FORM B10 (Official Form 10)

UNITED STATES BANKRUPTCY COURT
NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

PROOF OF CLAIM
Chapter 11

In Re Kmart Corporation, et. al.	Case Numbers 02-B02474 through 02-B02498

Your claim is scheduled as follows:

Class

Amount

Name of Debtor: (see attached for complete list of debtors)
Kmart Corporation

Case Number:
Chapter 11 - 02B02474

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):
Fla - Hospital - Apopka, Fl. 32703

Mattie Kent
doctor - 1
medicine

- ☐ 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.

If address differs from above, please complete the following:
Creditor Name:

Telephone: #

Address:

City/St/Zip:

This Space is for Court Use Only

Account or other number by which creditor identifies debtor:

Check here if this claim ☐ replaces ☐ 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 #: [redacted]
  Unpaid compensation for services performed
  from _____ (date) to _____ (date)

2. Date debt was incurred:

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 $4,650), 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 $ 2,100 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)(__).

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.

This Space is for Court Use Only
855 SM
RECEIVED
TRUMBULL SERVICES COMPANY
3-26-02
2002 MAR 26 PM 2:37
BANKRUPTCY

Date	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):
3-17-02	Mattie Kent Mattie Kent

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.

NOTICE

The preceding page is a copy of the creditor's proof of claim, with the Social Security number redacted for privacy.

Following this notice is the original (non-redacted) proof of claim.

TRUMBULL SERVICES, LLC

FORM B10 (Official Form 10)

UNITED STATES BANKRUPTCY COURT
NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

PROOF OF CLAIM
Chapter 11

In Re Kmart Corporation, et. al.	**Case Numbers 02-B02474 through 02-B02498**
Name of Debtor: (see attached for complete list of debtors) Kmart Corporation	**Case Number:** Chapter 11 - 02B02474

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.

Your claim is scheduled as follows:

Class

Amount

Name of Creditor (The person or other entity to whom the debtor owes money or property):
Fla - Hospital - Apopka Fl. 32703

Mattie Kent
doctor - +
medicine

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Telephone: #

Address:

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Account or other number by which creditor identifies debtor:

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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 #: 264-88-6440
  Unpaid compensation for services performed
  from _____ (date) to _____ (date)

2. Date debt was incurred:

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.
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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 $ _____
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- ☐ Contributions to an employee benefit plan – 11 U.S.C. §507(a)(4).
- ☐ Up to $ 2,100 of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 11 U.S.C. § 507(a)(6).
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Date	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):
3-17-02	Mattie Kent Mattie Kent

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.

FLORIDA HOSPITAL

FLORIDA HOSP / APOPKA
201 N. PARK AVENUE
APOPKA FL 32703
(407) 303-0500

IRS NO. 590724459N

A NON-PROFIT HOSPITAL LICENSED BY THE STATE

INSURANCE BENEFITS ARE ESTIMATES ONLY AND ARE NOT NECESSARILY FINAL

GUARANTOR

MATTIE M KENT
4220 RUNDLE RD
ORLANDO FL 328102814

PLEASE: REFER TO ACCOUNT NUMBER ON ALL CORRESPONDENCE & PAYMENTS

ACCOUNT NUMBER 10069207

PATIENT NAME	KENT, MATTIE M
PATIENT ADDRESS	4220 RUNDLE RD
INSURANCE COMPANY	SEDGEWICH CLAIM MGMT SVC
INS POLICY	264886440
EMPLOYER NAME	UNEMPLOYED
ADMISSION	01/19/02 03:23 PM
DISCHARGE	01/19/02 05:15 PM

TOTAL DAYS 1

PAGE 1 OF 1 PAGES

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

AMOUNT ENCLOSED $

REFERENCE NUMBER	INSUR CATEGORY	DESCRIPTION OF SERVICE	QUANTITY	UNIT	TOTAL AMOUNT	MAXIMUM ESTIMATED COVERAGE
		01/19/02				
73000079	252	TET DIPHTH TOX 0.5ML	1	26.35	26.35	
72103142	320	FINGER(S)-RT	1	116.00	116.00	
57802528	450	LEVEL 3 ED EMERGENCY	1	277.00	277.00	
57805306	450	INJECTION MEDS	1	53.00	53.00	
		TOTALS FOR 01/19/02			472.35	
		TOTAL CHARGES			472.35	

This was put on my ins, so Pt not owes AEtna this.

935-209 (10-90)

GPD-054116

THE RESPONSIBILITY OF THIS BILL RESTS WITH THE GUARANTOR

FINAL DIAGNOSIS
SURGICAL PROCEDURE

MRI 050750 PAYR 2IL SAT 03 C2204162 PJBB60 HOSPITAL REPRESENTATIVE/DATE

Robert

Kmart Customer Incident Information

Store Stamp

Dear Kmart Customer,

We want you to have a positive experience every time you visit our store. If you have experienced an accident or loss of any kind while visiting us, please provide the information requested below. This information will help us meet our goal of continuous improvement in the operation of our store. It will also help us in contacting you to make sure we are providing the service you expect.

