GARFUNKEL WILD, P.C.
Attorney for the Plan Administrator and Estates
111 Great Neck Road
Great Neck, New York 11021
Phone: 516.393-2200
Fax: 516.466-5964
Burton S. Weston
Afsheen A. Shah
Adam T. Berkowitz

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK
----------x

In re:

SOUND SHORE MEDICAL CENTER OF WESTCHESTER, et al.

Debtors.
----------x

Chapter 11

Case No. 13-22840 (RDD)

PLAN ADMINISTRATOR'S FIFTH OMNIBUS OBJECTION TO ALLOWANCE OF CERTAIN ADMINISTRATIVE PROOFS OF CLAIM

(Unsubstantiated Claims)

Monica Terrano, as Plan Administrator (the "Plan Administrator") for the estates of Sound Shore Medical Center of Westchester, and its affiliated debtors (collectively, the "Estate"), by and through her counsel, respectfully moves this court (the "Fifth Objection") for entry of an Order pursuant to 11 USC § 502 and Fed. R. Bankr. P. 3007 disallowing and expunging certain proofs of claim identified on Exhibit A, annexed hereto, on the basis that (i) the claims on Exhibit A are inconsistent with the Debtor's books and records and have been filed for amounts in excess of those owed to each respective claimant. In support of the Motion, the Plan Administrator represents as follows:

Background

1. On May 29, 2013 (the "Petition Date"), Sound Shore Medical Center of Westchester and its debtor affiliates (each a "Debtor" and together the "Debtors"), each Debtor filed with this court a voluntary petition for relief under chapter 11 of title 11 of the United States Code (the "Bankruptcy Code") with the United States Bankruptcy Court for the Southern District of New York (the "Court"). Pursuant to sections 1107 and 1108 of the Bankruptcy Code, the Debtors are continuing to administer their affairs as debtors-in-possession.

2. On June 10, 2013, the United States Trustee appointed an Official Committee of Unsecured Creditors (the "Committee"). [Docket No. 36]. The Committee retained Alston & Bird, LLP as its counsel. No Trustee or examiner has been appointed in this case.

3. On June 3, 2013, this Court granted an order to employ GCG, Inc. ("GCG"), as the Debtors' Claims and Noticing Agent [Docket No. 41].

4. On June 28, 2013, the Debtors filed their respective schedules of assets and liabilities and statement of financial affairs (the "Schedules") [Docket Nos. 125, 127, 129, 131, 133, 135, 137].

5. By order of this Court dated July 25, 2013 (the "General Bar Date Order"). [Docket No. 194], with certain exceptions, the general deadline for the filing of proofs of claim against the Debtors was established as September 16, 2013 (the "General Bar Date") and the deadline for governmental units to file claims against the estate was established as of November 25, 2015 (the "Governmental Bar Date" and collectively with the General Bar Date, the "Bar Date"). On August 13, 2013, the Debtors caused written notice of the Bar Date to be mailed to

the Debtor's known and potential creditors [Docket No. 265]. In addition, on August 15, 2013, the Debtors caused notice of the Bar Date to be published in The New York Times [Docket No. 299].

6. Thereafter, on December 13, 2013, an order was entered establishing January 31, 2014 (the "Administrative Bar Date") as the deadline for the filing of all administrative proofs of claim against the Debtors (the "Administrative Bar Date Order") [Docket No. 490]. On December 19, 2013, the Debtors caused written notice of the Administrative Bar Date to be mailed to the Debtors' known and potential administrative creditors [Docket No. 516]. Additionally, on December 26, 2013, the Debtors caused notice of the Administrative Bar Date to be published in The New York Times Local Edition [Docket No. 622].

7. On November 6, 2014, the Court entered an Order (the "Confirmation Order") confirming the Debtors' First Amended Plan of Liquidation Under Chapter 11 of the Bankruptcy Code of Sound Shore Medical Center of Westchester, *et al.* (the "Plan") [Docket No. 908]. Pursuant to the Confirmation Order, Monica Terrano has been appointed as Plan Administrator. Pursuant to the Plan, the Plan Administrator has the authority, among other things, to object to claims on behalf of the Estate.

8. On December 9, 2014, the Debtors filed their Notice of (I) Entry of Order Confirming Debtors' First Amended Plan of Liquidation; (II) Occurrence of Effective Date of Plan; (III) Supplemental Administrative Claims Bar Date; (IV) Professional Fee Claims Bar Date; and (V) Bar Date for Proofs of Claim Relating to Executory Contracts Rejected Pursuant to Plan declaring the Plan to be "effective" [Docket No. 940].

Jurisdiction

9. This Court has jurisdiction over this Application pursuant to 28 U.S.C. § 1408. This is a core proceeding pursuant to 28 U.S.C. § 157(b)(2)(B). The statutory predicates for the relief requested herein are Section 502 of the Bankruptcy Code and Rules 3001 and 3002 of the Federal Rules of Bankruptcy Procedure (the "Bankruptcy Rules").

Relief Requested

10. Since the passing of the Administrative Bar Date, the Plan Administrator, together with her counsel and advisors has reviewed the Debtors' books and records to identify objectionable claims. As a result of its review, numerous objectionable claims have been uncovered which are addressed by this Fifth Objection. The claims that are the subject of this Objection are those claims which have been filed in amounts that are inconsistent with the amounts set forth in the Debtor's books and records as being due to each respective claimant.

11. Upon examining the proofs of claim identified on Exhibit A under the heading "*Insufficient Documentation Administrative Claims*" (the "Unsubstantiated Claims"), the Plan Administrator determined that each such claim had been filed for amounts in excess of those owed to the claimant, as set forth in the Debtor's books and records, and as indicated under the heading "*Allowed Amount*" (the "Allowed Claim"). In addition, the supporting documentation provided by each respective claimant in support of the filed claim fails to substantiate the amount of the claim as filed.

12. The Plan Administrator thus seeks entry of an order or orders pursuant to Section 502 of the Bankruptcy Code and Rule 3001 of the Federal Rules of Bankruptcy Procedure

modifying and/or reducing the amounts of the Unsubstantiated Claims identified in Exhibit A, as attached hereto.

Basis for Relief Requested

13. Section 502 of the Bankruptcy Code provides, in pertinent part, as follows:

> (a) A claim or interest, proof of which is filed, under section 501 of this title, is deemed allowed, unless a party in interest, including a creditor of a general partner in a partnership, that is a debtor in a case under chapter 7 of this title, objects.

11 U.S.C. § 502(a).

14. Pursuant to Bankruptcy Rule 3001(f), a properly executed and filed proof of claim constitutes *prima facie* evidence of the validity and the amount of the underlying claim under section 502(a) of the Bankruptcy Code. *See* Fed. R. Bankr. P. 3001(f). To receive the benefit of *prima facie* validity, however, "the proof of claim must 'set forth facts necessary to support the claim.'". *In re Chain*, 255 B.R. 278, 280 (Bankr. D.Conn. 2000) (quoting *In re Marino*, 90 B.R. 25, 28 (Bankr. D. Conn. 1988)).

15. As set forth herein, the Plan Administrator has diligently and carefully reviewed and scrutinized each of the proofs of claim filed in this case and has determined that the claims set forth on Exhibit A hereto are not consistent with the Debtor's books and records. In addition, each claimant has provided insufficient documentary support in connection with the filed claim to substantiate the amount of its claim, as filed, or otherwise refute the amounts set forth in the Debtor's books and records as due and owing to such claimant. The Plan Administrator thus seeks to modify and reduce the Unsubstantiated Claims identified on Exhibit A.

RESERVATION OF RIGHTS

16. The Plan Administrator reserves all rights to object to any surviving claims asserted against the Plan Administrator, as identified on the annexed exhibits, whether asserted or unasserted by any of the claimants affected by the Fifth Objection against the Debtors. Should one or more of the objections contained herein be denied or dismissed, the Plan Administrator reserves its rights to further object to the disputed claim on any other grounds, discovered by the Plan Administrator during the pendency of this case.

NOTICE

17. Notice of this Objection will be given by mailing a copy of this Fifth Objection and the proposed order to (i) the Office of the United States Trustee for this district, (ii) counsel for the Post-Effective Date Committee, (iii) each of the claimants listed on Exhibit A, at their respective addresses as set forth on such exhibit, and (iv) all parties required to be served under the Case Management Order entered in this Case on June 4, 2013. In addition, as required under the Order Approving Omnibus Claim Objection Procedures [Docket No. 1036], each claimant whose claim is subject to this Fifth Objection has received, in such claimant's respective notice packet, a separate individualized notice informing the claimant that its claim is covered by this Fifth Objection and that the failure to timely oppose the objection, as set forth in the notice, may result in the grant of the relief requested by this Fifth Objection.

WHEREFORE, the Plan Administrator respectfully requests that the relief requested herein be granted and this Court enter an order, substantially in the form annexed hereto as Exhibit C, and grant such other and further relief as is just and proper.

Dated: Great Neck, New York
May _____, 2015

GARFUNKEL WILD, P.C.
Counsel for the Plan Administrator and Estates

By: _____
Burton S. Weston
Afsheen A. Shah
Adam T. Berkowitz
111 Great Neck Road
Great Neck, NY 11021
(516) 393-2200

GARFUNKEL WILD, P.C.
111 Great Neck Road
Great Neck, New York 11021
Telephone: (516) 393-220
Facsimile: (516) 466-5964
Burton S. Weston
Afsheen A. Shah
Adam T. Berkowitz

Counsel for the Estate

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

----------x

In re:

SOUND SHORE MEDICAL CENTER OF WESTCHESTER, et al.[1]	Chapter 11 Case No. 13-22840 (RDD)
Debtors.	(Jointly Administered)

----------x

DECLARATION OF MONICA TERRANO IN SUPPORT OF FIFTH OMNIBUS OBJECTIONS TO CLAIMS

STATE OF NEW YORK)

) ss.:

COUNTY OF NASSAU)

Pursuant to 28 U.S.C. § 1746, I, Monica Terrano, hereby declare:

1. I am the Plan Administrator ("PA") for the Estate of Sound Shore Medical Center of Westchester, and its debtor affiliates (the "Estates"). In my capacity as the PA, I am authorized to submit this declaration (the "Declaration") in support of the Estate's Fifth Omnibus Objection to Claims (the "Fifth Objection")[2].

[1] The debtors in these chapter 11 cases, along with the last four digits of each debtor's federal tax identification number include: Sound Shore Health System, Inc. (1398), Sound Shore Medical Center of Westchester (0117), The Mount Vernon Hospital (0115), Howe Avenue Nursing Home, Inc., d/b/a Helen and Michael Schaffer Extended Care Center (0781), NRHMC Services Corporation (9137), The M.V.H. Corporation (1514) and New Rochelle Sound Shore Housing, LLC (0117). There are certain additional affiliates of the Debtors who are not debtors and have not sought relief under Chapter 11.

[2] Capitalized terms, unless herein defined, shall have the meaning ascribed to them in the Seventh Omnibus Objection.

2. Except as otherwise indicated, all facts set forth in this Declaration are based upon: (a) my personal knowledge; (b) my review of relevant documents, including Proofs of Claim, (as defined below); (c) my experience and knowledge of the Estates' prior operations, books and records and personnel; and (d) as to matters involving United States bankruptcy law or rules or other applicable laws, my reliance on the advice of counsel or other advisors to the Estates. If called upon to testify, I could and would testify to the facts set forth herein on that basis.

3. I am a Certified Public Accountant with over 15 years of experience in the healthcare industry. Over the past five years, I have worked primarily on Chapter 11 cases relating to hospital restructurings and/or liquidations. During this time, I have specialized in all aspects of bankruptcy case administration, including claims review and reconciliation, and the preparation of related statements and required schedules and have been focusing primarily on bankrupt hospitals.

CLAIMS ADMINISTRATION PROCESS

4. Since the expiration of the Administrative Bar Date, considerable time and effort has been expended by the Estates and their professionals and advisors in connection with the claims administration process to ensure a high level of diligence in reviewing and reconciling approximately 500 administrative proofs of claim (the "Proofs of Claim") filed in connection with these Chapter 11 cases. Over the next several months, working directly with the Estates' professionals and advisors, I personally reviewed, analyzed and considered the merits of each Proof of Claim and determined that the claims covered by the Fifth Objection were objectionable. Throughout the process, I regularly interfaced with the Estates' professionals and

advisors to address potential legal issues impacting the Proofs of Claim, asses the validity of the Proofs of Claim and obtain additional source documents when necessary.

THE UNSUBSTANTIATED CLAIMS

5. I am generally familiar with the information contained in the Fifth Omnibus Objection. Based on my review of the Proofs of Claim, I assisted the Estates' bankruptcy counsel in the preparation of the Fifth Objection and related schedules by identifying all filed administrative claims that had been filed in amounts that were inconsistent with those set forth in the Debtors' books and records and thus should be disallowed, expunged, or otherwise reduced (the "Unsubstantiated Claims").

6. In evaluating the Unsubstantiated Claims, my advisors performed and I performed in-depth review of and comparison of the claims as listed on the Debtors' books and records, on one hand, and each of the filed proofs of claim, including any supporting documentation provided by the claimant, on the other hand. It was ultimately determined that each Unsubstantiated Claim was inconsistent with the Debtor's books and records. In addition, the supporting documentation provided by each claimant in support of the filed claim was insufficient to substantiate the amount of the claim as filed. Therefore, I believe that disallowance, expungement, reclassification, reduction, or modification of each Unsubstantiated Claim, for the reasons set forth in the Fifth Objection, is appropriate.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: June ___, 2015
Great Neck, New York

Monica Terrano

Sound Shore Medical Center of Westchester, *et al* .,
Exhibit A - Insufficient Documentation
Administrative Claims

Note: Claimants are listed alphabetically by last name or by entity name.

SEQ NO.	NAME	CLAIM NO.	DATE FILED	CLAIMED DEBTOR	CASE NO.	CLAIM AMOUNT	ALLOWED AMOUNT	BASIS FOR OBJECTION
1	AUSTIN, DALE 50 GUION PL APT 7B NEW ROCHELLE, NY 10801	1135	01/09/14	Sound Shore Medical Center of Westchester	13-22840	Unliquidated	$0.00	Documentation attached to proof of claim insufficient to determine liability.
2	CHAKRIAN, LEVON 47-20 215TH ST BAYSIDE, NY 11361	1100	12/31/13	Sound Shore Medical Center of Westchester	13-22840	Admin: $2,500.00	$0.00	Documentation attached to proof of claim insufficient to determine liability.
3	DEGUZMAN, VERINA 59 GUION PL APT 10B NEW ROCHELLE, NY 10801	1111	01/03/14	Sound Shore Medical Center of Westchester	13-22840	Unliquidated	$0.00	No invoice or other supporting documentation attached to proof of claim.
4	DERAFFELE, BARBARA J 463 PELHAM RD BLDG 6 NEW ROCHELLE, NY 10805	1313	01/30/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $10,500.00*	$0.00	No invoice or other supporting documentation attached to proof of claim.
5	DUNCAN, VIOLA 308 S 6TH AVE MOUNT VERNON, NY 10550	1080	12/28/13	Sound Shore Medical Center of Westchester	13-22840	Admin: $6,000.00	$0.00	No invoice or other supporting documentation attached to proof of claim.
6	ESTATE OF SEWARD C/O LOUIS SOLIMANO 305 E 204TH ST BRONX, NY 10467	1108	01/02/14	Sound Shore Medical Center of Westchester	13-22840	Unliquidated	$0.00	No invoice or other supporting documentation attached to proof of claim.
7	GRZELAK, EVA S 16 UNIVERSITY PL #1D PORT CHESTER, NY 10573	1105	01/02/14	Sound Shore Medical Center of Westchester	13-22840	Unliquidated	$0.00	No invoice or other supporting documentation attached to proof of claim.
8	JESMAJIAN, STEPHEN 121 EDGARS LN HASTINGS ON HUDSON, NY 10706	1454	01/31/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $69,230.00	$0.00	No invoice or other supporting documentation attached to proof of claim.
9	NEELKANTH LLC D/B/A SOUND SHORE PHARMACY INC 14 AGNOLA ST YONKERS, NY 10707	1376	01/30/14	The Mount Vernon Hospital, Inc.	13-22841	Admin: $8,796.39	$0.00	No invoice attached to proof of claim.
10	NUTRITION MANAGEMENT SERVICES CO C/O PORZIO BROMBERG & NEWMAN P C ATTN WARREN J MARTIN JR ESQ 100 SOUTHGATE PKWY MORRISTOWN, NJ 07962	656	09/13/13	The Mount Vernon Hospital, Inc.	13-22841	Admin: $9,353.80 Unsecured: $114,934.88	$0.00	Documentation attached to proof of claim insufficient to determine liability.

Sound Shore Medical Center of Westchester, *et al* .,
Exhibit A - Insufficient Documentation
Administrative Claims

Note: Claimants are listed alphabetically by last name or by entity name.

SEQ NO.	NAME	CLAIM NO.	DATE FILED	CLAIMED DEBTOR	CASE NO.	CLAIM AMOUNT	ALLOWED AMOUNT	BASIS FOR OBJECTION
11	NUTRITION MANAGEMENT SERVICES CO C/O PORZIO BROMBERG & NEWMAN P C ATTN WARREN J MARTIN JR, ESQ 100 SOUTHGATE PKWY MORRISTOWN, NJ 07962	657	09/13/13	Sound Shore Medical Center of Westchester	13-22840	Admin: $55,503.40 Unsecured: $607,262.56	$0.00	Documentation attached to proof of claim insufficient to determine liability.
12	PALI, ROZAFA L 89 MILL SPRING LN STAMFORD, CT 06903	1391	01/30/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $300,000.00	$0.00	No invoice or other supporting documentation attached to proof of claim.
13	PULMONARY & SLEEP SPECIALISTS OF SOUTHERN WESTCHESTER LLC 2365 BOSTON POST RD LARCHMONT, NY 10538	1301	01/30/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $5,646.70	$0.00	No invoice attached to proof of claim.
14	RODRIGUEZ, BARTHOLOME 19 DUSENBERRY RD BRONXVILLE, NY 10708	1402	01/30/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $300,000.00*	$0.00	No invoice or other supporting documentation attached to proof of claim.
15	SMITH, CHERRYLE 4225 HILL AVE BRONX, NY 10466	1127	01/07/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $8,781.76	$0.00	No invoice or other supporting documentation attached to proof of claim.
16	TISDALE, CHERYL D 321 MCCLELLAN AVE MOUNT VERNON, NY 10553	1220	01/24/14	Sound Shore Medical Center of Westchester	13-22840	Unliquidated	$0.00	No invoice or other supporting documentation attached to proof of claim.
* Denotes an unliquidated component.								

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

ADMINISTRATIVE EXPENSE PROOF OF CLAIM

Administrative Expense Bar Date
January 31, 2014

Note: This form should only be used by claimants asserting an Administrative Expense arising between May 29, 2013 and November 6, 2013 (the "Administrative Claim Period"). THIS FORM *SHOULD NOT BE USED FOR ANY CLAIMS THAT ARE NOT OF A KIND ENTITLED TO PRIORITY IN ACCORDANCE WITH 11 U.S.C. §§ 503(b) and 507(a)(2)*

Indicate Debtor(s) against which you assert a claim by checking the appropriate box(es) below.

