

**Fill in this information to identify the case:**

Debtor 1 <u>Hillcrest Enterprises LLC</u>
Debtor 2 (Spouse, if filing)
United States Bankruptcy Court <u>Northern District of Illinois</u>
Case number: <u>18-30047</u>

**FILED**  
 U.S. Bankruptcy Court  
 Northern District of Illinois  
 1/28/2019  
 Jeffrey P. Allsteadt, Clerk

**Official Form 410  
 Proof of Claim**

04/16

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**

<b>1. Who is the current creditor?</b>	Dawn Vandermeir _____ Name of the current creditor (the person or entity to be paid for this claim)  Other names the creditor used with the debtor _____	
<b>2. Has this claim been acquired from someone else?</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
<b>3. Where should notices and payments to the creditor be sent?</b>	<b>Where should notices to the creditor be sent?</b>	<b>Where should payments to the creditor be sent? (if different)</b>
	Dawn Vandermeir _____ Name 2110 Dartmoor DR. Joliet, IL 60435  Contact phone <u>815-348-0105</u> Contact email <u>VANCORACING@SBCGLOBAL.NET</u>  Uniform claim identifier for electronic payments in chapter 13 (if you use one): _____	_____ Name   Contact phone _____ Contact email _____
<b>4. Does this claim amend one already filed?</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on _____ <span style="float: right;">MM / DD / YYYY</span>	
<b>5. Do you know if anyone else has filed a proof of claim for this claim?</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

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

<p>6. Do you have any number you use to identify the debtor?</p>	<p><input checked="" type="checkbox"/> No  <input type="checkbox"/> Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: _____</p>
<p>7. How much is the claim?</p>	<p>\$ 1761.83</p> <p><b>Does this amount include interest or other charges?</b>  <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).</p>
<p>8. What is the basis of the claim?</p>	<p>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 Payments due to Non Payment of Insurance policy by HOBO (Hillcrest Enterprises LLC)</p>
<p>9. Is all or part of the claim secured?</p>	<p><input checked="" type="checkbox"/> No  <input type="checkbox"/> Yes. The claim is secured by a lien on property.  <b>Nature of property:</b>  <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: _____</p> <p><b>Basis for perfection:</b> _____</p> <p>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.)</p> <p><b>Value of property:</b> \$ _____</p> <p><b>Amount of the claim that is secured:</b> \$ _____</p> <p><b>Amount of the claim that is unsecured:</b> \$ _____ (The sum of the secured and unsecured amounts should match the amount in line 7.)</p> <p><b>Amount necessary to cure any default as of the date of the petition:</b> \$ _____</p> <p><b>Annual Interest Rate</b> (when case was filed) _____ %</p> <p><input type="checkbox"/> Fixed  <input type="checkbox"/> Variable</p>
<p>10. Is this claim based on a lease?</p>	<p><input checked="" type="checkbox"/> No  <input type="checkbox"/> Yes. <b>Amount necessary to cure any default as of the date of the petition.</b> \$ _____</p>
<p>11. Is this claim subject to a right of setoff?</p>	<p><input checked="" type="checkbox"/> No  <input type="checkbox"/> Yes. Identify the property: _____</p>

<b>12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. <i>Check all that apply.</i>	<b>Amount entitled to priority</b>
A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the 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 \$2,850* 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 \$12,850*) 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 4/1/19 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 1/28/2019

MM / DD / YYYY

/s/ Dawn Vandermeir

Signature

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

Name Dawn Vandermeir

First name      Middle name      Last name

Title \_\_\_\_\_

Company \_\_\_\_\_

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

Number Street \_\_\_\_\_

City State ZIP Code \_\_\_\_\_

Contact phone \_\_\_\_\_ Email \_\_\_\_\_



PO Box 660  
East Granby, CT 06026



001853

DAWN VANDERMEIR  
2110 DARTMOOR DRIVE  
JOLIET, IL 60435

DAWN VANDERMEIR		
Insured Name		
DAWN VANDERMEIR		
Invoice Number	Date	Due Date
5879-2609982	10-02-2018	PAST DUE
Insurance Name/ID		
S & S HEALTHCARE STRATEGIES BP / XXXXXXXXX2384		
Service Provider		
RELIACARE		

Pay online at: [www.carecentrix.com](http://www.carecentrix.com)  
Pay by phone (24/7): 877-989-9059  
Billing Questions: 866-441-4172

### FINAL NOTICE

DATE OF SERVICE	HCPC CODE	DESCRIPTION OF SERVICE	CHARGES BILLED TO INSURANCE
06-25-2018	S9131	REGISTERED PHYS THERAPY VISIT	\$166.52
06-13-2018	T1001	RN EVAL WITH SKILLED VISIT	\$144.22
06-13-2018	S9131	REGISTERED PHYS THERAPY VISIT	\$166.52

#### PLEASE SEE REVERSE SIDE FOR IMPORTANT MESSAGES

The balance due reflects your responsibility after insurance consideration. If you have any questions concerning your benefits, contact your insurance company.  
For billing questions call Customer Service at our toll free number 866-441-4172. Monday - Friday 8am to 6pm EST.

