Fill in this information to identify the case:
Debtor 1 Morgan Administration, Inc.
Debtor 2 (Spouse, if filing)
United States Bankruptcy Court **Northern District of Illinois**
Case number: **18−30039**

Official Form 410
Proof of Claim

04/19

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

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

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

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) **that you received.**

Part 1: Identify the Claim

1. Who is the current creditor?

MICHAEL LOBOREC

Name of the current creditor (the person or entity to be paid for this claim)

Other names the creditor used with the debtor: Diane Loborec, Heart Care Centers of IL, Palos Health, Primary Heatlh

2. Has this claim been acquired from someone else?

☑ No
☐ Yes. From whom? _____

3. Where should notices and payments to the creditor be sent?

Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)

Where should notices to the creditor be sent?	**Where should payments to the creditor be sent?** (if different)
MICHAEL LOBOREC	
Name	Name
15332 STRADFORD LANE ORLAND PARK, IL 60462	
Contact phone 708−305−0671	Contact phone
Contact email mikeloborec@gmail.com	Contact email

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

_____

4. Does this claim amend one already filed?

☑ No
☐ Yes. Claim number on court claims registry (if known) _____ Filed on _____ MM / DD / YYYY

5. Do you know if anyone else has filed a proof of claim for this claim?

☑ No
☐ Yes. Who made the earlier filing? _____

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

6. **Do you have any number you use to identify the debtor?**
- ☑ No
- ☐ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: _____

7. **How much is the claim?** $ 1123.70

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 healthcare information.

Unpaid medical bills from Quest Diagnostics for health insurance premiums paid by employee

9. **Is all or part of the claim secured?**
- ☑ No
- ☐ Yes. The claim is secured by a lien on property.

Nature of property:
- ☐ Real estate. If the claim is secured by the debtor's principal residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410−A) with this *Proof of Claim*.
- ☐ Motor vehicle
- ☐ Other. Describe: _____

Basis for perfection: _____

Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)

Value of property: $ _____

Amount of the claim that is secured: $ _____

Amount of the claim that is unsecured: $ _____ (The sum of the secured and unsecured amounts should match the amount in line 7.)

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

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

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

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

12. **Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?**	☐ No ☑ Yes. *Check all that apply*:	**Amount entitled to priority**
A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.	☐ Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	$
	☐ Up to $3,025* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	$
	☐ Wages, salaries, or commissions (up to $13,650*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).	$
	☐ Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	$
	☑ Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	$ 1123.70
	☐ 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.

Part 3: Sign Below

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

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

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

Check the appropriate box:

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

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

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

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

Executed on date 4/15/2019

MM / DD / YYYY

/s/ Michael Loborec

Signature

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

Name Michael Loborec

First name Middle name Last name

Title

Company

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

Address 15332 Stradford Lane

Number Street

Orland Park, IL 60462

City State ZIP Code

Contact phone 708−305−0671 Email mikeloborec@gmail.com

Quest Diagnostics™

Do not use address below:

P.O. Box 7306
Hollister, MO 65673-7306

Laboratory Invoice

For services not included in your physician's bill

Invoice Date:	Amount Due:	Due Date:
Apr. 09, 2019	$1,123.70	UPON RECEIPT

Invoice Number 6585036795

Lab Code WDL

AB 01 089058 06074 B 242 B

WDL 22675395 0003113 6585036795 R
MICHAEL LOBOREC
15332 STRADFORD LN
ORLAND PARK, IL 60462-6741

Patient Name: DIANE M LOBOREC
Responsible Party: MICHAEL LOBOREC
Date of Service: October 12, 2018

Lab Results and Diagnosis Questions Must Be Answered By Your Physician.

Laboratory Tests Were Requested By:

Referring Physician: ZANDER,JENNIFER
Physician Address: 15300 WEST AVE STE 122
ORLAND PARK, IL 60462

Most Recent Insurance Claim Filed To:

Insurance Name: CIGNA WEST PPO
Insurance ID: P89960603
Group Number: 0200328

Customer Service
LOG ON NOW at www.QuestDiagnostics.com/bill to conveniently pay your invoice, provide updated insurance information, or take a patient survey.