Name of Debtor (Check Only One):	Case No.	Name of Debtor (Check Only One):	Case No.
☑ Sound Shore Medical Center of Westchester	13-22840	☐ The M.V.H. Corporation	13-22843
☐ The Mount Vernon Hospital, Inc.	13-22841	☐ SoundShore Health System, Inc.	13-22844
☐ Howe Avenue Nursing Home, d/b/a Helen and Michael Schaffer Extended Care Center	13-22842	☐ NRHMC Services Corporation	13-22845
		☐ New Rochelle Sound Shore Housing LLC	13-22846

Name of Creditor
(The person or entity to whom the debtor owes money or property)
Dale Austin

☐ Check box if you are aware that anyone else has filed a proof of claim relating to your administrative expense claim. Attach copy of statement giving particulars.

THE GARDEN CITY GROUP, INC. JAN - 9 2014

Name and Addresses Where Notices Should be Sent:
DALE AUSTIN
50 GUION PL. APT 7B
NEW ROCHELLE NY. 10801

Check here if this claim: ☐ replaces or ☐ amends a previously filed administrative expense claim.

Claim Number (if known): _____

Dated: _____

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR:

1. BASIS FOR CLAIM:
☐ Goods sold ☐ Services performed ☐ Personal Injury/Wrongful Death ☒ Wages (Dates) SEVERANCE PAY
☐ Money loaned ☐ Taxes ☐ Retiree Benefits as Defined in 11 U.S.C. § 1114(a) ☐ Other(Specify): MAX - 4 WEEKS

2. DATE DEBT WAS INCURRED (IF KNOWN):

3. DESCRIPTION OF CLAIM (IF KNOWN): SEVERANCE PAY

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ _____ (Total) 4 WEEK PAY IS MAX 18.93 per hour Full Time Worker

5. CREDITS AND SETOFFS: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof. In filing this claim, claimant has deducted all amounts that claimant owes to debtor.

6. SUPPORTING DOCUMENTS. *Attach copies of supporting documents,* such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, or evidence of security interests. Do not send original documents. If the documents are not available, explain. If the documents are voluminous, attach a summary.

7. TIME-STAMPED COPY: To receive an acknowledgement 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

8. **Signature:** Check the appropriate box.
☐ I am the creditor. ☐ I am the creditor's authorized agent. (Attach copy of power of attorney, if any) ☐ I am the trustee, or the Debtor, or their authorized agent. (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: DALE AUSTIN
Title: UNIT CLERK
Company: _____
Address and telephone number (if different from notice address above):

Dale Austin (Signature) 12-24-2013 (Date)

Telephone number: 914-813-0244 email: DBOHANN@AOL.COM

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

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The attorneys for the Debtors and their court-appointed claims agent, GCG, are not authorized and are not providing you with any legal advice.

PLEASE SEND YOUR ORIGINAL, COMPLETED CLAIM FORM AS FOLLOWS: **IF BY MAIL:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, Inc., P.O. Box 9982, Dublin, Ohio 43017-5982. **IF BY HAND OR OVERNIGHT COURIER:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, 5151 Blazer Parkway, Suite A, Dublin, OH 43017. **IF BY HAND:** United States Bankruptcy Court, SDNY, 300 Quarropas Street, Room 248, White Plains, New York 10601; Attn: Clerk of the Court. ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR EMAIL WILL *NOT* BE ACCEPTED.

004016 - Austin,Dale - 1334 | Clock # 6EV00 | SSN 111-44-7979

3WP - Sound Shore Medical Center of | Payroll Dept 005065 - Unit Clerks

3WPSSMCWREG | Payroll Job

3WPSSMCWREG | Federal S 00 State S | Local

Active | 01/30/1978 | Reg/FT | Std Hrs 37.50 | Active | Hourly

004016 - Austin,Dale - 1334

Hours/Earnings/Deductions | Taxes | Memos/Tax Recalcs | RateSummary | Paid Time Off

	Qtr	Wk	Pyrl	Adj	Check #	Pay Date	Period End	W GPS ID	PR Dept #	Paid Dep	Gross Pay	
	3	39	1		390150	09/27/2012	09/22/2012		005065	005065	1564.85	

1 Check(s) Included | Pay Date 01/01/2012 To 12/31/2013 | 1564.85 | 0.00

Total Hours and Earnings

Earn Code	Description	Hours	Earnings
REG	Regular Pay	67.50	1231.09
OTP	Overtime @ 1.5	2.00	54.71
		77.00	1564.85

Total Deductions

Ded Code	Description	Amount
16	Gift Shop	152.67
18	Pre Aflac	21.05
		1221.68

PayForce screen print as of: 12/03/2013 09:59 AM

I WAS HIRED JANUARY 1978
LAID OFF NOVEMBER 5, 2013
I DID NOT RECEIVE MY SEVERANCE PAY.

DALE AUSTIN
50 GUION PL APT 7B
NEW ROCHELLE NY
10801

WESTCHESTER NY 105
26 DEC 2013 PM 1 L

USA FOREVER

SOUND SHORE MEDICAL CENTER OF WESTCHESTER
C/O GCG
P.O. BOX 9982
DUBLIN, OH 43017-5982

43017598282

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

ADMINISTRATIVE EXPENSE PROOF OF CLAIM

Administrative Expense Bar Date
January 31, 2014

Note: This form should only be used by claimants asserting an Administrative Expense arising between May 29, 2013 and November 6, 2013 (the "Administrative Claim Period"). THIS FORM SHOULD NOT BE USED FOR ANY CLAIMS THAT ARE NOT OF A KIND ENTITLED TO PRIORITY IN ACCORDANCE WITH 11 U.S.C. §§ 503(b) and 507(a)(2)

Indicate Debtor(s) against which you assert a claim by checking the appropriate box(es) below.

Name of Debtor (Check Only One):	Case No.	Name of Debtor (Check Only One):	Case No.
☒ Sound Shore Medical Center of Westchester	13-22840	☐ The M.V.H. Corporation	13-22843
☐ The Mount Vernon Hospital, Inc	13-22841	☐ SoundShore Health System, Inc.	13-22844
☐ Howe Avenue Nursing Home, d/b/a Helen and Michael Schaffer Extended Care Center	13-22842	☐ NRHMC Services Corporation	13-22845
		☐ New Rochelle Sound Shore Housing LLC	13-22846

Name of Creditor
(The person or entity to whom the debtor owes money or property)
Levon Chakrian

☐ Check box if you are aware that anyone else has filed a proof of claim relating to your administrative expense claim. Attach copy of statement giving particulars.

THE GARDEN CITY GROUP INC. DEC 31 2013

Name and Addresses Where Notices Should be Sent:
47-20 215th St.
Bayside, NY 11361

Check here if this claim: ☐ replaces or ☐ amends a previously filed administrative expense claim.
Claim Number (if known): 844
Dated: _____

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR:

1. BASIS FOR CLAIM:
☐ Goods sold ☐ Services performed ☐ Personal Injury/Wrongful Death ☐ Wages (Dates) _____
☐ Money loaned ☐ Taxes ☐ Retiree Benefits as Defined in 11 U.S.C. § 1114(a) ☒ Other (Specify): Attorney fee

2. DATE DEBT WAS INCURRED (IF KNOWN): August 2013

3. DESCRIPTION OF CLAIM (IF KNOWN): Attorney fee payable to Fusco, Brandenstein & Rada PC

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 2500 (Total)

5. CREDITS AND SETOFFS: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof. In filing this claim, claimant has deducted all amounts that claimant owes to debtor.

6. SUPPORTING DOCUMENTS: *Attach copies of supporting documents*, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, or evidence of security interests. Do not send original documents. If the documents are not available, explain. If the documents are voluminous, attach a summary.

7. TIME-STAMPED COPY: To receive an acknowledgement 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

8. **Signature:** Check the appropriate box.
☒ I am the creditor. ☐ I am the creditor's authorized agent. (Attach copy of power of attorney, if any) ☐ I am the trustee, or the Debtor, or their authorized agent. (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: Levon Chakrian
Title: _____
Company: _____
Address and telephone number (if different from notice address above):
_____
_____
_____
Telephone number: _____

Levon Chakrian (Signature) 12-27-13 (Date)
email: _____

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

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The attorneys for the Debtors and their court-appointed claims agent, GCG, are not authorized and are not providing you with any legal advice

PLEASE SEND YOUR ORIGINAL, COMPLETED CLAIM FORM AS FOLLOWS: **IF BY MAIL:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, Inc., P.O. Box 9982, Dublin, Ohio 43017-5982. **IF BY HAND OR OVERNIGHT COURIER:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, 5151 Blazer Parkway, Suite A, Dublin, OH 43017. **IF BY HAND:** United States Bankruptcy Court, SDNY, 300 Quarropas Street, Room 248, White Plains, New York 10601; Attn. Clerk of the Court. ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR EMAIL WILL NOT BE ACCEPTED.

Fusco, Brandenstein & Rada, PC
ATTORNEYS AT LAW
180 FROEHLICH FARM BLVD.
WOODBURY, NY 11797-2923

Hasler
12/27/2013
US POSTAGE

FIRST-CLASS MAIL
$00.46⁰

ZIP 11797
011D11640063

Sound Shore Medical of Westchester, et al
c/o GCG, Inc.
P.O. Box 9982
Dublin, Ohio 43017-5982

43017$5982 B050

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

ADMINISTRATIVE EXPENSE PROOF OF CLAIM

Administrative Expense Bar Date
January 31, 2014

Note: This form should only be used by claimants asserting an Administrative Expense arising between May 29, 2013 and November 6, 2013 (the "Administrative Claim Period"). THIS FORM SHOULD NOT BE USED FOR ANY CLAIMS THAT ARE NOT OF A KIND ENTITLED TO PRIORITY IN ACCORDANCE WITH 11 U.S.C. §§ 503(b) and 507(a)(2)

Indicate Debtor(s) against which you assert a claim by checking the appropriate box(es) below.

Name of Debtor (Check Only One):	Case No.	Name of Debtor (Check Only One):	Case No.
☑ Sound Shore Medical Center of Westchester	13-22840	☐ The M.V.H. Corporation	13-22843
☐ The Mount Vernon Hospital, Inc	13-22841	☐ SoundShore Health System, Inc.	13-22844
☐ Howe Avenue Nursing Home, d/b/a Helen and Michael Schaffer Extended Care Center	13-22842	☐ NRHMC Services Corporation	13-22845
		☐ New Rochelle Sound Shore Housing LLC	13-22846

Name of Creditor
(The person or entity to whom the debtor owes money or property)
VERINA DEGUZMAN

☐ Check box if you are aware that anyone else has filed a proof of claim relating to your administrative expense claim. Attach copy of statement giving particulars.

THE GARDEN CITY GROUP, INC. JAN - 3 2014

Name and Addresses Where Notices Should be Sent:
VERINA DEGUZMAN
50 GUION PL. APT 10B
NEW ROCHELLE NY. 10801

Check here if this claim: ☐ replaces or ☐ amends a previously filed administrative expense claim.
Claim Number (if known): _____
Dated: _____

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR: _____

1. BASIS FOR CLAIM:
☐ Goods sold ☐ Services performed ☐ Personal Injury/Wrongful Death ☑ Wages (Dates) _____
☐ Money loaned ☐ Taxes ☐ Retiree Benefits as Defined in 11 U.S.C. § 1114(a) ☐ Other (Specify): _____

2. DATE DEBT WAS INCURRED (IF KNOWN):

3. DESCRIPTION OF CLAIM (IF KNOWN): SEVERANCE PAY AND 90 HOURS VACATION PAY 4 WEEKS

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ _____ (Total)

5. CREDITS AND SETOFFS: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof. In filing this claim, claimant has deducted all amounts that claimant owes to debtor.

6. SUPPORTING DOCUMENTS: *Attach copies of supporting documents*, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, or evidence of security interests. Do not send original documents. If the documents are not available, explain. If the documents are voluminous, attach a summary.

7. TIME-STAMPED COPY: To receive an acknowledgement 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

8 **Signature:** Check the appropriate box.

☑ I am the creditor. ☐ I am the creditor's authorized agent. (Attach copy of power of attorney, if any) ☐ I am the trustee, or the Debtor, or their authorized agent. (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: VERINA DEGUZMAN
Title: NURSE - REGISTERED NURSE
Company: _____
Address and telephone number (if different from notice address above):
_____
_____
_____
Telephone number: 914- 516-761-8539 email: VerinaVdeguzman@AOL.com

VerinaVdeGuzman (Signature) _____ (Date)

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.

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The attorneys for the Debtors and their court-appointed claims agent, GCG, are not authorized and are not providing you with any legal advice.

PLEASE SEND YOUR ORIGINAL, COMPLETED CLAIM FORM AS FOLLOWS: **IF BY MAIL:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, Inc., P.O. Box 9982, Dublin, Ohio 43017-5982. **IF BY HAND OR OVERNIGHT COURIER:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, 5151 Blazer Parkway, Suite A, Dublin, OH 43017. **IF BY HAND:** United States Bankruptcy Court, SDNY, 300 Quarropas Street, Room 248, White Plains, New York 10601; Attn: Clerk of the Court. ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR EMAIL WILL NOT BE ACCEPTED.

FILED - 01111
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

REINA DEGUZMAN
50 GUION Pl. Apt 10B
NEW ROCHELLE N.Y.
10801

WESTCHESTER NY 365

30 DEC 2013 PM 2 L

SOUNDSHORE MEDICAL CENTER OF WESTCHESTER
C/O GCG
P.O. BOX 9982
DUBLIN, OH 43017-5982

43017598262

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

ADMINISTRATIVE EXPENSE PROOF OF CLAIM

Administrative Expense Bar Date
January 31, 2014

Note: This form should only be used by claimants asserting an Administrative Expense arising between May 29, 2013 and November 6, 2013 (the "Administrative Claim Period"). THIS FORM SHOULD NOT BE USED FOR ANY CLAIMS THAT ARE NOT OF A KIND ENTITLED TO PRIORITY IN ACCORDANCE WITH 11 U.S.C. §§ 503(b) and 507(a)(2)

Indicate Debtor(s) against which you assert a claim by checking the appropriate box(es) below.

Name of Debtor (Check Only One):	Case No.	Name of Debtor (Check Only One):	Case No.
☒ Sound Shore Medical Center of Westchester	13-22840	☐ The M.V.H. Corporation	13-22843
☐ The Mount Vernon Hospital, Inc.	13-22841	☐ SoundShore Health System, Inc.	13-22844
☐ Howe Avenue Nursing Home, d/b/a Helen and Michael Schaffer Extended Care Center	13-22842	☐ NRHMC Services Corporation	13-22845
		☐ New Rochelle Sound Shore Housing LLC	13-22846

Name of Creditor
(The person or entity to whom the debtor owes money or property)

BARBARA J. DERAFFELE

☐ Check box if you are aware that anyone else has filed a proof of claim relating to your administrative expense claim. Attach copy of statement giving particulars.

THE GARDEN CITY GROUP, INC. JAN 30 2014

Name and Addresses Where Notices Should be Sent:

463 PELHAM Rd Bldg 6
NEW ROCHELLE, NY 10805

Check here if this claim: ☐ replaces or ☐ amends a previously filed administrative expense claim

Claim Number (if known): _____

Dated: _____

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR:

1. BASIS FOR CLAIM:
☐ Goods sold ☐ Services performed ☐ Personal Injury/Wrongful Death ☐ Wages (Dates)_____
☐ Money loaned ☐ Taxes ☒ Retiree Benefits as Defined in 11 USC § 1114(a) ☐ Other(Specify): _____

2. DATE DEBT WAS INCURRED (IF KNOWN)

3. DESCRIPTION OF CLAIM (IF KNOWN): Balance of Retired Benefits

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ APPROX. # 10,500.00 (Total)

5. CREDITS AND SETOFFS: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof. In filing this claim, claimant has deducted all amounts that claimant owes to debtor.

6. SUPPORTING DOCUMENTS: *Attach copies of supporting documents*, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, or evidence of security interests. Do not send original documents. If the documents are not available, explain. If the documents are voluminous, attach a summary.

7. TIME-STAMPED COPY: To receive an acknowledgement 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

8. **Signature:** Check the appropriate box.
☒ I am the creditor. ☐ I am the creditor's authorized agent (Attach copy of power of attorney, if any) ☐ I am the trustee, or the Debtor, or their authorized agent. (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: BARBARA DERAFFELE Barbara DeRaffele 1/25/14
Title: _____ (Signature) (Date)
Company: Retired - Sound Shore Med. Ctr
Address and telephone number (if different from notice address above).

Telephone number: 914-633-8975 email: _____

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.

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The attorneys for the Debtors and their court-appointed claims agent, GCG, are not authorized and are not providing you with any legal advice

PLEASE SEND YOUR ORIGINAL, COMPLETED CLAIM FORM AS FOLLOWS: **IF BY MAIL:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, Inc., P.O. Box 9982, Dublin, Ohio 43017-5982. **IF BY HAND OR OVERNIGHT COURIER:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, 5151 Blazer Parkway, Suite A, Dublin, OH 43017 **IF BY HAND.** United States Bankruptcy Court, SDNY, 300 Quarropas Street, Room 248, White Plains, New York 10601; Attn: Clerk of the Court. ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR EMAIL WILL NOT BE ACCEPTED.

FILED - 01313
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

B DeRaffele
163 Rollon Rd Bld 6
New Rochelle, NY 10805

SOUND SHORE MEDICAL CTR
c/o GCG, INC
PO BOX 9982
DUBLIN, OH 43017-5982
43017598282

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

ADMINISTRATIVE EXPENSE PROOF OF CLAIM

Administrative Expense Bar Date
January 31, 2014

Note: This form should only be used by claimants asserting an Administrative Expense arising between May 29, 2013 and November 6, 2013 (the "Administrative Claim Period") THIS FORM SHOULD NOT BE USED FOR ANY CLAIMS THAT ARE NOT OF A KIND ENTITLED TO PRIORITY IN ACCORDANCE WITH 11 U.S.C. §§ 503(b) and 507(a)(2)

Indicate Debtor(s) against which you assert a claim by checking the appropriate box(es) below.

Name of Debtor (Check Only One):	Case No.	Name of Debtor (Check Only One):	Case No.
☒ Sound Shore Medical Center of Westchester	13-22840	☐ The M.V.H. Corporation	13-22843
☐ The Mount Vernon Hospital, Inc.	13-22841	☒ SoundShore Health System, Inc.	13-22844
☐ Howe Avenue Nursing Home, d/b/a Helen and Michael Schaffer Extended Care Center	13-22842	☐ NRHMC Services Corporation	13-22845
		☐ New Rochelle Sound Shore Housing LLC	13-22846

Name of Creditor
(The person or entity to whom the debtor owes money or property)
Viola DUNCAN

☒ Check box if you are aware that anyone else has filed a proof of claim relating to your administrative expense claim Attach copy of statement giving particulars

THE GARDEN CITY GROUP, INC. DEC 28 2013

Name and Addresses Where Notices Should be Sent:
308 South 6th Ave
Mount Vernon
N.Y 10550

Check here if this claim ☐ replaces or ☐ amends a previously filed administrative expense claim.