Please take the white copy of this document for your records. If after leaving the store you wish to provide further information or have any questions about your incident, please call our Store Team Manager.

We are sorry you had an unpleasant experience while our guest. We look forward to serving you better in the future.

Sincerely,

Your Kmart Store Management **Store Phone Number:** 407-644-8188

TO BE COMPLETED BY CUSTOMER:

Customer name: MATTIE KENT Customer's Street Address: 4220 RUNDLE RD

City: ORLANDO State: FL Zip: 32810 Phone: 407-299-3458

Customer's employer: Customer's sex: F

Customer's Date of Birth: 8/9/46 Customer's Social Security Number: 264-88-6440

If injury to a child: Child's name: N/A Child's age: N/A Parent's name: N/A

Customer's Description of Incident:

Date of incident: 1/20/02 Location of incident: FRONT END

Time of incident: 12:20 What happened?

CUSTOMER WENT TO RETRIEVE A PIECE OF CLOTHING FROM A SALESRACK AND A STAPLE THAT WAS IN THE CLOTHING PIERCED HER MIDDLE FINGER of her RIGHT HAND. STAPLE WAS REMOVED AND BAND-AID AND OINTMENT PUT ON

Do you wish to be contacted? Date reported: Signature of Customer:

White copy - for Customer

code (37) 094-4699-115 Rev 2/01 25/PK

This is the copy of letter that Robert wrote as you can see I did not even sign it.

KENT, MATTIE

Rx#: 7163394
Date: 01/19/2002

If you have any questions, please feel free to contact WESLEY KWAN at (407) 889-7707 or Dr. FLORIDA HOSPITAL APO at (407) 889-2566

IF YOU HAVE CONCERNS ABOUT TAKING THE MEDICATION BELOW, PLEASE CONTACT YOUR PHARMACIST OR PHYSICIAN IMMEDIATELY.

WAL*MART® PHARMACY

(407) 889-7707
RPh-WESLEY KWAN
FLORIDA HOSPITAL APOPKA

Directions: TAKE ONE CAPSULE BY MOUTH THREE TIMES A DAY

CEPHALEXIN 500MG CAP TEVA

CEPHALEXIN (sef-a-LEX-in)

COMMON USES: This medicine is a cephalosporin antibiotic used to treat bacterial infections.

HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. This medicine may be taken on an empty stomach or with food. STORE THIS MEDICINE at room temperature, away from heat and light. TO CLEAR UP YOUR INFECTION COMPLETELY, continue taking this medicine for the full course of treatment even if you feel better in a few days. Do not miss any doses. IF YOU MISS A DOSE OF THIS MEDICINE, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do not take 2 doses at once.

CAUTIONS: IF YOU HAVE HAD A SEVERE ALLERGIC REACTION to a cephalosporin antibiotic (such as Ceclor, Keflex, Ceftin, Duricef) or a penicillin antibiotic (such as amoxicillin, ampicillin), contact your doctor or pharmacist BEFORE TAKING THIS MEDICINE. A severe reaction includes a severe rash, hives, *breathing difficulties*, or dizziness. If you have a question about whether you are allergic to this medicine or if a certain medicine is a cephalosporin, contact your doctor or pharmacist. IF YOU EXPERIENCE difficulty breathing or tightness of chest, swelling of eyelids, face, or lips; or develop a rash or hives, tell your doctor immediately. Do not take any more of this medicine unless your doctor tells you to do so. If your symptoms do not improve within a few days or if they become worse, check with your doctor. IF MODERATE TO SEVERE DIARRHEA OCCURS during or after treatment with this medicine, check with your doctor or pharmacist. Do not treat it with non-prescription (over-the-counter) medicines. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. IF YOU HAVE DIABETES, this medicine may cause false test results with some urine glucose tests. Check with your doctor before you adjust the dose of your diabetes medicine or change your diet.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS that may go away during treatment include nausea, vomiting, or mild diarrhea. If they continue or are bothersome, check with your doctor. CHECK WITH YOUR DOCTOR AS SOON AS POSSIBLE if you experience skin rash, hives, or vaginal irritation or discharge. If you notice other effects not listed above, contact your doctor, nurse, or pharmacist.

BEFORE USING THIS MEDICINE: INFORM YOUR DOCTOR OR PHARMACIST of all prescription and over-the-counter medicine that you are taking. Inform your doctor of any other medical conditions, allergies, pregnancy, or breast-feeding.

