

UNITED STATES BANKRUPTCY COURT Northern District of Texas (Dallas Division)

PROOF OF CLAIM

Name of Debtor: Renaissance Gardens At Charlestown

Case Number: 09-37010

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

Name of Creditor (the person or other entity to whom the debtor owes money or property):

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

Name and address where notices should be sent:

MOBILEXUSA
185 WITMER RD
HORSHAM, PA 19044

FILED

JAN 22 2010

TAWANA C. MARSHALL, CLERK
U.S. BANKRUPTCY COURT
NORTHERN DISTRICT OF TEXAS

Court Claim Number: _____
(If known)

Filed on: _____

Name and address where

Mobilex USA
The Highlands
920 Ridgebrook Rd. 2nd floor
Sparks, MD 21152

Telephone number:

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

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

1. Amount of Claim as of Date Case Filed: \$ 280.00

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

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

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

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

Specify the priority of the claim.

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

Wages, salaries, or commissions (up to \$10,950*) earned within 180 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. §507 (a)(4).

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

Up to \$2,425* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 11 U.S.C. §507 (a)(7).

Taxes or penalties owed to governmental units - 11 U.S.C. §507 (a)(8).

Other - Specify applicable paragraph of 11 U.S.C. §507 (a)(___).

Amount entitled to priority:

\$ _____

*Amounts are subject to adjustment on 4/1/10 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.

2. Basis for Claim: Service performed
(See instruction #2 on reverse side.)

3. Last four digits of any number by which creditor identifies debtor: 90052

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

4. Secured Claim (See instruction #4 on reverse side.)

Check the appropriate box if your claim is secured by a lien on property or a right of setoff and provide the requested information.

Nature of property or right of setoff: Real Estate Motor Vehicle Other **RECEIVED**

Describe: Value of Property: \$ _____ Annual Interest Rate _____ %

FEB 01 2010

Amount of arrearage and other charges as of time case filed included in secured claim: **BMC GROUP**

if any: \$ _____ Basis for perfection: _____

Amount of Secured Claim: \$ _____ Amount Unsecured: \$ 280.00

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

7. Documents: Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. You may also attach a summary. Attach redacted copies of documents providing evidence of perfection of a security interest. You may also attach a summary. (See instruction 7 and definition of "redacted" on reverse side.)

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

If the documents are not available, please explain:

Date: 01/20/2010

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

FOR COURT USE ONLY

Erickson Ret. Comm. LLC



00709

Patricia A. Falice Patricia A. Falice, Senior Director

The Highlands
920 Ridgebrook Road
Sparks, MD 21152-9320

MOBILEXUSA
Billing Office

Tel: 800.786.8015
Fax: 800.288.1059
Fax: 443.662.4227

Facility Bill for: RENAISSANCE GARDENS AT CHARLESTOWN
Invoice Number: 90052*03-2009

Facility Telephone: 410.981.6640
Cost Center: 71140
Facility Fax: 410.536.0580

REVISED
**** Invoice Period March 2009 ****
Invoice Date: 04/17/2009

RENAISSANCE GARDENS AT CHARLESTOWN
MAIL STOP 601
P O BOX 22000
CATONSVILLE, MD 21228

All payments are to be remitted to:

MobilexUSA
P.O. Box 17462
Baltimore, MD 21297-0518

NOTE:
for questions regarding current invoice, please contact Ashley Ross at ext. 4186

-----Total for current invoice-----	
Medicare Part A	\$1,750.00
Managed Care	\$280.00
	<hr/>
Sub-total for current invoice:	\$2,030.00
	<hr/>
Total amount due:	\$2,030.00

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**** Medicare Part A Detail Summary ****

