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**UNITED STATES BANKRUPTCY COURT
DISTRICT OF IDAHO (BOISE)**

PROOF OF CLAIM

Name of Debtor
Martin Wayne Lewandowski
Sharon April Lewandowski

Case Number
00-01480

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):
St. Alphonsus RMC
Name and Address where notices should be sent:

St. Alphonsus RMC
P.O. Box 18
Boise, ID 83707-0018

- Check 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 box if you have never received any notices from the bankruptcy court in this case.
- Check box if the address differs from the address on the envelope sent to you by the court.

THIS SPACE IS FOR COURT USE ONLY

Telephone Number:

Account or other number by which creditor identifies debtor:
99229-00110

Check here if replaces this claim amends a previously filed claim, dated _____

- 1. Basis for Claim**
- Goods sold
 - Services performed
 - Money loaned
 - Personal injury/wrongful death
 - Taxes
 - Other

- Retiree benefits as defined in 11 U.S.C. §1114(a)
- Wages, salaries, and compensation (fill out below)
Your SS #: _____
Unpaid compensation for services performed from _____ to _____
(date) (date)

2. Date debt was incurred: 8/17/99

3. If court judgment, date obtained:

4. Total Amount of Claim at Time Case Filed: \$ _____
If all or part of your claim is secured or entitled to priority, also complete Item 5 or 6 below.
 Check this box if claim includes interest or other charges in addition to the principal amount of the claim. Attach itemized statement of all interest or additional charges.

5. Secured Claim.
 Check this box if your claim is secured by collateral (including a right of setoff).
Brief Description of Collateral:
 Real Estate Motor Vehicle
 Other _____

Value of Collateral: \$ _____

Amount of arrearage and other charges at time case filed included in secured claim, if any: \$ _____

6. Unsecured Priority Claim.
 Check this box if you have an unsecured priority claim
Amount entitled to priority \$ _____
Specify the priority of the claim:
 Wages, salaries, or commissions (up to \$4,300)* earned within 90 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. § 507(a)(3).
 Contributions to an employee benefit plan - 11 U.S.C. §507(a)(4).
 Up to \$ 1,950* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 11 U.S.C. § 507(a)(6).
 Alimony, maintenance, or support owed to a spouse, former spouse, or child - 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)(____).

**Amounts are subject to adjustment on 4/1/01 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.*

7. Credits: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim.
8. Supporting Documents: Attach copies of supporting documents, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, mortgages, security agreements, and evidence of perfection of lien. DO NOT SEND ORIGINAL DOCUMENTS. If the documents are not available, explain. If the documents are voluminous, attach a summary.
9. Date-Stamped Copy: To receive an acknowledgment of the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim.

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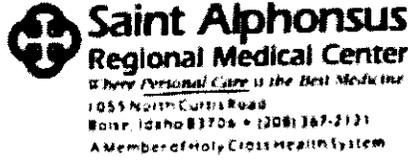
Date: 7/3/00
Sign and print the name and title, if any, of the creditor or other person authorized to file this claim (attach copy of power of attorney, if any):
Ann M. Fauglit Pt. Accts Support Clerk

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Penalty for presenting fraudulent claim: Fine of up to \$500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571.

Chapter 12 and 13 claims, along with any supporting must be filed in duplicate.

FINAL



TAX ID NO: 82-0000005

F/C:CT P/T:OPA

PATIENT:	ACCOUNT NUMBER	ADMISSION DATE	DISCHARGE DATE	PAGE
LEWANDOWSKI, MARTIN W	A9922900110	08/17/99	08/17/99	1
MARTIN W LEWANDOWSKI HC 34 SIMCO RD BOISE ID 83716		JOHN J ECK INSURANCE INFORMATION 300071 JAS/RETAIL STORES EMPL 51902248519022489 01/18/00		

POSTING DATE	SERVICE CODE	SERVICE DESCRIPTION	QUANTITY	CHARGE
	CODE	DESCRIPTION	QTY	
08/17	***731	HOLTER MONITOR	1	139.00
08/17	000267	HOLTER SCAN/REPORT (HF)	1	100.00
08/17	000296	SCANNING ANALYSIS		239.00
		AREA TOTAL ***		
08/17	***983	PROFESSIONAL FEE	1	60.00
	000299	HOLTER SCAN REPORT (PF)		60.00
		AREA TOTAL ***		
		TOTAL CHARGES		299.00
		TOTAL PAYMENTS/ADJUSTMENTS		239.20

Thank you for choosing Saint Alphonsus RMC for your healthcare needs. If you provided your insurance information at the time of service, we will be billing these charges to your carrier and notifying you after they process your claim. Deductible and coinsurance amounts are due at this time. For billing info, call 367-2130 or 800-358-6407. For arrangements, call 367-2281, 9:30-4:30

59.80

▲ THE DATES SHOWN ABOVE IN LEFT MARGIN REPRESENT POSTING DATES AND NOT NECESSARILY DATE OF SERVICE
NOTE: ANY UNPAID DEDUCTIBLE, CO-INSURANCE AND NON-COVERED CHARGES ARE DUE UPON RECEIPT OF THIS BILL

ACCOUNT BALANCE 59.80

FINANCE CHARGE: We compute the FINANCE CHARGE at a periodic rate of 1 1/4% per month, which is an ANNUAL PERCENTAGE RATE of 18% applied to the "adjusted balance" of your account. The adjusted balance is determined by taking the balance owed at the end of the previous billing cycle and subtracting all payments and credits received during the present billing cycle. Payments and credits received after the above billing statement will appear on your next statement.