\*\*\*\*FINAL NOTICE\*\*\*\*  
YOUR ACCOUNT IS PAST DUE. IF PAYMENT IS NOT RECEIVED OR YOU DO NOT CONTACT US TO MAKE PAYMENT ARRANGEMENTS, YOUR ACCOUNT WILL BE SENT TO AN OUTSIDE COLLECTION AGENCY WITHIN 30 DAYS.

### IMPORTANT MESSAGE

If you had government program secondary coverage (for example, Medicare, Medicaid, Tricare) on the above date(s) of service, you are not required to pay this bill, but you must contact us at 800-808-1902 to ensure we have your current correct secondary coverage information on file.

PLEASE DETACH AND RETURN THIS PORTION IN THE ENCLOSED ENVELOPE

DAWN VANDERMEIR  
2110 DARTMOOR DRIVE  
JOLIET, IL 60435

ACCOUNT NUMBER	INVOICE NUMBER	INTAKE PATIENT ID
5879-FM201	5879-2609982	6708389
PATIENT NAME		
DAWN VANDERMEIR		
DUE DATE	PAY THIS AMOUNT	
PAST DUE	\$75.00	

IF PAYING BY VISA, MASTERCARD OR DISCOVER, FILL OUT BELOW

VISA  MASTERCARD  DISCOVER

CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE		MUST INCLUDE 30DIGIT SECURITY CODE FROM BACK OF CARD
PRINT CARD HOLDER NAME		

Please direct Legal Correspondence or Bankruptcy Notifications to:  
Patient Billing, CareCentrix, 9119 Corporate Lake Drive, Tampa, FL 33634

PLEASE MAKE CHECKS PAYABLE TO:

CARECENTRIX  
PO BOX 277947  
ATLANTA GA 30384-7947

Please visit our Enhanced Patient Payment Portal to manage all of your payment needs. [www.carecentrix.com](http://www.carecentrix.com)



# DuPage Medical Group

**WE CARE FOR YOU**  
15921 Collections Center Drive | Chicago, IL 60693-0159

## Statement of Physician Services

**For Billing Inquiries: (630) 942-7998**  
**Hours: Monday - Friday, 8:00 am - 4:30 pm**

Please check if you have written on the back

### ADDRESSEE

DAWN R VANDERMEIR  
2110 DARTMOOR DR  
JOLIET IL 60435-3313



**SCHEDULE YOUR DOCTOR'S APPOINTMENT & FLU SHOT ONLINE, TODAY!**

DuPageMedicalGroup.com/online-schedule

Account Number	Invoice Number	Due Date	Amount Due
2073414	609835127	01/23/2019	\$70.53

Payment type: (pick only one)  Check  Credit Card (See Reverse)

Page 1

### PLEASE MAKE CHECKS PAYABLE AND REMIT TO:

DUPAGE MEDICAL GROUP  
15921 Collections Center Drive  
Chicago, IL 60693-0159

0609835127 000000002073414 00007053 4

Use myEasyMatch Code: RJ9-2CN-Q83 to pay your bill online

Return top portion with payment.

Account Number	Responsible Party	Invoice Number	Statement Date	Due Date
2073414	DAWN R VANDERMEIR	609835127	01/02/2019	01/23/2019

Date	Description	Charges	Payments/ Adjustments	Insurance Pending	Patient Balance
<b>PATIENT: DAWN R VANDERMEIR</b> <i>Service Date 08/30/2018 - STEFAN NEMETH</i> <i>Service Date 08/30/2018 - STEFAN NEMETH</i>					
08/30/2018	Complete CBC	\$33.00			
08/30/2018	Blood draw	\$20.00			
08/30/2018	Comprehensive metabolic panel	\$55.00			
08/30/2018	Lipid panel	\$69.00			
08/30/2018	Bilirubin direct	\$25.00			
08/30/2018	Glycosylated hemoglobin test	\$50.00			
09/27/2018	Contractual adjustment		\$131.47		
09/27/2018	Lockbox insurance payment (R)		\$0.00		
	<b>Insurance Pending</b>			\$50.00	
	<b>Patient Balance</b>				\$70.53
<b>Total Account Balance:</b>		\$120.53			
<b>Amount Pending with Insurance:</b>		\$50.00			
Insurance Denial Codes: (R) Copayment					

**THE DOCTOR WILL SEE YOU NOW**

**mychart**  
Manage your health online

**VIDEO VISITS NOW AVAILABLE**

See a DMG doctor online today.

