Fill in this information to identify the case:
Debtor 1 KLS Acquisition Corp.
Debtor 2 (Spouse, if filing)
United States Bankruptcy Court **Northern District of Illinois**
Case number: **18−30052**

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

1. Who is the current creditor?

Robin T Laabs

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)

Where should notices to the creditor be sent?	**Where should payments to the creditor be sent?** (if different)
Robin T Laabs	
Name	Name
1000 s 108th Street C17 West Allis, WI 53214−2496	
Contact phone 4143136131	Contact phone
Contact email RTLdesigns78@yahoo.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?** $ 2524.00

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.

Medical bills unpaid by insurance company Cigna dba Paradigm Health Systems

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 lawl imits 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 $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).	$
	☐ 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).	$
	☐ 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).	$
	☐ 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/ Robin Terese Laabs

Signature

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

Name: Robin Terese Laabs

First name Middle name Last name

Title:

Company:

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

Address: 1000 S 108th Street C17

Number Street

West Allis, WI 53214−2496

City State ZIP Code

Contact phone 414−313−6131 Email RTLdesigns78@yahoo.com

Aurora Health Care®

PO Box 091700
Milwaukee, WI 53209-8700

Statement of Hospital and Physician Services

Statement Date: 1/20/2019

Payment Options:
- **Pay Online: aurora.org/billing**
- **Phone: 800-326-2250**
- **Mail: PO Box 809418 Chicago, IL 60680-9418**

014561

AUR12A 1224647 617302638

Robin T Laabs
1000 S 108th St Lot C17
West Allis WI 53214-2496

Account Information

Guarantor Name: LAABS,ROBIN T
Guarantor Account Number: 299101

Guarantor Account Summary

Total Amount Owed	**$3,996.00**

Charge, payment, and adjustment detail can be found starting on Page 3

Payment Plan Information

Monthly Amount:	*$0.00*
Payment Plan Balance:	*$0.00*
Overdue:	*$0.00*

Payment Plan Amount Due	**$0.00**
Amount Due not on Payment Plan	**$3,996.00**
Amount Due	**$3,996.00**

Thank you for choosing **Aurora Health Care** for your health care needs!

Prepping for tax season?

Submitting medical expenses for your Flex Spending Account (FSA)?

We can help.

Get payment summaries and more at: **Aurora.org/TaxFlex**

Customer Care

- Please contact us for questions, or to discuss a possible payment plan or financial assistance based on need.
- Para español favor llamara a (866) 629-6033

Hours: Monday - Thursday 7:30am - 6:00pm, Friday 7:30am - 5:00pm

Contact us: **(800) 326-2250**
customerservice@aurora.org

Aurora Health Care®

Statement Date
1/20/2019

Account	Acct #	Date Due
LAABS,ROBIN T	**299101**	**2/2/2019**

Amount Due
$3,996.00

Amount I am Paying
$

Make check payable to **Aurora Health Care**

AURORA HEALTH CARE
PO Box 809418
Chicago IL 60680-9418

Select One: ☐ Payment Enclosed or Choose Card Below:

☐ VISA ☐ MasterCard ☐ DISCOVER ☐ AMERICAN EXPRESS

Card # _____
Exp. Date _____
Print Cardholder's Name _____
Signature _____

000001063275 012019 0000299101 0000399600 8

014561

Detail of Previous Services

Date of Service	Description	Charges	Payments/ Adjustments	Balance Due
Patient Name: LAABS,ROBIN T		Provider: MUSSAK, ERICH N		
11/15/18	168649779	Location: AURORA ADVANCED HEALTHCARE NEW BERLIN CLINIC		
11/15/18	CT 3D RENDERING	198.00		
11/15/18	LOW OSMOLAR CONT 300 to 399 MG ML IODINE PER ML (qty: 150)	300.00		
11/15/18	CT ABDOMEN AND PELVIS W AND W/O CONTRAST	5,250.00		
12/11/18	United Healthcare Payments		0.00	
12/21/18	United Healthcare Adjustments		-5,730.00	
11/26/18	PREPAYMENT		-18.00	
	Patient Balance			**$0.00**
	Previous Services Balance Due			$0.00

Detail of New Activity

Thank you for choosing Aurora Health Care. We appreciate your prompt payment.