Claim No.	DOS	Patient Name	ICD9	RV Code	CPT	Mod	Procedure	Amount Due
7549179	03/18/2009	ANACKER, MARIE CCI-106933	785.0	730	93005		EKG WITHOUT INTERP	\$70.00
							Claim sub-total:	\$70.00
7494734	03/02/2009	ANDERSON, VESTA CCI-66778	724.2 719.48	320 320	72100 72170		LUMBAR SPINE AP&LAT PELVIS AP ONLY	\$70.00 \$70.00
							Claim sub-total:	\$140.00
7505294	03/05/2009	ANDERSON, VESTA CCI-66778	787.3	320	74000		ABDOMEN 1V / KUB	\$70.00
							Claim sub-total:	\$70.00
7513324	03/07/2009	ANDERSON, VESTA CCI-66778	719.45	320	73510	LT	HIP UNI-LAT MIN 2V	\$70.00
							Claim sub-total:	\$70.00
7547230	03/17/2009	ATKINS, EARL CCI-105031	514	324	71010		CHEST - 1 VIEW (AP)	\$70.00
							Claim sub-total:	\$70.00
7540274	03/19/2009	BISHOP, SHIRLEY CCI-64557	724.2	320	72100		LUMBAR SPINE AP&LAT	\$70.00
							Claim sub-total:	\$70.00
7515873	03/22/2009	BONE, GEORGE CCI-96217	719.41 719.45	320 320	73030 73510	LT LT	SHOULDER MIN 2V HIP UNI-LAT MIN 2V	\$70.00 \$70.00
							Claim sub-total:	\$140.00
7570161	03/24/2009	CASEY, ISABELLA CCI-4904	511.1	324	71010		CHEST - 1 VIEW (AP)	\$70.00
							Claim sub-total:	\$70.00
7585860	03/30/2009	CHOMAS, GLORIA CCI-78114	719.41	320	73030	RT	SHOULDER MIN 2V	\$70.00
							Claim sub-total:	\$70.00
7515861	03/08/2009	CLEMENS, MARY CCI-66808	719.47	320	73610	RT	ANKLE COMP, MIN 3V	\$70.00
							Claim sub-total:	\$70.00
7517001	03/09/2009	CLEMENS, MARY CCI-66808	719.47	320	73620	RT	FOOT AP&LAT 2V	\$70.00
							Claim sub-total:	\$70.00
7502146	03/17/2009	CUMMINS, WILLA CCI-5076	719.45	320	73510	RT	HIP UNI-LAT MIN 2V	\$70.00
							Claim sub-total:	\$70.00
7578061	03/26/2009	GLASPEY, GERTRUDE CCI-4079	786.05 789.00	324 320	71010 74000		CHEST - 1 VIEW (AP) ABDOMEN 1V / KUB	\$70.00 \$70.00
							Claim sub-total:	\$140.00

*** PLEASE make all revisions within 60 days of the invoice date. Changes after that will not be honored. ***

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**** Medicare Part A Detail Summary ****

Claim No.	DOS	Patient Name	ICD9	RV Code	CPT	Mod	Procedure	Amount Due
7496722	03/03/2009	HARRIS, DORIS CCI-106567	786.2	324	71010		CHEST - 1 VIEW (AP)	\$70.00
							Claim sub-total:	\$70.00
7519331	03/09/2009	HARRIS, DORIS CCI-106567	786.2	324	71010		CHEST - 1 VIEW (AP)	\$70.00
							Claim sub-total:	\$70.00
7530694	03/19/2009	HARRIS, DORIS CCI-106567	786.2	324	71010		CHEST - 1 VIEW (AP)	\$70.00
							Claim sub-total:	\$70.00
7499991	03/03/2009	NARBETH, DOROTHY CCI-2324	719.45 719.45	320 320	73550 73510	RT RT	FEMUR AP&LAT 2V HIP UNI-LAT MIN 2V	\$70.00 \$70.00
							Claim sub-total:	\$140.00
7494224	03/02/2009	PRIDAY, ALLEN CCI-1347	789.00	320	74000		ABDOMEN 1V / KUB	\$70.00
							Claim sub-total:	\$70.00
7563712	03/27/2009	RATTELL, RITA CCI-82829	786.05	324	71010		CHEST - 1 VIEW (AP)	\$70.00
							Claim sub-total:	\$70.00
7494075	03/02/2009	SIKORA, YVETTE CCI-71714	786.05	324	71010		CHEST - 1 VIEW (AP)	\$70.00
							Claim sub-total:	\$70.00
7550092	03/18/2009	WARD, NANCY CCI-3258	564.00	320	74000		ABDOMEN 1V / KUB	\$70.00
							Claim sub-total:	\$70.00
Sub total for Medicare Part A :								\$1,750.00

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Cost Center: 71140
Facility Fax: 410.536.0580

**** Managed Care Detail Summary ****

Claim No.	DOS	Patient Name	ICD9	RV Code	CPT	Mod	Procedure	Amount Due
7498456	03/03/2009	KLEIN, MILTON CCI-70139	820.8	320	73550	RT	FEMUR AP&LAT 2V	\$70.00
							Claim sub-total:	\$70.00
7588536	03/30/2009	MOYLAN, MARY CCI-5293	724.1	320	72070		THORACIC SPINE AP&LAT	\$70.00
							Claim sub-total:	\$70.00
7500642	03/03/2009	SLEEPER, MARGERY CCI-2110	719.41	320	73060	LT	HUMERUS MINIMUM 2V	\$70.00
							Claim sub-total:	\$70.00
7503891	03/05/2009	SLEEPER, MARGERY CCI-2110	401.9	730	93005		EKG WITHOUT INTERP	\$70.00
							Claim sub-total:	\$70.00
Sub total for Managed Care:								\$280.00

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