Claim Number (if known). _____

Dated: _____

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR: _____

1. BASIS FOR CLAIM
☐ Goods sold ☐ Services performed ☐ Personal Injury/Wrongful Death ☐ Wages (Dates) _____
☐ Money loaned ☐ Taxes ☒ Retiree Benefits as Defined in 11 U.S.C. § 1114(a) ☐ Other(Specify: _____

2. DATE DEBT WAS INCURRED (IF KNOWN): Not Sure

3. DESCRIPTION OF CLAIM (IF KNOWN): not Sure

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $40000 (Total)

5 CREDITS AND SETOFFS: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof. In filing this claim, claimant has deducted all amounts that claimant owes to debtor.

6. SUPPORTING DOCUMENTS: *Attach copies of supporting documents*, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, or evidence of security interests Do not send original documents If the documents are not available, explain. If the documents are voluminous, attach a summary.

7. TIME-STAMPED COPY. To receive an acknowledgement 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

8 **Signature:** Check the appropriate box

☐ I am the creditor. ☐ I am the creditor's authorized agent (Attach copy of power of attorney, if any) ☐ I am the trustee, or the Debtor, or their authorized agent (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: ~~Viola~~ Viola DUNCAN
Title: house keeping
Company: Sound Shore Medical

Viola Duncan (Signature) 12-23-13 (Date)

Address and telephone number (if different from notice address above):
308 South 6th AVE
Mount Vernon N.Y 10550

Telephone number: 914-371-7445 email: _____

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

INSTRUCTIONS FOR PROOF OF CLAIM FORM

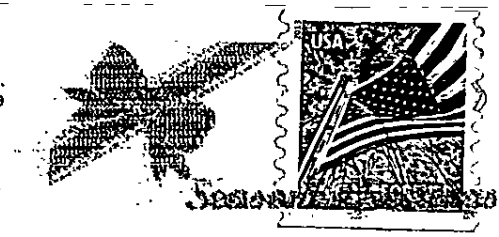
The attorneys for the Debtors and their court-appointed claims agent, GCG, are not authorized and are not providing you with any legal advice.

PLEASE SEND YOUR ORIGINAL, COMPLETED CLAIM FORM AS FOLLOWS: **IF BY MAIL:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, Inc., P O Box 9982, Dublin, Ohio 43017-5982. **IF BY HAND OR OVERNIGHT COURIER:** Sound Shore Medical of Westchester, *et al* , c/o GCG, 5151 Blazer Parkway, Suite A, Dublin, OH 43017. **IF BY HAND**: United States Bankruptcy Court, SDNY, 300 Quarropas Street, Room 248, White Plains, New York 10601; Attn. Clerk of the Court. ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR EMAIL WILL NOT BE ACCEPTED.

Viola DUNCAN
306 South 6th Ave
Mount Vernon N.Y 10550

WESTCHESTER NY 105

24 DEC 2013 PM 2 L



To: Sound Shore Medical Center of Westch
C/O GCG
P.O. BOX 9982
Dublin, OH 43017-5982

43017598282

UNITED STATES BANKRUPTCY COURT SOUTHERN DISTRICT OF NEW YORK	**ADMINISTRATIVE EXPENSE PROOF OF CLAIM**	**Administrative Expense Bar Date** January 31, 2014

Note: This form should only be used by claimants asserting an Administrative Expense arising between May 29, 2013 and November 6, 2013 (the "Administrative Claim Period"). THIS FORM SHOULD NOT BE USED FOR ANY CLAIMS THAT ARE NOT OF A KIND ENTITLED TO PRIORITY IN ACCORDANCE WITH 11 U S C §§ 503(b) and 507(a)(2)

Indicate Debtor(s) against which you assert a claim by checking the appropriate box(es) below.

Name of Debtor (Check Only One):	Case No.	Name of Debtor (Check Only One):	Case No.
☒ Sound Shore Medical Center of Westchester	13-22840	☐ The M.V.H. Corporation	13-22843
☒ The Mount Vernon Hospital, Inc.	13-22841	☐ SoundShore Health System, Inc.	13-22844
☐ Howe Avenue Nursing Home, d/b/a Helen and Michael Schaffer Extended Care Center	13-22842	☐ NRHMC Services Corporation	13-22845
		☐ New Rochelle Sound Shore Housing LLC	13-22846

Name of Creditor
(The person or entity to whom the debtor owes money or property)
ESTATE OF EDWARD

☐ Check box if you are aware that anyone else has filed a proof of claim relating to your administrative expense claim. Attach copy of statement giving particulars.

THE GARDEN CITY GROUP, INC. JAN - 2 2014

Name and Addresses Where Notices Should be Sent
LOUIS POLIMENO
3DT FL 2ND ST
BRONX, N.Y 10467

Check here if this claim: ☐ replaces or ☐ amends a previously filed administrative expense claim

Claim Number (if known): _____

Dated: _____

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR.

1. BASIS FOR CLAIM:
☐ Goods sold ☐ Services performed ☒ Personal Injury/Wrongful Death ☐ Wages (Dates)_____
☐ Money loaned ☐ Taxes ☐ Retiree Benefits as Defined in 11 U S C § 1114(a) ☐ Other(Specify:_____

2. DATE DEBT WAS INCURRED (IF KNOWN):

3. DESCRIPTION OF CLAIM (IF KNOWN): Medical Malpractice

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $_____ **(Total)**

5. CREDITS AND SETOFFS. The amount of all payments on this claim has been credited and deducted for the purpose of making this proof. In filing this claim, claimant has deducted all amounts that claimant owes to debtor.

6. SUPPORTING DOCUMENTS: *Attach copies of supporting documents,* such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, or evidence of security interests. Do not send original documents If the documents are not available, explain If the documents are voluminous, attach a summary.

7. TIME-STAMPED COPY To receive an acknowledgement 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

8. **Signature:** Check the appropriate box.
☐ I am the creditor. ☒ I am the creditor's authorized agent (Attach copy of power of attorney, if any) ☐ I am the trustee, or the Debtor, or their authorized agent (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: LOUIS POLIMENO
Title: ATTORNEY
Company: _____
Address and telephone number (if different from notice address above).
3DT FL 2ND ST
BRONX, NY 10467
Telephone number: 718-817-4500

(Signature) 2/20/14 (Date)

email: POLIMENO26@GMAIL.COM

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.

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The attorneys for the Debtors and their court-appointed claims agent, GCG, are not authorized and are not providing you with any legal advice

PLEASE SEND YOUR ORIGINAL, COMPLETED CLAIM FORM AS FOLLOWS. **IF BY MAIL:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, Inc., P.O. Box 9982, Dublin, Ohio 43017-5982. **IF BY HAND OR OVERNIGHT COURIER:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, 5151 Blazer Parkway, Suite A, Dublin, OH 43017. **IF BY HAND.** United States Bankruptcy Court, SDNY, 300 Quarropas Street, Room 248, White Plains, New York 10601; Attn: Clerk of the Court ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR EMAIL WILL NOT BE ACCEPTED.

The Law Office of Louis G. Solimano
305 East 204th Street
Bronx, New York 10467

CERTIFIED MAIL

7012 0470 0001 4595 7985

UNITED STATES POSTAL SERVICE

1000

43017

U.S. POSTAGE
PAID
YONKERS,NY
10706
DEC 30, '13
AMOUNT
$6.11
00033460-12

Sound Shore Medical Center
c/o GCG, Inc.
PO Box 9982
Dublin, OH 43017-5982

43017B5982 B050

UNITED STATES BANKRUPTCY COURT SOUTHERN DISTRICT OF NEW YORK	ADMINISTRATIVE EXPENSE PROOF OF CLAIM	Administrative Expense Bar Date January 31, 2014

Note: This form should only be used by claimants asserting an Administrative Expense arising between May 29, 2013 and November 6, 2013 (the "Administrative Claim Period") THIS FORM SHOULD NOT BE USED FOR ANY CLAIMS THAT ARE NOT OF A KIND ENTITLED TO PRIORITY IN ACCORDANCE WITH 11 U.S.C. §§ 503(b) and 507(a)(2).

Indicate Debtor(s) against which you assert a claim by checking the appropriate box(es) below.

Name of Debtor (Check Only One):	Case No.	Name of Debtor (Check Only One):	Case No.
☒ Sound Shore Medical Center of Westchester	13-22840	☐ The M.V.H. Corporation	13-22843
☒ The Mount Vernon Hospital, Inc.	13-22841	☐ SoundShore Health System, Inc.	13-22844
☐ Howe Avenue Nursing Home, d/b/a Helen and Michael Schaffer Extended Care Center	13-22842	☐ NRHMC Services Corporation	13-22845
		☐ New Rochelle Sound Shore Housing LLC	13-22846

Name of Creditor
(The person or entity to whom the debtor owes money or property)
EVA S. GRZELAK

☐ Check box if you are aware that anyone else has filed a proof of claim relating to your administrative expense claim. Attach copy of statement giving particulars

THE GARDEN CITY GROUP, INC. JAN - 2 2014

Name and Addresses Where Notices Should be Sent:
16 UNIVERSITY PLACE #1D
PORT CHESTER NY 10573

Check here if this claim: ☐ replaces or ☐ amends a previously filed administrative expense claim.

Claim Number (if known): _____

Dated. _____

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR: —

1. BASIS FOR CLAIM:
☐ Goods sold ☒ Services performed ☐ Personal Injury/Wrongful Death ☐ Wages (Dates)_____
☐ Money loaned ☐ Taxes ☐ Retiree Benefits as Defined in 11 U.S.C. § 1114(a) ☐ Other(Specify:_____

2. DATE DEBT WAS INCURRED (IF KNOWN):

3. DESCRIPTION OF CLAIM (IF KNOWN) PAIN IN HIP & FEMUR, DEPRESSION, HYPOTHERMIA

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: 7, $_____ (Total)

5 CREDITS AND SETOFFS The amount of all payments on this claim has been credited and deducted for the purpose of making this proof. In filing this claim, claimant has deducted all amounts that claimant owes to debtor.

6. SUPPORTING DOCUMENTS: *Attach copies of supporting documents,* such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, or evidence of security interests. Do not send original documents. If the documents are not available, explain. If the documents are voluminous, attach a summary.

7. TIME-STAMPED COPY. To receive an acknowledgement 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

8 **Signature:** Check the appropriate box.

☒ I am the creditor. ☐ I am the creditor's authorized agent. (Attach copy of power of attorney, if any) ☐ I am the trustee, or the Debtor, or their authorized agent. (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorser, or other codebtor (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: EVA S. GRZELAK
Eva S. Grzelak (Signature)
Dec. 26th 2013 (Date)
Title: _____
Company: _____
Address and telephone number (if different from notice address above):
_____
_____
Telephone number: 914 939-1407 email: evagrzelak@verizon.net

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.

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The attorneys for the Debtors and their court-appointed claims agent, GCG, are not authorized and are not providing you with any legal advice.

PLEASE SEND YOUR ORIGINAL, COMPLETED CLAIM FORM AS FOLLOWS: **IF BY MAIL:** Sound Shore Medical of Westchester, *et al*, c/o GCG, Inc., P.O. Box 9982, Dublin, Ohio 43017-5982 **IF BY HAND OR OVERNIGHT COURIER:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, 5151 Blazer Parkway, Suite A, Dublin, OH 43017. **IF BY HAND:** United States Bankruptcy Court, SDNY, 300 Quarropas Street, Room 248, White Plains, New York 10601; Attn: Clerk of the Court. ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR EMAIL WILL NOT BE ACCEPTED

FILED - 01105
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

WESTCHESTER

28 DEC 2013

Sound Shore Medical Center
of Westchester
% GCG
P.O. Box 9982
Dublin, OH 43017-5982

43017598282

Eva D. [illegible]
16 University Place 1D
Port Chester, NY 10573

UNITED STATES BANKRUPTCY COURT SOUTHERN DISTRICT OF NEW YORK	**ADMINISTRATIVE EXPENSE PROOF OF CLAIM**	Administrative Expense Bar Date January 31, 2014

Note: This form should only be used by claimants asserting an Administrative Expense arising between May 29, 2013 and November 6, 2013 (the "Administrative Claim Period") THIS FORM SHOULD NOT BE USED FOR ANY CLAIMS THAT ARE NOT OF A KIND ENTITLED TO PRIORITY IN ACCORDANCE WITH 11 U.S.C. §§ 503(b) and 507(a)(2)

Indicate Debtor(s) against which you assert a claim by checking the appropriate box(es) below.

Name of Debtor (Check Only One):	Case No.	Name of Debtor (Check Only One):	Case No.
☒ Sound Shore Medical Center of Westchester	13-22840	☐ The M.V.H. Corporation	13-22843
☐ The Mount Vernon Hospital, Inc.	13-22841	☐ SoundShore Health System, Inc.	13-22844
☐ Howe Avenue Nursing Home, d/b/a Helen and Michael Schaffer Extended Care Center	13-22842	☐ NRHMC Services Corporation	13-22845
		☐ New Rochelle Sound Shore Housing LLC	13-22846

Name of Creditor
(The person or entity to whom the debtor owes money or property)
Stephen Jesmajian

☐ Check box if you are aware that anyone else has filed a proof of claim relating to your administrative expense claim. Attach copy of statement giving particulars.

Name and Addresses Where Notices Should be Sent.
121 Edgars Lane
Hastings on Hudson NY 10706

Check here if this claim ☐ replaces or ☐ amends a previously filed administrative expense claim.
Claim Number (if known): _____
Dated: _____

S.D. OF N.Y.
FILED
2014 JAN 31 P 4:36
U.S. BANKRUPTCY COURT

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR:

1. BASIS FOR CLAIM:
☐ Goods sold ☐ Services performed ☐ Personal Injury/Wrongful Death ☐ Wages (Dates) _____
☐ Money loaned ☐ Taxes ☐ Retiree Benefits as Defined in 11 U.S.C. § 1114(a) ☒ Other (Specify): Sick Time Compensation

2. DATE DEBT WAS INCURRED (IF KNOWN):

3. DESCRIPTION OF CLAIM (IF KNOWN): Sick time owed 90 hrs/year x 20 years → max 900 hrs

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 69,230 (Total)

5. CREDITS AND SETOFFS: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof. In filing this claim, claimant has deducted all amounts that claimant owes to debtor.

6. SUPPORTING DOCUMENTS *Attach copies of supporting documents,* such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, or evidence of security interests Do not send original documents If the documents are not available, explain. If the documents are voluminous, attach a summary.

7. TIME-STAMPED COPY: To receive an acknowledgement 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

THE GARDEN CITY GROUP INC. FEB - 7 2014

8 **Signature:** Check the appropriate box.

☒ I am the creditor. ☐ I am the creditor's authorized agent. (Attach copy of power of attorney, if any) ☐ I am the trustee, or the Debtor, or their authorized agent. (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief

Print Name: Stephen Jesmajian
Title: Chief of Medicine
Company: Sound Shore Medical Center
Address and telephone number (if different from notice address above):
16 Guion Pl
New Rochelle NY 10802
Telephone number: (914) 365-3681

(Signature) 1/31/14 (Date)

email: jesmajian@sshsw.org

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.

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The attorneys for the Debtors and their court-appointed claims agent, GCG, are not authorized and are not providing you with any legal advice.

PLEASE SEND YOUR ORIGINAL, COMPLETED CLAIM FORM AS FOLLOWS: **IF BY MAIL:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, Inc., P.O Box 9982, Dublin, Ohio 43017-5982. **IF BY HAND OR OVERNIGHT COURIER:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, 5151 Blazer Parkway, Suite A, Dublin, OH 43017. **IF BY HAND:** United States Bankruptcy Court, SDNY, 300 Quarropas Street, Room 248, White Plains, New York 10601; Attn: Clerk of the Court. ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR EMAIL WILL NOT BE ACCEPTED.

CRT

FILED - 01454
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

ROUTING SHEET FOR CASES WITH CLAIMS AGENTS

Date: February 5, 2014

To: GCG, Inc.
1985 Marcus Avenue, Suite 200
Lake Success, NY 11042

From: Mimi Correa
Deputy Clerk

1. a. Number of claims in this transmittal: 24

b. Case name (*if applicable*): **Sound Shore Medical Center, et al.**
c. Description of claim: (Creditor name and amount of claim.)

LaTonya Buchanan	$TBD
LaTonya Buchanan	$TBD
LaTonya Buchanan	$TBD
AAA Office Solutions	$869.00
AAA Office Solutions	$6,351.00
Janice Bistritz	$5,630.60
Janice Bistritz	$5,630.60
Sieman Healthcare	$3,515.60
Sieman Healthcare	$5,583.37
Consuelo Rodriguez MD	$2,185.25
Consuelo Rodriguez MD	$81,000.00
Anna Kazanskaya MD	$13,415.58
Linda Williams MD	$4,156.11
Daniel Pomerantz MD	$10,834.00
Roger Coron	$5,181.03
Kameswari Lakshmi	$1,730.76
Frank Tamuzzo MD	$6,034.00
Prasanta [illegible]	$3,928.00
Jeffrey [illegible]	$6,000.00
Michelle [illegible]	$4,500.00
Stephen Jesserjian	$69,230.00
Munima R. Gaikh	$1,000.00
Danila Del[illegible]	$3,928.30
Margaret [illegible] MD	$2,528.64 plus

2. a. Courier: Federal Express
b. Receipt to pick up at Court: _____

CONFIRMATION BY RECIPIENT

NOTE: *The portion below is to be completed by recipient and returned to the Court by FAX* [914-390-4073].

Date: _____

*I have received the number and description of claims as indicated in line # **1.a.** above.*

Employee's name: _____
[*Please print*]
Employee's signature: _____

Employee's telephone number: _____
Name of Employer: _____

From: (631) 470-5000
Attn: Arturo D. Tavarez
Case Adm./ECF Trainer
US Bankruptcy Court, SDNY
300 Quarropas Street
WHITE PLAINS, NY 10601

Origin ID: NESA

FedEx Express

J13111302120326

Ship Date: 10JUL13
ActWgt: 1.0 LB
CAD: 100098143/INET3370

Delivery Address Bar Code

Ref # -SSM-

RMA #:
Return Reason:

SHIP TO: (631) 470-5000 BILL THIRD PARTY

Attn: Bankruptcy Dept.
c/o GCG, Inc.
5151 Blazer Parkway
Suite A
DUBLIN, OH 43017

RETURNS MON-FRI
STANDARD OVERNIGHT

TRK# 7961 9382 6590
0221

43017
OH-US

518G1/AA04/93AB

1. Select the 'Print' button to print 1 copy of each label.
2. The Return Shipment instructions, which provide your recipient with information on the returns process, will be printed with the label(s).
3 After printing, select your next step by clicking one of the displayed buttons.

Note: To review or print individual labels, select the Label button under each label image above.

UNITED STATES BANKRUPTCY COURT SOUTHERN DISTRICT OF NEW YORK	**ADMINISTRATIVE EXPENSE PROOF OF CLAIM**	**Administrative Expense Bar Date** January 31, 2014

Note: This form should only be used by claimants asserting an Administrative Expense arising between May 29, 2013 and November 6, 2013 (the "Administrative Claim Period"). THIS FORM SHOULD NOT BE USED FOR ANY CLAIMS THAT ARE NOT OF A KIND ENTITLED TO PRIORITY IN ACCORDANCE WITH 11 U.S.C. §§ 503(b) and 507(a)(2)

Indicate Debtor(s) against which you assert a claim by checking the appropriate box(es) below.