Pay by Phone: 1-855-606-0567 (24 hours/7 days)
Questions: 1-800-888-8333
MON-TH 8:30AM-5:00PM;FRI 09:00 AM - 04:00 PM CST
Se Habla Espanol!

Please have your invoice available for reference.

This invoice is for laboratory tests performed at the request of the referring physician. CIGNA WEST PPO did not cover the testing because the patient was not eligible on the date of service. If you are insured, your insurance carrier may not have record of our claim because it may have rejected before entering into their claim system. Please contact us to provide correct insurance information or to make payment.

Date	CPT Code*	Test Description	Charge	Adjustment	Insurance Paid	Patient Paid	Patient Responsibility	Reason
10/12/18	83036	HEMOGLOBIN, GLYCOSYLATED	$74.25					
10/12/18	84439	THYROXINE, FREE	$146.23					
10/12/18	80061	LIPID PANEL	$148.10					
10/12/18	82607	VITAMIN B-12	$120.36					
10/12/18	36415	VENIPUNCTURE	$21.37					
10/12/18	82570	CREATININE	$57.37					
10/12/18	80050	GENERAL HEALTH PANEL	$241.07					
10/12/18	82306	25-OH VITAMIN D-3	$241.84					
10/12/18	82043	MICROALBUMIN (QN)	$73.11					
Tax ID: 36-4257926	**ICD Codes: E11.9 Z79.4 E03.9 E55.9**		**$1,123.70**	**$0.00**	**$0.00**	**$0.00**	**$1,123.70**	

Services Performed by: QUEST DIAGNOSTICS WOOD DALE WOOD DALE, IL
Services Performed by: QUEST DIAGNOSTICS ORLAND PARK ORLAND PARK, IL
* The CPT codes provided are for information purposes only, and are based on AMA guidelines without regard to specific payer requirements

089058 1/1

▲ Please fold and tear along perforation and remit with payment in the envelope provided. ▲

Quest Diagnostics™

LOG ON NOW. Pay your bill online securely at
www.questdiagnostics.com/bill
or call 1-855-606-0567 .
Quest Diagnostics also accepts:

VISA MasterCard AMERICAN EXPRESS DISCOVER NETWORK

Please make checks payable to Quest Diagnostics.
Be sure to include invoice number on your check.

☐ Check here if address has changed.
Please provide your new address information on the back.
Quest Diagnostics reserves the right to assign this receivable to any of its affiliates.

Lab Code: WDL

Amount Due: $1,123.70

Due Date: UPON RECEIPT **Invoice Number: 6585036795**

Patient Name: DIANE M LOBOREC

Amount Enclosed: $

If you received an explanation of benefits showing your responsibility is less than the amount shown on this bill, please pay the lesser amount. To fully resolve your invoice, please provide a copy of your explanation of benefits.

MAIL PAYMENTS ONLY TO:

QUEST DIAGNOSTICS
PO BOX 740397
CINCINNATI, OH 45274-0397

01WDL00016585036795001123705040916040000000000000005

Northern District of Illinois
Claims Register

18-30039 Morgan Administration, Inc.

Honorable Judge: Jacqueline P. Cox **Chapter:** 11
Office: Eastern Division **Last Date to file claims:** 01/28/2019
Trustee: **Last Date to file (Govt):** 04/23/2019

Creditor: (27199452)
MICHAEL LOBOREC
15332 STRADFORD LANE
ORLAND PARK, IL
60462

Claim No: 136
Original Filed Date: 04/15/2019
Original Entered Date: 04/15/2019

Status:
Filed by: CR
Entered by: EPoc ADI
Modified:

Amount claimed: $1123.70
Priority claimed: $1123.70

History:

Details	136-1	04/15/2019	Claim #136 filed by MICHAEL LOBOREC, Amount claimed: $1123.70 (ADI, EPoc)

Description:

Remarks:

Claims Register Summary

Case Name: Morgan Administration, Inc.
Case Number: 18-30039
Chapter: 11
Date Filed: 10/25/2018
Total Number Of Claims: 1

Total Amount Claimed*	$1123.70
Total Amount Allowed*	

*Includes general unsecured claims

The values are reflective of the data entered. Always refer to claim documents for actual amounts.

	Claimed	Allowed
Secured		
Priority	$1123.70	
Administrative		