OVERDOSE: If overdose is suspected, contact your local poison control center or emergency room immediately. Symptoms of overdose may include muscle spasms and seizures.

WAL*MART® PHARMACY (407) 889-7707 10-0955
1700 S ORANGE BLOSSOM TRAIL
APOPKA, FL 32703
RECEIPT

KENT, MATTIE 01/19/2002 KENTMA2
4220 RUNDLE RD AET
ORLANDO FL 32818 NEW COPAY
(407) 299-3458
RX:*7163394 TX: 2221529 DAW: 0 $10.00
CEPHALEXIN 500MG CAP TEVA
NDC: 00093-3147-05 QTY: 21 DS: 7
TEVA USA REFILLS: 0
FLORIDA HOSPITAL APOPKA
NABP: 1054294
TP Ref #: 02101148031845
$15.62

WAL*MART® PHARMACY (407) 889-7707 10-0955
1700 S ORANGE BLOSSOM TRAIL
APOPKA, FL 32703
RECEIPT

KENT, MATTIE 01/19/2002
4220 RUNDLE RD AET
ORLANDO FL 32818 NEW COPAY
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RX:*7163394 TX: 2221529 DAW: 0 $10.00
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FLORIDA HOSPITAL APOPKA
NABP: 1054294

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Rx#: 7163395
Date: 01/19/2002

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IF YOU HAVE CONCERNS ABOUT TAKING THE MEDICATION BELOW, PLEASE CONTACT YOUR PHARMACIST OR PHYSICIAN IMMEDIATELY.

WAL★MART® PHARMACY
(407) 889-7707
RPh-WESLEY KWAN
FLORIDA HOSPITAL APOPKA

Directions: TAKE ONE TABLET BY MOUTH THREE TIMES DAILY AS NEEDED FOR PAIN

IBUPROFEN 800MG TAB GREE

IBUPROFEN (eye-byoo-PROE-fen)

COMMON USES: This medicine is a nonsteroidal anti-inflammatory drug (NSAID) used to relieve the symptoms of arthritis. It is also used to relieve pain and to treat other conditions as determined by your doctor.

HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. TAKE THIS MEDICINE with food and a glass of water or with milk. STORE THIS MEDICINE at room temperature, away from heat and light. IF YOU MISS A DOSE OF THIS MEDICINE, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do not take 2 doses at once.

CAUTIONS: DO NOT TAKE THIS MEDICINE if you ever had any unusual or allergic reaction to aspirin, ibuprofen, naproxen, or any other medicine used to treat pain, fever, swelling, or arthritis. DO NOT DRIVE, OPERATE MACHINERY, OR DO ANYTHING ELSE THAT COULD BE DANGEROUS until you know how you react to this medicine. Using this medicine alone, with other medicines, or with alcohol may lessen your ability to drive or to perform other potentially dangerous tasks. ALCOHOL WARNING: If you consume 3 or more alcoholic drinks every day, ask your doctor whether you should take this medicine or other pain relievers/fever reducers. This medicine may cause stomach bleeding. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. This includes *any medicine which contains aspirin* or other non-prescription pain relievers. FOR WOMEN: USE OF THIS MEDICINE DURING PREGNANCY has resulted in fetal and newborn death. If you think you may be pregnant, contact your doctor immediately. THIS MEDICINE IS EXCRETED IN BREAST MILK. IF YOU ARE OR WILL BE BREAST-FEEDING while you are using this medicine, check with your doctor or pharmacist to discuss the risks to your baby.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS, that may go away during treatment, include nausea, vomiting, diarrhea, gas, constipation, indigestion, dizziness, lightheadedness, drowsiness, or headache. If they continue or are bothersome, check with your doctor. CHECK WITH YOUR DOCTOR AS SOON AS POSSIBLE if you experience swelling of hands or ankles, ringing in ears, rash, itching. CONTACT YOUR DOCTOR IMMEDIATELY if you experience swelling of hands, face, lips, eyes, throat, or tongue; difficulty swallowing or breathing; or hoarseness. CONTACT YOUR DOCTOR IMMEDIATELY AND STOP TAKING THIS MEDICINE if you notice any of the following unlikely but very serious side effects: black stools, persistent stomach/abdominal pain, vomit that looks like coffee grounds. If you notice other effects not listed above, contact your doctor, nurse, or pharmacist.

BEFORE USING THIS MEDICINE: Some medicines or medical conditions may interact with this medicine. INFORM YOUR DOCTOR OR PHARMACIST of all prescription and over-the-counter medicine that you are taking. DO NOT TAKE THIS MEDICINE if you are also taking heparins or tacrolimus. ADDITIONAL MONITORING OF YOUR DOSE OR CONDITION may be needed if you are taking aminoglycoside antibiotics, anticoagulants, cyclosporine, lithium, or methotrexate. Inform your doctor of any other medical conditions, allergies, pregnancy, or breast-feeding. Contact your doctor or pharmacist if you have any questions or concerns about taking this medicine.