Name of Debtor (Check Only One):	Case No.	Name of Debtor (Check Only One):	Case No.
☐ Sound Shore Medical Center of Westchester	13-22840	☐ The M.V.H. Corporation	13-22843
☒ The Mount Vernon Hospital, Inc.	13-22841	☐ SoundShore Health System, Inc	13-22844
☐ Howe Avenue Nursing Home, d/b/a Helen and Michael Schaffer Extended Care Center	13-22842	☐ NRHMC Services Corporation	13-22845
		☐ New Rochelle Sound Shore Housing, LLC	13-22846

Name of Creditor
(The person or entity to whom the debtor owes money or property)
Neelkanth LLC D/B/A Soundshore Pharmacy Inc.

☐ Check box if you are aware that anyone else has filed a proof of claim relating to your administrative expense claim. Attach copy of statement giving particulars.

Name and Addresses Where Notices Should be Sent:
14 Agnola Street
Yonkers, NY 10707

Check here if this claim: ☐ replaces or ☐ amends a previously filed administrative expense claim.

Claim Number (if known): _____

Dated: _____

FILED
2014 JUN 30 P 1:14
U.S. BANKRUPTCY COURT

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR:

1. BASIS FOR CLAIM:
☒ Goods sold ☒ Services performed ☐ Personal Injury/Wrongful Death ☐ Wages (Dates) _____
☐ Money loaned ☐ Taxes ☐ Retiree Benefits as Defined in 11 U.S.C. § 1114(a) ☒ Other (Specify) _____

2. DATE DEBT WAS INCURRED (IF KNOWN): January 2013 to May 2013

3. DESCRIPTION OF CLAIM (IF KNOWN): - Filled RXs for employees of Mount Vernon Hospital

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM $ 8796.39 (Total) - bills not paid, co-pays not paid/union employees when they was off. for Medications of

5. CREDITS AND SETOFFS: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof. In filing this claim, claimant has deducted all amounts that claimant owes to debtor.

6. SUPPORTING DOCUMENTS. *Attach copies of supporting documents,* such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, or evidence of security interests. Do not send original documents. If the documents are not available, explain. If the documents are voluminous, attach a summary.

7. TIME-STAMPED COPY: To receive an acknowledgement 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

THE GARDEN CITY GROUP, INC. FEB - 7 2014

8 **Signature:** Check the appropriate box.

☒ I am the creditor. ☐ I am the creditor's authorized agent. (Attach copy of power of attorney, if any) ☐ I am the trustee, or the Debtor, or their authorized agent. (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: Mukesh J. Patel
Title: Owner
Company: Neelkanth LLC
Address and telephone number (if different from notice address above):
14 Agnola Street
Yonkers, NY 10707
Telephone number: 914-714-2886

(Signature) _____ (Date) 1/18/2014

soundshorepharmacy@gmail.com.
email: mjpRPh@gmail.com

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

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The attorneys for the Debtors and their court-appointed claims agent, GCG, are not authorized and are not providing you with any legal advice

PLEASE SEND YOUR ORIGINAL, COMPLETED CLAIM FORM AS FOLLOWS: **IF BY MAIL:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, Inc., P.O Box 9982, Dublin, Ohio 43017-5982. **IF BY HAND OR OVERNIGHT COURIER:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, 5151 Blazer Parkway, Suite A, Dublin, OH 43017 **IF BY HAND** United States Bankruptcy Court, SDNY, 300 Quarropas Street, Room 248, White Plains, New York 10601; Attn: Clerk of the Court. ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR EMAIL WILL NOT BE ACCEPTED.

FILED - 01376
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

CRT

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

ROUTING SHEET FOR CASES WITH CLAIMS AGENTS

Date: February 5, 2014

To: GCG, Inc.
1985 Marcus Avenue, Suite 200
Lake Success, NY 11042

From: Mimi Correa
Deputy Clerk

2 of 3 Packs

1. a. Number of claims in this transmittal: 39

b. Case name (*if applicable*): **Sound Shore Medical Center, et al.**
c. Description of claim: (Creditor name and amount of claim.)

Mary K. Murphy	$See Attachment
Renella Mitchell	$2,995.00
Bio-Rad Laboratories, Inc.	$3,850.37
Joseph DeRose	$9,639.57
Maria S. Albito	$7,597.09
Beverly Stewart	$17,731.00
Daisy Kuriakose	$26,000.00
Daisy Kuriakose	$1,000.00
Sonia P. Slavicjo	$51,587.00
Cynthia Holmes	$3,520.00
Sanipro Disposal Inc.	$29,448.22
Sanipro Disposal Inc.	$12,387.50
Robert C. Goldstein	$2,000.00
Edna Buckley	???
Stephen Jesmajian	$70,000.00
Susan Kurian	$22,865.50
Veronica Turnbull	$2,458.33
Silvie Maria Correia	$4,127.24
Siemens Medical Solutions	$63,663.49
Robin Ten Eyck	$45,116.43
Saramma George	$3,080.00
Benedicte Hauser	$See Attachment
Neelkanth LLC	$8,796.39
Neelkanth LLC	$267,992.00
Neelkanth LLC	$16,020.54
Frank D'Ambrosio	$300.00
Metro Blood Service	$104,169.00
Orange Pathology Associates	$See Attachment
Orange Pathology Associates	$See Attachment
Dr. Bartholome Rodriguez	$300,000.00
Dr. Patricia Ann Devine	$185,113.55
Dr. Rozafa L. Pali	$300,000.00
Empire Healthchoice Assurance	See Attachment
Empire Healthchoice Assurance	See Attachment
Empire Healthchoice Assurance	See Attachment
Empire Healthchoice Assurance	See Attachment

Empire Healthchoice Assurance See Attachment
Empire Healthchoice Assurance See Attachment

2. a. Courier: Federal Express
b. Recipient to pick up at Court: _____

CONFIRMATION BY RECIPIENT

NOTE: *The portion* ***below is to be completed by recipient and returned to the Court by*** *FAX* **[914-390-4073].**

Date: _____

I have received the number and description of claims as indicated in line # ***1.a.*** *above.*

Employee's name: _____
[*Please print*]
Employee's signature: _____

Employee's telephone number: _____
Name of Employer: _____

From. (631) 470-5000
Attn: Arturo D. Tavarez
Case Adm./ECF Trainer
US Bankruptcy Court, SDNY
300 Quarropas Street
WHITE PLAINS, NY 10601

Origin ID: NESA

FedEx Express

J13111302120326

Ship Date: 10JUL13
ActWgt: 1.0 LB
CAD: 100098143/INET3370

Delivery Address Bar Code

Ref # -SSM-

RMA #:
Return Reason:

SHIP TO: (631) 470-5000 BILL THIRD PARTY

Attn: Bankruptcy Dept.
c/o GCG, Inc.
5151 Blazer Parkway
Suite A
DUBLIN, OH 43017

RETURNS MON-FRI
STANDARD OVERNIGHT

TRK# 7961 9382 5788
0221

43017
OH-US

518G1/AA04/03AB

1. Select the 'Print' button to print 1 copy of each label.
2. The Return Shipment instructions, which provide your recipient with information on the returns process, will be printed with the label(s).
3. After printing, select your next step by clicking one of the displayed buttons.

Note: To review or print individual labels, select the Label button under each label image above.

B10 (Official Form 10) (04/13)

UNITED STATES BANKRUPTCY COURT SOUTHERN DISTRICT OF NEW YORK		Proof of Claim
Name of Debtor: **The Mount Vernon Hospital, Inc.**	Case Number: **13-22841**	

NOTE: *Do not use this form to make a claim for an administrative expense that arises after the bankruptcy filing. You may file a request for payment of an administrative expense according to 11 U.S.C. § 503.*

Name of Creditor (the person or other entity to whom the debtor owes money or property):
Nurtrition Management Services Co.

COURT USE ONLY

Name and address where notices should be sent:
Warren J. Martin Jr., Esq.
Porzio, Bromberg & Newman, P.C
100 Southgate Parkway
Morristown, NJ 07962-1997
Telephone number: **(973) 538-4006** email: **wjmartin@pbnlaw.com**

☐ Check this box if this claim amends a previously filed claim.

Court Claim Number: ____
(If known)

Filed on: ____

Name and address where payment should be sent (if different from above):
Nutrition Management Services Co.
2071 Kimberton Road
PO Box 725
Kimberton, PA 19442
Telephone number: **(610) 935-2050** email: **jvroberts@nmsc.com**

☐ Check this box if you are aware that anyone else has filed a proof of claim relating to this claim. Attach copy of statement giving particulars.

1. Amount of Claim as of Date Case Filed: **$124,288.68**

If all or part of your claim is secured, complete item 4.

If all or part of your claim is entitled to priority, complete item 5.

☐ Check this box if claim includes interest or other charges in addition to the principal amount of claim. Attach a statement that itemizes interest or charges.

2. Basis for Claim: **Goods Sold / Services Performed**
(See instruction #2)

3. Last four digits of any number by which creditor identifies debtor:	**3a. Debtor may have scheduled account as:**	**3b. Uniform Claim Identifier (optional):**
____	____ (See instruction #3a)	____ (See instruction #3b)

4. Secured Claim (See instruction #4)
Check the appropriate box if the claim is secured by a lien on property or a right of setoff, attach required redacted documents, and provide the requested information.

Nature of property or right of setoff: ☐ Real Estate ☐ Motor Vehicle ☐ Other
Describe:

Value of Property: $____

Annual Interest Rate: 0 % ☐ Fixed or ☐ Variable
(when case was filed)

Amount of arrearage and other charges, as of the time case was filed, included in secured claim, if any: $____

Basis for perfection: ____

Amount of Secured Claim: $____

Amount Unsecured: $____

5. Amount of Claim Entitled to Priority under 11 U.S.C. §507(a). If any portion of the claim falls into one of the following categories, check the box specifying the priority and state the amount.

☐ Domestic support obligations under 11 U.S.C. §507(a)(1)(A) or (a)(1)(B).

☐ Wages, salaries, or commissions (up to $12,475*) earned within 180 days before the case was filed or the debtor's business ceased, whichever is earlier - 11 U.S.C. §507(a)(4).

☐ Contributions to an employee benefit plan - 11 U.S.C. §507(a)(5).

Amount entitled to priority:

☐ Up to $2,775* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 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)(**§503(b)(9)**).

$ **9,353.80**

**Amounts are subject to adjustment on 4/01/16 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.*

6. Credits. The amount of all payments on this claim has been credited for the purpose of making this proof of claim (See instruction #6)

B10 (Official Form 10) (04/13)

7. **Documents:** Attached are **redacted** copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, security agreements, or, in the case of a claim based on an open-end or revolving consumer credit agreement, a statement providing the information required by FRBP 3001(c)(3)(A). If the claim is secured, box 4 has been completed, and **redacted** copies of documents providing evidence of perfection of a security interest are attached. If the claim is secured by the debtor's principal residence, the Mortgage Proof of Claim Attachment is being filed with this claim. (*See instruction #7, and the definition of "**redacted**".*)

DO NOT SEND ORIGINAL DOCUMENTS. ATTACHED DOCUMENTS MAY BE DESTROYED AFTER SCANNING.

If the documents are not available, please explain: **Priority Administrative Claim is based on §503(b)(9)**

8. **Signature:** (See instruction #8)

Check the appropriate box.

☐ I am the creditor. ■ I am the creditor's authorized agent. ☐ I am the trustee, or the debtor, or their authorized agent. (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: **Warren J. Martin Jr., Esq.**
Title: **Attorney**
Company: **Porzio, Bromberg & Newman, P.C.**
Address and telephone number (if different from notice address above):
100 Southgate Parkway
P.O. Box 1997
Morristown, NJ 07962-1997
Telephone number: **973-538-4006** email: **wjmartin@pbnlaw.com**

(Signature) 9/12/2013 (Date)

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.

PORZIO
BROMBERG&NEWMAN P.C.

ATTORNEYS AT LAW

MORRISTOWN NJ • NEW YORK NY • PRINCETON NJ • WESTBOROUGH MA

MARIA P. DERMATIS
SENIOR PARALEGAL
DIRECT DIAL NO.: 973-889-4252
E-MAIL ADDRESS: MPDERMATIS@PBNLAW.COM

September 12, 2013

VIA FEDERAL EXPRESS OVERNIGHT
Sound Shore Medical Center of Westchester, *et al.*
c/o GCG, Inc.
5151 Blazer Parkway, Suite A
Dublin, OH 43017

Re: *In re:* Sound Shore Medical Center of Westchester, *et al.*
Case No.: 13-28840 (RDD)
Our File No.: 09999-48003

Dear Sir or Madam:

In connection with the *Sound Shore Medical Center of Westchester* bankruptcy matter, enclosed please find an original and one copy of a Proof of Claim Form, filed on behalf of Nutrition Management Services Company.

Kindly return a copy of the proof of claim form marked "filed" to me in the enclosed federal express envelope.

Thank you for your attention to this matter.

Very truly yours,

Maria P. Dermatis

Maria P. Dermatis.
Senior Paralegal to Warren J. Martin Jr.

/mpd
Enclosures

100 SOUTHGATE PARKWAY, P.O. BOX 1997
MORRISTOWN, NJ 07962-1997
TELEPHONE (973) 538-4006
FAX (973) 538-5146
www.pbnlaw.com

LIMITED POWER OF ATTORNEY

The undersigned hereby grants Warren J. Martin Jr. Esq., Limited Power of Attorney for the specific purpose of signing proof(s) of claim on behalf of Nutrition Management Services Company in connection with the bankruptcy proceedings of (i) Sound Shore Medical Center of Westchester (Case No. 13-22840), (ii) The Mount Vernon Hospital (Case No. 13-22841), (iii) Howe Avenue Nursing Home, Inc. (Case No. 13-22842), (iv) The M.V.H. Corporation (Case No. 13-22843), (v) Sound Shore Health System, Inc. (Case No. 13-22844), (vi) NRHMC Services Corporation (Case No. 13-22845), and (vii) New Rochelle Sound Shore Housing, LLC (Case No. 13-22846), which are currently pending in the United States Bankruptcy Court for the Southern District of New York.

Nutrition Management Services Company

By: _____

Name: Joseph V. Roberts

Title: Chief Executive Officer

Nutrition Management Services Company
Summary of Pre-Petition Obligations Receivable from
Sound Shore Medical Center and Mount Vernon Hospital
As of May 29, 2013

Sound Shore Medical Center

Pre-Petition Accounts Receivable includes $55,503.40 20-days prior to filing charges 20 days @ $2,775.17/day		207,635.03	
Note Receivable (Principle)		423,759.14	
Interest on Note - Jan - April	($423,759.14 * 1.5% * 4 mo.)	25,425.49	
May (29 days)	($423,759.14 * 1.5% / 31 * 29)	5,946.30	662,765.96

Mount Vernon Hospital

Pre-Petition Accounts Receivable includes $9,353.80 20-days prior to filing charges 20 days @ $467.69/day		44,741.44	
Note Receivable (Principle)		73,043.97	
Interest on Note - Dec - April	($73,043.97 * 1.5% * 5 mo.)	5,478.30	
May (29 days)	($73,043.97 * 1.5% / 31 * 29)	1,024.97	124,288.68
	TOTAL		**$787,054.64**

Prepared by Mark S. Aeder 09/05/2013

PROMISSORY NOTE
MOUNT VERNON HOSPITAL
12 N. 7TH AVENUE
MOUNT VERNON, NY 10550

$73,043.97

This promissory note (the "Note") is made and effective November 15, 2012, by and between Mount Vernon Hospital, a [corporation] (the "Borrower"), and Nutrition Management Services Company, a [corporation] (the "Payee").

1. PROMISE OF PAYMENT.

FOR VALUE RECEIVED, the Borrower promises to pay to the Payee, at 2071 Kimberton Road, Kimberton, Pa 19442, or at such other place as the Payee may designate in writing from time to time, the past due principal amount of Seventy Three Thousand Forty Three Dollars and Ninety Seven Cents ($73,043.97), together with interest accruing on the unpaid balance thereof until due. The interest rate on this Note shall bear interest equal to 1.5% percent monthly on the unpaid balance, or the maximum amount allowed by applicable law. Interest shall be computed on the basis of a year of 365 days and the actual number of days elapsed.

2. MONTHLY INSTALLMENT PAYMENTS.

The Borrower will pay the first payment of Fourteen Thousand Six Hundred Eight Dollars and Seventy Nine Cents ($14,608.79) which is equal to 20% of said past due principal. This payment is due at the signing of the Promissory Note. The Borrower will pay the remaining past due principal and interest, accruing at the rate of 1.5 % per month on the unpaid balance to the Payee in 12 equal installment payments of $5,357.34 on or before the 31st day of each month, until the past due principal and interest have been paid in full. Payments shall be to the Payee's address as designated above. All payments will be applied first to interest and the remainder to past due principal. Acceptance by the Payee of any payment differing from the designated installment payment listed above does not relieve the Borrower of the obligation to honor the requirements of this Note.

3. INITIAL DATE.

The first payment of $14,608.79 under this Note is due and payable on the day of signing of the Promissory note, on the 31st day of December, 2012. The balance of the note shall be paid in 12 equal installments beginning on or before January 31, 2013.

4. **PREPAYMENT.**

The Borrower may prepay this Note, in whole or in part, at any time before maturity without penalty or premium.

5. **EVENTS OF DEFAULT.**

The Borrower will be deemed to be in default under this Note on the occurrence of any of the following events (each an "Event of Default"): (i) on the Borrower's failure to make any payment when due under this Note, which failure continues for a period of ten (10) days after such due date; (ii) on the filing regarding the Borrower of any voluntary or involuntary petition for relief under the United States Bankruptcy Code or the initiation of any proceeding under federal law or law of any other jurisdiction for the general relief of debtors; or (iii) on the execution by the Borrower of an assignment for the benefit of creditors or the appointment of a receiver, custodian, trustee, or similar party to take possession of the Borrower's assets or property.

6. **ACCELERATION; REMEDIES ON DEFAULT.**

On the occurrence of any Event of Default, at the option of the Payee, all principal and other amounts owed under this Note shall become immediately due and payable without notice or demand by the Payee, and the Payee, in addition to its rights and remedies under this Note, may pursue any legal or equitable remedies that are available to it.

7. **WAIVER OF PRESENTMENT; DEMAND.**

The Borrower hereby waives presentment, demand, notice of dishonor, notice of default or delinquency, notice of protest and nonpayment, notice of costs, expenses or losses and interest thereon, notice of interest on interest and late charges, and diligence in taking any action to collect any sums owing under this Note, including (to the extent permitted by law) waiving the pleading of any statute of limitations as a defense to any demand against the undersigned.

8. (*Optional*) **TIME OF ESSENCE.**

Time is of the essence with respect to every provision of this Note.

9. **SUCCESSORS AND ASSIGNS.**

All references in this Note to the Borrower and the Payee shall be deemed to include, as applicable, a reference to their respective successors and assigns. The provisions of this Note shall be binding upon and shall inure to the benefit of the successors and assigns of the Borrower and the Payee.

