FORM B10 (Official Form 10)

4041915

UNITED STATES BANKRUPTCY COURT
NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

PROOF OF CLAIM
Chapter 11

In Re Kmart Corporation, et al.

Case Numbers 02-02462 through 02-02499

Your claim is scheduled as follows:

Class

UNSECURED NON PRIORITY

Amount

CONTINGENT, DISPUTED, UNLIQUIDATED

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

Kmart Corp. Tax ID 38-0729500

Case Number:

02 ~~B~~02474

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):

My File# 20011299932

11 2381091

THOMAS, IDA
54 S W TIMBER TRAIL
STUART, FL 34997

☐ 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. Currently 1 notice

☐ 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:

Address:

City/St/Zip:

Telephone: # ~~561~~ 772-287-1807

10088542

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 #: ____________
Unpaid compensation for services performed from ________ (date) to ________ (date)

2. Date debt was incurred: 12-26/27-2001

3. If court judgment, date obtained:

4. Total Amount of Claim at Time Case Filed: $ 698.00

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

CL 4877

4-12-02

Date: 4-4-02

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):

Ida M. Thomas

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.

Computer Credit, Inc.

CLAIM DEPT 03450 . 640 West Fourth Street . Post Office Box 5238 . Winston-Salem, NC . 27113-5238

April 04, 2002

019 00 CH1 3459
Ida M Thomas
541 SW Timber Trl
Stuart, FL 34997-6266

CREDITOR **Martin Memorial Health Systems**

Telephone: (561) 223-5680
Attention: Patient Financial Services

ACCOUNT **NUMBER: M1708651**
AMOUNT DUE: $425.00

Dear Ida M Thomas:

PLEASE SEE IMPORTANT NOTICE ON BACK

This letter will serve to inform you that your overdue balance with Martin Memorial Health Systems has been referred to Computer Credit, Inc., a debt collector (referred to in this letter as CCI). The hospital insists on payment. CCI is not aware of any reason for your nonpayment, therefore we expect you to pay the balance due. The law prohibits CCI from collecting any amount greater than the obligation stated above.

Unless you notify CCI to the contrary, we will assume the amount due is correct. This letter is sent to you in an attempt to collect this debt. Any information obtained will be used for that purpose. If there is no need to further delay payment, then pay the balance due and resolve this obligation. Payment can be sent directly to the hospital.

C. W. Jordan

C. W. Jordan
Director of Operations

Computer Credit, Inc. is a debt collector and a member of the American Collectors Association.

RETURN THIS PORTION WITH YOUR PAYMENT

CREDIT CARD INFORMATION

☐Visa ☐Mastercard ☐Discover ☐American Express

EXPIRATION DATE ☐☐ - ☐☐

CARD NUMBER

SIGNATURE $ AMOUNT CHARGED

Computer Credit, Inc.
CLAIM NUMBER: 03450-M1708651

H1 Z•3666 3459

ACCT. NAME: **Ida M Thomas**

ACCT. NO: **M1708651**

AMT. DUE: **$425.00**

You may make check payable to:

Martin Memorial Health Systems
Post Office Box 9033
Stuart, FL 34995-9033

STATEMENT OF ACCOUNT

MARTIN MEMORIAL *Health Systems, Inc.*

A family of services serving your family.

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS

CARD NUMBER	AMOUNT
SIGNATURE	EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT #
02/05/02	$ 425.00	M1708651

Page - 1 | SHOW AMOUNT PAID HERE $

ADDRESSEE:

***********AUTO**5-DIGIT 34997
IDA M THOMAS M1708651
541 SW TIMBER TRL
STUART FL 34997-6266

REMIT TO:

Martin Memorial Medical Center
Martin Memorial Hospital South
P. O. Box 9033
Stuart, FL 34995

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

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

PATIENT NAME	SERVICE DATE(S)	PATIENT ACCOUNT #
IDA M THOMAS	12/26/01 12/26/01	M1708651

DATE	TRANSACTION	AMOUNT
12/26/01	2.10732 RT FOOT,COMPL,MIN 3 VIEWS - RIGHT	210.00
12/26/01	2.01992 ER LEVEL2 - LOW COMPLEXITY	215.00
	Charges to date:	425.00
	Estimated insurance due:	0

WE HAVE NOT RECEIVED A PAYMENT FROM YOU. THIS BALANCE IS DUE NOW. PLEASE CONTACT OUR OFFICE TO MAKE PAYMENT ARRANGEMENTS. YOU MAY CALL US AT 561-223-5680 OR YOU MAY EMAIL US AT BILLING@MMHS-FLA.ORG

THANK YOU

TOTAL BALANCE DUE - 425.00

Martin Memorial Medical Center
Martin Memorial Hospital South
P. O. Box 9033
Stuart, FL 34995 Phone: 561-223-5680
Office Hours: Mon-Fri 9:00am to 5:00pm

NOTICE: Payments and charges received after statement date will be reflected on next statement.

Please Pay THIS AMOUNT ▶▶▶▶▶▶▶▶ 425.00

CC

MAKE CHECKS PAYABLE TO:

DIAGNOSTIC IMAGING SERVICES
919 Central Parkway
P.O. Box 4
Stuart, FL 34995-0004
IRS #65-0044211

K mart

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	ACCT. #
1/10/02	33.00	176890

SHOW AMOUNT PAID HERE $

ADDRESSEE:

IDA M THOMAS
541 SW TIMBER TRL
STUART FL 34997-6266

REMIT TO:

DIAGNOSTIC IMAGING SERVICES
PO BOX 4
STUART, FL 34995

561 220-1391

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

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE OF SERVICE	DESCRIPTION	AMOUNT CHARGED	AMT. PD.	AMT. ADJ.	AMOUNT DUE	ENCOUNTER NO.
SUMMARY	FOR IDA WITH DR MARSHALL	33.00			33.00	2482941
12/26/01	FOOT, 3 + VIEWS	33.00				

CURRENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS	TOTAL DUE
33.00	.00	.00	.00	.00	33.00

PLEASE CONTACT THIS OFFICE IF YOU HAVE
INSURANCE. THANK YOU.