OVERDOSE: If overdose is suspected, contact your local poison control center or emergency room

Continued...

WAL★MART® PHARMACY (407) 889-7707 10-0955
1700 S ORANGE BLOSSOM TRAIL
APOPKA, FL 32703
RECEIPT

KENT, MATTIE 01/19/2002 KENTMA2
4220 RUNDLE RD AET
ORLANDO FL 32818 NEW
(407) 299-3458 COPAY
RX:*7163395 TX: 2221530 DAW: 0
IBUPROFEN 800MG TAB GREE $10.00
NDC: 59762-7380-02 QTY: 21 DS: 7
UPJOHN REFILLS: 0
FLORIDA HOSPITAL APOPKA
NABP: 1054294
TP Ref #: 02101148035236
$10.54 Page No: 1

WAL★MART® PHARMACY (407) 889-7707 10-0955
1700 S ORANGE BLOSSOM TRAIL
APOPKA, FL 32703
RECEIPT

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4220 RUNDLE RD AET
ORLANDO FL 32818 NEW
(407) 299-3458 COPAY
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NDC: 59762-7380-02 QTY: 21 DS: 7
UPJOHN REFILLS: 0
FLORIDA HOSPITAL APOPKA
NABP: 1054294

I pay copay
INS pay the rest

PARK AVENUE MEDICAL CENTER
202 NORTH PARK AVENUE
APOPKA, FLORIDA 32703 407-889-4711

RAHN L. SHAW MD, PA
ROBERTO S. PEREZ MD
SANDRA LAREAU, MMSc, PA-C TAX ID 59-2696120

DIAGNOSIS	CODE	DIAGNOSIS	CODE	DIAGNOSIS	CODE	DIAGNOSIS	CODE
Abdominal Pain Unspecified	789.07	Conjunctivitis		Influenza	487.1		
Abnormal Bleeding	626.8	DJD-Degenerative Joint Disease	715.00	Irritable Bowel Syndrome	564.1		
Acne	706.1	Diverticulosis	562.1	Low Back Pain	724.2		
Allergic Rhinitis		Diabetes Controlled	250.03	Lower Respiratory			
Amenorrhea		Diabetes Mellitus NDDM	250.02	Migraine Headache	346.9		
Anemia	285.9	Diabetes Mellitus IDDM	250.01	Nausea & Vomiting	787.01		
Anemia due to blood loss	280	Edema	782.3	Otitis Externa			
Anxiety	300	Eczema	692.9	Otitis Media	382.9		
Arrythmyia, Cardiac	427	Fatigue / Malaise	780.7	Pneumonia	486		
Arteriosclerotic Heart Disease	414	Gastroenteritis		Rectal Bleeding	569.3		
Arthritis Unknown		GI Bleed	578.9	Sinusitis- Acute	461.9		
Asthma	493.9	Hypertriglyceridemia	272.1	Syncope	780.2		
Atrial Fibrillation	427.31	Hypoglycemia	251.2	Sciatica	724.3		
Breast Mass or Lump	611.72	Hemmorrhoids	455	TIA-Transient Ischemic Attack	435.9		
Bronchitis - Acute	466	Headache, Tension	307.81	Tobacco Abuse			
Cellulitis/Abcess	682.9	Hematuria	599.7	Tonsilitis	463		
Chest Pain	786.5	Hyperlipidemia	272.0	Upper Respiratory Infection	487.1		
Chronic Obstructive Pulmonary	496	Hypertension	401.1	Urinary Tract Infection	599		
Congestive Heart Failure	428.0			Vaginitis	616.1		
				Viral Syndrome	079.9		