10. NOTICE.

Any notice or other communication provided for herein or given hereunder to a party hereto shall be in writing and shall be given in person, by overnight courier, or by mail (registered or certified mail, postage prepaid, return receipt requested) to the respective party as follows:

If to the Payee:
Nutrition Management Services Company
2071 Kimberton Road
Kimberton, Pa. 19442

If to the Borrower:
Mount Vernon Hospital
12 North 7th Avenue
Mt. Vernon, NY. 10550

11. GOVERNING LAW.

This Note shall be governed as to validity, interpretation, construction, effect, and in all other respects by the laws and decisions of the State of Pennsylvania, without regards to its conflict-of-law provisions. The Borrower hereby irrevocably consents to the jurisdiction of the courts of Chester County, Pennsylvania with respect to any matter arising under this Note, and further irrevocably consents to service of process by hand delivery to the address listed above for the Borrower.

12. ENTIRE AGREEMENT.

This Note constitutes the final, complete, and exclusive statement of the agreement of the parties with respect to the subject matter hereof, and supersedes any and all other prior and contemporaneous agreements and understandings, both written and oral, between the parties.

13. NO IMPLIED WAIVER.

The Payee's failure to exercise any right or remedy provided in this Note shall not be construed as a waiver of any future exercise of that right or exercise of any other right or remedy to which the Payee may be entitled.

14. COLLECTION COSTS AND ATTORNEYS' FEES.

The Borrower agrees to pay any and all costs incurred by the Payee in collecting sums payable under this Note, including reasonable attorneys' fees and court costs in addition to other amounts due, without protest of any kind.

15. SEVERABILITY.

If one or more of the provisions of this Note shall be declared or held to be invalid, illegal, or unenforceable in any respect in any jurisdiction, the validity, legality, and enforceability of the remaining provisions hereof shall not in any way be affected or impaired thereby and any such declaration or holding shall not invalidate or render unenforceable such provision in any other jurisdiction.

16. HEADINGS.

Headings used in this Note are provided for convenience only and shall not be used to construe meaning or intent.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the parties have executed this Note as of the date first above written.

PAYEE Nutrition Management Services Company

By: _____
Name: Joseph V. Roberts
Title: CEO

BORROWER Mount Vernon Hospital

By: _____
Name: John Spicer
Title: President & CEO

Mount Vernon Note Receivable
Payment Schedule
As of 11/15/12

Original Balance	$73,043.97	
Monthly Interest Rate	1.50%	

Period	Payment	Principal	Interest	Balance	Payment Due Dates
1	$14,608.79	$14,608.79	$0.00	$58,435.18	12/31/2012
2	$5,357.34	$4,480.81	$876.53	$53,954.37	1/31/2013
3	$5,357.34	$4,548.02	$809.32	$49,406.34	2/28/2013
4	$5,357.34	$4,616.24	$741.10	$44,790.10	3/31/2013
5	$5,357.34	$4,685.49	$671.85	$40,104.61	4/30/2013
6	$5,357.34	$4,755.77	$601.57	$35,348.84	5/31/2013
7	$5,357.34	$4,827.11	$530.23	$30,521.73	6/30/2013
8	$5,357.34	$4,899.51	$457.83	$25,622.22	7/31/2013
9	$5,357.34	$4,973.01	$384.33	$20,649.21	8/31/2013
10	$5,357.34	$5,047.60	$309.74	$15,601.61	9/30/2013
11	$5,357.34	$5,123.32	$234.02	$10,478.29	10/31/2013
12	$5,357.34	$5,200.17	$157.17	$5,278.13	11/30/2013
13	$5,357.34	$5,278.13	$79.17	($0.00)	12/31/2013
	$78,896.87	$73,043.97	$5,852.86		

Statement

NUTRITION MANAGEMENT SERVICES CO.
2071 Kimberton Road
P.O. Box 725
Kimberton, PA 19442

Date
11/9/2012

To:
Mount Vernon Hospital ATTN: Nick Daddesio 12 N 7th Ave Mt Vernon NY 10550

Amount Due	Amount Enc.
$73,043.97	

Date	Transaction	Amount	Balance
06/30/2011	INV #SOL6321. Due 07/30/2011. Orig. Amount $212.20. transfer of 06/30/11 Solomon finance charges	212.20	212.20
01/31/2012	CREDMEM #55362.	-4,166.00	-3,953.80
02/29/2012	CREDMEM #55446.	-3,005.46	-6,959.26
06/01/2012	INV #55555. Due 07/01/2012. Orig. Amount $14,498.39.	3,195.17	-3,764.09
07/01/2012	INV #55615. Due 07/31/2012. Orig. Amount $14,498.39.	14,498.39	10,734.30
08/01/2012	INV #55693. Due 08/31/2012. Orig. Amount $14,498.39.	14,498.39	25,232.69
09/01/2012	INV #55752. Due 09/30/2012. Orig. Amount $14,498.39.	14,498.39	39,731.08
10/01/2012	INV #55804. Due 10/31/2012. Orig. Amount $14,498.39.	14,498.39	54,229.47
10/02/2012	INV #FC 11. Due 10/02/2012. Orig. Amount $3,372.80. Finance Charge	3,372.80	57,602.27
11/01/2012	INV #55875. Due 11/30/2012. Orig. Amount $14,498.39.	14,498.39	72,100.66
11/09/2012	INV #FC 17. Due 11/09/2012. Orig. Amount $943.31. Finance Charge	943.31	73,043.97

CURRENT	1-30 DAYS PAST DUE	31-60 DAYS PAST DUE	61-90 DAYS PAST DUE	OVER 90 DAYS PAST DUE	Amount Due
15,441.70	14,498.39	17,871.19	14,498.39	10,734.30	$73,043.97

Statement

NUTRITION MANAGEMENT SERVICES CO.
2071 Kimberton Road
P.O. Box 725
Kimberton, PA 19442

Date
5/29/2013

To:
Mount Vernon Hospital
ATTN: Nick Daddesio
12 N 7th Ave
Mt Vernon NY 10550

Amount Due	Amount Enc.
$44,741.44	

Date	Transaction	Amount	Balance
03/01/2013	INV #56082. Due 03/30/2013. Orig. Amount $14,498.39.	12,636.22	12,636.22
04/01/2013	INV #56140. Due 04/30/2013. Orig. Amount $14,498.39.	14,498.39	27,134.61
04/25/2013	INV #FC 19. Due 04/25/2013. Orig. Amount $3,624.60. Finance Charge	3,624.60	30,759.21
05/29/2013	INV #56190. Due 06/28/2013. Orig. Amount $13,563.01.	13,563.01	44,322.22
05/29/2013	INV #FC 25. Due 05/29/2013. Orig. Amount $419.22. Finance Charge	419.22	44,741.44

CURRENT	1-30 DAYS PAST DUE	31-60 DAYS PAST DUE	61-90 DAYS PAST DUE	OVER 90 DAYS PAST DUE	Amount Due
13,982.23	14,498.39	16,260.82	0.00	0.00	$44,741.44

Sound Shore Medical Center of Westchester (Dkt. 13-22840)

First Class Mail

FedEx Ship Manager - Print Your Label(s)

From: (973) 889-4252 Origin ID: LKKA
Maria Dermatis
Porzio, Bromberg & Newman, P.C.
100 Southgate Parkway
Morristown, NJ 07962

FedEx Express

J13201306280326

Ship Date: 12SEP13
ActWgt. 1.0 LB
CAD: 7365764/INET3430

Delivery Address Bar Code

SHIP TO: (614) 289-5400 BILL SENDER
Sound Shore Medical Center of West.
The Garden City Group, Inc.
5151 Blazer Parkway
Suite A
DUBLIN, OH 43017

Ref # 09999.48003
Invoice #
PO #
Dept #

RT 219 3 A
ST 16
9879
09.13

FRI - 13 SEP AA
STANDARD OVERNIGHT

TRK# 7966 7771 9879
0201

XX OSUA

43017
OH-US
LCK

51AG1/9256/1AGE

After printing this label:

1. Use the 'Print' button on this page to print your label to your laser or inkjet printer.
2. Fold the printed page along the horizontal line.
3. Place label in shipping pouch and affix it to your shipment so that the barcode portion of the label can be read and scanned.

Warning: Use only the printed original label for shipping. Using a photocopy of this label for shipping purposes is fraudulent and could result in additional billing charges, along with the cancellation of your FedEx account number.

Use of this system constitutes your agreement to the service conditions in the current FedEx Service Guide, available on fedex.com. FedEx will not be responsible for any claim in excess of $100 per package, whether the result of loss, damage, delay, non-delivery, misdelivery, or misinformation, unless you declare a higher value, pay an additional charge, document your actual loss and file a timely claim. Limitations found in the current FedEx Service Guide apply. Your right to recover from FedEx for any loss, including intrinsic value of the package, loss of sales, income interest, profit, attorney's fees, costs, and other forms of damage whether direct, incidental, consequential, or special is limited to the greater of $100 or the authorized declared value. Recovery cannot exceed actual documented loss. Maximum for items of extraordinary value is $1,000, e.g. jewelry, precious metals, negotiable instruments and other items listed in our ServiceGuide. Written claims must be filed within strict time limits, see current FedEx Service Guide.

B10 (Official Form 10) (04/13)

UNITED STATES BANKRUPTCY COURT SOUTHERN DISTRICT OF NEW YORK		Proof of Claim
Name of Debtor: **Sound Shore Medical Center of Westchester**	Case Number: **13-22840**	

NOTE: *Do not use this form to make a claim for an administrative expense that arises after the bankruptcy filing. You may file a request for payment of an administrative expense according to 11 U.S.C § 503.*

Name of Creditor (the person or other entity to whom the debtor owes money or property):
Nutrition Management Services Co.

COURT USE ONLY

Name and address where notices should be sent:
Warren J. Martin Jr., Esq.
Porzio, Bromberg & Newman, P.C.
100 Southgate Parkway
Morristown, NJ 07962-1997
Telephone number: **973-538-4006** email: **wjmartin@pbnlaw.com**

☐ Check this box if this claim amends a previously filed claim.

Court Claim Number: ____
(If known)

Filed on: ____

Name and address where payment should be sent (if different from above):
Nutrition Management Services Co.
2071 Kimberton Rd.
PO Box 725
Kimberton, PA 19442
Telephone number: **(610) 935-2050** email: **jvroberts@nmsc.com**

☐ Check this box if you are aware that anyone else has filed a proof of claim relating to this claim. Attach copy of statement giving particulars.

1. Amount of Claim as of Date Case Filed: **$662,765.96**

If all or part of your claim is secured, complete item 4.

If all or part of your claim is entitled to priority, complete item 5.

FILED - 00657
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

☐ Check this box if claim includes interest or other charges in addition to the principal amount of claim. Attach a statement that itemizes interest or charges.

2. Basis for Claim: **Goods Sold / Services Performed**
(See instruction #2)

3. Last four digits of any number by which creditor identifies debtor:	3a. Debtor may have scheduled account as:	3b. Uniform Claim Identifier (optional):
____	____ (See instruction #3a)	____ (See instruction #3b)

4. Secured Claim (See instruction #4)
Check the appropriate box if the claim is secured by a lien on property or a right of setoff, attach required redacted documents, and provide the requested information.

Nature of property or right of setoff: ☐ Real Estate ☐ Motor Vehicle ☐ Other
Describe:

Value of Property: $____

Annual Interest Rate: 0 % ☐ Fixed or ☐ Variable
(when case was filed)

Amount of arrearage and other charges, as of the time case was filed, included in secured claim, if any:
$____

Basis for perfection: ____

Amount of Secured Claim: $____

Amount Unsecured: $____

5. Amount of Claim Entitled to Priority under 11 U.S.C. §507(a). If any portion of the claim falls into one of the following categories, check the box specifying the priority and state the amount.

☐ Domestic support obligations under 11 U.S.C. §507(a)(1)(A) or (a)(1)(B).

☐ Wages, salaries, or commissions (up to $12,475*) earned within 180 days before the case was filed or the debtor's business ceased, whichever is earlier - 11 U.S.C. §507(a)(4).

☐ Contributions to an employee benefit plan - 11 U.S.C. §507(a)(5).

Amount entitled to priority:

☐ Up to $2,775* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 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)(**§503(b)(9)**).

$ **55,503.40**

**Amounts are subject to adjustment on 4/01/16 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.*

6. Credits. The amount of all payments on this claim has been credited for the purpose of making this proof of claim. (See instruction #6)

B10 (Official Form 10) (04/13)

7. **Documents:** Attached are **redacted** copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, security agreements, or, in the case of a claim based on an open-end or revolving consumer credit agreement, a statement providing the information required by FRBP 3001(c)(3)(A). If the claim is secured, box 4 has been completed, and **redacted** copies of documents providing evidence of perfection of a security interest are attached. If the claim is secured by the debtor's principal residence, the Mortgage Proof of Claim Attachment is being filed with this claim. (*See instruction #7, and the definition of "**redacted**".*)

DO NOT SEND ORIGINAL DOCUMENTS. ATTACHED DOCUMENTS MAY BE DESTROYED AFTER SCANNING.

If the documents are not available, please explain: **Priority Administrative Claim is based on §503(b)(9)**

8. **Signature:** (See instruction #8)

Check the appropriate box.

☐ I am the creditor. ■ I am the creditor's authorized agent. ☐ I am the trustee, or the debtor, or their authorized agent. (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: **Warren J. Martin Jr., Esq.**
Title: **Attorney**
Company: **Porzio, Bromberg & Newman, P.C.**
Address and telephone number (if different from notice address above):
100 Southgate Parkway
P.O. Box 1997
Morristown, NJ 07962-1997
Telephone number: **973-538-4006** email: **wjmartin@pbnlaw.com**

(Signature) 9/13/2013 (Date)

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.

PORZIO
BROMBERG&NEWMAN P.C.

ATTORNEYS AT LAW

MORRISTOWN NJ • NEW YORK NY • PRINCETON NJ • WESTBOROUGH MA

MARIA P. DERMATIS
SENIOR PARALEGAL
DIRECT DIAL NO.: 973-889-4252
E-MAIL ADDRESS: MPDERMATIS@PBNLAW.COM

September 12, 2013

VIA FEDERAL EXPRESS OVERNIGHT
Sound Shore Medical Center of Westchester, *et al.*
c/o GCG, Inc.
5151 Blazer Parkway, Suite A
Dublin, OH 43017

Re: *In re:* The Mount Vernon Hospital, Inc.
Case No.: 13-28841 (RDD)
Our File No.: 09999-48003

Dear Sir or Madam:

In connection with *The Mount Vernon Hospital, Inc.* bankruptcy matter, enclosed please find an original and one copy of a Proof of Claim Form, filed on behalf of Nutrition Management Services Company.

Kindly return a copy of the proof of claim form marked "filed" to me in the enclosed federal express envelope.

Thank you for your attention to this matter.

Very truly yours,

Maria P. Dermatis
Senior Paralegal to Warren J. Martin Jr.

/mpd
Enclosures

100 SOUTHGATE PARKWAY, P.O. BOX 1997
MORRISTOWN, NJ 07962-1997
TELEPHONE (973) 538-4006
FAX (973) 538-5146
www.pbnlaw.com

LIMITED POWER OF ATTORNEY

The undersigned hereby grants Warren J. Martin Jr. Esq., Limited Power of Attorney for the specific purpose of signing proof(s) of claim on behalf of Nutrition Management Services Company in connection with the bankruptcy proceedings of (i) Sound Shore Medical Center of Westchester (Case No. 13-22840), (ii) The Mount Vernon Hospital (Case No. 13-22841), (iii) Howe Avenue Nursing Home, Inc. (Case No. 13-22842), (iv) The M.V.H. Corporation (Case No. 13-22843), (v) Sound Shore Health System, Inc. (Case No. 13-22844), (vi) NRHMC Services Corporation (Case No. 13-22845), and (vii) New Rochelle Sound Shore Housing, LLC (Case No. 13-22846), which are currently pending in the United States Bankruptcy Court for the Southern District of New York.

Nutrition Management Services Company

By: 

Name: Joseph V. Roberts

Title: Chief Executive Officer

Nutrition Management Services Company
Summary of Pre-Petition Obligations Receivable from
Sound Shore Medical Center and Mount Vernon Hospital
As of May 29, 2013

Sound Shore Medical Center

Pre-Petition Accounts Receivable includes $55,503.40 20-days prior to filing charges 20 days @ $2,775.17/day		207,635.03	
Note Receivable (Principle)		423,759.14	
Interest on Note - Jan - April	($423,759.14 * 1.5% * 4 mo.)	25,425.49	
May (29 days)	($423,759.14 * 1.5% / 31 * 29)	5,946.30	662,765.96

Mount Vernon Hospital

Pre-Petition Accounts Receivable includes $9,353.80 20-days prior to filing charges 20 days @ $467.69/day		44,741.44	
Note Receivable (Principle)		73,043.97	
Interest on Note - Dec - April	($73,043.97 * 1.5% * 5 mo.)	5,478.30	
May (29 days)	($73,043.97 * 1.5% / 31 * 29)	1,024.97	124,288.68
	TOTAL		**$787,054.64**

Prepared by Mark S. Aeder 09/05/2013

PROMISSORY NOTE
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE NY 10802
$498,759.14

This promissory note (the "Note") is made and effective November 15, 2012, by and between Sound Shore Medical Center of Westchester, a [corporation] (the "Borrower"), and Nutrition Management Services Company, a [corporation] (the "Payee").

1. PROMISE OF PAYMENT.

FOR VALUE RECEIVED, the Borrower promises to pay to the Payee, at 2071 Kimberton Road, Kimberton, Pa 19442, or at such other place as the Payee may designate in writing from time to time, the principal amount of Four Hundred Ninety Eight Thousand Seven Hundred Fifty Nine Dollars and Fourteen Cents ($498,759.14), together with interest accruing on the unpaid balance thereof until due. The interest rate on this Note shall be an annual rate of interest equal to 1.5% percent, or the maximum amount allowed by applicable law, whichever is less. Interest shall be computed on the basis of a year of 365 days and the actual number of days elapsed.

2. MONTHLY INSTALLMENT PAYMENTS.

The Borrower will pay the first payment of Ninety Nine Thousand Seven Hundred Fifty One Dollars and eighty three Cents ($75,000) of said principal. This payment is due at the signing of the Promissory Note. The Borrower will pay the remaining principal and interest at the rate of 1.5 % to the Payee in 24 equal installment payments of Twenty One Thousand One Fifty Five Dollars and Seventy Nine Cents ($21,155.79) on or before the 31st day of each month, until the principal and interest has been paid in full. Payments shall be to the Payee's address as designated above. All payments will be applied first to interest and the remainder to principal. Acceptance by the Payee of any payment differing from the designated installment payment listed above does not relieve the Borrower of the obligation to honor the requirements of this Note.

3. INITIAL DATE.

The first payment of $75,000 under this Note is due and payable on the day of signing of the Promissory note, on the 31st day of December, 2012. The balance of the note shall be paid in 24 equal installments beginning on or before January 31, 2013.

The Borrower may prepay this Note, in whole or in part, at any time before maturity without penalty or premium.