Medicare Summary Notice

January 25, 2002
FL-NL089349

IDA M THOMAS
541 SW TIMBER TRL
STUART FL 34997-6266

CUSTOMER SERVICE INFORMATION

Your Medicare Number: 236-38-1175A

If you have questions,write or call:
Medicare Part B
P.O. Box 2360
Jacksonville, FL. 32231

Toll-free: 1-800-333-7586
TTY for Hearing Impaired: 1-800-754-7820

HELP STOP FRAUD: Do not sell your Medicare Number or Medicare Summary Notice.

This is a summary of claims processed from 12/28/2001 through 01/11/2002.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
	Claim number 54-1365-09446-00 **S FL ORTH & SPORTS MED, PO BOX 2900, STUART FL 34995-2900** Referred by: PAUL GAETA, M.D. SCOTT M DESMAN, M.D.					a
12/27/01	1 Office/outpatient visit, new (99203)	$125.00	$94.59	$75.67	$18.92	
	Claim number 53-1365-03413-00 **STUART CARDIOLOGY GRP PA, STE 300, 1001 SE MONTEREY COMM, STUART FL 34996-3329** JOSEPH S GAGE, M.D.					
12/27/01	1 Analyze pacemaker system (93734)	$65.00	$38.48	$30.78	$7.70	
	Claim number 53-1351-57967-00 **JAMES J VOPAL, M.D., 801 E OSCEOLA ST, STUART FL 34994-2431** Referred by: PAUL GAETA, M.D.					
10/30/01	1 Office consultation (99243)	$159.00	$122.20	$97.76	$24.44	

K Mart accident

Pace maker check

Broom

PATIENT NAME: IDA M THOMAS

PHYSICIAN SERVICES RENDERED AT: MARTIN MEMORIAL SOUTH

NAME AS IT APPEARS ON CARD

ACCT. NUMBER 13266932/4 | CHECK NUMBER

PLEASE WRITE YOUR ACCOUNT NUMBER ON YOUR CHECK. MAKE PAYABLE IN U.S. DOLLARS TO:

IDA M THOMAS 13266932/4
541 SW TIMBER TRL
STUART FL 34997-6266

EMERGENCY PHYS MARTIN SOUTH
P O BOX 850001
ORLANDO FL 32885-1002

018000132669326026004610181200050002400027

TAXPAYER ID: 65-0622862

BILLING INQUIRIES: 1-888-952-6772

HOURS OF OPERATION: MONDAY - FRIDAY 8AM TO 8PM & SATURDAY 10AM TO 3PM ET
PROVIDE INSURANCE INFO OR PAY BY CREDIT CARD ONLINE AT HCFS.TEAMHEALTH.COM

DATE/INVOICE #	DX / CPT CODE	DESCRIPTION	PROVIDER	CHARGES	PAYMENTS/CREDITS
12/26/01	99283	EMERGENCY DEPT VISIT - 99283		240.00	
29846208	924.20		NICOSIA D.O.,ROGER / WEBER PA-C,ROGER		

acct 13266932/4 1-20-02 240.00

PHYSICIAN CHARGES ARE NOT INCLUDED IN THE FACILITY BILL
PAYMENTS AND INSURANCE INFORMATION MAILED SEVEN DAYS PRIOR TO THE ABOVE STATEMENT DATE MAY NOT YET APPEAR.

EMERGENCY PHYS MARTIN SOUTH
P.O. BOX 189040
PLANTATION, FL 33318

CREDIT CARD PAYMENT ☐ MasterCard ☐ VISA ☐ ☐ DISCOVER

CREDIT CARD CHAR(
CARD NUMBER
SIGNATURE
NAME AS IT APPEARS ON CAR
ACCT. NUMBER 1:
PLEASE WRITE YOUR ACC

PATIENT NAME: IDA M THOMAS

PHYSICIAN SERVICES RENDERED AT: MARTIN MEMORIAL SOUTH

IDA M THOMAS 13266932/4
541 SW TIMBER TRL
STUART FL 34997-6266

EME
P O
OR

01800013266932
HOURS OF OPERATION: MONDAY - FRIDAY 8AM TO 8F
PROVIDE INSURANCE INFO OR PAY BY CREDIT CARD ON

DATE/INVOICE #	DX / CPT CODE	DESCRIPTION
12/26/01	99283	EMERGENCY DEPT VISIT - 99283
29846208	924.20	NICOSIA D.O.,ROGER / WEBE

3

PHYSICIAN CHARGES ARE NOT INCLUDED IN THE FACILITY BILL

PAYMENTS AND INSURANCE INFORMATION MAILED SEVEN DAYS PRIOR TO THE ABOVE STATEMENT DATE MAY NOT YET APPEAR.

ACCOUNT NUMBER: 13266932/4 STATEMENT DATE: 01/20/02 TOTAL NOW DUE ▶ $240.00

IF YOU HAVE INSURANCE COVERAGE OR WANT TO PAY BY CREDIT CARD, VISIT OUR WEBSITE AT HTTP://HCFS.TEAMHEALTH.COM OR FILL OUT THE BACK COPY OF THIS STATEMENT OR SEND THE FRONT & BACK COPY OF YOUR INSURANCE CARD.

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