PROCEDURES	CODE	PROCEDURES	CODE	PROCEDURES	CODE	PROCEDURES	CODE
E&M VISITS		INJECTIONS		SURGERY		MISCELLANEOUS	
New, Focused	99201	Varicella (Chicken pox) Vaccine	90716	Benign Lesion	17000	Flexsigmoidoscopy	45330
New, Expanded	99202	Tetanus & Diptheria Toxoids Adult	90718	Benign Lesion	17003	Fasting Blood Sugar	82962
New, Detailed	99203	Hepatitis A	90730	Benign Lesion, 15 & up	17004	Random Blood Sugar	82962
Estab, Minimal	99211	Pneumococcal Vaccine	90732	Excision Benign Lesion		Urinalysis	81002
Establ, Focused	99212	Hep B Immunization, 0-11 yrs	90744	Size		H Pylori Quick View	83014
Establ, Expanded	99213	Hep B Immunization, 11-19 yrs	90745	Location		H Pylori Breath Test	83014
Establ, Detailed	99214	Hep B Immunization, 20 and up	90746	Excision Malignant Lesion			
Hosp Consult	99254	Rocephin	J0696	Size/Location			
Hosp Subseq	99233	Testosterone	J3130	I&D Cyst Simple	10060		
Confirm Cconsult	99273	Flu Vaccine	90659	I&D Cyst Complicated	10061		
NH New/Establ	99313	DTaP/HIB	90721	Ingrown Toenail	11750		
Rest Home, New	99323	Estrogen	J1410	Laceration Repair			
Rest Home, Establ	99333	Depoprovera	J1055	Size			
Postop Care	99024	Depo Med 80mg	J1040	Location			
OFFICE PROCEDURES		TB PPD	86580	Skin Tags ^15	11200		
EKG W/Interpretation	93000	Phenergan	J2550	Circumcision	54150		
24 HR Holter Monitor	93230	Prevnar	90669	Biopsy	11100	MODIFIERS	
Ear Irrigation	69210			Arthrocentesis, Small	20600	Unusual Procedure Service	22
				Arthrocentesis, Medium	20605	Sep E&M during postop	24
INJECTIONS				Arthrocentesis, Major	20610	Oth Signif E&M Service	25
Allergy	95115					Professional Component	26
B12	J3420			PREVENTATIVE (new)		Bilateral Procedures	50
DTP	90701			UNDER 1 yr 99391	99381	Multiple Procedures	51
DT	90702			1-4 years 99392	99382	Reduced Services	52
Tetanus Toxoid	90703			5-11 Years 99393	99383	Decision fro Surgery	57
MMR Live	90707			12-17 Years 99394	99384	Rel Proc during postop	58
Poliomyelitis Vaccine Injection	90713			18-30 Years 99395	99385	Sep Proc same day	59
				40-54 Years 99396	99386	Repeat Procedure	76
				55 & Over 99397	99387	Return to OR	78
						Unrel Proc during Postop	79
						Assistant Surgeon	80
						Advanced Notice	GA

PRIOR BALANCE	
TODAY'S CHARGE	
ADJUSTMENTS	
PAYMENT	
BALANCE DUE	

ADVANCE NOTICE REQUIREMENT
I understand that Medicare or my insurance company may deny payment for the above service(s) due to frequency or lack of medical necessity, and I will assume full financial responsibility.

Patient Signature Date

ASSIGNMENT & RELEASE
I authorize the release of pertinent medical information to carriers and authorize my insurance benefits to be paid directly to the doctor, and I accept responsibility to pay for non-covered services.

Patient Signature Date

P33200 (Rev 12/01)

$10.00

Bill

Kmart Customer Incident Center
Sedgwick Claims Management Services, Inc.
P.O. Box 5058, Troy, MI 48007-5058
Phone: (248) 463-7577
Fax: (248) 463-6637

Edith

February 14, 2002

MATTIE KENT
4220 RUNDLE ROAD
ORLANDO FL 32810

RE:	Our Client:	Kmart Corporation
	Claimant:	MATTIE-KENT
	Date of Loss:	01/19/2002
	Our File Number:	200201067070001

Dear Claimant,

Sedgwick Claims Management Services, Inc. is the claims administrator for the Kmart Corporation. We are in receipt of your claim relative to the captioned matter. We are currently conducting an investigation in connection with your claim.

Please be advised the Kmart Corporation and its thirty-seven subsidiaries filed a Voluntary Petition, pursuant to Chapter 11 of the Bankruptcy Code, in the United States Bankruptcy Court for the Northern district of Illinois. The matter has been assigned case number 02-B02474 and is pending before Judge Susan Pierson Sonderby. Pursuant to 11 U.S.C. § 362 (a), a stay of creditor actions against the debtor automatically goes into effect with the filing of the bankruptcy petition. The automatic stay provided by section 362 prohibits "the commencement or continuation, including the issuance or employment of process, of a judicial, administrative, or other action or proceeding against the debtor..." Attached please find a copy of the Voluntary Petition.

As a result of that filing, we are precluded from negotiating or settling any claims on behalf of Kmart that arose out of incidents that occurred prior to January 22, 2002 until/unless we are authorized to do so. Such authorization may or may not be extended.

Should you have any questions, or wish to discuss this matter in any way, please do not hesitate to contact the undersigned at your convenience.