5. **EVENTS OF DEFAULT.**

The Borrower will be deemed to be in default under this Note on the occurrence of any of the following events (each an "Event of Default"): (i) on the Borrower's failure to make any payment when due under this Note, which failure continues for a period of ten (10) days after such due date; (ii) on the filing regarding the Borrower of any voluntary or involuntary petition for relief under the United States Bankruptcy Code or the initiation of any proceeding under federal law or law of any other jurisdiction for the general relief of debtors; or (iii) on the execution by the Borrower of an assignment for the benefit of creditors or the appointment of a receiver, custodian, trustee, or similar party to take possession of the Borrower's assets or property.

6. **ACCELERATION; REMEDIES ON DEFAULT.**

On the occurrence of any Event of Default, at the option of the Payee, all principal and other amounts owed under this Note shall become immediately due and payable without notice or demand by the Payee, and the Payee, in addition to its rights and remedies under this Note, may pursue any legal or equitable remedies that are available to it.

7. **WAIVER OF PRESENTMENT; DEMAND.**

The Borrower hereby waives presentment, demand, notice of dishonor, notice of default or delinquency, notice of protest and nonpayment, notice of costs, expenses or losses and interest thereon, notice of interest on interest and late charges, and diligence in taking any action to collect any sums owing under this Note, including (to the extent permitted by law) waiving the pleading of any statute of limitations as a defense to any demand against the undersigned.

8. **(*Optional*) TIME OF ESSENCE.**

Time is of the essence with respect to every provision of this Note.

9. **SUCCESSORS AND ASSIGNS.**

All references in this Note to the Borrower and the Payee shall be deemed to include, as applicable, a reference to their respective successors and assigns. The provisions of this Note shall be binding upon and shall inure to the benefit of the successors and assigns of the Borrower and the Payee.

10. **NOTICE.**

Any notice or other communication provided for herein or given hereunder to a party hereto shall be in writing and shall be given in person, by overnight courier, or by mail (registered or certified mail, postage prepaid, return receipt requested) to the respective party as follows:

If to the Payee:
Nutrition Management Services Company
2071 Kimberton Road
Kimberton, Pa. 19442

If to the Borrower:
Sound Shore Medical Center of Westchester
16 Guion Place
New Rochelle, NY. 10802

11. GOVERNING LAW.

This Note shall be governed as to validity, interpretation, construction, effect, and in all other respects by the laws and decisions of the State of Pennsylvania, without regards to its conflict-of-law provisions. The Borrower hereby irrevocably consents to the jurisdiction of the courts of Chester County, Pennsylvania with respect to any matter arising under this Note, and further irrevocably consents to service of process by hand delivery to the address listed above for the Borrower.

12. ENTIRE AGREEMENT.

This Note constitutes the final, complete, and exclusive statement of the agreement of the parties with respect to the subject matter hereof, and supersedes any and all other prior and contemporaneous agreements and understandings, both written and oral, between the parties.

13. NO IMPLIED WAIVER.

The Payee's failure to exercise any right or remedy provided in this Note shall not be construed as a waiver of any future exercise of that right or exercise of any other right or remedy to which the Payee may be entitled.

14. COLLECTION COSTS AND ATTORNEYS' FEES.

The Borrower agrees to pay any and all costs incurred by the Payee in collecting sums payable under this Note, including reasonable attorneys' fees and court costs in addition to other amounts due, without protest of any kind.

15. SEVERABILITY.

If one or more of the provisions of this Note shall be declared or held to be invalid, illegal, or unenforceable in any respect in any jurisdiction, the validity, legality, and enforceability of the remaining provisions hereof shall not in any way be affected or impaired thereby and any such declaration or holding shall not invalidate or render unenforceable such provision in any other jurisdiction.

16. HEADINGS.

Headings used in this Note are provided for convenience only and shall not be used to construe meaning or intent.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the parties have executed this Note as of the date first above written.

PAYEE Nutrition Management Services Company

By: _____
Name: Joseph V. Roberts
Title: CEO

BORROWER Sound Shore Medical Center of Westchester

By: _____
Name: John Spicer
Title: President & CEO

Sound Shore Note Receivable
Payment Schedule
As of 03/04/13

Original Balance	**$498,759.14**
Monthly Interest Rate	**1.50%**

Period	Payment	Principal	Interest	Balance	Payment Due Dates	Status
1	$75,000.00	$75,000.00	$0.00	$423,759.14	12/31/2012	Paid
2	$21,155.79	$14,799.40	$6,356.39	$408,959.74	1/31/2013	
3	$21,155.79	$15,021.39	$6,134.40	$393,938.34	2/28/2013	
4	$21,155.79	$15,246.71	$5,909.08	$378,691.63	3/31/2013	
5	$21,155.79	$15,475.42	$5,680.37	$363,216.21	4/30/2013	
6	$21,155.79	$15,707.55	$5,448.24	$347,508.67	5/31/2013	C/P 268062.14
7	$21,155.79	$15,943.16	$5,212.63	$331,565.51	6/30/2013	
8	$21,155.79	$16,182.31	$4,973.48	$315,383.20	7/31/2013	
9	$21,155.79	$16,425.04	$4,730.75	$298,958.16	8/31/2013	
10	$21,155.79	$16,671.42	$4,484.37	$282,286.74	9/30/2013	
11	$21,155.79	$16,921.49	$4,234.30	$265,365.25	10/31/2013	
12	$21,155.79	$17,175.31	$3,980.48	$248,189.94	11/30/2013	
13	$21,155.79	$17,432.94	$3,722.85	$230,757.00	12/31/2013	
14	$21,155.79	$17,694.44	$3,461.35	$213,062.56	1/31/2014	230757.00
15	$21,155.79	$17,959.85	$3,195.94	$195,102.71	2/28/2014	
16	$21,155.79	$18,229.25	$2,926.54	$176,873.46	3/31/2014	
17	$21,155.79	$18,502.69	$2,653.10	$158,370.77	4/30/2014	
18	$21,155.79	$18,780.23	$2,375.56	$139,590.55	5/31/2014	
19	$21,155.79	$19,061.93	$2,093.86	$120,528.61	6/30/2014	
20	$21,155.79	$19,347.86	$1,807.93	$101,180.75	7/31/2014	
21	$21,155.79	$19,638.08	$1,517.71	$81,542.67	8/31/2014	
22	$21,155.79	$19,932.65	$1,223.14	$61,610.02	9/30/2014	
23	$21,155.79	$20,231.64	$924.15	$41,378.38	10/31/2014	
24	$21,155.79	$20,535.11	$620.68	$20,843.27	11/30/2014	
25	$21,155.79	$20,843.27	$312.65	($0.00)	12/31/2014	
	$582,738.96	$498,759.14	$83,979.95			

Statement

NUTRITION MANAGEMENT SERVICES CO.
2071 Kimberton Road
P.O. Box 725
Kimberton, PA 19442

Date
11/9/2012

To:

Sound Shore Medical Center of Westchester
ATTN: Dietary Department
16 Guion Place
New Rochelle NY 10802

Amount Due	Amount Enc.
$498,759.14	

Date	Transaction	Amount	Balance
06/30/2011	INV #SOL6338. Due 06/30/2011. Orig. Amount $226.93. Finance Charge	226.93	226.93
04/30/2012	INV #55537. Due 05/30/2012. Orig. Amount $27,966.03.	10,340.11	10,567.04
05/01/2012	INV #55506. Due 05/31/2012. Orig. Amount $162,914.42.	81,457.21	92,024.25
05/31/2012	INV #55589. Due 06/30/2012. Orig. Amount $28,754.30.	8,754.30	100,778.55
06/30/2012	INV #55640. Due 07/30/2012. Orig. Amount $25,578.66.	25,578.66	126,357.21
07/01/2012	INV #55623. Due 07/23/2012. Orig. Amount $162,914.42.	81,457.21	207,814.42
07/31/2012	INV #55725. Due 08/30/2012. Orig. Amount $26,693.48.	26,693.48	234,507.90
07/31/2012	CREDMEM #55818. ref. invoice 55623	-34,940.39	199,567.51
08/01/2012	INV #55699. Due 08/31/2012. Orig. Amount $162,914.42.	162,914.42	362,481.93
08/31/2012	INV #55782. Due 09/30/2012. Orig. Amount $25,336.49.	25,336.49	387,818.42
08/31/2012	CREDMEM #55819. ref. invoice 55699	-112,403.96	275,414.46
09/01/2012	INV #55830. Due 09/28/2012. Orig. Amount $162,914.42.	162,914.42	438,328.88
09/30/2012	CREDMEM #55831. ref. invoice 55830	-85,111.42	353,217.46
09/30/2012	INV #55833. Due 10/30/2012. Orig. Amount $23,171.46.	23,171.46	376,388.92
10/01/2012	INV #55832. Due 10/26/2012. Orig. Amount $162,914.42.	162,914.42	539,303.34
10/02/2012	INV #FC 13. Due 10/02/2012. Orig. Amount $11,963.51. Finance Charge	11,963.51	551,266.85
10/31/2012	INV #55912. Due 11/30/2012. Orig. Amount $32,546.84.	32,546.84	583,813.69
10/31/2012	CREDMEM #55913. ref. invoice 55912	-96,144.18	487,669.51
11/09/2012	INV #FC 15. Due 11/09/2012. Orig. Amount $11,089.63. Finance Charge	11,089.63	498,759.14

CURRENT	1-30 DAYS PAST DUE	31-60 DAYS PAST DUE	61-90 DAYS PAST DUE	OVER 90 DAYS PAST DUE	Amount Due
43,636.47	186,085.88	200,214.42	68,822.37	0.00	$498,759.14

Statement

NUTRITION MANAGEMENT SERVICES CO.
2071 Kimberton Road
P.O. Box 725
Kimberton, PA 19442

Date
5/29/2013

To:

Sound Shore Medical Center of Westchester
ATTN: Dietary Department
16 Guion Place
New Rochelle NY 10802

Amount Due	Amount Enc.
$207,635.03	

Date	Transaction	Amount	Balance
03/31/2013	INV #56181. Due 04/30/2013. Orig. Amount $23,524.41.	20,236.78	20,236.78
03/31/2013	INV #56182. Due 04/30/2013. Orig. Amount $2,700.00.	2,700.00	22,936.78
04/01/2013	INV #56150. Due 04/26/2013. Orig. Amount $162,914.42.	72,932.25	95,869.03
04/25/2013	INV #FC 21. Due 04/25/2013. Orig. Amount $1,505.69. Finance Charge	1,505.69	97,374.72
04/30/2013	INV #56230. Due 05/30/2013. Orig. Amount $28,265.27.	28,265.27	125,639.99
05/29/2013	INV #56200. Due 06/28/2013. Orig. Amount $80,480.12.	80,480.12	206,120.11
05/29/2013	INV #FC 27. Due 05/29/2013. Orig. Amount $1,514.92. Finance Charge	1,514.92	207,635.03

CURRENT	1-30 DAYS PAST DUE	31-60 DAYS PAST DUE	61-90 DAYS PAST DUE	OVER 90 DAYS PAST DUE	Amount Due
110,260.31	22,936.78	74,437.94	0.00	0.00	$207,635.03

Mount Vernon Hospital Inc
13-22841 (RDD)

First Class Mail

From: (973) 889-4252 Origin ID: LKKA
Maria Dermatis
Porzio, Bromberg & Newman, P.C
100 Southgate Parkway

Morristown, NJ 07962

FedEx Express

J13201306280326

Ship Date: 12SEP13
ActWgt: 1.0 LB
CAD: 7365764/INET3430

Delivery Address Bar Code

Ref # 09999.48003
Invoice #
PO #
Dept #

RT 219 3 A
ST 16 9879 09.13

SHIP TO: (614) 289-5400 BILL SENDER
Sound Shore Medical Center of West.
The Garden City Group, Inc.
5151 Blazer Parkway
Suite A
DUBLIN, OH 43017

FRI - 13 SEP AA
STANDARD OVERNIGHT

TRK# 0201 7966 7771 9879

XX OSUA

43017
OH-US
LCK

51AG1/9256/1A9E

After printing this label:
1. Use the 'Print' button on this page to print your label to your laser or inkjet printer.
2. Fold the printed page along the horizontal line.
3. Place label in shipping pouch and affix it to your shipment so that the barcode portion of the label can be read and scanned.

Warning: Use only the printed original label for shipping. Using a photocopy of this label for shipping purposes is fraudulent and could result in additional billing charges, along with the cancellation of your FedEx account number.
Use of this system constitutes your agreement to the service conditions in the current FedEx Service Guide, available on fedex.com.FedEx will not be responsible for any claim in excess of $100 per package, whether the result of loss, damage, delay, non-delivery,misdelivery,or misinformation, unless you declare a higher value, pay an additional charge, document your actual loss and file a timely claim.Limitations found in the current FedEx Service Guide apply. Your right to recover from FedEx for any loss, including intrinsic value of the package, loss of sales, income interest, profit, attorney's fees, costs, and other forms of damage whether direct, incidental,consequential, or special is limited to the greater of $100 or the authorized declared value. Recovery cannot exceed actual documented loss.Maximum for items of extraordinary value is $1,000, e.g. jewelry, precious metals, negotiable instruments and other items listed in our ServiceGuide. Written claims must be filed within strict time limits, see current FedEx Service Guide.

UNITED STATES BANKRUPTCY COURT SOUTHERN DISTRICT OF NEW YORK	**ADMINISTRATIVE EXPENSE PROOF OF CLAIM**	Administrative Expense Bar Date January 31, 2014

Note: This form should only be used by claimants asserting an Administrative Expense arising between May 29, 2013 and November 6, 2013 (the "Administrative Claim Period"). THIS FORM SHOULD NOT BE USED FOR ANY CLAIMS THAT ARE NOT OF A KIND ENTITLED TO PRIORITY IN ACCORDANCE WITH 11 U.S.C. §§ 503(b) and 507(a)(2).

Indicate Debtor(s) against which you assert a claim by checking the appropriate box(es) below.

Name of Debtor (Check Only One):	Case No.	Name of Debtor (Check Only One):	Case No.
☒ Sound Shore Medical Center of Westchester	13-22840	☐ The M.V.H. Corporation	13-22843
☐ The Mount Vernon Hospital, Inc.	13-22841	☐ SoundShore Health System, Inc.	13-22844
☐ Howe Avenue Nursing Home, d/b/a Helen and Michael Schaffer Extended Care Center	13-22842	☐ NRHMC Services Corporation	13-22845
		☐ New Rochelle Sound Shore Housing LLC	13-22846

Name of Creditor
(The person or entity to whom the debtor owes money or property)
Dr ROZAFA L. PALI

☐ Check box if you are aware that anyone else has filed a proof of claim relating to your administrative expense claim. Attach copy of statement giving particulars.

THE GARDEN CITY GROUP, INC. FEB - 7 2014

Name and Addresses Where Notices Should be Sent:
Dr ROZAFA L. PALI
89 MILL SPRING Lane
Stamford, CT 06903

Check here if this claim. ☐ replaces or ☐ amends a previously filed administrative expense claim

Claim Number (if known) _____

Dated: _____

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR:

1. BASIS FOR CLAIM:
☐ Goods sold ☐ Services performed ☐ Personal Injury/Wrongful Death ☐ Wages (Dates) _____
☐ Money loaned ☐ Taxes ☐ Retiree Benefits as Defined in 11 U.S.C. § 1114(a) ☒ Other (Specify) insurance tail, pension, sick days & vacation days

2. DATE DEBT WAS INCURRED (IF KNOWN): 5/29/13 - 11/6/13

3. DESCRIPTION OF CLAIM (IF KNOWN): malpractice insurance tail, pension, sick days & vacation days

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM. $ 300,000.00 (Total)

5. CREDITS AND SETOFFS: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof. In filing this claim, claimant has deducted all amounts that claimant owes to debtor.

6. SUPPORTING DOCUMENTS. *Attach copies of supporting documents,* such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, or evidence of security interests. Do not send original documents. If the documents are not available, explain. If the documents are voluminous, attach a summary.

7. TIME-STAMPED COPY: To receive an acknowledgement 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

2014 JUN 30 P 3:31 CLERK'S OFFICE U.S. BANKR. CT S.D.N.Y.

8 Signature: Check the appropriate box

☒ I am the creditor. ☐ I am the creditor's authorized agent. (Attach copy of power of attorney, if any) ☐ I am the trustee, or the Debtor, or their authorized agent. (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: ROZAFA L. PALI
Title: MD
Company: _____
Address and telephone number (if different from notice address above):

(Signature) (Date) 1/30/14

Telephone number: 914 310 4300 email: Rpali@optonline.net

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.

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The attorneys for the Debtors and their court-appointed claims agent, GCG, are not authorized and are not providing you with any legal advice.

PLEASE SEND YOUR ORIGINAL, COMPLETED CLAIM FORM AS FOLLOWS: IF BY MAIL: Sound Shore Medical of Westchester, *et al.*, c/o GCG, Inc., P.O. Box 9982, Dublin, Ohio 43017-5982. IF BY HAND OR OVERNIGHT COURIER: Sound Shore Medical of Westchester, *et al.*, c/o GCG, 5151 Blazer Parkway, Suite A, Dublin, OH 43017. IF BY HAND. United States Bankruptcy Court, SDNY, 300 Quarropas Street, Room 248, White Plains, New York 10601; Attn. Clerk of the Court. ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR EMAIL WILL NOT BE ACCEPTED.

FILED - 01391
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

CRT

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

ROUTING SHEET FOR CASES WITH CLAIMS AGENTS

Date: February 5, 2014

To: GCG, Inc.
1985 Marcus Avenue, Suite 200
Lake Success, NY 11042

From: Mimi Correa
Deputy Clerk

2 g 3 Packs

1. a. Number of claims in this transmittal: 39

b. Case name (*if applicable*): **Sound Shore Medical Center, et al.**
c. Description of claim: (Creditor name and amount of claim.)

Mary K. Murphy	$See Attachment
Renella Mitchell	$2,995.00
Bio-Rad Laboratories, Inc.	$3,850.37
Joseph DeRose	$9,639.57
Maria S. Albito	$7,597.09
Beverly Stewart	$17,731.00
Daisy Kuriakose	$26,000.00
Daisy Kuriakose	$1,000.00
Sonia P. Slavicjo	$51,587.00
Cynthia Holmes	$3,520.00
Sanipro Disposal Inc.	$29,448.22
Sanipro Disposal Inc.	$12,387.50
Robert C. Goldstein	$2,000.00
Edna Buckley	???
Stephen Jesmajian	$70,000.00
Susan Kurian	$22,865.50
Veronica Turnbull	$2,458.33
Silvie Maria Correia	$4,127.24
Siemens Medical Solutions	$63,663.49
Robin Ten Eyck	$45,116.43
Saramma George	$3,080.00
Benedicte Hauser	$See Attachment
Neelkanth LLC	$8,796.39
Neelkanth LLC	$267,992.00
Neelkanth LLC	$16,020.54
Frank D'Ambrosio	$300.00
Metro Blood Service	$104,169.00
Orange Pathology Associates	$See Attachment
Orange Pathology Associates	$See Attachment
Dr. Bartholome Rodriguez	$300,000.00
Dr. Patricia Ann Devine	$185,113.55
Dr. Rozafa L. Pali	$300,000.00
Empire Healthchoice Assurance	See Attachment
Empire Healthchoice Assurance	See Attachment
Empire Healthchoice Assurance	See Attachment
Empire Healthchoice Assurance	See Attachment

Empire Healthchoice Assurance See Attachment
Empire Healthchoice Assurance See Attachment

2. a. Courier: Federal Express
b. Recipient to pick up at Court: _____

CONFIRMATION BY RECIPIENT

NOTE: *The portion below is to be completed by recipient and returned to the Court by FAX* [914-390-4073].