**MESSAGE**

You have a balance of \$70.53 that will be placed in Collections in 10 days, please pay immediately.

**PAY THIS AMOUNT \$70.53**

Please see statement back for financial options.



**LOYOLA  
MEDICINE**

*We also treat the human spirit.®*

Please Note: Payments are applied to oldest accounts first. If you wish to apply a payment to specific accounts, call Customer Service at 1-800-424-4840 Monday through Friday 8 am to 6 pm or pay online ([www.loyolamedicine.org](http://www.loyolamedicine.org)). Please contact Customer Service to request an itemized statement.

You have not met our payment requirements. Please pay the remaining balance in full or contact us to arrange a payment plan for your balance.

GUARANTOR ACCT NUMBER		1869938			
Date	Description	Charges	Insurance Pmts/Adjs	Patient Pmts/Adjs	Patient Balance
<b>Acct #10364000016 Vandermeir,Dawn</b>					
<b>Inpatient</b>					
<b>LOYOLA HOSPITAL</b>					
	Previous Charges	105,829.43			
08/20/18	CIGNA Payments		-30,229.16		
08/20/18	CIGNA Adjustments		-73,948.27		
	Total Insurance Payments and Adjustments		-104,177.43		
10/02/18	POINT OF SVC COPAY			-35.70	
	<u>Patient Balance</u>				<u>1,616.30</u>
<b>Balance Due</b>					<b>1,616.30</b>

Itemized summaries of previous statements will be provided upon request.

<b>TOTAL AMOUNT DUE</b>	<b>\$1,616.30</b>
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**LOYOLA  
MEDICINE**

*We also treat the human spirit.®*

Two Westbrook Corporate Center, Suite 700  
Westchester, IL 60154

Please check the box if below address is incorrect or if the insurance information has changed. Indicate the change(s) on the reverse side.

005069

LOY100 1140733 585467413  
Dawn Vandermeir  
2110 Dartmoor Dr  
Joliet, IL 60435-3313



IF PAYING BY CREDIT CARD, PLEASE FILL OUT BELOW.			
<input type="checkbox"/> VISA	<input type="checkbox"/> AMERICAN EXPRESS	<input type="checkbox"/> DISCOVER	<input type="checkbox"/> MASTERCARD
CARD NUMBER			EXP. DATE
CARD NAME		SIGNATURE	
ACCOUNT NUMBER	PAYMENT DUE DATE	STATEMENT DATE	
1869938	12/04/18	11/06/18	
PLEASE PAY THIS AMOUNT		AMOUNT PAID HERE	
\$1,616.30		\$	

\*Make checks payable and remit to:  
Loyola University Medical Center  
PO Box 3021  
Milwaukee, WI 53201-3021



# Northern District of Illinois Claims Register

[18-30047 Hillcrest Enterprises LLC](#)

**Honorable Judge:** Jacqueline P. Cox      **Chapter:** 11  
**Office:** Eastern Division                      **Last Date to file claims:**  
**Trustee:**    **Last Date to file (Govt):**

<i>Creditor:</i> (27483788) Dawn Vandermeir 2110 Dartmoor DR. Joliet, IL 60435	<b>Claim No: 37</b> <i>Original Filed Date:</i> 01/28/2019 <i>Original Entered Date:</i> 01/28/2019	<i>Status:</i> Filed by: CR Entered by: EPoc ADI Modified:
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Amount claimed: \$1761.83

*History:*  
[Details](#)                      [37-1](#)      01/28/2019 Claim #37 filed by Dawn Vandermeir, Amount claimed: \$1761.83 (ADI, EPoc)

*Description:*  
*Remarks:*

## Claims Register Summary

**Case Name:** Hillcrest Enterprises LLC  
**Case Number:** 18-30047  
**Chapter:** 11  
**Date Filed:** 10/25/2018  
**Total Number Of Claims:** 1

<b>Total Amount Claimed*</b>	\$1761.83
<b>Total Amount Allowed*</b>	

\*Includes general unsecured claims

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

	Claimed	Allowed
<b>Secured</b>		
<b>Priority</b>		
<b>Administrative</b>		