Sincerely,

Edith Smith

Edith Smith
Examiner I
Kmart Customer Incident Center

MAKE CHECKS PAYABLE TO:

FLORIDA EMERGENCY PHYSICIANS
Dept 1949, PO Box 628282
Orlando, FL 32862-8282

For Billing Questions call (407) 302-2277

IF PAYING BY MASTERCARD OR VISA, FILL OUT BELOW

CHECK CARD USING FOR PAYMENT ☐ MASTERCARD ☐ VISA

CARD NUMBER | AMOUNT

SIGNATURE | EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT #
02/19/02	168.00	46829

SHOW AMOUNT PAID HERE

REMIT TO:

2 - 831

MATTIE M KENT M050750
4220 RUNDLE RD
ORLANDO FL 32810-2814

FLORIDA EMERGENCY PHYSICIANS
Dept 1949, PO Box 628282
Orlando, FL 32862-8282

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	DESCRIPTION	CHARGES	MEDICARE RECEIPTS	INSURANCE RECEIPTS	PATIENT RECEIPTS	ADJUSTMENT	BALANCE	INS
01/19/02	E/M LEVEL 3	168.00	.00	.00	.00	.00	168.00	

this has been turn over
to my dr
AETna
BBDH72YB
Jimmy Kent 1-800-323-9930
GN.209383

** PAYMENT DUE UPON RECEIPT * THANK YOU **

To view your account information please visit: http://www.codingedge.com/fep

PATIENT DUE AMOUNT IS YOUR RESPONSIBILITY. PATIENT DUE AMOUNT REFLECTS ALL COPAYMENTS, DEDUCTIBLES, AND INSURANCE PAYMENTS RECEIVED TO DATE. PAYMENTS EXPECTED FROM INSURANCE ARE NOT INCLUDED IN THIS AMOUNT.

CURRENT	30-60	60-90	90-120	OVER 120	ACCT BAL	INS BILLED	PATIENT DUE
168.00	.00	.00	.00	.00	168.00	.00	168.00

THIS BILL REPRESENTS CHARGES FOR TREATMENT RENDERED BY THE EMERGENCY ROOM PHYSICIAN AT FLORIDA HOSPITAL.

LORIDA HOSPITAL

601 E. ROLLINS ST., ORLANDO, FLORIDA ..... (407) 303-1940
601 E. ALTAMONTE AVE., ALTAMONTE SPGS., FLORIDA ... (407) 303-2230
7727 LAKE UNDERHILL RD., ORLANDO, FLORIDA ..... (407) 281-2667
1201 N. PARK AVE., APOPKA, FLORIDA ..... (407) 889-1052
200 HILDA ST., KISSIMMEE, FLORIDA ..... (407) 933-6632
200 N. LAKEMONT, WINTER PARK, FLORIDA ..... (407) 646-7320
400 CELEBRATION PLACE, CELEBRATION, FLORIDA ..... (407) 303-4034

Mattie Kent

Follow-Up Instructions

Return to Emergency Immediately if condition worsens (i.e. pain, vomiting, bleeding, fever, difficulty breathing).

Make appointment for Follow-Up Care with:

Dr Perez

in _____ Days or ☐ As Needed. HMO / PPO Patients should contact their Primary Care Physician for approval prior to making an appointment with any specialist.

☐ Pick up X-Rays before appointment and take to physician.

☐ Copy of chart given to patient to take to physician.

☐ Call for Lab results in 72 hours if you had a culture.

☐ Do not drive or use machinery when on certain medications.

☐ Do not drive or use machinery while wearing eyepatch.

☐ When filling your prescription, inform Pharmacist of current medication and Allergies. Take Antibiotics until they are gone. Do not stop when symptoms improve.

You have been given written instructions for the following:

☐ _____

☐ Abdominal Pain	☒ Medications
☐ Burn	☐ PID
☐ Chest Pain	☐ Pneumonia
☐ Child / Fever	☐ Sprains or Fractures
☐ Crutch Walking	☐ Seizures
☐ Gastro Diet	☐ STD
☐ Head Injury	☒ Sutured Wound
☐ Kidney Stone	☐ Your Cast

X-Rays are read by the Emergency Physician. They will be reviewed by the Specialist (Radiologist). If there is a change in reading, efforts will be made to contact you or your doctor.

PATIENT ORIGINAL

Other Instructions

(1) BP- 154/112 Dam. Follow up with Dr Perez regarding ↑ BP (407-581-476)

(2) Rx - Keflex, as directed (c/m counter given)
Rx - Ibuprofen, as directed

(3) Follow up with Dr Perez re finger in 2-3 days

Do you have any religious / cultural practices that may alter your care or education? ☐ Yes ☐ No

Describe _____

Patient / other verbalizes understanding of Instructions ☐ Yes ☐ No

NURSE SIGNATURE

I HEREBY ACKNOWLEDGE RECEIPT OF THE INSTRUCTIONS ABOVE. I UNDERSTAND THAT I HAVE HAD EMERGENCY TREATMENT ONLY, AND THAT I MAY BE RELEASED BEFORE ALL MY MEDICAL CONDITIONS ARE KNOWN OR TREATED. I WILL ARRANGE FOR FOLLOW-UP CARE AS INSTRUCTED.