Date of Service	Description	Charges	Payments/ Adjustments	Balance Due
Patient Name: LAABS,ROBIN T		Provider: MCDONALD, MARK C		
09/13/18	166681582	Location: AURORA ADVANCED HEALTHCARE NEW BERLIN CLINIC		
09/13/18	UA W/OUT MICRO UROLOGY ONLY	29.00		
09/13/18	CULTURE, BACTERIAL; QUANTITATIVE C	77.00		
09/13/18	INJ IM SQ THERAPEUTIC PROPHYLACTIC DIAGNOS	90.00		
09/13/18	URINE BACTERIAL CULTURE ID	72.00		
09/13/18	ANTIBIOTIC SENSITIVITY,MIC,EAC (qty: 2)	146.00		
09/13/18	OFFICE/OUTPT VISIT	374.00		
09/13/18	CEFTRIAXONE SODIUM PER 250MG (qty: 4)	36.00		
09/13/18	PATIENT PAYMENT		-25.00	
	Patient Balance			**$799.00**
Patient Name: LAABS,ROBIN T		Provider: BAHR, JEFFREY K		
09/13/18	166682056	Location: AURORA ADVANCED HEALTHCARE ACL NEW BERLIN		
09/13/18	INFLUENZA A & B (qty: 2)	156.00		
	Patient Balance			**$156.00**
Patient Name: LAABS,ROBIN T		Provider: SHIGRI, NAZIA		
09/14/18	166716526	Location: AURORA ADVANCED HEALTHCARE NEW BERLIN CLINIC		
09/14/18	OFFICE/OUTPT VISIT	252.00		
09/14/18	PATIENT PAYMENT		-25.00	
	Patient Balance			**$227.00**
Patient Name: LAABS,ROBIN T		Provider: MCDONALD, MARK C		
09/22/18	166968962	Location: AURORA ADVANCED HEALTHCARE NEW BERLIN CLINIC		
09/22/18	UA W/OUT MICRO UROLOGY ONLY	29.00		
09/22/18	OFFICE/OUTPT VISIT	374.00		
09/22/18	PATIENT PAYMENT		-25.00	
	Patient Balance			**$378.00**

Date of Service	Description	Charges	Payments/ Adjustments	Balance Due
Patient Name: LAABS,ROBIN T		Provider: BAHR, JEFFREY K		
09/22/18	166969278	Location: ACL LABORATORIES		
09/22/18	CULTURE, BACTERIAL; QUANTITATIVE C	77.00		
09/22/18	URINE BACTERIAL CULTURE ID	72.00		
	Patient Balance			$149.00
Patient Name: LAABS,ROBIN T		Provider: MARQUART, MICHAEL J		
09/22/18	166969317	Location: AURORA ADVANCED HEALTHCARE NEW BERLIN CLINIC		
09/22/18	XRAY ABDOMEN 2 VIEWS	302.00		
	Patient Balance			$302.00
Patient Name: LAABS,ROBIN T		Provider: BAHR, JEFFREY K		
09/22/18	167268226	Location: AURORA MEDICAL GROUP EDGERTON		
09/22/18	COMPREHENSIVE METABOLIC PANEL	111.00		
09/22/18	VENIPUNCTURE	30.00		
09/22/18	AUTO HEMOGRAM/PLATE/DIFF	68.00		
	Patient Balance			$209.00
Patient Name: LAABS,ROBIN T		Provider: WAPLES, MARK J		
10/01/18	167239879	Location: AURORA MEDICAL GROUP ST LUKE'S MEDICAL OFFICE BLDG		
10/01/18	CULTURE, BACTERIAL; QUANTITATIVE C	77.00		
10/01/18	OFFICE/OUTPT VISIT	252.00		
10/01/18	PATIENT PAYMENT		-25.00	
	Patient Balance			$304.00
Patient Name: LAABS,ROBIN T				2524.00
11/28/18	169094032	Location: AHCM St Lukes Urology Center		
	PHARMACY - GENERAL CLASSIFICATION	1,436.12		
	MEDICAL/SURGICAL SUPPLIES AND DEVICES - GENERAL CLASSIFICATION	2,816.08		
	LABORATORY - GENERAL CLASSIFICATION	249.00		
	OPERATING ROOM SERVICES - GENERAL CLASSIFICATION	8,560.00		
	ANESTHESIA - GENERAL CLASSIFICATION	2,066.00		
	RECOVERY ROOM - GENERAL CLASSIFICATION	2,480.00		
12/28/18	United Healthcare Payments		-8,143.00	
12/28/18	United Healthcare Adjustments		-7,982.20	
01/08/19	PATIENT PAYMENT		-10.00	
	Patient Balance			$1,472.00
	New Activity Balance Due			$3,996.00

Total Amount Owed to Aurora (As of this Statement)	**$3,996.00**

Northern District of Illinois
Claims Register

18-30052 KLS Acquisition Corp.

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

Creditor: (27485282) Robin T Laabs 1000 s 108th Street C17 West Allis, WI 53214-2496	**Claim No: 80** *Original Filed Date*: 01/28/2019 *Original Entered Date*: 01/28/2019	*Status:* *Filed by:* CR *Entered by:* EPoc ADI *Modified:*

Amount claimed: $2524.00

History:

Details 80-1 01/28/2019 Claim #80 filed by Robin T Laabs, Amount claimed: $2524.00 (ADI, EPoc)

Description:

Remarks:

Claims Register Summary

Case Name: KLS Acquisition Corp.
Case Number: 18-30052
Chapter: 11
Date Filed: 10/25/2018
Total Number Of Claims: 1

Total Amount Claimed*	$2524.00
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		
Administrative		