Date: _____

*I have received the number and description of claims as indicated in line # **1.a.** above.*

Employee's name: _____
[*Please print*]
Employee's signature: _____

Employee's telephone number: _____
Name of Employer: _____

From: (631) 470-5000
Attn: Arturo D. Tavarez
Case Adm./ECF Trainer
US Bankruptcy Court, SDNY
300 Quarropas Street
WHITE PLAINS, NY 10601

Origin ID: NESA

FedEx Express

J13111302120326

Ship Date: 10JUL13
ActWgt: 1.0 LB
CAD: 100098143/INET3370

Delivery Address Bar Code

Ref # -SSM-

RMA #:
Return Reason:

SHIP TO: (631) 470-5000 BILL THIRD PARTY

Attn: Bankruptcy Dept.
c/o GCG, Inc.
5151 Blazer Parkway
Suite A
DUBLIN, OH 43017

RETURNS MON-FRI
STANDARD OVERNIGHT

TRK# 0221 **7961 9382 5788**

43017
OH-US

518G1/AA04/93AB

1. Select the 'Print' button to print 1 copy of each label.
2. The Return Shipment instructions, which provide your recipient with information on the returns process, will be printed with the label(s).
3. After printing, select your next step by clicking one of the displayed buttons.

Note:To review or print individual labels, select the Label button under each label image above.

UNITED STATES BANKRUPTCY COURT SOUTHERN DISTRICT OF NEW YORK	**ADMINISTRATIVE EXPENSE PROOF OF CLAIM**	**Administrative Expense Bar Date** January 31, 2014

Note: This form should only be used by claimants asserting an Administrative Expense arising between May 29, 2013 and November 6, 2013 (the "Administrative Claim Period"). THIS FORM SHOULD NOT BE USED FOR ANY CLAIMS THAT ARE NOT OF A KIND ENTITLED TO PRIORITY IN ACCORDANCE WITH 11 U.S.C. §§ 503(b) and 507(a)(2).

Indicate Debtor(s) against which you assert a claim by checking the appropriate box(es) below.

Name of Debtor (Check Only One):	Case No.	Name of Debtor (Check Only One):	Case No.
Sound Shore Medical Center of Westchester	13-22840	The M.V.H. Corporation	13-22843
The Mount Vernon Hospital, Inc.	13-22841	Sound Shore Health System, Inc.	13-22844
Howe Avenue Nursing Home, d/b/a Helen and Michael Schaffer Extended Care Center	13-22842	NRHMC Services Corporation	13-22845
		New Rochelle Sound Shore Housing LLC	13-22846

Name of Creditor
(The person or entity to whom the debtor owes money or property)
Pulmonary and Sleep Specialists of Southern Westchester, LLC

☐ Check box if you are aware that anyone else has filed a proof of claim relating to your administrative expense claim. Attach copy of statement giving particulars.

THE GARDEN CITY GROUP, INC. JAN 30 2014

Name and Addresses Where Notices Should be Sent.
Pulmonary & Sleep Specialists of
Southern Westchester, LLC
2365 Boston Post Road
Larchmont, NY 10538

Check here if this claim: ☐ replaces or ☐ amends a previously filed administrative expense claim
Claim Number (if known). _____
Dated: _____

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR:

1. BASIS FOR CLAIM:
☐ Goods sold ☒ Services performed ☐ Personal Injury/Wrongful Death ☐ Wages (Dates) _____
☐ Money loaned ☐ Taxes ☐ Retiree Benefits as Defined in 11 U.S.C. § 1114(a) ☒ Other (Specify) Post Petition Lease Agreement

2. DATE DEBT WAS INCURRED (IF KNOWN): August 2013 to November 2013

3. DESCRIPTION OF CLAIM (IF KNOWN): Services Performed and Post Petition Lease Agreement

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM. $ 5,646.70 (Total)

5. CREDITS AND SETOFFS: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof. In filing this claim, claimant has deducted all amounts that claimant owes to debtor.

6. SUPPORTING DOCUMENTS: *Attach copies of supporting documents*, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, or evidence of security interests. Do not send original documents. If the documents are not available, explain. If the documents are voluminous, attach a summary.

7. TIME-STAMPED COPY: To receive an acknowledgement 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

8. Signature: Check the appropriate box.
☐ I am the creditor. ☒ I am the creditor's authorized agent. (Attach copy of power of attorney, if any) ☐ I am the trustee, or the Debtor, or their authorized agent. (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: Michael Mandel
Title: PARTNER
Company: Pulmonary & Sleep Specialists of Southern Westchester, LLC
Address and telephone number (if different from notice address above):
2365 Boston Post Road
Larchmont, NY 10538
Telephone number: 914-833-2020

MMMandel MD (Signature) 1/29/14 (Date)
email: mandelmd@optonline.net

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.

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The attorneys for the Debtors and their court-appointed claims agent, GCG, are not authorized and are not providing you with any legal advice.

PLEASE SEND YOUR ORIGINAL, COMPLETED CLAIM FORM AS FOLLOWS: **IF BY MAIL:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, Inc., P.O. Box 9982, Dublin, Ohio 43017-5982. **IF BY HAND OR OVERNIGHT COURIER:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, 5151 Blazer Parkway, Suite A, Dublin, OH 43017. **IF BY HAND:** United States Bankruptcy Court, SDNY, 300 Quarropas Street, Room 248, White Plains, New York 10601; Attn: Clerk of the Court. ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR EMAIL WILL NOT BE ACCEPTED.

FILED - 01301
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

Two originals.

Please stamp one as received and return to me.

Mandel
1/29/14

FedEx.
TRK# 0200 8987 4861 6456

THU - 30 JAN AA
STANDARD OVERNIGHT

43017
OH-US
LCK

XX OSUA

FID 822132 29JAN14 HPNA 51AC1/D6EC/65DD

RT 219 3 A
ST 17
6456
01.30

HPNA 224

FedEx Express **NEW Package US Airbill**

FedEx Tracking Number 8987 4861 6456

0200 Form ID No.

FedEx Retrieval Copy

1 From

Date 1/29/14

Sender's Name Michael Mandel MD Phone 914 833 2020

Company Pulmonary & Sleep Specialists of Southern Westchester LLC

Address 2365 Boston Post Road Dept/Floor/Suite/Room

City Larchmont State NY ZIP 10538

2 Your Internal Billing Reference

3 To

Recipient's Name Sound Shore Medical Center/Westlake Phone

Company c/o GCG

Address 5151 Blazer Parkway Dept/Floor/Suite/Room

We cannot deliver to P.O. boxes or P.O. ZIP codes.

Address Suite A

Use this line for the HOLD location address or for continuation of your shipping address.

City Dublin State OH ZIP 43017

01 ☐ HOLD Weekday — FedEx location address REQUIRED. NOT available for FedEx First Overnight.

31 ☐ HOLD Saturday — FedEx location address REQUIRED. Available ONLY for FedEx Priority Overnight and FedEx 2Day to select locations.

8987 4861 6456

4 Express Package Service * To most locations.

NOTE: Service order has changed. Please select carefully

Packages up to 150 lbs. *For packages over 150 lbs., use the new FedEx Express Freight US Airbill.*

Next Business Day

06 ☐ FedEx First Overnight — Earliest next business morning delivery to select locations. Friday shipments will be delivered on Monday unless SATURDAY Delivery is selected

01 ☐ FedEx Priority Overnight — Next business morning.* Friday shipments will be delivered on Monday unless SATURDAY Delivery is selected.

05 ☒ FedEx Standard Overnight — Next business afternoon.* Saturday Delivery NOT available

2 or 3 Business Days

49 ☐ NEW FedEx 2Day A.M. — Second business morning.* Saturday Delivery NOT available

03 ☐ FedEx 2Day — Second business afternoon.* Thursday shipments will be delivered on Monday unless SATURDAY Delivery is selected

20 ☐ FedEx Express Saver — Third business day.* Saturday Delivery NOT available

5 Packaging * Declared value limit $500.

06 ☒ FedEx Envelope* 02 ☐ FedEx Pak* 03 ☐ FedEx Box 04 ☐ FedEx Tube 01 ☐ Other

6 Special Handling and Delivery Signature Options

03 ☐ **SATURDAY DELIVERY**

☒ No Signature Required — Package may be left without obtaining a signature for delivery.

10 ☐ Direct Signature — Someone at recipient's address may sign for delivery. Fee applies.

34 ☐ Indirect Signature — If no one is available at recipient's address, someone at a neighboring address may sign for delivery. For residential deliveries only. Fee applies.

Does this shipment contain dangerous goods? One box must be checked.

☒ No 04 ☐ Yes As per attached Shipper's Declaration. ☐ Yes Shipper's Declaration not required. 06 ☐ Dry Ice Dry ice, 9, UN 1845 ____ x ____ kg

Dangerous goods (including dry ice) cannot be shipped in FedEx packaging or placed in a FedEx Express Drop Box. ☐ Cargo Aircraft Only

7 Payment *Bill to:*

Enter FedEx Acct. No. or Credit Card No. below. Obtain recip Acct. No ☐

1 ☒ Sender Acct. No. in Section 1 will be billed. 2 ☐ Recipient 3 ☐ Third Party 4 ☑ Credit Card 5 ☐ Cash/Check

Total Packages 2 Total Weight ____ lbs. Credit Card Auth. ____

†Our liability is limited to $100 unless you declare a higher value. See the current FedEx Service Guide for details.

612

Rev. Date 11/10 • Part #163136 • ©1994–2010 FedEx • PRINTED IN U.S.A. SRY

Terms And Conditions Summary

For the current FedEx Service Guide, which contains the complete Terms and Conditions, go to ***fedex.com.***

Definitions On this Airbill, "we," "our," "us," and "FedEx" refer to Federal Express Corporation, its employees, and agents. "You" and "your" refer to the sender, its employees, and agents.

Agreement To Terms By giving us your package to deliver, you agree to all the terms on this Airbill and in the current FedEx Service Guide, which is available at **fedex.com** or at a FedEx location. You also agree to those terms on behalf of any third party with an interest in the package. If there is a conflict between the current FedEx Service Guide and this Airbill, the current FedEx Service Guide will control. No one is authorized to change the terms of our Agreement.

Responsibility For Packaging And Completing Airbill You are responsible for adequately packaging your goods and properly filling out this Airbill. If you omit the number of packages and/or weight per package, our billing will be based on our best estimate of the number of packages we received and/or an estimated "default" weight per package as determined by us

Responsibility For Payment Even if you give us different payment instructions, you will always be primarily responsible for all delivery costs, as well as any cost we incur in either returning your package to you or warehousing it pending disposition

Limitations On Our Liability And Liabilities Not Assumed

- Unless a higher value is declared and paid for, our liability for each package is limited to US$100 You may pay an additional charge for each additional US$100 of declared value. The declared value does not constitute, nor do we provide, cargo liability insurance.
- In any event, we will not be liable for any damage, whether direct, incidental, special, or consequential, in excess of the declared value of a shipment, whether or not FedEx had knowledge that such damages might be incurred, including but not limited to loss of income or profits
- We won't be liable
  - for your acts or omissions, including but not limited to improper or insufficient packing, securing, marking, or addressing, or those of the recipient or anyone else with an interest in the package.
  - if you or the recipient violates any of the terms of our Agreement.
  - for loss of or damage to shipments of prohibited items.
  - for loss, damage, or delay caused by events we cannot control, including but not limited to acts of God, perils of the air, weather conditions, acts of public enemies, war, strikes, civil commotions, or acts of public authorities with actual or apparent authority.

Declared Value Limits

- The maximum declared value allowed for a FedEx Envelope or FedEx Pak shipment is US$500.
- For other shipments, the maximum declared value allowed is US$50,000 per package, unless your package contains items of extraordinary value, in which case the maximum declared value allowed is US$1,000 per package.
- Items of extraordinary value include shipments containing such items as artwork, jewelry, furs, precious metals, negotiable instruments, and other items listed in the current FedEx Service Guide.
- You may send more than one package on this Airbill and fill in the total declared value for all packages, not to exceed the US$500, US$1,000, or US$50,000 per package limit described above. (Example: 5 packages can have a total declared value of up to US$250,000) In that case, our liability is limited to the actual value of the package(s) lost or damaged, but may not exceed the maximum allowable declared value(s) or the total declared value, whichever is less. You are responsible for proving the actual loss or damage.

Filing A Claim YOU MUST MAKE ALL CLAIMS IN WRITING or online at **fedex.com** and notify us of your claim within strict time limits set out in the current FedEx Service Guide

You may call our Customer Service department at 1.800 GoFedEx 1.800.463.3339 to report a claim; however, you must still file a timely written claim We aren't obligated to act on any claim until you have paid all transportation charges, and you may not deduct the amount of your claim from those charges

If the recipient accepts your package without noting any damage on the delivery record, we will assume the package was delivered in good condition. For us to process your claim, you must make the original shipping cartons and packing available for inspection.

Right To Inspect We may, at our option, open and inspect your packages before or after you give them to us to deliver

Right Of Rejection We reserve the right to reject a shipment when such shipment would be likely to cause delay or damage to other shipments, equipment, or personnel, or if the shipment is prohibited by law; or if the shipment would violate any terms of our Airbill or the current FedEx Service Guide

C.O.D. Services C.O.D. SERVICE IS NOT AVAILABLE WITH THIS AIRBILL If C.O.D. Service is required, please use a FedEx C.O.D. Airbill.

Air Transportation Tax Included A federal excise tax when required by the Internal Revenue Code on the air transportation portion of this service, if any, is paid by us.

Money-Back Guarantee In the event of untimely delivery, FedEx will, at your request and with some limitations, refund or credit all transportation charges. See the current FedEx Service Guide for more information.

Part 163135/163136 • Rev. Date 11/10

UNITED STATES BANKRUPTCY COURT SOUTHERN DISTRICT OF NEW YORK	**ADMINISTRATIVE EXPENSE PROOF OF CLAIM**	Administrative Expense Bar Date January 31, 2014

Note: This form should only be used by claimants asserting an Administrative Expense arising between May 29, 2013 and November 6, 2013 (the "Administrative Claim Period"). THIS FORM SHOULD NOT BE USED FOR ANY CLAIMS THAT ARE NOT OF A KIND ENTITLED TO PRIORITY IN ACCORDANCE WITH 11 U.S.C. §§ 503(b) and 507(a)(2)

Indicate Debtor(s) against which you assert a claim by checking the appropriate box(es) below:

Name of Debtor (Check Only One):	Case No.	Name of Debtor (Check Only One):	Case No.
☒ Sound Shore Medical Center of Westchester	13-22840	☐ The M.V.H. Corporation	13-22843
☐ The Mount Vernon Hospital, Inc.	13-22841	☐ SoundShore Health System, Inc.	13-22844
☐ Howe Avenue Nursing Home, d/b/a Helen and Michael Schaffer Extended Care Center	13-22842	☐ NRHMC Services Corporation	13-22845
		☐ New Rochelle Sound Shore Housing LLC	13-22846

Name of Creditor
(The person or entity to whom the debtor owes money or property)
Dr BARTHOLOME RUDRIGUEZ

☐ Check box if you are aware that anyone else has filed a proof of claim relating to your administrative expense claim. Attach copy of statement giving particulars.

THE GARDEN CITY GROUP, INC. FEB - 7 2014

Name and Addresses Where Notices Should be Sent
Dr BARTHOLOME RUDRIGUEZ
19 DUSENBERRY ROAD
BRUNXVILLE NEW YORK 10708

Check here if this claim: ☐ replaces or ☐ amends a previously filed administrative expense claim

Claim Number (if known): _____

Dated _____

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR:

1. BASIS FOR CLAIM:
☐ Goods sold ☐ Services performed ☐ Personal Injury/Wrongful Death ☐ Wages (Dates) _____
☐ Money loaned ☐ Taxes ☐ Retiree Benefits as Defined in 11 U.S.C. § 1114(a) ☒ Other (Specify): insurance tail, pension, sick days, vacation days

2. DATE DEBT WAS INCURRED (IF KNOWN): 5/29/13 - 11/6/13

3. DESCRIPTION OF CLAIM (IF KNOWN): malpractice insurance tail, pension, sick days & vacation days

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 300,000 (Approximately)
(Total)

5. CREDITS AND SETOFFS: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof. In filing this claim, claimant has deducted all amounts that claimant owes to debtor.

6. SUPPORTING DOCUMENTS: *Attach copies of supporting documents*, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, or evidence of security interests. Do not send original documents. If the documents are not available, explain. If the documents are voluminous, attach a summary.

7. TIME-STAMPED COPY: To receive an acknowledgement 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

FILED - 01402
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

8 Signature: Check the appropriate box.

☒ I am the creditor. ☐ I am the creditor's authorized agent. (Attach copy of power of attorney, if any) ☐ I am the trustee, or the Debtor, or their authorized agent (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: BARTHOLOME RUDRIGUEZ
Title MD
Company: _____
Address and telephone number (if different from notice address above).

Barthol Rodrigu (Signature) 1/30/14 (Date)

Telephone number 718 801 1497 914 329262 Email BARTHOLOME@AYA.YALE.EDU

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

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The attorneys for the Debtors and their court-appointed claims agent, GCG, are not authorized and are not providing you with any legal advice.

PLEASE SEND YOUR ORIGINAL, COMPLETED CLAIM FORM AS FOLLOWS: IF BY MAIL: Sound Shore Medical of Westchester, *et al.*, c/o GCG, Inc., P.O. Box 9982, Dublin, Ohio 43017-5982. IF BY HAND OR OVERNIGHT COURIER: Sound Shore Medical of Westchester, *et al.*, c/o GCG, 5151 Blazer Parkway, Suite A, Dublin, OH 43017. IF BY HAND: United States Bankruptcy Court, SDNY, 300 Quarropas Street, Room 248, White Plains, New York 10601, Attn: Clerk of the Court. ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR EMAIL WILL NOT BE ACCEPTED

CRT

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

ROUTING SHEET FOR CASES WITH CLAIMS AGENTS

Date: February 5, 2014

To: GCG, Inc.
1985 Marcus Avenue, Suite 200
Lake Success, NY 11042

From: Mimi Correa
Deputy Clerk

2 93 Pages

1. a. Number of claims in this transmittal: 39

b. Case name (*if applicable*): **Sound Shore Medical Center, et al.**
c. Description of claim: (Creditor name and amount of claim.)