PATIENT'S SIGNATURE OR PERSON RECEIVING INSTRUCTIONS

Mattie Kent

PATIENT NAME | SEEN BY | DATE

MAY RETURN TO:

☐ Work ☐ Light Duty _____ Date ☐ Re-evaluate before returning
☐ P.E.
☐ School ☐ Full Duty _____ Date _____

PHYSICIAN SIGNATURE M.D./D.O.

This is were I went to doctor

Here is papers I got which I didn't understand on what to do.

VOLUNTARY PETITION

United States Bankruptcy Court Northern District of Illinois	VOLUNTARY PETITION
Name of Debtor (if individual, enter Last, First, Middle): KMART CORPORATION	Name of Joint Debtor (Spouse) (Last, First, Middle):
All Other Names used by Debtor in the last 6 years (include married, maiden, and trade names):	All Other Names used by Joint Debtor in the last 6 years (include married, maiden, and trade names):
Soc. Sec./Tax I.D. No. (if more than one, state all): 38-0729500	Soc. Sec./Tax I.D. No. (if more than one, state all):
Street Address of Debtor (No. & Street, City, State & Zip Code): 3100 West Big Beaver Road Troy, MI 48084	Street Address of Debtor (No. & Street, City, State & Zip Code):
County of Residence or of the Principal Place of Business: Oakland	County of Residence or of the Principal Place of Business:
Mailing Address of Debtor (if different from street address):	Mailing Address of Joint Debtor (if different from street address):
Location of Principal Assets of Business Debtor (if different from addresses listed above):	

INFORMATION REGARDING DEBTOR (Check the Applicable Boxes)

Venue (Check any applicable box)

- ☐ Debtor has been domiciled or has had a residence, principal place of business or principal assets in this District for 180 days immediately preceding the date of this petition or for a longer part of such 180 days than in any other District.
- ☒ There is a bankruptcy case concerning debtor's affiliate, general partner, or partnership pending in this District.

Type of Debtor (Check all boxes that apply)

- ☐ Individual
- ☒ Corporation
- ☐ Partnership
- ☐ Railroad
- ☐ Stockbroker
- ☐ Commodity Broker
- ☐ Other

Nature of Debts (Check one box)

- ☐ Consumer/Non-Business
- ☒ Business

Chapter or Section of Bankruptcy Code Under Which the Petition Is Filed (Check one box)

- ☐ Chapter 7
- ☒ Chapter 11
- ☐ Chapter 13
- ☐ Chapter 9
- ☐ Chapter 12
- ☐ Sec. 304-Case ancillary to foreign proceeding

Chapter 11 Small Business (Check all boxes that apply)

- ☐ Debtor is a small business as defined in 11 U.S.C. § 101.
- ☐ Debtor is and elects to be considered a small business under 11 U.S.C. § 1121(e). (optional)

Filing Fee (Check one box)

- ☒ Full Filing Fee attached.
- ☐ Filing Fee to be paid in installments (Applicable to individuals only)

Must attach signed application for the court's consideration certifying that the debtor is unable to pay fee except in installments. Rule 1006(b). See Official Form No. 3.

THIS SPACE IS FOR COURT USE ONLY

Statistical/Administrative Information(Estimates only)

- ☒ Debtor estimates that funds will be available for distribution to unsecured creditors.
- ☐ Debtor estimates that, after any exempt property is excluded and administrative expenses paid, there will be no funds available for distribution to unsecured creditors

Estimated Number of Creditors	1-15	16-49	50-99	100-199	200-999	1,000-over
	☐	☐	☐	☐	☐	☒

Estimated Assets						
$0 to $50,000	$50,001 to $100,000	$100,001 to $500,000	$500,001 to $1 million	$1,000,001 to $10 million	$10,000,001 to $50 million	$50,00 $100 m
☐	☐	☐	☐	☐	☐	

Estimated Debts						
$0 to $50,000	$50,001 to $100,000	$100,001 to $500,000	$500,001 to $1 million	$1,000,001 to $10 million	$10,000,001 to $50 million	$50,00 $100 m
☐	☐	☐	☐	☐	☐	

U.S. Bankruptcy Court
Northern District of Illinois
RECEIVED: 01/22/02
Time: 8:02 a.m.
Debtor: KMART CORPORATION
Case #: 02-02474
Chapter 11 Rec# 324660
Judge Susan Pierson Sonderby

