentist) Date 54. NPI 1760858153 55. License Number 64834 56. Address, City, State, Zip Code 12611 Hesperia Rd. 56a. Provider Specialty Code 1223G0001X Victorville CA 923958307															
49. NPI 1760858153 50. License Number 64834 51. SSN 822169868					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. 294
of 297

Claim #304 Date Filed: 4/15/2024

Your claim can be filed electronically on KCC's website at <https://kccs.uscourts.gov/forresterhealth>.

Fill in this information to identify the case:

Creditor: Monica Cummings Health Foundation
United States Bankruptcy Court for the Southern District of California
Case number: 22-02384

Official Form 410
Proof of Claim

04/23

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

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both, 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed.

Part 1 Identify the Claim

1. Who is the current creditor?	<u>Monica Cummings Health Foundation</u> <small>Name of the current creditor (the person or entity to be paid for this claim)</small> <small>Other names the creditor used with the debtor</small>	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent?	Where should notices to the creditor be sent? <u>Monica Cummings Health Foundation</u> <u>1201 Hesperia Rd. Ste C</u> <u>Victorville, CA 92395</u> <u>USA</u> <small>Name</small> <small>Number Street</small> <small>City State ZIP Code</small> <small>Country</small> <small>Contact phone</small> <u>760-243-4366</u> <small>Contact email</small> <u>leeofficemanager@gmail.com</u>	Where should payments to the creditor be sent? (if different) <small>Name</small> <small>Number Street</small> <small>City State ZIP Code</small> <small>Country</small> <small>Contact phone</small> <small>Contact email</small>
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on <u>4/15/2024</u>	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

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Proof of Claim
page 1

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

6. Do you have any number you use to identify the debtor? ☐ No
☒ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 9868
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 for 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 claim 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
<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (A)(1)(B).	\$ _____
<input type="checkbox"/> Up to \$2,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
<input type="checkbox"/> 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).	\$ _____
<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)() that applies:	\$ _____

* Amounts are subject to adjustment on 40 U.S.C. and every 3 years after that for dates 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 9006(a)(2) authorizes courts to establish local rules specifying when 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 1571.

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 this information is true and correct.

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

Executed on date 03/28/2020

[Signature]

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

Name: Young Hee Lee

Title: Debit

Company: Young Hee Lee DDS Inc.

Address: 12411 Hesperia Rd Ste C

City: Victorville, CA State: 92395

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

RECEIVED

APR 15 2024

NOTICE OF CARSON CONSULTANTS

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