Mary K. Murphy	$See Attachment
Renella Mitchell	$2,995.00
Bio-Rad Laboratories, Inc.	$3,850.37
Joseph DeRose	$9,639.57
Maria S. Albito	$7,597.09
Beverly Stewart	$17,731.00
Daisy Kuriakose	$26,000.00
Daisy Kuriakose	$1,000.00
Sonia P. Slaviejo	$51,587.00
Cynthia Holmes	$3,520.00
Sanipro Disposal Inc.	$29,448.22
Sanipro Disposal Inc.	$12,387.50
Robert C. Goldstein	$2,000.00
Edna Buckley	???
Stephen Jesmajian	$70,000.00
Susan Kurian	$22,865.50
Veronica Turnbull	$2,458.33
Silvie Maria Correia	$4,127.24
Siemens Medical Solutions	$63,663.49
Robin Ten Eyck	$45,116.43
Saramma George	$3,080.00
Benedicte Hauser	$See Attachment
Neelkanth LLC	$8,796.39
Neelkanth LLC	$267,992.00
Neelkanth LLC	$16,020.54
Frank D'Ambrosio	$300.00
Metro Blood Service	$104,169.00
Orange Pathology Associates	$See Attachment
Orange Pathology Associates	$See Attachment
Dr. Bartholome Rodriguez	$300,000.00
Dr. Patricia Ann Devine	$185,113.55
Dr. Rozafa L. Pali	$300,000.00
Empire Healthchoice Assurance	See Attachment
Empire Healthchoice Assurance	See Attachment
Empire Healthchoice Assurance	See Attachment
Empire Healthchoice Assurance	See Attachment

Empire Healthchoice Assurance See Attachment
Empire Healthchoice Assurance See Attachment

2. a. Courier: Federal Express
b. Recipient to pick up at Court: _____

CONFIRMATION BY RECIPIENT

NOTE: *The portion below is to be completed by recipient and returned to the Court by FAX* [914-390-4073].

Date: _____

*I have received the number and description of claims as indicated in line # **1.a.** above.*

Employee's name: _____
[*Please print*]
Employee's signature: _____

Employee's telephone number: _____
Name of Employer: _____

From: (631) 470-5000
Attn: Arturo D. Tavarez
Case Adm./ECF Trainer
US Bankruptcy Court, SDNY
300 Quarropas Street
WHITE PLAINS, NY 10601

Origin ID: NESA

FedEx Express

J13111302120326

Ship Date: 10JUL13
ActWgt: 1.0 LB
CAD: 100098143/INET3370

Delivery Address Bar Code

SHIP TO: (631) 470-5000

BILL THIRD PARTY

Attn: Bankruptcy Dept.
c/o GCG, Inc.
5151 Blazer Parkway
Suite A
DUBLIN, OH 43017

Ref # -SSM-

RMA #:
Return Reason:

RETURNS MON-FRI
STANDARD OVERNIGHT

TRK# 7961 9382 5788
0221

43017
OH-US

518G1/AA04/33AB

1. Select the 'Print' button to print 1 copy of each label.
2. The Return Shipment instructions, which provide your recipient with information on the returns process, will be printed with the label(s).
3. After printing, select your next step by clicking one of the displayed buttons.

Note: To review or print individual labels, select the Label button under each label image above.

UNITED STATES BANKRUPTCY COURT SOUTHERN DISTRICT OF NEW YORK	**ADMINISTRATIVE EXPENSE PROOF OF CLAIM**	**Administrative Expense Bar Date** January 31, 2014

Note: This form should only be used by claimants asserting an Administrative Expense arising between May 29, 2013 and November 6, 2013 (the "Administrative Claim Period"). THIS FORM SHOULD NOT BE USED FOR ANY CLAIMS THAT ARE NOT OF A KIND ENTITLED TO PRIORITY IN ACCORDANCE WITH 11 U.S.C. §§ 503(b) and 507(a)(2).

Indicate Debtor(s) against which you assert a claim by checking the appropriate box(es) below.

Name of Debtor (Check Only One):	Case No.	Name of Debtor (Check Only One):	Case No.
☑ Sound Shore Medical Center of Westchester	13-22840	☐ The M.V.H. Corporation	13-22843
☐ The Mount Vernon Hospital, Inc	13-22841	☐ SoundShore Health System, Inc.	13-22844
☐ Howe Avenue Nursing Home, d/b/a Helen and Michael Schaffer Extended Care Center	13-22842	☐ NRHMC Services Corporation	13-22845
		☐ New Rochelle Sound Shore Housing LLC	13-22846

Name of Creditor
(The person or entity to whom the debtor owes money or property)
CHERRYLE SMITH

☐ Check box if you are aware that anyone else has filed a proof of claim relating to your administrative expense claim. Attach copy of statement giving particulars

THE GARDEN CITY GROUP INC JAN 07 2014

Name and Addresses Where Notices Should be Sent.
4225 Hill AVENUE
BRONX, NY 10466

Check here if this claim. ☐ replaces or ☐ amends a previously filed administrative expense claim.
Claim Number (if known): _____
Dated _____

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR:

1. BASIS FOR CLAIM:
☐ Goods sold ☐ Services performed ☐ Personal Injury/Wrongful Death ☑ Wages (Dates)_____
☐ Money loaned ☐ Taxes ☐ Retiree Benefits as Defined in 11 U.S.C. § 1114(a) ☐ Other(Specify. _____

2. DATE DEBT WAS INCURRED (IF KNOWN):

3. DESCRIPTION OF CLAIM (IF KNOWN):

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 8,781.76 (Total)

5. CREDITS AND SETOFFS: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof. In filing this claim, claimant has deducted all amounts that claimant owes to debtor.

6. SUPPORTING DOCUMENTS: *Attach copies of supporting documents*, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, or evidence of security interests. Do not send original documents. If the documents are not available, explain. If the documents are voluminous, attach a summary.

7. TIME-STAMPED COPY: To receive an acknowledgement 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

8. **Signature:** Check the appropriate box
☑ I am the creditor. ☐ I am the creditor's authorized agent. (Attach copy of power of attorney, if any) ☐ I am the trustee, or the Debtor, or their authorized agent (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: CHERRYLE SMITH
Title: UNIT CLERK
Company SOUND SHORE MEDICAL CENTER
Cherrylle Smith (Signature) 1/1/14 (Date)

Address and telephone number (if different from notice address above):
- SAME AS ABOVE -

Telephone number: 347-602-6209 email: CHERRYLE64@yahoo.com

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.

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The attorneys for the Debtors and their court-appointed claims agent, GCG, are not authorized and are not providing you with any legal advice.

PLEASE SEND YOUR ORIGINAL, COMPLETED CLAIM FORM AS FOLLOWS: **IF BY MAIL:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, Inc., P.O. Box 9982, Dublin, Ohio 43017-5982. **IF BY HAND OR OVERNIGHT COURIER:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, 5151 Blazer Parkway, Suite A, Dublin, OH 43017. **IF BY HAND:** United States Bankruptcy Court, SDNY, 300 Quarropas Street, Room 248, White Plains, New York 10601; Attn: Clerk of the Court ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR EMAIL WILL NOT BE ACCEPTED

FILED - 01127
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

Cherryle Smith
4225 Hill Avenue
Bronx, NY 10466

UNITED STATES POSTAL SERVICE

BRONX, NY
10469
JAN 02, 14
AMOUNT
$0.46
00035244-06

1000 43017

Sound Shore Medical of Westchester
et al., c/o GCG Inc.,
P.O. Box 9982
Dublin, Ohio 43017-5982

43017598282

UNITED STATES BANKRUPTCY COURT SOUTHERN DISTRICT OF NEW YORK	**ADMINISTRATIVE EXPENSE PROOF OF CLAIM**	**Administrative Expense Bar Date** January 31, 2014

Note: This form should only be used by claimants asserting an Administrative Expense arising between May 29, 2013 and November 6, 2013 (the "Administrative Claim Period"). THIS FORM SHOULD NOT BE USED FOR ANY CLAIMS THAT ARE NOT OF A KIND ENTITLED TO PRIORITY IN ACCORDANCE WITH 11 U.S.C. §§ 503(b) and 507(a)(2).

Indicate Debtor(s) against which you assert a claim by checking the appropriate box(es) below.

Name of Debtor (Check Only One):	Case No.	Name of Debtor (Check Only One):	Case No.
☑ Sound Shore Medical Center of Westchester	13-22840	☐ The M.V.H. Corporation	13-22843
☐ The Mount Vernon Hospital, Inc.	13-22841	☐ SoundShore Health System, Inc	13-22844
☐ Howe Avenue Nursing Home, d/b/a Helen and Michael Schaffer Extended Care Center	13-22842	☐ NRHMC Services Corporation	13-22845
		☐ New Rochelle Sound Shore Housing LLC	13-22846

Name of Creditor
(The person or entity to whom the debtor owes money or property)
CHERYL D. TISDALE

☐ Check box if you are aware that anyone else has filed a proof of claim relating to your administrative expense claim. Attach copy of statement giving particulars

Name and Addresses Where Notices Should be Sent:
321 McClellan Ave
Mount Vernon, NY 10553-2001

Check here if this claim. ☐ replaces or ☐ amends a previously filed administrative expense claim.

Claim Number (if known). _____

Dated: _____

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR

1. BASIS FOR CLAIM:
☐ Goods sold ☑ Services performed ☐ Personal Injury/Wrongful Death ☐ Wages (Dates) _____
☐ Money loaned ☐ Taxes ☐ Retiree Benefits as Defined in 11 U.S.C. § 1114(a) ☑ Other (Specify) _____

2. DATE DEBT WAS INCURRED (IF KNOWN):

3. DESCRIPTION OF CLAIM (IF KNOWN): Severances Pay (Laid off) 11/5/13 Bonus pay

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ _____ (Total)

5. CREDITS AND SETOFFS: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof. In filing this claim, claimant has deducted all amounts that claimant owes to debtor.

6. SUPPORTING DOCUMENTS. *Attach copies of supporting documents,* such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, or evidence of security interests. Do not send original documents. If the documents are not available, explain. If the documents are voluminous, attach a summary.

7. TIME-STAMPED COPY: To receive an acknowledgement 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

8 **Signature:** Check the appropriate box

☑ I am the creditor. ☐ I am the creditor's authorized agent. (Attach copy of power of attorney, if any) ☐ I am the trustee, or the Debtor, or their authorized agent. (See Bankruptcy Rule 3004.) ☐ I am a guarantor, surety, indorser, or other codebtor. (See Bankruptcy Rule 3005.)

I declare under penalty of perjury that the information provided in this claim is true and correct to the best of my knowledge, information, and reasonable belief.

Print Name: _____
Title: _____
Company: _____
Address and telephone number (if different from notice address above):

Cheryl Tisdale 1/16/14
(Signature) (Date)

Telephone number 914-667-0652 email: _____

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.

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The attorneys for the Debtors and their court-appointed claims agent, GCG, are not authorized and are not providing you with any legal advice.

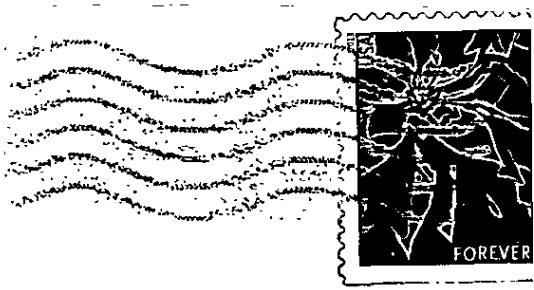
PLEASE SEND YOUR ORIGINAL, COMPLETED CLAIM FORM AS FOLLOWS. **IF BY MAIL:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, Inc., P.O. Box 9982, Dublin, Ohio 43017-5982. **IF BY HAND OR OVERNIGHT COURIER:** Sound Shore Medical of Westchester, *et al.*, c/o GCG, 5151 Blazer Parkway, Suite A, Dublin, OH 43017. **IF BY HAND.** United States Bankruptcy Court, SDNY, 300 Quarropas Street, Room 248, White Plains, New York 10601; Attn. Clerk of the Court. ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR EMAIL WILL NOT BE ACCEPTED.

FILED - 01220
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

THE GARDEN CITY GROUP, INC. JAN 24 2014

Cheryl Tisdale
321 McClellan Avenue
Mount Vernon, NY 10553-2110

WESTCHESTER NY 105
21 JAN 2014 PM 3 L



Sound Shore Medical Center of Westchester
C/O GCG
PO Box 9982
Dublin, OH 43017-5982

43017$5982

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

In re:

SOUND SHORE MEDICAL CENTER OF WESTCHESTER, et al.	Chapter 11 Case No. 13-22840 (RDD)
Debtors.	(Jointly Administered)

ORDER GRANTING FIFTH OMNIBUS OBJECTION TO CLAIMS

THIS MATTER having come before the Court upon the motion of the Plan Administrator appointed in these cases (the "Motion")[1] for entry of an order pursuant to 11 U.S.C. § 502 and Rule 3007 of the Federal Rules of Bankruptcy expunging, and/or disallowing each of the proofs of claim listed on Exhibit A attached hereto, on the basis that insufficient documentation was provided to support the claims; the Court having reviewed the Fifth Objection; and notice having been provided (i) to the claimants listed on Exhibit A at the addresses set forth on the claimants' respective proofs of claim, (ii) counsel for the Committee, and (iii) the Office of the United States Trustee; and no response having been filed thereto; and the Court having jurisdiction to consider the Fifth Objection; and the Fifth Objection having come before the Court for a hearing held on August 4, 2015 (the "Hearing"); and upon the record made before the Court on that date; and the Court having found that the relief requested in the Fifth Objection is in the best interest of the Debtors' estate, creditors and other parties in interest; and it appearing that sufficient notice of the Fifth Objection has been given, and the Court having determined that the legal and factual basis set forth in the Fifth Objection establish cause for the relief granted herein; and after due deliberation and consideration of the Motion having been

[1] Unless otherwise defined, capitalized terms used herein shall have the meanings ascribed to them in the Motion

had; and it appearing that good and sufficient cause exists for granting the Fifth Objection, it is hereby

ORDERED, that the relief requested in the Fifth Objection is GRANTED to the extent set forth below and upon the terms and conditions set forth herein; and it is further

ORDERED, that the Claims listed on Exhibit A, as attached hereto, are hereby expunged and disallowed; and it is further

ORDERED, that the Debtors' claims and noticing agent, Garden City Group, LLC, and the Clerk of this Court are authorized to take any and all actions that are necessary or appropriate to give effect to this Order; and it is further

ORDERED, that this Court shall retain jurisdiction over any and all issues arising from or related to the implementation and interpretation of this Order.

Dated: August____, 2015
White Plains, New York

_____
HONORABLE ROBERT D. DRAIN
UNITED STATES BANKRUPTCY JUDGE

Hearing Date: August 4, 2015 at 10:00 a.m. (Prevailing Eastern Time)
Objection Deadline: July 28, 2015 at 4:00 p.m. (Prevailing Eastern Time)

GARFUNKEL WILD, P.C.
Counsel for the Plan Administrator and Estate
111 Great Neck Road
Great Neck, New York 11021
Phone: 516.393-2200
Fax: 516.466-5964
Burton S. Weston
Afsheen A. Shah

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

----------x

In re:

SOUND SHORE MEDICAL CENTER OF WESTCHESTER, et al[1].,	Chapter 11 Case
	No. 13-22840 (RDD)
Debtors.	(Jointly Administered)

----------x

THE OMNIBUS CLAIMS OBJECTION LISTED BELOW SEEKS TO DISALLOW AND EXPUNGE CERTAIN FILED PROOFS OF CLAIM. YOU ARE RECEIVING THIS NOTICE BECAUSE YOUR CLAIM IS COVERED BY THE FIFTH OMNIBUS OBJECTION. YOUR FAILURE TO TIMELY OPPOSE THE RELIEF SOUGHT HEREIN MAY RESULT IN THE GRANTING OF THE RELIEF REQUESTED BY THIS OBJECTION.

NOTICE OF PLAN ADMINISTRATOR'S FIFTH OMNIBUS OBJECTION TO CLAIMS THAT HAVE BEEN UNSUBSTANTIATED

PLEASE TAKE NOTICE, that a hearing on the annexed Fifth Omnibus Objection to Claims, dated June 30, 2015 (the "Fifth Omnibus Objection"), of the Post Confirmation Estate of Sound Shore Medical Center of Westchester, et al. (the "Estate"), will be held before the Honorable Robert D. Drain, United States Bankruptcy Judge, at the United States Bankruptcy

[1] The debtors in these chapter 11 cases, along with the last four digits of each debtor's federal tax identification number include: Sound Shore Health System, Inc. (1398), Sound Shore Medical Center of Westchester (0117), The Mount Vernon Hospital (0115), Howe Avenue Nursing Home, Inc., d/b/a Helen and Michael Schaffer Extended Care Center (0781), NRHMC Services Corporation (9137), The M.V.H. Corporation (1514) and New Rochelle Sound Shore Housing, LLC (0117). There are certain additional affiliates of the Debtors who are not debtors and have not sought relief under Chapter 11.

Court for the Southern District of New York (the "Court"), 300 Quarropas Street, White Plains, New York, on the 4th day of August 2015 at 10:00 a.m. or as soon thereafter as counsel may be hard seeking the relief set forth on Exhibit A to the Fifth Omnibus Objection.

ALL PARTIES RECEIVING THIS NOTICE SHOULD REVIEW THE FIFTH OMNIBUS OBJECTION CAREFULLY TO DETERMINE IF A RESPONSE IS REQUIRED. THE FAILURE TO TIMELY FILE A RESPONSE OR OTHERWISE OPPOSE THE OBJECTION MAY RESULT IN THE GRANTING OF THE RELIEF.

PLEASE TAKE FURTHER NOTICE that responses if any, to the proposed Fifth Omnibus Objection (the "Responses") shall be made in writing, shall conform to the Federal Rules of Bankruptcy Procedure and the Local Rules for the Southern District of New York, shall state with particularity the grounds upon with such Response is based, and shall be filed with the Bankruptcy Court, in electronic format in accordance with General Order M-399, by utilizing the Court's electronic case filing system at www.nysb.uscourts.gov, or if the same cannot be filed electronically, by manually filing same with the Clerk of the Court together with a cd-rom containing same in Word, Wordperfect or pdf format, with a hard copy provided to the Clerk's Office at the Bankruptcy Court for delivery to the Chambers of the Honorable Robert D. Drain and served on (i) Garfunkel Wild, P.C., 111 Great Neck Road, Great Neck, New York 11021, Attention: Burton S. Weston, Esq., Afsheen A. Shah, Esq. and Adam T. Berkowitz, Esq., counsel to the Plan Administrator; (ii) Alston & Bird LLP, 90 Park Avenue, New York, New York 10016 Attention: Martin G. Bunin, Esq. and Craig E. Freeman, Esq., counsel to the Committee; and (iii) the Office of the United States Trustee for this district so as to be received by all such parties no later than 4:00 p.m. (Prevailing Eastern Time) on July 28, 2015.

PLEASE TAKE FURTHER NOTICE that if no Responses are timely filed and served with respect to the Fifth Omnibus Objection, the Estate may, on or after the Objection Deadline, submit to the Bankruptcy Court an order substantially in the form of the proposed order annexed to the Fifth Omnibus Objection, which order may be entered with no further notice or opportunity to be heard.

PLEASE TAKE FURTHER NOTICE that the hearing on the Fifth Omnibus Objection may be adjourned without further notice except an announced in open court on the Hearing Date, or at any adjourned hearing.

Dated: Great Neck, New York
June 30, 2015

GARFUNKEL WILD, P.C.
Counsel for the Plan Administrator and Estate

By: _____
Burton S. Weston
Afsheen A. Shah
111 Great Neck Road
Great Neck, NY 11021
(516) 393-2200