1:02BK02474-BK001

VOLUNTARY PETITION *(This page must be completed and filed in every case)*	Name of Debtor(s): KMART CORPORATION	Form B1, Page 2
Prior Bankruptcy Case Filed Within Last 6 Years (If more than one, attach additional sheet)		
Location Where Filed: None	Case Number:	Date Filed:
Pending Bankruptcy Case Filed by Any Spouse, Partner, or Affiliate of this Debtor (If more than one, attach additional sheet)		
Name of Debtor: See Annex A	Case Number:	Date Filed:
District:	Relationship:	Judge:

SIGNATURES

Signature(s) of Debtor(s) (Individual/Joint)

I declare under penalty of perjury that the information provided in this petition is true and correct.
[If petitioner is an individual whose debts are primarily consumer debts and has chosen to file under chapter 7] I am aware that I may proceed under chapter 7, 11, 12 or 13 of title 11, United States Code, understand the relief available under each such chapter, and choose to proceed under chapter 7.
I request relief in accordance with the chapter of title 11, United States Code, specified in this petition.

Signature of Debtor

X
Signature of Joint Debtor

Telephone Number (If not represented by attorney)

Date

Signature of Debtor (Corporation/Partnership)

I declare under penalty of perjury that the information provided in this petition is true and correct, and that I have been authorized to file this petition on behalf of the debtor.

The debtor requests relief in accordance with the chapter of title 11, United States Code, specified in this petition.

Signature of Authorized Individual

Charles C. Conaway
Name of Authorized Individual

Chief Executive Officer
Title of Authorized Individual

January 22, 2002
Date

Signature of Attorney

Signature of Attorney for Debtor(s)

John Wm. Butler, Jr.
Printed Name of Attorney for Debtor(s)

Skadden, Arps, Slate, Meagher & Flom (Illinois)
Firm Name

333 W. Wacker Drive, Chicago, IL 60606
Address

(312) 407-0700
Telephone Number

January 22, 2002
Date

Signature of Non-Attorney Petition Preparer

I certify that I am a bankruptcy petition preparer as defined in 11 U.S.C. § 110, that I prepared this document for compensation, and that I have provided the debtor with a copy of this document.

Printed Name of Bankruptcy Petition Preparer

Social Security Number

Address

Names and Social Security numbers of all other individuals who prepared or assisted in preparing this document:

If more than one person prepared this document, attach additional sheets conforming to the appropriate official form for each person.

Signature of Bankruptcy Petition Preparer

Date

A bankruptcy petition preparer's failure to comply with the provisions of title 11 and the Federal Rules of Bankruptcy Procedure may result in fines or imprisonment or both 11 U.S.C. § 110; 18 U.S.C. § 156.

EXHIBIT A

(To be completed if debtor is required to file periodic reports (e.g., forms 10K and 10Q) with the Securities and Exchange Commission pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 and is requesting relief under chapter 11)

☒ Exhibit A is attached and made a part of this petition.

EXHIBIT B

(To be completed if debtor is an individual whose debts are primarily consumer debts)

I, the attorney for the petitioner named in the foregoing petition, declare that I have informed the petitioner that [he or she] may proceed under chapter 7, 11, 12, or 13 of title 11, United States Code, and have explained the relief available under each such chapter.

X
Signature of Attorney for Debtor(s) Date

I Mattie Kent went to Kmart on
10-93 1-19-02

I went to remove a skirt off
the sales rack a staple went through
my middle finger three was more than one on skirt
pull it out But it hurt to much so there
was a lady & Man there shoping also, I
did not know them, but they saw
what happen.

A girl came over first she
try to remove the staple but she went
and got Robert, he cut the staple.
from the tag, then I thought I was
going to pass out, the lady Debbie told
someone to get me some water & a cold towel,
Then Robert pull the staple out of my
finger I did not let him to do that, he should
have left that for the doctor to do Debbie Parker
& her husband heard & saw everything. Robert
done & go to Central Care but they would not
take me so then Robert told my husband to
take me to Ft. Hospital in Apopka they
gave me a shot, did x-rays, then I had to go to
my doctor that Monday pay $100 copay then I went
and pay $20.00 for Medicine copay, DNS pay the rest.

now the bills are coming to me,
so here is all the papers & bills
that I have on this case.
I think Kmart is reasonable for
this.
They should pay my loss book also
pay me for my bills that I pay also
I will have to pay a copy for the E.R.
Plus pain, also I lost
$100.00 because I didn't get to go and
clean a house. So for my pain, medicine
doctor, & hospital copy I will have to pay, I
should get at least $300.00, for myself.
Kmart will have to
pay my loss back. Bills have been sent to them

AETNA HMO
P.O Box 1125
Blue Bell, PA. 19422
Jimmy Kent
G.N. 209383
1-800-323-9930

One bill is
$168.00
One bill is
$472.35

Mattie Kent
3-18-02