United States Bankruptcy Court for the District of Delaware

Indicate Debtor against which you assert a claim by checking the appropriate box below. **(Check only one Debtor per claim form.)**

- ☐ HRI Holding Corp. (Case No. 19-12415)
- ☒ Houlihan's Restaurants, Inc. (Case No. 19-12416)
- ☐ HDJG Corp. (Case No.19-12417)
- ☐ Red Steer, Inc. (Case No. 19-12418)
- ☐ Sam Wilson's/Kansas, Inc. (Case No. 19-12419)
- ☐ Darryl's of St. Louis County, Inc. (Case No. 19-12420)
- ☐ Darryl's of Overland Park, Inc. (Case No. 19-12421)
- ☐ Houlihan's of Ohio, Inc. (Case No. 19-12422)
- ☐ HRI O'Fallon, Inc. (Case No. 19-12423)
- ☐ Algonquin Houlihan's Restaurant, L.L.C. (Case No. 19-12424)
- ☐ Houlihan's Texas Holdings, Inc. (Case No. 19-12425)
- ☐ Houlihan's Restaurants of Texas, Inc. (Case No. 19-12426)
- ☐ Geneva Houlihan's Restaurant, L.L.C. (Case No. 19-12427)
- ☐ Hanley Station Houlihan's Restaurant, LLC (Case No. 19-12428)
- ☐ JGIL Mill OP LLC (Case No. 19-12429)
- ☐ JGIL Millburn, LLC (Case No. 19-12430)
- ☐ JGIL Milburn Op LLC (Case No. 19-12431)
- ☐ JGIL, LLC (Case No. 19-12432)
- ☐ JGIL Holding Corp. (Case No. 19-12433)
- ☐ JGIL Omaha, LLC (Case No. 19-12434)
- ☐ HOP NJ NY, LLC (Case No. 19-12435)
- ☐ HOP Farmingdale LLC (Case No. 19-12436)
- ☐ HOP Cherry Hill LLC (Case No. 19-12437)
- ☐ HOP Paramus LLC (Case No. 19-12438)
- ☐ HOP Lawrenceville LLC (Case No. 19-12439)
- ☐ HOP Brick LLC (Case No. 19-12440)
- ☐ HOP Secaucus LLC (Case No. 19-12441)
- ☐ HOP Heights LLC (Case No. 19-12442)
- ☐ HOP Bayonne LLC (Case No. 19-12443)
- ☐ HOP Fairfield LLC (Case No. 19-12444)
- ☐ HOP Ramsey LLC (Case No. 19-12445)
- ☐ HOP Bridgewater LLC (Case No. 19-12446)
- ☐ HOP Parsippany LLC (Case No. 19-12447)
- ☐ HOP Westbury LLC (Case No. 19-12448)
- ☐ HOP Weehawken LLC (Case No. 19-12449)
- ☐ HOP New Brunswick LLC (Case No. 19-12450)
- ☐ HOP Holmdel LLC (Case No. 19-12451)
- ☐ HOP Woodbridge LLC (Case No. 19-12452)
- ☐ Houlihan's of Chesterfield, Inc. (Case No. 19-12453)

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. 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

NameID: 13948934

1. **Who is the current creditor?**
   AUGUST, THOMAS
   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)

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   Where should notices to the creditor be sent?
   AUGUST, THOMAS
   21920 ROBINHOOD AVE
   FAIRVIEW PARK, OH 44126

   See Above
   Address
   Contact phone 4406653000
   Contact email thomasaugust@yahoo.com

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   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 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? _____

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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?**
   - [x] 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?** $ 730-32 **Does this amount include interest or other charges?**
   - [x] 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.
   Health Insurance deductions for plan I did not sign up for, since I was on my parents health coverage.

9. **Is all or part of the claim secured?**
   - [x] 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

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10. **Is this claim based on a lease?**
    - [x] 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?**
    - [x] 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
☐ 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).	$ 730.32
☐ Other. Specify subsection of 11 U.S.C. § 507(a)(__) that applies.	$

* Amounts are subject to adjustment on 4/01/22 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 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 / 15 / 2020
MM / DD / YYYY

Signature

Print the name of the person who is completing and signing this claim: not applicable, completed form myself.

Name _____
First name Middle name Last name

Title _____

Company _____
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address _____
Number Street

_____
City State ZIP Code Country

Contact phone _____ Email _____

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Form 1095-C (2019)

600118

Part I Applicable Large Employer Member (Employer) *(Boxes 7, 9-13)*
EMPLOYER's name, street address (including apartment no.), city or town, state or province, ZIP or foreign postal code, and contact telephone number

HOULIHAN'S RESTAURANTS, INC.
8700 STATE LINE ROAD
SUITE 100
LEAWOOD, KS 66206-1564
(913) 901-2500

Employer-Provided Health Insurance Offer and Coverage

▶ Go to *www.irs.gov/Form1095C* for instructions and the latest information.
▶ Do not attach to your tax return. Keep for your records.

8 EMPLOYER's identification number (EIN)
43-1618489

OMB No. 1545-2251

2019

Form **1095-C**

Department of the Treasury
Internal Revenue Service

Employee *(Boxes 1, 3-6)*
EMPLOYEE's name, street address (including apartment no.), city or town, state or province, and ZIP or foreign postal code.
THOMAS E. AUGUST
21920 ROBINHOOD AVE
FAIRVIEW PARK, OH 44126

2 Social security number (SSN)
[redacted]9485

☐ VOID
☐ CORRECTED

1102

Form 1095-C (2019)

Part II Employee Offer of Coverage — **Plan Start Month** (enter 2-digit number): 04

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1E	1E	1E	1E	1E	1E	1H
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$ 121.72	$ 121.72	$ 121.72	$ 121.72	$ 121.72	$ 121.72	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2D	2D	2H	2H	2H	2H	2H	2H	2B

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.

TIP - Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, the premium tax credit, and the employer shared responsibility provisions, see www.irs.gov/ACA or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

Part I. Employee

Lines 1 -6. Part I, lines 1 -6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7 -13. Part I, lines 7 -13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14 -16

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Reserved.

1J. Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).

1K. Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest-cost self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, see IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17 -22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, see the additional covered individuals on Part III, Continuation Sheet(s).